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July 12, 2024

Shawn Fleming
The Gehring Group
3500 Kyoto Gardens Dr.
Palm Beach Gardens, FL 33410

Re: THE CITY OF GAINESVILLE – MEDICAL AND PHARMACY RFP

Dear Shawn,

Thank you for the opportunity to provide a comprehensive renewal response for the City of Gainesville (COG). As the current longtime carrier for COG and with extensive experience in the Florida Municipal sector, including enrolled today nearly 75% of the 67 Florida county governments, school boards, countless cities, towns, and other taxing authorities; Florida Blue understands their needs and can continue to deliver the right solutions better than any other carrier or third-party administrator in the industry.

Importantly, Florida Blue's local presence cannot be matched in Florida, which means greater service, community support, network access and deeper claims savings for our customers and their families. We are a mission-driven company, and our mission is to help people and communities achieve better health. We live and work in the communities we serve and are very proud and humbled by the opportunity to partner with our friends from COG. In fact, our office on North Gainesville has been there for over 25 years now.

We paid very close attention to the needs and requests within the RFP. As such, we are confident that after a collaborative review has been completed, the committee will agree that our offer continues to provide the best overall value to COG.

The committee will find that our offer:

- Third party actuaries, Milliman and AON, both global leaders in their field, recognize and confirm that Florida Blue continues to be the leader in provider discounts in North Florida.
- In 2023, COG had Network Savings utilizing the Florida Blue network in excess of **$69,000,000**! All of which was realized by COG and none retained by Florida Blue as some healthcare companies do to reduce their administrative fees.
- Florida Blue provides the largest provider network of any carrier in the area with the highest provider network discounts combining to produce the lowest net cost possible for the COG and its members.
- In 2023, **COG overall network savings** utilizing the Florida Blue networks was **80.62%**.
- In 2023, **99.12%** of COG's medical claims spend was with in network providers.
- The graph below illustrates that each reported discount percentage from 60% to the 2023 actual network discount achieved **(80.62%)** within Florida Blue's provider network would have cost **COG MORE IN CLAIMS COST** and its members would have had higher out of pocket costs.

2023 CITY OF GAINESVILLE			
Aggregate Discount	Amount of Billed Charges Reduced Based on Network Discount	Claim Amount Allowed After Network Discount	Additional Claims Cost
60%	$52,029,889	$34,686,592	$17,882,643
61%	$52,897,053	$33,819,428	$17,015,479
62%	$53,764,218	$32,952,263	$16,148,314
63%	$54,631,383	$32,085,098	$15,281,149
64%	$55,498,548	$31,217,933	$14,413,984
65%	$56,365,713	$30,350,768	$13,546,819
66%	$57,232,877	$29,483,604	$12,679,655
67%	$58,100,042	$28,616,439	$11,812,490
68%	$58,967,207	$27,749,274	$10,945,325
69%	$59,834,372	$26,882,109	$10,078,160
70%	$60,701,537	$26,014,944	$9,210,995
71%	$61,568,702	$25,147,779	$8,343,830
72%	$62,435,866	$24,280,615	$7,476,666
73%	$63,303,031	$23,413,450	$6,609,501
74%	$64,170,196	$22,546,285	$5,742,336
75%	$65,037,361	$21,679,120	$4,875,171
76%	$65,904,526	$20,811,955	$4,008,006
77%	$66,771,690	$19,944,791	$3,140,842
78%	$67,638,855	$19,077,626	$2,273,677
79%	$68,506,020	$18,210,461	$1,406,512
80.62%	**$69,912,532**	**$16,803,949**	**2023 Actual Florida Blue**

- Should COG remain ASO, they will continue to receive 100% of the Rx rebates, an additional reduction to their ASO cost. The total of their most recent 4 quarters of rebate payments were **$2,681,325 (Stated differently $116.08 pepm).**
- Florida Blue's Comprehensive on-site wellness program, Better You, providing customized wellness initiatives for targeted audiences. In addition, health risk assessment tools, biometric screenings, individual counseling, targeted interventions, and an annual executive summary are all provided at **NO ADDITIONAL COST** to COG.
- Wellness commitment of **$75,000 upon Board approval in 2024** as well as **$75,000 annually** at each renewal.
- Florida Blue's suite of utilization management, care management and cost containment programs, coupled with Florida Blue's best in class provider network cost, means best overall healthcare program and lowest net cost for COG and its members.
- Employees and their family members will continue to enjoy the trust and peace of mind of having the No. 1 health insurance plans in Florida and the U.S.

It is our belief that our proposal offers a best-in-class opportunity for COG's employees and their family members and reflects our continued commitment and partnership. Should we be fortunate enough to retain the business we are confident that our performance will exceed expectations.

If I can be of any more assistance, please feel free to call me at (904) 905-8068.

Respectfully,

Andy Carroll, Strategic Account Executive – Public Sector

Table of Attachments

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  - BCBSF Open Formulary
  - BCBSF Standard Drug Exclusions

Florida Blue

Leading the Way to Better Health Care

We offer **stable, affordable health care solutions** with results that help your business thrive. Results may include **reduced costs, reduced absenteeism and improved productivity.**

Through our breadth of experience, our extensive data resources and our deep insights, we have the vision to understand and anticipate your needs.

More specifically, our expansive global understanding of the market allows us to:

- **Balance** employees' health care **benefits with the bottom line**
- Work with providers to **improve care delivery**
- Deliver **meaningful results** with innovative solutions
- Guide employees to **higher-quality, lower-cost** care
- Engage employees to achieve **improved health and well-being**

When we look at the Blue System nationally, **we are successfully meeting current needs and providing solutions** that anticipate future needs for thousands of large and small employers, including **76% of America's Fortune 100 employers and 107 million people—one in three Americans.***

Financial Ratings

STANDARD & POOR'S: **A+** A.M. BEST: **A+**

*Blue Facts, April 2020, Blue Cross and Blue Shield Association

Making Health Care Work Better for You

We understand the challenge employers face with the rising costs of health care, lost worker productivity and employee absenteeism. To address the cost challenge, we are relentlessly focused on the pursuit of better health care by offering "smarter plans" that deliver a superior combination of cost, quality, access and service. We know what matters most to you:

Attractive Coverage Options

Having the flexibility to offer a wide range of health plan solutions that deliver higher-quality care at lower costs while also preserving choice is crucial to employers' long-term business success.

Personalized and Tailored Health Engagement

Guiding and rewarding employees to take a more active role in improving their health and well-being results in happier, healthier and more productive employees.

Convenient High-Quality Care In Every Community

Large footprint of value-based provider partners and exclusive relationships with primary care and multi-specialty practices allow us to influence and positively change the way health care is delivered.

Purposeful Innovation

Continuous innovation and optimization are fundamental to driving better care and lower costs, both now and into the future.

Relentless Pursuit of Lower Total Cost of Care

Working behind the scenes to maximize your health care investment by supporting your employees and the providers who care for them with coaching, chronic and complex condition management, utilization management, quality outreach, and programs to prevent fraud, waste, and abuse.

Making Health Care Work Better for Your Employees

Florida Blue provides your employees with a robust solution for their health care needs. We help keep a company's most valuable resource—its employees—healthy. Our emphasis on staying healthy means employees are more productive and take fewer sick days. We do this by:

Value-Based Provider Programs give employees easy access to primary care and specialists who work together to improve their health by focusing on a coordinated, proactive approach to educate employees on staying well and how to manage their health conditions.

Better You Strides, our online well-being and rewards platform, connects employees to highly personalized, relevant and timely recommended actions to guide them toward improving their health.

Care Consultation and Advocacy Program offers a helping hand to employees to help them maximize their benefits, understand their conditions and be connected to programs and resources inside and outside of Florida Blue.

24/7 Nurseline ensures employees have access to registered nurses who rapidly assess symptoms and provide expert advice to help employees make the right health care choices.

Case Management Programs provide a "whole person" approach to an employee's care needs through customized and collaborative support. This helps members understand their options and better navigate the health care system.

Personalized Condition Management Program offers health coaching to educate employees about their conditions and the importance of sticking to their treatment plan.

Online Member Portal and Mobile App puts health and benefit information at the employee's fingertips, including virtual options, finding the closest urgent care center, making doctor appointments and seeing estimated costs for future services.

Face-to-face support at Florida Blue Centers give employees located in Florida a go-to source for answers to their benefit and treatment option questions, health screenings and preventive care, personalized advice for how to improve their health and the opportunity to participate in health improvement programs.

Making Health Care Easier for Your Company

We offer value-added programs that help you manage your benefits more easily.

Customized reports available to fully insured and self-funded groups that deliver insights to demystify health care cost trends.

Intuitive web portal to make administrative tasks quick and seamless.

Advocates dedicated to each of our customers to help simplify enrollment, invoicing, reconciliation and more.

Florida Blue gives you the advantage of a community caring for the health of your company and the health of your employees. Together, we'll create a solution to keep your company operating at its best—now and in the future.

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Current Benefits Will Remain The Same For Self-Insured and Fully-Insured.

1. Please fill out this table if you are providing a quote for a Medical plan with In Network and Out of Network Benefits.

Schedule of Benefits	Current Plan - In Network	Current Plan - Out of Network	Proposed Plan - In Network	Proposed Plan - Out of Network
Network(s) Utilized	Florida Blue BlueOptions	Florida Blue BlueOptions	NetworkBlue for Florida and BlueCard PPO for all other states	N/A
Deductible - Plan Year or Calendar Year	Calendar Year	Calendar Year	CYD	CYD
Individual Deductible	$600 Rx Deductible: $300	Combined with In-Network	Medical DED $600 Rx DED: $300	Combined with In-Network
Family Deductible	$1,800	Combined with In-Network	$1,800	Combined with In-Network
Out-of-Pocket Maximum Individual	$4,500	$5,000	$4,500	$5,000
Out-of-Pocket Maximum Family	$7,500	$10,000	$7,500	$10,000
Member Coinsurance	20%	40%	20%	40%
Physician Office Visit	$15	40% after CYD	$15	40% after CYD
Specialist Office Visit	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Preventive Care	No Charge	40%	No Charge	40%
Telehealth / Virtual Visit	$15 (PCP) / 20% after CYD (Specialist)	40% after CYD	$15 (PCP) / 20% after CYD (Specialist)	40% after CYD
Independent Clinical Lab	No Charge	40% after CYD	No Charge	40% after CYD
X-rays	$50	40% after CYD	$50	40% after CYD
Advanced Imaging (MRI, PET, CT)	$125	40% after CYD	$125	40% after CYD
Urgent Care Visit	$30	$30	$30	$30
Outpatient Surgery in Surgical Center	$100	40% after CYD	$100	40% after CYD
Physician Services at Surgical Center	20% after CYD	40% after CYD	20% after CYD	40% after CYD
Inpatient Hospital (Per Admit)	$750	40% after CYD	$750	40% after CYD
Outpatient Hospital (Per Visit)	$150	40% after CYD	$150	40% after CYD

Physician Services at Hospital	20% after CYD	20% after in-network CYD	20% after CYD	20% after in-network CYD
Emergency Room (Per Visit)	$250	$250	$250	$250
Mental Health & Substance Abuse Inpatient Hospital (Per Admit)	$750	40% after CYD	$750	40% after CYD
Mental Health & Substance Abuse Outpatient Services (Per Visit)	$150	40% after CYD	$150	40% after CYD
Mental Health & Substance Abuse Office Visit	$15	40% after CYD	$15	40% after CYD
Prescription Drugs - Tier 1 / Generic	$10	40%	$10	40%
Prescription Drugs - Tier 2 / Preferred Brand Name	$300 Rx Ded + $50	$300 Rx Ded + 40%	$300 Rx Ded + $50	$300 Rx Ded + 40%
Prescription Drugs - Tier 3 / Non-Preferred Brand Name	$300 Rx Ded + $80	$300 Rx Ded + 40%	$300 Rx Ded + $80	$300 Rx Ded + 40%
Prescription Drugs - Tier 4 / Specialty	$160	$300 Rx Ded + 40%	$160	$300 Rx Ded + 40%
Prescription Drugs - 90 day supply Mail Order	Tier 1 - $20 Tier 2 - $300 Rx Ded + $100 Tier 3 - $300 Rx Ded + $160	N/A	Tier 1 - $20 Tier 2 - $300 Rx Ded + $100 Tier 3 - $300 Rx Ded + $160	N/A

Administrative Services Only (ASO) Funding Arrangement

City of Gainesville

Administrative Fees Per Employee Per Month*	1/1/2025	1/1/2026	1/1/2027
Medical and Pharmacy Administrative Fee (EE)	$ 28.23	$ 28.23	$ 29.08
Medical and Pharmacy Administrative Fee (EF)	$ 65.92	$ 65.92	$ 67.90

Access fees will be waived for claims rendered in the following states if City of Gainesville has active membership in those states. Active membership will be determined on the group's anniversary date and will apply for the entire contract year.

Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Illinois, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York (Empire), North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, Wisconsin.

*Network Access Fees for 2025

Up to 1.93% of network savings will be applied to all PPO claims and up to 3.46% to all Traditional claims **outside** of the Blue Plan service areas where fees are waived (see list above). The applicable percentage of network savings is capped at $2,000 per claim.

The access fee percentage is determined by the Blue Cross and Blue Shield Association and is subject to change annually.

Proposal Assumptions

- Fees assume an effective date of January 1, 2025.
- Fees do not include consultant commission.
- Our proposal is based on information received from City of Gainesville and The Gehring Group.
- This proposal includes an alternatively funded arrangement. In order to provide this arrangement, financial eligibility is required. The group may be asked to provide appropriate financial documentation including the most recent audited financial statements and in some cases a deposit of up to 3 months of estimated claims may be required.
- Fees are based on 1,925 enrolled lives. If enrollment changes by more than 5% from those used for quotation, we reserve the right to re-rate the quoted fees.
- Federal law requires active employees age 65 and over be allowed a choice of coverage between the employer's plan and Medicare. This proposal assumes such employees all select the employer's coverage as primary.
- Notice of fee change for subsequent contract periods will be given 180 days in advance.
- The following services are included in our administrative fee:
  - Account management/account administration services
  - Employee education and implementation services
  - Standard member ID cards including printing and mailing
  - Benefit booklets available online
  - Online provider directories with print capabilities for custom directories
  - Member website available 24/7
  - Enrollment materials

- Online enrollment maintenance and support when business criteria is met
- Standard eligibility processing and maintenance
- Standard billing practice
- Standard reporting
- Standard underwriting and actuarial services
- Claim processing
- Member services
- Consolidated Omnibus Budget Reconciliation Act (COBRA) administration
- Health Insurance Portability and Accountability Act (HIPAA) administration
- Utilization Management/Case Management
- Interactive online member health management tools
- Healthy Addition® prenatal program
- Discount programs
- e-medicine capabilities
- Member Health Statement
- Reinsurance coordination

Helpful information about our ASO

Under the Blue Cross and Blue Shield of Florida (BCBSF) Administrative Services Only (ASO) agreement, BCBSF serves as the Administrator, processing claims and issuing payments from the employer's funds. There is no insurance contract because your group self-insures its health benefits package. Instead, a service agreement is established between BCBSF (acting as the Administrator) and your group (the buyer of administrative services).

Administrative Services Agreement (ASA)

We offer a full service ASO funding arrangement, which includes:

- employee communications and enrollment;
- the use of our extensive networks;
- the use of our utilization review programs;
- our claims processing and customer service capabilities; and
- the use of standard BCBSF banking arrangements.

All banking arrangements must be completed prior to processing any claims or paying benefits under the ASO program. This is accomplished through the establishment of an Administrative Services Agreement (ASA) between you and BCBSF. This Agreement contains the terms and conditions of the ASO funding arrangement, including a description of the benefit plan selected, a list of services we will provide, and a schedule of the administrative fees which you agree to pay.

The ASO Bank Account

Prior to the implementation of an ASO funding arrangement, a satisfactory credit review must be completed and approved by BCBSF. If complete credit reporting information cannot be obtained from our credit reporting vendor then other documentation of financial performance will be required of your group, such as audited financial statements. We reserve the right to obtain a deposit and/or a letter of credit should the credit review process suggest it to be a high credit risk. The credit review can be conducted at any time during the contract year and at subsequent renewals as necessary to protect us from undue credit risk.

We use our own bank account to pay claims. Approximately 15 days after the end of each month, we will bill your group for the amount of actual claims paid in the preceding month.

- We will provide your group the ability to download and view a detailed report of the actual claims paid for the previous month. Payments will be made by direct debit ACH to your group's local operating

bank account to be initiated by us on or immediately following the due date. Prior to the effective date of your group, you will need to provide us the bank name, contact, account number, ABA/Routing number, and a copy of a letter to your bank granting us permission to debit the account for paid claims each month.

- If the direct debit ACH transaction cannot be conducted prior to the tenth calendar day of the month due to refusal by the group's bank to allow the transaction to occur, the payment is considered late and is subject to a charge, calculated on a daily basis, at an annual rate of 15 percent. Any such charge will be added to the amount due on the next billing.
- Approximately 15 days before the first of each month, we will bill your group for the monthly administrative fees and stop loss premium (if applicable). Payment will be made by check or wire transfer initiated by your group.

ASO Stop Loss Provisions

- The risk taken by your group under the ASO arrangement can be reduced by adding stop loss coverage. Under specific stop loss coverage the maximum payment per individual chargeable to your group is limited to a fixed amount based on claims paid during that contract year.
- Under the aggregate stop loss coverage the maximum claims paid for all individuals chargeable to your group is limited to an amount, expressed in terms of a fixed amount of claims dollars paid per contract.
- A stop loss quote is included at the end of this section.

Advantages of the ASO Funding Arrangement

- You receive single source administration, including:
  - Accurate and timely claims processing;
  - Customer Service with toll-free telephone lines;
  - Access to an extensive network of participating providers, including a traditional wraparound network;
  - A pharmacy network with access to participating providers;
  - Utilization management programs;
  - Employee communication materials;
  - Onsite enrollment and employee education; and
  - A nationally recognized and accepted identification card.
- The ASO accommodates flexible plan design.
- Your group immediately shares in any surplus.
- Your cash flow is improved.
- There is no risk charge in retention.
- You do not pay premium taxes.
- Private employers are not required to offer state mandated benefits.
- Pharmacy rebates will be returned to the group.

Considerations

- Your group assumes all plan risks, including monthly claims fluctuations not covered by aggregate or specific stop loss protection;
- Legal services are not provided by BCBSF;
- Your group is responsible for incurred but not reported (IBNR) claims at cancellation; and
- Cash flow may be unpredictable due to claims fluctuations.

Fully Insured Funding Arrangement
City of Gainesville

Coverage	Monthly Rates BlueOptions Plan 03359 Rx DED $300 + $10/$50/$80
Employee Only	$ 852.38
Employee/Spouse	$ 1,943.42
Employee/Child(ren)	$ 1,704.75
Employee/Family	$ 2,727.60

Proposal Assumptions

- Premium amounts include an estimate of any fee(s) mandated by the Affordable Care Act to fund related programs and services. These fees are assessed by the federal government on an aggregate basis based on BCBSF's business and generally not specifically assigned to a covered employer or person. For more information on these fees, please visit http://floridabluehealthcarereform.com/educational-resources
- All rates are subject to Florida Department of Financial Services (DFS) approval. Policyholders will not be billed the proposed rates until the rates are approved by the Florida Department of Financial Services. A check equal to the first month's premium based on the proposed rates must accompany the application.
- All benefits, rates, effective date, terms and conditions of the proposed contract are subject to approval by Blue Cross and Blue Shield of Florida Corporate Headquarters and the Florida Department of Financial Services.
- Rates developed assume 1,925 employees, 1,442 dependents, and no change in the employer contribution.
- Blue Cross and Blue Shield of Florida, Inc. will be the only health benefit plans offered to your employees.
- Quoted rates will be subject to change if the total group's final enrollment (age/sex/coverage and area factors) varies by more than 5% from the original factors used to calculate rates.
- Final approved benefits and rates are guaranteed for the initial 12 month period beginning no later than January 1, 2025.
- Eligible employees are those active full-time employees who regularly work a minimum of 30 hours per week.
- New employees will be eligible for enrollment on the billing date following completion of 30 days of full-time employment. The employer agrees to submit all enrollment applications to Blue Cross and Blue Shield of Florida within the required eligibility period.
- Federal law requires active employees age 65 and over be allowed a choice of coverage between the employer's plan and Medicare. This proposal assumes such employees all select the employer's coverage as primary.
- Notice of rate change for subsequent contract periods will be given 45 days in advance.
- Monthly premiums are due and payable on the 1st of each month.
- This proposal assumes that 98.8% of all employees reside within the state of Florida.
- Rates include a 0.0% agent of record fee.
- Rates include a fee for premium taxes.
- If the City decides to move to a fully insured arrangement they will need to Amend their current StopLoss agreement for 2024 to include runout protection.
- The following services are included in our rates:
  - Account management/account administration services
  - Employee education and implementation services
  - Standard member ID cards including printing and mailing

- Benefit booklets available online
- Online provider directories with print capabilities for custom directories
- Member website available 24/7
- Enrollment materials
- Online enrollment maintenance and support when business criteria is met
- Standard eligibility processing and maintenance
- Standard billing practice
- Standard reporting
- Standard underwriting and actuarial services
- Claim processing
- Member services
- Consolidated Omnibus Budget Reconciliation Act (COBRA) administration
- Health Insurance Portability and Accountability Act (HIPAA) administration
- Utilization Management/Case Management
- Interactive online member health management tools
- Healthy Addition® prenatal program
- Discount programs
- e-medicine capabilities
- Member Health Statement

Helpful information about Fully Insured Funding

Fully insured funding is a standard group insurance arrangement generally available to all accounts, regardless of size. Blue Cross and Blue Shield of Florida determines and sets premium rates based on:

- The amount of claims anticipated; and
- Anticipated administrative expenses, commissions, taxes, contribution to contingency reserves and a risk charge.

Premiums are remitted prospectively, on a monthly basis, to Blue Cross and Blue Shield of Florida without regard to the number and amount of actual claims. The financial results of all Blue Cross and Blue Shield of Florida fully insured groups are combined.

Advantages of Fully Insured Funding

- Fully insured funding provides no risk to your group at the lowest possible cost.
- Employers know their costs and can budget effectively during the contract period.
- Rate levels are guaranteed during the first year as long as no major demographic or benefit plan changes occur.
- Participating provider discounts are reflected in the employer's experience.

Considerations

- Since Blue Cross and Blue Shield of Florida assumes all risk, rates are adjusted to reflect charges necessary to underwrite the level of risk associated with each account.
- Since Blue Cross and Blue Shield of Florida holds the claims reserve, there are no cash-flow advantages for the employer.
- Since your group does not participate in the risk, all underwriting gains and losses remain with BCBSF. Deficits are not recovered and surpluses are not returned.

Performance Guarantees

City of Gainesville – Eff Date 1/1/2025 – 12/31/2027

Guarantees are based on book of business results.

Service Level Measures	Goals	Amount at Risk
Abandon Rate Number of calls that reach the call center and are placed in queue but do not reach the final destination because the caller hangs up before a representative becomes available.	≤5% ≥5.1%	0% 1.25%
Average ACD Phone Queue Time Actual length of time a member waits to speak with a customer service associate after all ACD options have been chosen.	≤30 seconds ≥31 seconds	0% 1.25%
Blockage Rate Percentage of calls blocked during business hours.	≤8% ≥8.1%	0% 1.25%
Enrollment Timeliness Percentage of ID cards mailed by effective date provided that the enrollment data is received from the employer 30 days prior to the effective date of coverage.	≥99% ≤98.9%	0% 1.25%
Claims Processing Timeliness Percentage of provider and subscriber claims processed within 30 calendar days from receipt to the date that a claim has passed all edits and is pending the issuance of a check, voucher or denial.	≥97% ≤96.9%	0% 1.25%
Claims Processing Accuracy Percentage of claims processed accurately.	≥97% ≤96.9%	0% 1.25%
Claims Dollar Accuracy Percentage of claim dollars paid accurately.	≥98% ≤97.9%	0% 1.25%
Inquiry Timeliness Percentage of inquiries finalize within 7 days	<90%	1.25%
Total Percent at Risk of proposed ASO fee not to exceed a maximum payout of 10%		

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City of Gainesville

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- Notice of rate change for subsequent contract periods will be given 45 days in advance.
- Monthly premiums are due and payable on the 1st of each month.
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- Standard eligibility processing and maintenance
- Standard billing practice
- Standard reporting
- Standard underwriting and actuarial services
- Claim processing
- Member services
- Consolidated Omnibus Budget Reconciliation Act (COBRA) administration
- Health Insurance Portability and Accountability Act (HIPAA) administration
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Fully insured funding is a standard group insurance arrangement generally available to all accounts, regardless of size. Blue Cross and Blue Shield of Florida determines and sets premium rates based on:

- The amount of claims anticipated; and
- Anticipated administrative expenses, commissions, taxes, contribution to contingency reserves and a risk charge.

Premiums are remitted prospectively, on a monthly basis, to Blue Cross and Blue Shield of Florida without regard to the number and amount of actual claims. The financial results of all Blue Cross and Blue Shield of Florida fully insured groups are combined.

Advantages of Fully Insured Funding

- Fully insured funding provides no risk to your group at the lowest possible cost.
- Employers know their costs and can budget effectively during the contract period.
- Rate levels are guaranteed during the first year as long as no major demographic or benefit plan changes occur.
- Participating provider discounts are reflected in the employer's experience.

Considerations

- Since Blue Cross and Blue Shield of Florida assumes all risk, rates are adjusted to reflect charges necessary to underwrite the level of risk associated with each account.
- Since Blue Cross and Blue Shield of Florida holds the claims reserve, there are no cash-flow advantages for the employer.
- Since your group does not participate in the risk, all underwriting gains and losses remain with BCBSF. Deficits are not recovered and surpluses are not returned.

Please refer to City of Gainesville Group Specific Network Savings Report

City of Gainesville:

Please answer the below question as part of your proposal:

What are the average network discounts for the area the census covers broken down by County:

Charge Type	Alachua County	Marion County	Levy County	Columbia County	Gilchrist County	Putnam County	Clay County	Union County	Bradford County
Doctors									
Outpatient Hospital									
Inpatient Hospital									
Urgent Care Centers									
Emergency Room									

Network Savings Report

Group: 16035 - CITY OF GAINESVILLE

Period: Inc: 05/01/2023 - 04/30/2024 Paid: 05/01/2023 - 04/30/2024

Florida Blue

In Network

Category	Billed	Allowed	Savings	Paid	Savings %	Util %	Spend %
Inpatient	$ 18,607,012	$ 4,546,295	$ 14,060,717	$ 4,426,783	75.57%	95.11%	99.76%
Outpatient	$ 14,688,042	$ 3,751,297	$ 10,936,745	$ 3,474,511	74.46%	99.81%	99.39%
Emergency Room	$ 9,954,909	$ 1,648,358	$ 8,306,551	$ 1,498,848	83.44%	100.00%	100.00%
Professional	$ 43,466,518	$ 6,857,999	$ 36,608,518	$ 5,337,488	84.22%	94.93%	98.17%
Sub-Total	*$ 86,716,481*	*$ 16,803,949*	*$ 69,912,532*	*$ 14,737,631*	*80.62%*	*95.25%*	*99.12%*

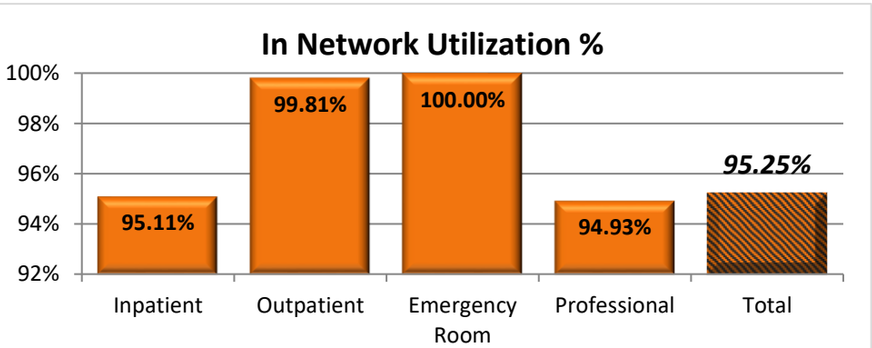
Traditional

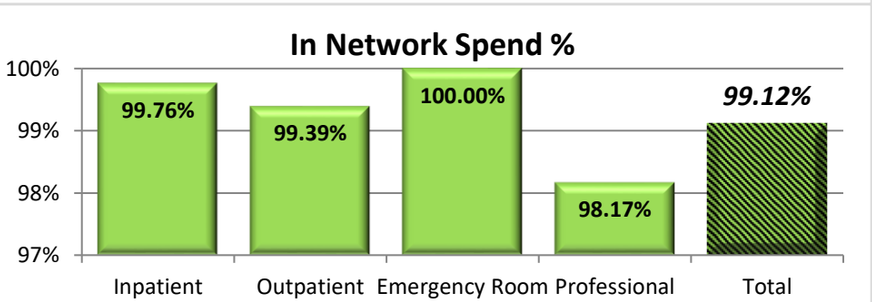
Category	Billed	Allowed	Savings	Paid	Savings %	Util %	Spend %
Inpatient	$ 600	$ 486	$ 114	$ 486	19.00%	0.54%	0.01%
Outpatient	$ 8,537	$ 1,452	$ 7,085	$ 871	82.99%	0.04%	0.02%
Emergency Room	$ -	$ -	$ -	$ -	0.00%	0.00%	0.00%
Professional	$ 21,378	$ 4,086	$ 17,292	$ 1,759	80.89%	0.18%	0.03%
Sub-Total	*$ 30,515*	*$ 6,024*	*$ 24,491*	*$ 3,117*	*80.26%*	*0.17%*	*0.02%*

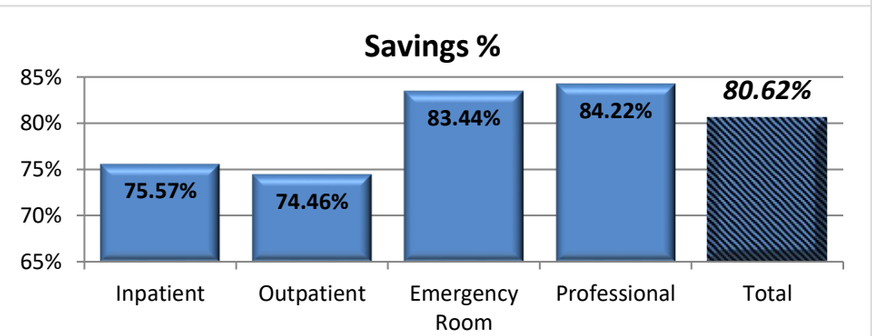
Out of Network

Category	Billed	Allowed	Savings	Paid	Savings %	Util %	Spend %
Inpatient	$ 71,673	$ 12,807	$ 58,866	$ 10,012	82.13%	4.35%	0.23%
Outpatient	$ 100,577	$ 24,816	$ 75,762	$ 20,514	75.33%	0.15%	0.59%
Emergency Room	$ -	$ -	$ -	$ -	0.00%	0.00%	0.00%
Professional	$ 745,638	$ 195,884	$ 549,754	$ 97,865	73.73%	4.89%	1.80%
Sub-Total	*$ 917,889*	*$ 233,507*	*$ 684,382*	*$ 128,390*	*74.56%*	*4.58%*	*0.86%*

Total In Network	**$ 86,746,995**	**$ 16,809,973**	**$ 69,937,023**	**$ 14,740,747**	**80.62%**	**95.25%**	**99.12%**







Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

STOP LOSS PROPOSAL FOR
City of Gainesville

Sales Representative: Andrew Carroll
Broker: Gehring Group Inc
Claims Administrator: Florida Blue
Provider Network(s): FL Blue
Utilization Review Vendor(s): Florida Blue
Retirees: Both Medicare Retirees and Under 65 Retirees Included

Proposed Effective Date: 01/01/2025
Through Date: 12/31/2025
RFP Situs State: FL

Specific (Check one option)	Lives	Current	☐ Renewal	☐ Option 1	☐ Option 2
Specific Deductible (per Covered Participant)		$375,000	$375,000	$400,000	$425,000
Policy Year Maximum Specific Benefit		Inforce	Unlimited	Unlimited	Unlimited
Lifetime Maximum Specific Benefit		Inforce	Unlimited	Unlimited	Unlimited
Eligible Claims Expenses		Med, Rx	Med, Rx	Med, Rx	Med, Rx
Specific Premium					
Composite Rate	1,971	$30.21	$32.33	$29.16	$26.32
Total Lives	**1,971**				
Estimated Policy Term Specific Premium		$714,527	$764,669	$689,692	$622,521
Policy Term Aggregating Specific Loss Fund		$100,000	$100,000	$100,000	$100,000
Specific Covered Claims Basis		108/12	120/12	120/12	120/12
Commission		0.00%	0.00%	0.00%	0.00%

Note: This proposal is not complete unless accompanied by the proposal notes and the basis of offer noted on the following pages.

Individual Special Requirements:

- This proposal is subject to large claim evaluation by medical underwriting. We will need updated claims through 9/30/2024 to firm. This will determine whether any individuals need to be set at a specific deductible higher than the group level.

PROPOSAL NOTES

- The rates in this proposal are tentative and will be subject to review or change based on up-to-date experience and large claim information including any concerns listed under Individual Special Requirements.
- All ongoing claims are pended and must be submitted for underwriting and claim review. Large claim data must be submitted for any claims that are at or have the likelihood to exceed 50% of the group specific deductible. Large claim data must include age, sex, diagnosis, prognosis, treatment plan, case management notes (if applicable), Pre-Cert and paid/pended claims.
- The Specific rates in this proposal are based on an Aggregating Specific arrangement. Maximum Specific Liability includes estimated Policy Term Specific premium and the Aggregating Specific fund.
- Human Organ Transplant benefits are payable in accordance with the Covered Underlying Plan and are subject to the proposed Lifetime Maximum Specific Benefit offered within this proposal.
- Once updated large claimant information and updated monthly claims (if applicable) through 9 months of the current contract period are received and reviewed by HM, a firm quote will be issued.
- At renewal, We will not apply any new lasers, including but not limited to, an Alternate Specific Deductible or Excluded Claim Expense, within the Special Risk Limitations section of the policy, unless requested.

BASIS OF OFFER

Assumptions

- This proposal is subject to revision if there is a change in Proposed Effective or Renewal Dates or a change in the Covered Underlying Plan.
- This proposal is based on the utilization of the Provider Network(s) and the Utilization Review Vendor(s) listed in this proposal.
- This proposal assumes a minimum participation level of 50%.
- This proposal assumes the Covered Underlying Plan includes a pre-certification, utilization review and large case management program.
- This proposal is based on a description of the employee benefit plan(s) provided and approved by HM; employee and dependent census data; submission of any requested claim information; and any other information relevant to the underwriting risk. If any of the information was incorrect or changes the risk involved, the rates will be modified, and the Specific claims will be adjusted accordingly.
- Surcharges (including the bad debt and charity surcharge portion of the New York Reform Act applicable to services are rendered in New York State), pool charges, and/or covered lives assessments may be covered under the Stop Loss Policy if such charges are considered a claim cost. HM is not responsible for the filing and/or payment of any assessment for which HM is not directly liable including, but not limited to, the New Hampshire Vaccine Assessment as modified by NH HB 664.
- All standard policy provisions apply. The laws of the state where the policy is issued will apply. Certain exclusions and limitations may apply.
- The terms of this proposal are subject to revision by HM if there is a change in any state law or regulation between the date of this proposal and the effective date of the proposed Stop Loss coverage if HM deems such change to have a material effect on the risk being assumed. Such a revision can be made even if the proposal has already been accepted.
- This proposal will expire on the Proposed Effective Date.
- Unless otherwise limited or excluded by the Stop Loss Policy or under the Individual Special Requirements, Eligible Claim expenses under the Stop Loss Policy will follow the Covered Underlying Plan, up to the proposed Maximum Specific Benefit.
- The Agent is properly licensed and appointed by HM.
- The initial rates are guaranteed for the proposed Policy Term unless otherwise noted.
- There are no more than 15% COBRA participants.

Qualifications

- Any Stop Loss insurance requested and the Proposed Effective Date of that coverage must be approved by HM under Our current rules and practices.

- Specific rates and premium are subject to change upon receipt and review of individual large claim detail reports; clinical and case management information; any other requested data as identified in the Proposal Notes and Individual Special Requirements sections; and the approved disclosure.
- The premium rates are subject to change should the number of Covered Units change by 10% or more, either in total and/or by single/family mix.
- If the descriptions of the benefits or plan provisions differ from what was initially utilized to underwrite the risk, an updated Summary Plan Document or other acceptable plan description is required within 60 days of the Effective Date, and the premium rates may be subject to re-rating, retro-active to the Effective Date.
- This quote assumes the Covered Underlying Plan will include standard industry provisions and definitions including, but not limited to, eligibility, HIPAA, termination, leave of absence or disability, FMLA, subrogation, transplants and COB and exclusions for job-related injuries, treatments that are experimental and/or investigational, cosmetic, not medically necessary, war, felonies, charges in excess of usual and customary, and foreign medical care when traveling outside of the U.S. solely for the purpose of receiving medical care. In the event that a Summary Plan Document is not available within 60 days from the Proposed Effective Date, We reserve the right to issue the policy assuming standard exclusions will apply.
- HIPAA Privacy rules permit the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as part of "Health Care Operations." HM will use this information solely for the purpose of evaluating and accepting the risk and will not disclose any PHI collected except to perform this risk evaluation.
- The rates in this proposal are based on the Disclosure of all individuals considered a special enrollee due to having previously satisfied the plan's lifetime maximum. Written acceptance by HM must be acknowledged before terms of coverage for such individuals are included under HM's Stop Loss Policy.
- Any Stop Loss Policy issued by HM may be rescinded or re-underwritten if any information requested in connection with this proposal was intentionally concealed or misrepresented by or on behalf of the Policyholder and/or the Policyholder's Agent, or if the Policyholder and/or the Policyholder's Agent commits fraud.
- As used above: An "Agent" is the prospective Policyholder's representative including, but not limited to, the agent, producer or broker of record, or Claims Administrator. A "Claims Administrator" is a third-party administrator (TPA) designated by the Policyholder and approved by Us. Disclosure or Disclosed means to provide Claim Information and any other documentation or data requested by Us including, but not limited to, Census and Demographic Information and the estimated number of Covered Units prior to the beginning of the Policy Term.

BlueCard® Program for BlueOptions

Inter-Plan Arrangements

BCBSF has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever members access healthcare services outside the geographic area BCBSF serves, the claim for those services may be processed through one of these Inter-Plan Arrangements.

Typically, when accessing care outside the geographic area BCBSF serves, members obtain care from healthcare providers that have a contractual agreement (“participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement (“nonparticipating providers”) with the Host Blue. BCBSF remains responsible for fulfilling our contractual obligations to the Employer.

This document briefly describes our Inter-Plan arrangements. Additional details are available upon request.

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when members access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers.

Value-Based Programs Overview

Employer’s members may access covered healthcare services from providers that participate in a Host Blue’s Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BCBSF they will be credited to the Employer. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Employer as a percentage of the recovery.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSF will disclose any such surcharge, tax or other fee to the Employer, which will be the Employer’s liability.

Non-Participating Providers

When covered healthcare services are provided outside of Florida Blue's service area by nonparticipating providers, the amount(s) a member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Florida Blue will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

BlueCard Global® Core Program

If members are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), they may be able to take advantage of the BCBS Global® Core Program when accessing covered services. The BCBS Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BCBS Global Core Program assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, the members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

SAMPLE

MyBlueInsight (MBI) Reports

Fully Insured with Pharmacy

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Brand Vs Generic

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

Utilization	Retail	Retail 90 Day	Total
Total Rx Users	13,183	4,008	13,346
Total Rx	155,455	20,287	175,742
Generic	128,305	17,576	145,881
Multi-Source Brand Generic Available	2,925	622	3,547
Multi-Source Brand w/o Generic Available	23,340	2,065	25,405
Single Source Brand	885	24	909
Acute Rx %	40.50%	8.31%	36.78%
Maintenance Rx %	59.50%	91.69%	63.22%
Member Utilization			
Rx/1000	9,797	1,279	11,076
Member PMPM	$15.44	$4.12	$19.56
Member PMPY	$185.28	$49.44	$234.72
Generic %	82.54%	86.64%	83.01%
Multi-Source Brand %	15.01%	10.18%	14.46%
Multi-Source Brand Generic Available %	1.88%	3.07%	2.02%
Single Source Brand %	0.57%	0.12%	0.52%
Generic Substitution %	97.77%	96.58%	97.63%
Formulary %	91.46%	93.88%	91.74%
Days Supply			
Total Days Supply	3,835,159	1,826,315	5,661,474
Average Days Supply	24.67	90.02	32.21
Cost			
Plan Paid PMPM	$63.26	$9.44	$72.70
Member Paid PMPM	$15.44	$4.12	$19.56
Total PMPM	$78.70	$13.56	$92.27
Generic PMPM	$18.76	$4.81	$23.57
Brand PMPM	$59.94	$8.75	$68.69
Total PMPY	$944.47	$162.82	$1,107.29

Notes:
- Retail 90 Days = Prescription filled for a days supply greater than 31 up to a maximum of 93.
- Member Submitted = Manually submitted paper claim. Member Submitted amounts are included in Retail, Retail 90 Days and Mail Order.
- Total for Total Rx Users does not represent a summation of Retail, Retail 90 Days and Mail Order. A member's Rx may be filled in more than one category.
- Utilization counts are determined by scripts written. Retail, Mail Order and Retail 90 Days count as 1 unit.

TOTAL COST	Retail	Retail 90 Day	Mail Order	Total
Total Cost	$14,986,353.20	$2,583,585.87	$0.00	$17,569,939.07
Total Ingredient Cost	$14,852,133.21	$2,570,950.66	$0.00	$17,423,083.87
Total Ingredient Cost - Generic	$3,447,060.25	$904,851.22	$0.00	$4,351,911.47
Total Ingredient Cost - Multi-Source Brand	$10,674,873.67	$1,453,683.23	$0.00	$12,128,556.90
Total Ingredient Cost - Single Source Brand	$290,441.07	$16,492.26	$0.00	$306,933.33
Total Ingredient Cost - Brand Generic Available	$439,758.22	$195,923.95	$0.00	$635,682.17
Total Cost - Formulary	$10,778,377.02	$1,974,020.64	$0.00	$12,752,397.66
Total Cost - Non-Formulary	$4,207,976.18	$609,565.23	$0.00	$4,817,541.41
Avg Total Cost / Claim	$96.40	$127.35	$0.00	$99.97
Avg Total Cost / Day	$3.90	$1.41	$0.00	$3.10
Total Cost PMPY	$944.47	$162.82	$0.00	$1,107.29
Total Cost PMPM	$78.70	$13.56	$0.00	$92.27
Avg Total Cost - Generic	$27.84	$52.15	$0.00	$30.77
Avg Total Cost - Multi-Source Brand	$458.29	$704.81	$0.00	$478.32
Avg Total Cost - Single Source Brand	$329.01	$690.25	$0.00	$338.54
Avg Total Cost - Brand Generic Available	$145.76	$313.36	$0.00	$175.15
Avg Total Cost - Formulary	$75.80	$103.64	$0.00	$79.09
Avg Total Cost - Non-Formulary	$317.03	$491.18	$0.00	$331.92
PLAN PAID				
Total Plan Paid Amount	$12,045,780.52	$1,798,200.06	$0.00	$13,843,980.58
Plan Paid - Generic	$2,223,965.79	$470,005.88	$0.00	$2,693,971.67
Plan Paid - Multi-Source Brand	$9,264,670.13	$1,181,071.91	$0.00	$10,445,742.04
Plan Paid - Single Source Brand	$253,069.75	$13,864.62	$0.00	$266,934.37
Plan Paid - Brand Generic Available	$304,074.85	$133,257.65	$0.00	$437,332.50
Plan Paid - Formulary	$8,700,622.99	$1,366,152.66	$0.00	$10,066,775.65
Plan Paid - Non-Formulary	$3,345,157.53	$432,047.40	$0.00	$3,777,204.93
Avg Total Plan Paid / Claim	$77.48	$88.63	$0.00	$78.77
Avg Total Plan Paid / Day	$3.14	$0.98	$0.00	$2.44
Plan Paid PMPY	$759.15	$113.33	$0.00	$872.47
Plan Paid PMPM	$63.26	$9.44	$0.00	$72.70
Plan Cost Share Contribution %	80.00%	69.00%	0.00%	78.00%
Avg Plan Paid - Generic	$17.33	$26.74	$0.00	$18.46
Avg Plan Paid - Multi-Source Brand	$396.94	$571.94	$0.00	$411.16
Avg Plan Paid - Single Source Brand	$285.95	$577.69	$0.00	$293.65
Avg Plan Paid - Brand Generic Available	$103.95	$214.24	$0.00	$123.29
Avg Plan Paid - Formulary	$61.19	$71.72	$0.00	$62.43
Avg Plan Paid - Non-Formulary	$252.02	$348.14	$0.00	$260.24
MEMBER PAID				
Total Member Paid Amount	$2,940,572.68	$785,385.81	$0.00	$3,725,958.49
Member Paid - Generic	$1,348,354.30	$446,654.39	$0.00	$1,795,008.69
Member Paid - Multi-Source Brand	$1,431,824.08	$274,374.37	$0.00	$1,706,198.45
Member Paid - Single Source Brand	$38,104.16	$2,701.60	$0.00	$40,805.76
Member Paid - Brand Generic Available	$122,290.14	$61,655.45	$0.00	$183,945.59
Member Paid - Formulary	$2,077,754.03	$607,867.98	$0.00	$2,685,622.01
Member Paid - Non-Formulary	$862,818.65	$177,517.83	$0.00	$1,040,336.48
Avg Total Member Paid / Claim	$18.91	$38.71	$0.00	$21.20
Avg Total Member Paid / Day	$0.76	$0.43	$0.00	$0.65
Member Paid PMPY	$185.32	$49.50	$0.00	$234.82
Member Paid PMPM	$15.44	$4.12	$0.00	$19.56
Member Cost Share Contribution %	19.00%	30.00%	0.00%	21.00%
Avg Member Paid - Generic	$10.50	$25.41	$0.00	$12.30
Avg Member Paid - Multi-Source Brand	$61.34	$132.86	$0.00	$67.15
Avg Member Paid - Single Source Brand	$43.05	$112.56	$0.00	$44.89
Avg Member Paid - Brand Generic Available	$41.80	$99.12	$0.00	$51.85
Avg Member Paid - Formulary	$14.61	$31.91	$0.00	$16.65
Avg Member Paid - Non-Formulary	$65.00	$143.04	$0.00	$71.67
PRICING / NETWORK PERFORMANCE				
Avg Ingredient Cost / Rx	$95.53	$126.72	$0.00	$99.14
Avg Ingredient Cost / Generic Rx	$26.86	$51.48	$0.00	$29.83
Avg Ingredient Cost / Multi-Source Brand Rx	$457.36	$703.96	$0.00	$477.40
Avg Ingredient Cost / Single Source Brand Rx	$328.18	$687.17	$0.00	$337.66
Avg Ingredient Cost / Brand Generic Available Rx	$150.34	$314.99	$0.00	$179.21
Avg Ingredient Cost / Formulary	$74.79	$102.95	$0.00	$78.12
Avg Ingredient Cost / Non-Formulary	$317.71	$491.61	$0.00	$332.58
Avg Dispense Fee / Rx	$0.96	$0.66	$0.00	$0.92
Avg Dispense Fee / Generic Rx	$0.97	$0.67	$0.00	$0.94
Avg Dispense Fee / Multi-Source Brand Rx	$0.87	$0.67	$0.00	$0.86
Avg Dispense Fee / Single Source Brand Rx	$0.83	$0.35	$0.00	$0.82
Avg Dispense Fee / Brand Generic Available Rx	$0.91	$0.60	$0.00	$0.85
Avg Dispense Fee / Formulary	$0.96	$0.67	$0.00	$0.93
Avg Dispense Fee / Non-Formulary	$0.89	$0.64	$0.00	$0.87

Notes:

- Retail 90 Days = Prescription filled for a days supply greater than 31 up to a maximum of 93.

- Member Submitted = Manually submitted paper claim. Member Submitted amounts are included in Retail, Retail 90 Days and Mail Order.

- Total for Total Rx Users does not represent a summation of Retail, Retail 90 Days and Mail Order. A member's Rx may be filled in more than one category.

- Utilization counts are determined by scripts written. Retail, Mail Order and Retail 90 Days count as 1 unit.

Capitation Summary

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

Paid Year/Month	Group Number	Group Name	Div	Product	Location	PCP Amt	SPC Amt	Alternate Cap Amt	Total Cap Amt
201512			001	BLUEOPTIONS	00	$0.00	$14,991.91	$0.00	$14,991.91
Total						**$0.00**	**$225,362.58**	**$0.00**	**$225,362.58**

Census Summary

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

CONTRACTS	MALE					FEMALE					
Age Band Desc	Single	Emp/Sp	Emp/Ch	Family	Sub Total	Single	Emp/Sp	Emp/Ch	Family	Sub Total	Grand Total
00-29	2,025	253	110	225	**2,613**	8,011	1,150	1,167	876	**11,204**	**13,817**
30-34	1,226	162	131	616	**2,135**	3,955	706	1,866	2,665	**9,192**	**11,327**
35-39	719	171	217	1,100	**2,207**	2,548	428	1,829	3,238	**8,043**	**10,250**
40-44	714	164	272	1,397	**2,547**	1,938	570	2,323	3,574	**8,405**	**10,952**
45-49	711	146	253	996	**2,106**	2,551	648	1,936	2,713	**7,848**	**9,954**
50-54	755	418	303	1,033	**2,509**	3,319	1,503	1,448	2,070	**8,340**	**10,849**
55-59	654	595	164	760	**2,173**	3,675	1,773	560	1,285	**7,293**	**9,466**
60-64	657	762	20	259	**1,698**	3,051	1,670	255	296	**5,272**	**6,970**
65+HOI	129	502	14	86	**731**	1,026	443	12	-	**1,481**	**2,212**
Total	**7,590**	**3,173**	**1,484**	**6,472**	**18,719**	**30,074**	**8,891**	**11,396**	**16,717**	**67,078**	**85,797**

Note: Enrollment is recast to reflect retroactive adjustments.

MEMBERS	MALE					FEMALE					
Age Band Desc	Single	Emp/Sp	Emp/Ch	Family	Sub Total	Single	Emp/Sp	Emp/Ch	Family	Sub Total	Grand Total
00-29	2,025	1,135	11,191	24,874	**39,225**	8,011	1,481	12,414	24,135	**46,041**	**85,266**
30-34	1,227	895	143	2,730	**4,995**	3,955	915	1,866	3,636	**10,372**	**15,367**
35-39	719	650	229	3,574	**5,172**	2,548	554	1,829	4,600	**9,531**	**14,703**
40-44	714	675	272	4,880	**6,541**	1,938	713	2,323	4,757	**9,731**	**16,272**
45-49	711	729	253	4,049	**5,742**	2,551	822	1,936	3,732	**9,041**	**14,783**
50-54	755	1,428	303	3,475	**5,961**	3,319	1,962	1,448	3,051	**9,780**	**15,741**
55-59	654	2,078	164	2,297	**5,193**	3,675	2,499	560	1,788	**8,522**	**13,715**
60-64	657	2,699	20	966	**4,342**	3,051	2,295	255	437	**6,038**	**10,380**
65+HOI	129	1,657	14	397	**2,197**	1,026	937	12	11	**1,986**	**4,183**
Total	**7,591**	**11,946**	**12,589**	**47,242**	**79,368**	**30,074**	**12,178**	**22,643**	**46,147**	**111,042**	**190,410**

Notes:

- **This report contains SUMMARY HEALTH INFORMATION**.
- Experience is reflective of both active and terminated members.
- Enrollment is recast to reflect retroactive adjustments.

Claims Lag

Company:
Group:
Current Service Period: From 01/2015 to 12/2015
Current Paid Period: From 01/2015 to 12/2015

		Medical Claims										
		Service Month										
Paid Month	Paid Month Total	Jan2015	Feb2015	Mar2015	Apr2015	May2015	Jun2015	Jul2015	Aug2015	Sep2015	Oct2015	Nov2015
Jan2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Feb2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mar2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Apr2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
May2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Jun2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Jul2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Aug2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Sep2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Oct2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Nov2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Dec2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Note: Excludes Pharmacy and Capitation Data

		Pharmacy Claims										
		Service Month										
Paid Month	Paid Month Total	Jan2015	Feb2015	Mar2015	Apr2015	May2015	Jun2015	Jul2015	Aug2015	Sep2015	Oct2015	Nov2015
Jan2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Feb2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mar2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Apr2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
May2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Jun2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Jul2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Aug2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Sep2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Oct2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Nov2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Dec2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Note: Excludes Medical and Capitation Data

		Medical and Pharmacy Claims										
		Service Month										
Paid Month	Paid Month Total	Jan2015	Feb2015	Mar2015	Apr2015	May2015	Jun2015	Jul2015	Aug2015	Sep2015	Oct2015	Nov2015
Jan2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Feb2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mar2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Apr2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
May2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Jun2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Jul2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Aug2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Sep2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Oct2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Nov2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Dec2015	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Note: Excludes Capitation Data

Claims Summary by Product Plan

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014

Current								
Product	Plan	Div	Loc	Service Date	Medical	Pharmacy	Capitation	Total Amt
Total					$0.00	$0.00	$0.00	$0.00

Prior								
Product	Plan	Div	Loc	Service Date	Medical	Pharmacy	Capitation	Total Amt
Total					$0.00	$0.00	$0.00	$0.00

Employee Dependent Utilization

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

		Year 1	Year 2	% Chg	Year 3	% Chg	Year 4	% Chg
Employee	Avg Number of Contracts	0	0	-100.0%	0	0.0%	0	0.0%
	Paid Amount	$0.00	$0.00	-100.0%	$0.00	0.0%	$0.00	0.0%
	Annual Experience Per 1000 Contracts	$0.00	$0.00	-100.0%	$0.00	0.0%	$0.00	0.0%
Dependent	Avg Number of Contracts	0	0	-100.0%	0	0.0%	0	0.0%
	Paid Amount	$0.00	$0.00	-100.0%	$0.00	0.0%	$0.00	0.0%
	Annual Experience Per 1000 Contracts	$0.00	$0.00	-100.0%	$0.00	0.0%	$0.00	0.0%
Total	Avg Number of Contracts	0	0	-100.0%	0	0.0%	0	0.0%
	Paid Amount	$0.00	$0.00	-100.0%	$0.00	0.0%	$0.00	0.0%
	Annual Experience Per 1000 Contracts	$0.00	$0.00	-100.0%	$0.00	0.0%	$0.00	0.0%

Notes:
- Experience is reflective of both active and termed members.
- The Paid Amount includes medical and pharmacy.
- Excludes Capitation payments.
- Enrollment is recast to reflect retroactive adjustments.

FFS Paid and Utilization by Diagnostic Category

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014

	Current						Prior		
Diagnostic Category	Inpatient	Outpatient	Professional	Pharmacy	Total Paid	% of Total	Total Paid	% of Total	% Chg
NEOPLASMS	$2,125,656.54	$2,355,841.37	$4,369,496.55	$0.00	$8,850,994.46	11.0%	$6,858,270.46	10.1%	29.1%
MUSCULOSKELETAL SYSTEM	$2,653,072.07	$2,030,425.78	$2,675,760.00	$0.00	$7,359,257.85	9.1%	$6,714,703.86	9.8%	9.6%
PREGNANCY/CHILDBIRTH	$5,285,775.84	$358,283.52	$1,700,419.21	$0.00	$7,344,478.57	9.1%	$5,073,263.36	7.4%	44.8%
ILL-DEFINED CONDITIONS	$387,857.82	$3,416,402.38	$2,544,874.54	$0.00	$6,349,134.74	7.9%	$6,061,385.81	8.9%	4.7%
CIRCULATORY SYSTEM	$2,945,159.12	$1,651,381.60	$1,460,657.83	$0.00	$6,057,198.55	7.5%	$3,979,239.47	5.8%	52.2%
DIGESTIVE SYSTEM	$1,318,948.63	$1,304,017.32	$1,595,447.14	$0.00	$4,218,413.09	5.2%	$3,686,688.05	5.4%	14.4%
INJURY/POISONING	$1,871,828.89	$1,295,562.12	$1,018,294.39	$0.00	$4,185,685.40	5.2%	$3,619,654.17	5.3%	15.6%
OTHER CONDITIONS	$129,478.17	$1,448,948.21	$2,530,930.74	$0.00	$4,109,357.12	5.1%	$3,547,394.63	5.2%	15.8%
GENITOURINARY SYSTEM	$418,415.66	$1,659,138.45	$1,538,940.52	$0.00	$3,616,494.63	4.5%	$3,430,162.12	5.0%	5.4%
NERVOUS SYSTEM/SENSE ORGAN	$379,598.57	$1,337,558.25	$1,791,803.24	$0.00	$3,508,960.06	4.4%	$2,902,219.29	4.3%	20.9%
RESPIRATORY SYSTEM	$908,918.68	$637,205.95	$1,306,495.54	$0.00	$2,852,620.17	3.5%	$2,803,706.03	4.1%	1.7%
ENDOCRINE/METABOLIC	$796,306.29	$757,371.96	$1,083,817.52	$0.00	$2,637,495.77	3.3%	$2,282,645.20	3.3%	15.5%
MENTAL DISORDERS	$390,992.95	$268,905.70	$1,044,025.18	$0.00	$1,703,923.83	2.1%	$1,290,438.12	1.9%	32.0%
INFECTIOUS/PARASITIC	$763,041.59	$82,541.13	$535,820.75	$0.00	$1,381,403.47	1.7%	$1,539,658.67	2.3%	-10.3%
SKIN & SUBCUTANEOUS TISSUE	$133,163.43	$195,559.88	$585,083.97	$0.00	$913,807.28	1.1%	$911,441.44	1.3%	0.3%
CONGENITAL ANOMALIES	$261,264.42	$140,615.81	$293,040.83	$0.00	$694,921.06	0.9%	$624,827.46	0.9%	11.2%
BLOOD/BLOOD ORGANS	$275,218.52	$156,944.33	$192,756.08	$0.00	$624,918.93	0.8%	$314,009.29	0.5%	99.0%
PERINATAL PERIOD	$33,149.58	$7,456.85	$266,365.55	$0.00	$306,971.98	0.4%	$270,017.23	0.4%	13.7%
NO DIAGNOSIS	$0.00	$0.00	$0.00	$0.00	$0.00	0.0%	$0.00	0.0%	0.0%
PHARMACY	$0.00	$0.00	$0.00	$13,843,980.58	$13,843,980.58	17.2%	$12,271,444.65	18.0%	12.8%
Total	**$21,077,846.77**	**$19,104,160.61**	**$26,534,029.58**	**$13,843,980.58**	**$80,560,017.54**	**100.0%**	**$68,181,169.31**	**100.0%**	**18.2%**

Diagnostic Category	Current								
	Inpatient			Outpatient			Professional		
	Admits	Members	% of Total Inpatient	Visits	Members	% of Total Outpatient	Services	Members	% of Total Professional
NEOPLASMS	52	50	3.9%	2,930	2,159	11.8%	16,558	3,261	7.6%
MUSCULOSKELETAL SYSTEM	106	105	7.9%	2,921	1,796	11.7%	25,439	4,236	11.6%
PREGNANCY/CHILDBIRTH	489	495	36.3%	497	290	2.0%	5,435	780	2.5%
ILL-DEFINED CONDITIONS	50	48	3.7%	4,199	2,856	16.9%	22,917	6,263	10.5%
CIRCULATORY SYSTEM	95	86	7.0%	1,357	958	5.5%	10,794	2,757	4.9%
DIGESTIVE SYSTEM	110	107	8.2%	915	720	3.7%	6,107	1,809	2.8%
INJURY/POISONING	82	85	6.1%	1,182	1,073	4.7%	6,762	2,376	3.1%
OTHER CONDITIONS	5	6	0.4%	3,546	2,536	14.2%	34,676	8,827	15.9%
GENITOURINARY SYSTEM	38	40	2.8%	1,724	1,228	6.9%	12,470	3,267	5.7%
NERVOUS SYSTEM/SENSE ORGAN	38	41	2.8%	970	781	3.9%	17,446	3,931	8.0%
RESPIRATORY SYSTEM	64	63	4.7%	762	638	3.1%	13,868	4,722	6.3%
ENDOCRINE/METABOLIC	49	53	3.6%	2,463	1,706	9.9%	10,468	3,222	4.8%
MENTAL DISORDERS	78	74	5.8%	288	222	1.2%	15,901	2,144	7.3%
INFECTIOUS/PARASITIC	47	50	3.5%	164	151	0.7%	8,957	3,353	4.1%
SKIN & SUBCUTANEOUS TISSUE	15	16	1.1%	319	269	1.3%	6,980	2,749	3.2%
CONGENITAL ANOMALIES	6	6	0.4%	150	111	0.6%	887	236	0.4%
BLOOD/BLOOD ORGANS	18	14	1.3%	452	329	1.8%	1,733	579	0.8%
PERINATAL PERIOD	6	7	0.4%	47	36	0.2%	1,358	153	0.6%
NO DIAGNOSIS	0	0	0.0%	0	0	0.0%	0	1	0.0%
PHARMACY	0	0	0.0%	0	0	0.0%	0	0	0.0%
Total	**1,348**	**1,346**	**100.0%**	**24,886**	**17,859**	**100.0%**	**218,756**	**54,666**	**100.0%**

High Cost Claims Summary

Company:
Group:
High Cost Claims Threshold: 50000
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014

CURRENT					Inpatient		Outpatient		Professional		Pharmacy			
Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
Total				0	0	$0.00	0	$0.00	0	$0.00	0	$0.00	$0.00	$0.00

PRIOR					Inpatient		Outpatient		Professional		Pharmacy			
Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
Total				0	0	$0.00	0	$0.00	0	$0.00	0	$0.00	$0.00	$0.00

High Cost Members by Thresholds

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

Normal Underwriting Maximums	Number of Claimants	Amount Paid in Excess of Threshold
$10,000	0	$0.00
$15,000	0	$0.00
$20,000	0	$0.00
$25,000	0	$0.00
$30,000	0	$0.00
$35,000	0	$0.00
$40,000	0	$0.00
$45,000	0	$0.00
$50,000	0	$0.00
$60,000	0	$0.00
$75,000	0	$0.00
$80,000	0	$0.00
$85,000	0	$0.00
$90,000	0	$0.00
$100,000	0	$0.00
$105,000	0	$0.00
$110,000	0	$0.00
$125,000	0	$0.00
$130,000	0	$0.00
$135,000	0	$0.00
$145,000	0	$0.00
$150,000	0	$0.00
$155,000	0	$0.00
$160,000	0	$0.00
$170,000	0	$0.00
$175,000	0	$0.00
$195,000	0	$0.00
$200,000	0	$0.00
$250,000	0	$0.00
$255,000	0	$0.00
$260,000	0	$0.00
$295,000	0	$0.00

Note: Excludes Capitation.

Inpatient By Diagnosis Related Grouping

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

Diagnosis Category	DRG Code	DRG Description	Rank	Paid Amt	% of Total	Admits	Paid Per Admit	Days	ALOS	Days/1000	Admits/1000
PREGNANCY/CHILDBIRTH	790	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	1	$2,953,633.69	14.01%	9	$328,181.52	653	72.56	41.15	0.57
	795	NORMAL NEWBORN	16	$237,237.31	1.13%	159	$1,492.06	343	2.16	21.62	10.02
	775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	6	$426,189.04	2.02%	131	$3,253.35	297	2.27	18.72	8.26
	765	CESAREAN SECTION W CC/MCC	5	$516,942.40	2.45%	36	$14,359.51	150	4.17	9.45	2.27
	766	CESAREAN SECTION W/O CC/MCC	4	$563,567.78	2.67%	59	$9,552.00	178	3.02	11.22	3.72
		Sub Total		**$4,697,570.22**	**22.29%**	**394**	**$11,922.77**	**1,621**	**4.11**	**102.16**	**24.83**
MUSCULOSKELETAL SYSTEM	470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2	$1,055,433.85	5.01%	45	$23,454.09	100	2.22	6.30	2.84
	473	CERVICAL SPINAL FUSION W/O CC/MCC	13	$261,327.47	1.24%	16	$16,332.97	17	1.06	1.07	1.01
	460	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3	$742,464.48	3.52%	13	$57,112.65	39	3.00	2.46	0.82
		Sub Total		**$2,059,225.80**	**9.77%**	**74**	**$27,827.38**	**156**	**2.11**	**9.83**	**4.66**
CIRCULATORY SYSTEM	247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	7	$383,192.86	1.82%	11	$34,835.71	25	2.27	1.58	0.69
	001	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	15	$258,194.36	1.22%	1	$258,194.36	22	22.00	1.39	0.06
	251	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	12	$275,560.75	1.31%	5	$55,112.15	24	4.80	1.51	0.32
		Sub Total		**$916,947.97**	**4.35%**	**17**	**$53,938.12**	**71**	**4.18**	**4.47**	**1.07**
NEOPLASMS	982	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	11	$297,305.55	1.41%	1	$297,305.55	52	52.00	3.28	0.06
	025	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	19	$190,140.58	0.90%	2	$95,070.29	15	7.50	0.95	0.13
	016	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC	14	$260,057.82	1.23%	2	$130,028.91	35	17.50	2.21	0.13
		Sub Total		**$747,503.95**	**3.55%**	**5**	**$149,500.79**	**102**	**20.40**	**6.43**	**0.32**
INJURY/POISONING	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	8	$375,836.56	1.78%	1	$375,836.56	24	24.00	1.51	0.06
	907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	18	$203,647.03	0.97%	1	$203,647.03	55	55.00	3.47	0.06
		Sub Total		**$579,483.59**	**2.75%**	**2**	**$289,741.80**	**79**	**39.50**	**4.98**	**0.13**
ENDOCRINE/METABOLIC	621	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	9	$357,747.40	1.70%	13	$27,519.03	25	1.92	1.58	0.82
		Sub Total		**$357,747.40**	**1.70%**	**13**	**$27,519.03**	**25**	**1.92**	**1.58**	**0.82**
INFECTIOUS/PARASITIC	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	10	$344,117.02	1.63%	16	$21,507.31	81	5.06	5.10	1.01
		Sub Total		**$344,117.02**	**1.63%**	**16**	**$21,507.31**	**81**	**5.06**	**5.10**	**1.01**
MENTAL DISORDERS	885	PSYCHOSES	17	$206,889.79	0.98%	43	$4,811.39	182	4.23	11.47	2.71
		Sub Total		**$206,889.79**	**0.98%**	**43**	**$4,811.39**	**182**	**4.23**	**11.47**	**2.71**
DIGESTIVE SYSTEM	330	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	20	$176,179.42	0.84%	4	$44,044.86	41	10.25	2.58	0.25
		Sub Total		**$176,179.42**	**0.84%**	**4**	**$44,044.86**	**41**	**10.25**	**2.58**	**0.25**
OTHER		OTHER DRGS	21	$10,992,181.61	52.15%	780	$14,092.54	2,660	3.41	167.64	49.16
		Sub Total		**$10,992,181.61**	**52.15%**	**780**	**$14,092.54**	**2,660**	**3.41**	**167.64**	**49.16**
Total				**$21,077,846.77**	**100.00%**	**1,348**	**$15,636.38**	**5,018**	**3.72**	**316.24**	**84.95**

Key Indicators

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014

	Current	Prior	Change	Change %
Payments Per Employee Per Year	$11,298.96	$10,152.60	$1,146.36	11.29%
Payments Per Member Per Year	$5,091.24	$4,527.72	$563.52	12.45%
Enrollment:				
Employees	7,150	6,727	423	6.29%
Members	15,868	15,083	785	5.20%
Payments:				
Inpatient Facility	$21,077,846.77	$15,414,682.87	$5,663,163.90	36.74%
Outpatient Facility	$19,104,160.61	$17,051,180.03	$2,052,980.58	12.04%
Total Facility	**$40,182,007.38**	**$32,465,862.90**	**$7,716,144.48**	**23.77%**
Professional	$26,534,029.58	$23,443,861.76	$3,090,167.82	13.18%
PCP	$5,091,794.21	$4,804,524.49	$287,269.72	5.98%
Specialist	$21,442,235.37	$18,639,337.27	$2,802,898.10	15.04%
Capitation	$225,362.58	$111,045.65	$114,316.93	102.95%
Pharmacy	$13,843,980.58	$12,271,444.65	$1,572,535.93	12.81%
Grand Total	**$80,785,380.12**	**$68,292,214.96**	**$12,493,165.16**	**18.29%**

	Current	Prior	Change	Change %
Payments Per Member Per Month:				
Inpatient Facility	$110.69	$85.16	$25.53	29.98%
Outpatient Facility	$100.33	$94.20	$6.13	6.51%
Total Facility	**$211.02**	**$179.37**	**$31.65**	**17.65%**
Professional	$139.35	$129.52	$9.83	7.59%
PCP	$26.74	$26.54	$0.20	0.75%
Specialist	$112.61	$102.98	$9.63	9.35%
Capitation	$1.18	$0.61	$0.57	93.44%
Pharmacy	$72.70	$67.80	$4.90	7.23%
Grand Total	**$424.27**	**$377.31**	**$46.96**	**12.45%**
Other Key Payment Indicators:				
Inpatient Payments/Day	$4,200.44	$3,816.46	$383.98	10.06%
Inpatient Payments/Admissions	$15,636.38	$13,063.29	$2,573.09	19.70%
Outpatient Payments/Visit	$767.66	$708.57	$59.09	8.34%
Professional Payments/Service	$121.29	$113.36	$7.93	7.00%
PCP Payments/Service	$71.39	$67.94	$3.45	5.08%
Specialist Payments/Service	$145.43	$136.97	$8.46	6.18%
Pharmacy Payments/Script	$78.77	$69.40	$9.37	13.50%

	Current	Prior	Change	Change %
Key Utilization Indicators:				
Inpatient Facility				
Inpatient Days/1000 Members	316	268	48	18.09%
Inpatient Admissions/1000 Members	85	78	7	8.59%
Average Length of Inpatient Stay	3.72	3.42	0.30	8.75%
% Facility Admissions > 10	6.23%	5.51%		
Outpatient Facility				
Outpatient Visits/1000 Members	1,568	1,595	(27)	-1.70%
Emer Rm Visits/1000 Members	196	193	3	1.65%
Other Visits/1000 Members	1,372	1,402	(30)	-2.16%
Professional				
Professional Services/1000 Members	13,786	13,710	76	0.55%
PCP Services/1000 Members	4,495	4,689	(194)	-4.14%
Specialist Services/1000 Members	9,292	9,022	270	2.99%
Mental Health Services/1000 Members	0	0	0	0.00%
Pharmacy:				
Pharmacy Scripts/1000 Members	11,076	11,723	(647)	-5.52%

Monitoring by Relationship

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

	Enrollment		Premium			Capitation			Fee for Service Claims				
Service Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Subscriber	Spouse	Dependent	Total	Grand Total
Total	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Grouping Avg	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Monthly Avg	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Notes:
- Grand Total includes Medical FFS, Pharmacy FFS and Capitation.
- Enrollment is recast to reflect retroactive adjustments.
- Grouping Avg – Average of the distinct groupings chosen by the user.
- Monthly Avg – Average of a measure over Service/Paid time period.
- FFS = Fee For Service.
- MLR = Medical Loss Ratio.

Monitoring by Utilization and Enrollment

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

	Enrollment		Premium			Capitation			Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
201501	6,957	15,539	$173,525.00	$0.00	$173,525.00	$0.00	$9,717.88	$9,717.88	$1,178,320.07	$1,373,873.35	$1,867,379.16	$178,168.98	$4,597,741.56	$889,964.47	$5,497,423.91
201502	6,941	15,515	$173,475.00	$0.00	$173,475.00	$0.00	$9,724.08	$9,724.08	$1,049,353.15	$1,492,363.89	$1,826,824.23	$209,504.60	$4,578,045.87	$962,804.88	$5,550,574.83
201503	6,970	15,474	$179,150.00	$0.00	$179,150.00	$0.00	$9,883.42	$9,883.42	$3,177,917.48	$1,766,765.40	$1,939,387.18	$252,924.28	$7,136,994.34	$1,020,517.67	$8,167,395.43
201504	7,043	15,604	$179,350.00	$0.00	$179,350.00	$0.00	$21,084.78	$21,084.78	$1,765,981.19	$1,630,058.73	$2,074,346.05	$243,785.44	$5,714,171.41	$1,210,579.84	$6,945,836.03
201505	7,072	15,731	$174,350.00	$0.00	$174,350.00	$0.00	$21,465.18	$21,465.18	$1,637,521.58	$1,756,180.05	$1,777,398.93	$196,104.39	$5,367,204.95	$1,042,315.32	$6,430,985.45
201506	7,094	15,775	$173,450.00	$0.00	$173,450.00	$0.00	$21,425.92	$21,425.92	$2,182,257.74	$1,857,215.57	$2,101,661.41	$283,463.97	$6,424,598.69	$978,965.67	$7,424,990.28
201507	7,158	15,891	$181,350.00	$0.00	$181,350.00	$0.00	$21,562.06	$21,562.06	$1,568,698.95	$1,336,557.14	$1,987,663.24	$238,569.00	$5,131,488.33	$1,429,236.79	$6,582,287.18
201508	7,191	15,943	$182,225.00	$0.00	$182,225.00	$0.00	$21,838.34	$21,838.34	$1,443,739.66	$1,940,233.52	$2,077,608.73	$251,262.30	$5,712,844.21	$1,133,325.65	$6,868,008.20
201509	7,246	16,038	$179,125.00	$0.00	$179,125.00	$0.00	$22,165.10	$22,165.10	$2,556,641.00	$1,909,726.42	$2,097,691.40	$305,455.74	$6,869,514.56	$1,405,782.27	$8,297,461.93
201510	7,344	16,246	$180,575.00	$0.00	$180,575.00	$0.00	$21,981.15	$21,981.15	$1,593,452.91	$1,301,980.86	$1,933,789.27	$245,540.90	$5,074,763.94	$1,199,254.91	$6,296,000.00
201511	7,376	16,284	$179,850.00	$0.00	$179,850.00	$0.00	$22,446.08	$22,446.08	$1,325,779.29	$1,055,059.94	$1,876,996.48	$237,050.53	$4,494,886.24	$1,165,256.31	$5,682,588.63
201512	7,405	16,370	$187,025.00	$0.00	$187,025.00	$0.00	$22,068.59	$22,068.59	$1,598,183.75	$1,684,145.74	$2,020,264.29	$311,189.08	$5,613,782.86	$1,405,976.80	$7,041,828.25
Total	**85,797**	**190,410**	**$2,143,450.00**	**$0.00**	**$2,143,450.00**	**$0.00**	**$225,362.58**	**$225,362.58**	**$21,077,846.77**	**$19,104,160.61**	**$23,581,010.37**	**$2,953,019.21**	**$66,716,036.96**	**$13,843,980.58**	**$80,785,380.12**
Grouping Avg	**7,150**	**15,868**	**$178,620.83**	**$0.00**	**$178,620.83**	**$0.00**	**$18,780.22**	**$18,780.22**	**$1,756,487.23**	**$1,592,013.38**	**$1,965,084.20**	**$246,084.93**	**$5,559,669.75**	**$1,153,665.05**	**$6,732,115.01**
Monthly Avg	**7,150**	**15,868**	**$178,620.83**	**$0.00**	**$178,620.83**	**$0.00**	**$18,780.22**	**$18,780.22**	**$1,756,487.23**	**$1,592,013.38**	**$1,965,084.20**	**$246,084.93**	**$5,559,669.75**	**$1,153,665.05**	**$6,732,115.01**

Notes:
- Grand Total includes Medical FFS, Pharmacy FFS and Capitation.
- Enrollment is recast to reflect retroactive adjustments.
- Grouping Avg – Average of the distinct groupings chosen by the user.
- Monthly Avg – Average of a measure over Service/Paid time period.
- FFS = Fee For Service.
- MLR = Medical Loss Ratio.

Monitoring by Utilization and Enrollment

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201501	2,997	990	1,074	1,896	0	0	0	6,957	15,539
201502	2,994	980	1,067	1,900	0	0	0	6,941	15,515
201503	3,059	973	1,043	1,895	0	0	0	6,970	15,474
201504	3,101	991	1,045	1,906	0	0	0	7,043	15,604
201505	3,094	990	1,057	1,931	0	0	0	7,072	15,731
201506	3,100	1,006	1,063	1,925	0	0	0	7,094	15,775
201507	3,147	1,010	1,073	1,928	0	0	0	7,158	15,891
201508	3,162	1,016	1,080	1,933	0	0	0	7,191	15,943
201509	3,196	1,026	1,083	1,941	0	0	0	7,246	16,038
201510	3,251	1,025	1,097	1,971	0	0	0	7,344	16,246
201511	3,278	1,028	1,100	1,970	0	0	0	7,376	16,284
201512	3,285	1,029	1,098	1,993	0	0	0	7,405	16,370
Total	**37,664**	**12,064**	**12,880**	**23,189**	**0**	**0**	**0**	**85,797**	**190,410**
Grouping Avg	**3,139**	**1,005**	**1,073**	**1,932**	**0**	**0**	**0**	**7,150**	**15,868**
Monthly Avg	**3,139**	**1,005**	**1,073**	**1,932**	**0**	**0**	**0**	**7,150**	**15,868**

Notes:

- Enrollment is recast to reflect retroactive adjustments.

- Grouping Avg – Average of the distinct groupings chosen by the user.

- Monthly Avg – Average of a measure over Service/Paid time period.

Monitoring Enrollment

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201501	2,997	990	1,074	1,896	0	0	0	6,957	15,539
201502	2,994	980	1,067	1,900	0	0	0	6,941	15,515
201503	3,059	973	1,043	1,895	0	0	0	6,970	15,474
201504	3,101	991	1,045	1,906	0	0	0	7,043	15,604
201505	3,094	990	1,057	1,931	0	0	0	7,072	15,731
201506	3,100	1,006	1,063	1,925	0	0	0	7,094	15,775
201507	3,147	1,010	1,073	1,928	0	0	0	7,158	15,891
201508	3,162	1,016	1,080	1,933	0	0	0	7,191	15,943
201509	3,196	1,026	1,083	1,941	0	0	0	7,246	16,038
201510	3,251	1,025	1,097	1,971	0	0	0	7,344	16,246
201511	3,278	1,028	1,100	1,970	0	0	0	7,376	16,284
201512	3,285	1,029	1,098	1,993	0	0	0	7,405	16,370
Total	**37,664**	**12,064**	**12,880**	**23,189**	**0**	**0**	**0**	**85,797**	**190,410**
Grouping Avg	**3,139**	**1,005**	**1,073**	**1,932**	**0**	**0**	**0**	**7,150**	**15,868**
Monthly Avg	**3,139**	**1,005**	**1,073**	**1,932**	**0**	**0**	**0**	**7,150**	**15,868**

Notes:
- Enrollment is recast to reflect retroactive adjustments.
- Grouping Avg – Average of the distinct groupings chosen by the user.
- Monthly Avg – Average of a measure over Service/Paid time period.

Paid Claims By Relationship and LOS

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

Relationship	Location of Service	Paid Amt	Billed Amt
SUBSCRIBER	Emergency	$2,247,556.81	$10,574,087.43
	Inpatient	$9,403,006.25	$33,531,259.94
	Outpatient	$9,105,176.61	$36,994,921.23
	Physician	$12,527,586.30	$30,738,318.40
	Other Medical	$1,309,133.84	$4,195,082.25
	Pharmacy	$7,686,490.13	$9,937,848.38
	Sub Total	**$42,278,949.94**	**$125,971,517.63**
SPOUSE	Emergency	$768,501.63	$2,705,059.59
	Inpatient	$6,064,250.87	$18,665,440.53
	Outpatient	$4,448,067.44	$18,997,712.94
	Physician	$5,853,952.63	$14,757,969.55
	Other Medical	$959,422.89	$2,481,199.85
	Pharmacy	$3,951,768.27	$4,927,286.77
	Sub Total	**$22,045,963.73**	**$62,534,669.23**
DEPENDENT	Emergency	$793,107.22	$4,078,962.38
	Inpatient	$5,610,589.65	$14,979,388.50
	Outpatient	$1,741,750.90	$7,510,371.97
	Physician	$5,199,471.44	$11,772,453.81
	Other Medical	$684,462.48	$2,058,480.59
	Pharmacy	$2,205,722.18	$2,733,717.67
	Sub Total	**$16,235,103.87**	**$43,133,374.92**
Total	Emergency	$3,809,165.66	$17,358,109.40
	Inpatient	$21,077,846.77	$67,176,088.97
	Outpatient	$15,294,994.95	$63,503,006.14
	Physician	$23,581,010.37	$57,268,741.76
	Other Medical	$2,953,019.21	$8,734,762.69
	Pharmacy	$13,843,980.58	$17,598,852.82
	Grand Total	**$80,560,017.54**	**$231,639,561.78**

Professional Paid and Utilization by Service Type

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014

	Total Paid					Services		Services Per 1000 Members			Paid Per Service		
Type of Service	Current	% of Total	Prior	% of Total	Chg Pct	# of Services	% of Services	Current	Prior	Chg Pct	Current	Prior	Chg Pct
EVALUATION & MANAGEMENT	$9,001,589.08	33.92%	$8,179,930.46	34.89%	10.04%	77,830	35.58%	4,904.99	4,869.27	0.73%	$115.65	$111.37	3.84%
SURGERY	$5,367,254.65	20.23%	$4,673,712.73	19.94%	14.84%	19,935	9.11%	1,256.34	1,241.68	1.18%	$269.23	$249.55	7.89%
OTHER SERVICES	$4,681,952.04	17.65%	$3,937,905.48	16.80%	18.89%	24,510	11.20%	1,544.67	1,405.71	9.89%	$191.02	$185.73	2.85%
RADIOLOGY	$2,431,662.09	9.16%	$1,992,435.28	8.50%	22.04%	23,492	10.74%	1,480.51	1,424.34	3.94%	$103.51	$92.74	11.61%
ANESTHESIOLOGY	$1,729,046.43	6.52%	$1,557,773.53	6.64%	10.99%	2,758	1.26%	173.81	171.26	1.49%	$626.92	$603.08	3.95%
IMMUN. INJECTIIONS	$969,315.27	3.65%	$895,879.41	3.82%	8.20%	17,122	7.83%	1,079.06	1,165.44	-7.41%	$56.61	$50.96	11.09%
PATHOLOGY & LAB	$862,375.21	3.25%	$790,289.14	3.37%	9.12%	27,758	12.69%	1,749.36	1,681.13	4.06%	$31.06	$31.16	-0.32%
MEDICINE	$730,798.40	2.75%	$704,649.64	3.01%	3.71%	9,030	4.13%	569.09	563.69	0.96%	$80.93	$82.88	-2.35%
PSYCHIATRY	$196,190.61	0.74%	$169,839.06	0.72%	15.52%	3,170	1.45%	199.78	178.42	11.97%	$61.88	$63.11	-1.95%
CARDIOGRAPHY/ECHOCARDIOGRAPHY	$165,014.80	0.62%	$149,534.25	0.64%	10.35%	5,605	2.56%	353.24	337.21	4.75%	$29.44	$29.40	0.14%
NON-INVASIVE VASCULAR STUDIES	$127,209.42	0.48%	$129,005.77	0.55%	-1.39%	1,075	0.49%	67.75	63.58	6.55%	$118.33	$134.52	-12.04%
CHEMOTHERAPY	$112,949.45	0.43%	$122,764.47	0.52%	-8.00%	907	0.41%	57.16	67.49	-15.31%	$124.53	$120.59	3.27%
CARDIAC CATH & INTRACARDIAC PROCEDURES	$53,692.49	0.20%	$24,320.28	0.10%	120.77%	108	0.05%	6.81	3.45	97.42%	$497.15	$467.69	6.30%
PHYSICAL MEDICINE & REHAB	$50,011.90	0.19%	$56,788.06	0.24%	-11.93%	3,455	1.58%	217.74	313.27	-30.49%	$14.47	$12.01	20.48%
PULMONARY	$25,976.92	0.10%	$30,255.73	0.13%	-14.14%	1,001	0.46%	63.08	73.20	-13.81%	$25.95	$27.40	-5.29%
DIALYSIS	$11,945.51	0.05%	$5,860.57	0.02%	103.83%	109	0.05%	6.87	2.78	146.69%	$109.59	$139.53	-21.46%
IV INFUSION ADMIN.	$7,439.86	0.03%	$5,212.76	0.02%	42.72%	60	0.03%	3.78	2.98	26.74%	$123.99	$115.83	7.04%
DERMATOLOGY	$4,137.04	0.02%	$5,519.23	0.02%	-25.04%	111	0.05%	7.00	7.16	-2.31%	$37.27	$51.10	-27.06%
CHIROPRACTIC	$3,280.70	0.01%	$9,617.48	0.04%	-65.89%	710	0.32%	44.75	137.51	-67.46%	$4.62	$4.63	-0.22%
CARDIOVASCULAR THERAPEUTIC SERVICES	$2,187.71	0.01%	$2,568.43	0.01%	-14.82%	10	0.00%	0.63	0.93	-32.10%	$218.77	$183.45	19.25%
Total	**$26,534,029.58**	**100.00%**	**$23,443,861.76**	**100.00%**	**13.18%**	**218,756**	**100.00%**	**13,786.42**	**13,710.50**	**0.55%**	**$121.30**	**$113.37**	**6.99%**

Top Diagnoses by Outpatient ER

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

Diagnosis Category	Diagnosis Code	Diagnosis Description	Rank	Paid Amt	% of Total	ER Visits	Members	Paid/Visit	Visits/ 1000
ILL-DEFINED CONDITIONS	786	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS	1	$627,874.45	16.48%	230	226	$2,729.89	14.50
	789	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS	2	$377,691.16	9.92%	225	212	$1,678.63	14.18
	780	GENERAL SYMPTOMS	3	$285,557.93	7.50%	167	178	$1,709.92	10.52
	784	SYMPTOMS INVOLVING HEAD AND NECK	4	$180,389.53	4.74%	127	105	$1,420.39	8.00
	787	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	8	$66,335.63	1.74%	83	94	$799.22	5.23
	785	SYMPTOMS INVOLVING CARDIOVASCULAR SYSTEM	10	$53,536.60	1.41%	35	35	$1,529.60	2.21
	782	SYMPTOMS INVOLVING SKIN AND OTHER INTEGUMENTARY TISSUE	14	$46,539.58	1.22%	35	35	$1,329.69	2.21
		Sub Total		**$1,637,924.88**	**43.00%**	**902**	**885**	**$1,815.88**	**56.85**
DIGESTIVE SYSTEM	540	ACUTE APPENDICITIS	5	$84,835.09	2.23%	12	14	$7,069.58	0.76
	558	OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS	13	$50,352.29	1.32%	47	49	$1,071.32	2.96
	530	DISEASES OF ESOPHAGUS	20	$36,305.90	0.95%	16	18	$2,269.06	1.01
		Sub Total		**$171,493.28**	**4.50%**	**75**	**81**	**$2,286.57**	**4.73**
GENITOURINARY SYSTEM	592	CALCULUS OF KIDNEY AND URETER	6	$77,798.31	2.04%	50	47	$1,555.96	3.15
	599	OTHER DISORDERS OF URETHRA AND URINARY TRACT	12	$51,546.04	1.35%	51	59	$1,010.71	3.21
	620	NONINFLAMMATORY DISORDERS OF OVARY, FALLOPIAN TUBE, AND BROAD LIGAMENT	15	$43,739.62	1.15%	21	22	$2,082.81	1.32
	625	PAIN AND OTHER SYMPTOMS ASSOCIATED WITH FEMALE GENITAL ORGANS	17	$39,677.72	1.04%	20	23	$1,983.85	1.26
		Sub Total		**$212,761.69**	**5.59%**	**142**	**151**	**$1,498.32**	**8.95**
NERVOUS SYSTEM/SENSE ORGAN	346	MIGRAINE	7	$74,866.58	1.97%	54	47	$1,386.41	3.40
		Sub Total		**$74,866.58**	**1.97%**	**54**	**47**	**$1,386.41**	**3.40**
CIRCULATORY SYSTEM	401	ESSENTIAL HYPERTENSION	11	$52,470.90	1.38%	24	26	$2,186.25	1.51
	427	CARDIAC DYSRHYTHMIAS	16	$41,159.60	1.08%	15	13	$2,743.93	0.95
		Sub Total		**$93,630.50**	**2.46%**	**39**	**39**	**$2,400.77**	**2.46**
PREGNANCY/CHILDBIRTH	646	OTHER COMPLICATIONS OF PREGNANCY, NOT ELSEWHERE CLASSIFIED	19	$36,916.22	0.97%	34	30	$1,085.76	2.14
		Sub Total		**$36,916.22**	**0.97%**	**34**	**30**	**$1,085.76**	**2.14**
MUSCULOSKELETAL SYSTEM	724	OTHER AND UNSPECIFIED DISORDERS OF BACK	9	$64,276.97	1.69%	70	71	$918.23	4.41
		Sub Total		**$64,276.97**	**1.69%**	**70**	**71**	**$918.23**	**4.41**
SKIN & SUBCUTANEOUS TISSUE	682	OTHER CELLULITIS AND ABSCESS	18	$38,749.85	1.02%	65	65	$596.14	4.10
		Sub Total		**$38,749.85**	**1.02%**	**65**	**65**	**$596.14**	**4.10**
OTHER		OTHER DIAGNOSTICS		$1,478,545.69	38.82%	1,734	1633	$852.68	109.28
		Sub Total		**$1,478,545.69**	**38.82%**	**1,734**	**1633**	**$852.68**	**109.28**
Total				**$3,809,165.66**	**100.00%**	**3,115**	**2543**	**$1,222.85**	**196.31**

Top Diagnosis by FFS

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015

			Inpatient										
Diagnosis Category	Diagnosis Code	Diagnosis Description	Rank	Paid Amt	% of Total	# of Members	Admits	Paid/Admits	Admits/ 1000	Days	ALOS	ALOS/1000	Avg Age
PREGNANCY/CHILDBIRTH	V30	SINGLE LIVEBORN	1	$2,245,415.68	10.65%	211	209	$10,743.61	13.17	888	4.25	55.96	0.00
	V31	TWIN BIRTH, MATE LIVEBORN	2	$1,281,883.85	6.08%	6	5	$256,376.60	0.32	265	53.00	16.70	0.00
	654	ABNORMALITY OF ORGANS AND SOFT TISSUES OF PELVIS COMPLICATING PREGNANCY, CHILDBIRTH, OR THE PUERPERIUM	11	$382,950.39	1.82%	43	39	$9,819.23	2.46	97	2.49	6.11	31.74
	642	HYPERTENSION COMPLICATING PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	18	$284,587.28	1.35%	27	29	$9,813.34	1.83	131	4.52	8.26	30.74
		SubTotal		**$4,194,837.20**	**19.90%**	**287**	**282**	**$14,875.31**	**17.77**	**1,381**	**4.90**	**87.03**	**15.62**
MUSCULOSKELETAL SYSTEM	715	OSTEOARTHROSIS AND ALLIED DISORDERS	3	$1,110,681.68	5.27%	42	45	$24,681.80	2.84	99	2.20	6.24	59.17
	722	INTERVERTEBRAL DISC DISORDERS	6	$503,264.25	2.39%	22	17	$29,603.76	1.07	25	1.47	1.58	50.45
	721	SPONDYLOSIS AND ALLIED DISORDERS	13	$370,113.28	1.76%	9	9	$41,123.67	0.57	17	1.89	1.07	50.67
	724	OTHER AND UNSPECIFIED DISORDERS OF BACK	19	$272,380.84	1.29%	7	8	$34,047.50	0.50	24	3.00	1.51	53.86
		SubTotal		**$2,256,440.05**	**10.71%**	**80**	**79**	**$28,562.53**	**4.98**	**165**	**2.09**	**10.40**	**53.54**
INJURY/POISONING	996	COMPLICATIONS PECULIAR TO CERTAIN SPECIFIED PROCEDURES	4	$750,339.08	3.56%	20	20	$37,516.95	1.26	131	6.55	8.26	46.35
	806	FRACTURE OF VERTEBRAL COLUMN WITH SPINAL CORD INJURY	12	$375,836.56	1.78%	1	1	$375,836.00	0.06	24	24.00	1.51	49.00
		SubTotal		**$1,126,175.64**	**5.34%**	**21**	**21**	**$53,627.41**	**1.32**	**155**	**7.38**	**9.77**	**47.68**
INFECTIOUS/PARASITIC	038	SEPTICEMIA	5	$546,646.12	2.59%	29	28	$19,523.07	1.76	120	4.29	7.56	50.10
		SubTotal		**$546,646.12**	**2.59%**	**29**	**28**	**$19,523.08**	**1.76**	**120**	**4.29**	**7.56**	**50.10**
CIRCULATORY SYSTEM	414	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE	7	$437,977.70	2.08%	12	10	$43,797.70	0.63	36	3.60	2.27	59.17
	410	ACUTE MYOCARDIAL INFARCTION	9	$401,915.86	1.91%	15	12	$33,492.92	0.76	45	3.75	2.84	58.33
	427	CARDIAC DYSRHYTHMIAS	14	$361,237.29	1.71%	21	24	$15,051.54	1.51	56	2.33	3.53	55.19
	428	HEART FAILURE	16	$308,723.94	1.46%	4	5	$61,744.60	0.32	50	10.00	3.15	57.75
	404	HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE	20	$258,194.36	1.22%	1	1	$258,194.00	0.06	22	22.00	1.39	62.00
		SubTotal		**$1,768,049.15**	**8.39%**	**53**	**52**	**$34,000.95**	**3.28**	**209**	**4.02**	**13.17**	**58.49**
ENDOCRINE/METABOLIC	278	OVERWEIGHT, OBESITY AND OTHER HYPERALIMENTATION	8	$429,933.66	2.04%	22	16	$26,870.81	1.01	31	1.94	1.95	43.00
		SubTotal		**$429,933.66**	**2.04%**	**22**	**16**	**$26,870.85**	**1.01**	**31**	**1.94**	**1.95**	**43.00**
NEOPLASMS	198	SECONDARY MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES	10	$395,582.19	1.88%	4	6	$65,930.33	0.38	62	10.33	3.91	57.00
	174	MALIGNANT NEOPLASM OF FEMALE BREAST	15	$330,341.96	1.57%	8	8	$41,292.63	0.50	24	3.00	1.51	56.00
	228	HEMANGIOMA AND LYMPHANGIOMA, ANY SITE	17	$297,305.55	1.41%	1	1	$297,305.00	0.06	52	52.00	3.28	0.00
		SubTotal		**$1,023,229.70**	**4.85%**	**13**	**15**	**$68,215.31**	**0.95**	**138**	**9.20**	**8.70**	**37.67**
OTHER		OTHER DIAGNOSTICS		$9,732,535.25	46.17%	786	855	$11,383.08	53.88	2,819	3.30	177.66	36.50
		SubTotal		**$9,732,535.25**	**46.17%**	**786**	**855**	**$11,383.08**	**53.88**	**2,819**	**3.30**	**177.66**	**36.50**
Total				**$21,077,846.77**	**100.00%**	**1,291**	**1,348**	**$15,636.38**	**84.95**	**5,018**	**3.72**	**316.24**	**43.19**

			Outpatient							
Diagnosis Category	Diagnosis Code	Diagnosis Description	Rank	Paid Amt	% of Total	# of Members	Visits	Paid/Visits	Visits/ 1000	Avg Age
ILL-DEFINED CONDITIONS	786	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS	1	$903,733.17	4.73%	603	699	$1,292.89	44.05	42.73
	789	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS	2	$689,815.30	3.61%	596	774	$891.23	48.78	38.77
	780	GENERAL SYMPTOMS	5	$515,940.62	2.70%	575	636	$811.23	40.08	38.73
	785	SYMPTOMS INVOLVING CARDIOVASCULAR SYSTEM	12	$276,857.53	1.45%	220	265	$1,044.74	16.70	39.31
	784	SYMPTOMS INVOLVING HEAD AND NECK	14	$257,389.28	1.35%	223	257	$1,001.51	16.20	35.85
		SubTotal		**$2,643,735.90**	**13.84%**	**2,217**	**2,631**	**$1,004.84**	**165.81**	**39.08**
NEOPLASMS	V76	SPECIAL SCREENING FOR MALIGNANT NEOPLASMS	3	$668,340.55	3.50%	1861	1939	$344.68	122.20	52.84
	V58	ENCOUNTER FOR OTHER AND UNSPECIFIED PROCEDURE AND AFTERCARE	7	$461,311.51	2.41%	26	229	$2,014.46	14.43	48.46
	174	MALIGNANT NEOPLASM OF FEMALE BREAST	17	$243,454.53	1.27%	58	150	$1,623.03	9.45	53.14
		SubTotal		**$1,373,106.59**	**7.19%**	**1,945**	**2,318**	**$592.37**	**146.08**	**51.48**
CIRCULATORY SYSTEM	427	CARDIAC DYSRHYTHMIAS	4	$522,667.87	2.74%	84	119	$4,392.16	7.50	47.46
	414	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE	9	$356,005.86	1.86%	70	98	$3,632.70	6.18	60.06
	401	ESSENTIAL HYPERTENSION	18	$220,314.70	1.15%	562	664	$331.80	41.85	52.01
		SubTotal		**$1,098,988.43**	**5.75%**	**716**	**881**	**$1,247.43**	**55.52**	**53.18**
OTHER CONDITIONS	V57	CARE INVOLVING USE OF REHABILITATION PROCEDURES	6	$485,978.47	2.54%	446	902	$538.78	56.85	41.14
	V70	GENERAL MEDICAL EXAMINATION	8	$360,494.23	1.89%	1246	1288	$279.89	81.17	45.35
	V58	ENCOUNTER FOR OTHER AND UNSPECIFIED PROCEDURE AND AFTERCARE	15	$255,581.56	1.34%	172	239	$1,069.38	15.06	44.95
		SubTotal		**$1,102,054.26**	**5.77%**	**1,864**	**2,429**	**$453.71**	**153.08**	**43.82**
GENITOURINARY SYSTEM	611	OTHER DISORDERS OF BREAST	10	$289,026.27	1.51%	351	393	$735.44	24.77	44.51
	592	CALCULUS OF KIDNEY AND URETER	19	$201,040.66	1.05%	90	131	$1,534.66	8.26	44.16
		SubTotal		**$490,066.93**	**2.57%**	**441**	**524**	**$935.24**	**33.02**	**44.33**
MUSCULOSKELETAL SYSTEM	722	INTERVERTEBRAL DISC DISORDERS	11	$288,220.36	1.51%	232	322	$895.09	20.29	49.53
	719	OTHER AND UNSPECIFIED DISORDERS OF JOINT	13	$272,340.21	1.43%	503	702	$387.95	44.24	42.71
	724	OTHER AND UNSPECIFIED DISORDERS OF BACK	16	$244,718.05	1.28%	322	403	$607.24	25.40	44.51
		SubTotal		**$805,278.62**	**4.22%**	**1,057**	**1,427**	**$564.32**	**89.93**	**45.58**
NERVOUS SYSTEM/SENSE ORGAN	327	ORGANIC SLEEP DISORDERS	20	$198,158.06	1.04%	130	162	$1,223.20	10.21	46.55
		SubTotal		**$198,158.06**	**1.04%**	**130**	**162**	**$1,223.20**	**10.21**	**46.55**
OTHER		OTHER DIAGNOSTICS		$11,392,771.82	59.64%	6777	14514	$784.95	914.70	41.26
		SubTotal		**$11,392,771.82**	**59.64%**	**6,777**	**14,514**	**$784.95**	**914.70**	**41.26**
Total				**$19,104,160.61**	**100.00%**	**15,147**	**24,886**	**$767.67**	**1,568.36**	**45.43**

			Professional							
Diagnosis Category	Diagnosis Code	Diagnosis Description	Rank	Paid Amt	% of Total	# of Members	Services	Paid/Services	Services/ 1000	Avg Age
OTHER CONDITIONS	V20	HEALTH SUPERVISION OF INFANT OR CHILD	1	$1,060,574.60	4.00%	2640	16410	$64.63	1,034.19	7.28
	V72	SPECIAL INVESTIGATIONS AND EXAMINATIONS	5	$545,104.78	2.05%	3773	7302	$74.65	460.19	38.37
	V70	GENERAL MEDICAL EXAMINATION	6	$500,477.35	1.89%	2894	6900	$72.53	434.85	43.66
		SubTotal		**$2,106,156.73**	**7.94%**	**9,307**	**30,612**	**$68.80**	**1,929.23**	**29.77**
NEOPLASMS	174	MALIGNANT NEOPLASM OF FEMALE BREAST	2	$936,990.38	3.53%	95	2090	$448.32	131.72	53.33
	V76	SPECIAL SCREENING FOR MALIGNANT NEOPLASMS	4	$550,337.62	2.07%	2100	4443	$123.87	280.01	52.12
	162	MALIGNANT NEOPLASM OF TRACHEA, BRONCHUS, AND LUNG	13	$335,138.73	1.26%	12	621	$539.67	39.14	58.50
		SubTotal		**$1,822,466.73**	**6.87%**	**2,207**	**7,154**	**$254.75**	**450.86**	**54.65**
ILL-DEFINED CONDITIONS	789	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS	3	$590,590.60	2.23%	1291	3538	$166.93	222.97	36.62
	786	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS	7	$462,125.62	1.74%	1745	4591	$100.66	289.33	38.02
	780	GENERAL SYMPTOMS	10	$426,315.33	1.61%	1756	4101	$103.95	258.45	34.26
		SubTotal		**$1,479,031.55**	**5.57%**	**4,792**	**12,230**	**$120.93**	**770.76**	**36.30**
MUSCULOSKELETAL SYSTEM	722	INTERVERTEBRAL DISC DISORDERS	8	$427,642.24	1.61%	608	2841	$150.53	179.05	49.92
	724	OTHER AND UNSPECIFIED DISORDERS OF BACK	12	$362,651.11	1.37%	1114	4338	$83.60	273.39	44.81
	715	OSTEOARTHROSIS AND ALLIED DISORDERS	14	$330,247.10	1.24%	468	1917	$172.27	120.81	55.15
	719	OTHER AND UNSPECIFIED DISORDERS OF JOINT	17	$307,211.29	1.16%	1415	4126	$74.46	260.03	41.80
		SubTotal		**$1,427,751.74**	**5.38%**	**3,605**	**13,222**	**$107.98**	**833.28**	**47.92**
ENDOCRINE/METABOLIC	250	DIABETES MELLITUS	9	$426,368.35	1.61%	790	3585	$118.93	225.93	51.74
		SubTotal		**$426,368.35**	**1.61%**	**790**	**3,585**	**$118.93**	**225.93**	**51.74**
PREGNANCY/CHILDBIRTH	650	NORMAL DELIVERY	11	$372,848.88	1.41%	157	200	$1,864.24	12.60	29.20
		SubTotal		**$372,848.88**	**1.41%**	**157**	**200**	**$1,864.24**	**12.60**	**29.20**
MENTAL DISORDERS	299	PERVASIVE DEVELOPMENTAL DISORDERS	15	$316,022.16	1.19%	37	2900	$108.97	182.76	12.43
		SubTotal		**$316,022.16**	**1.19%**	**37**	**2,900**	**$108.97**	**182.76**	**12.43**
DIGESTIVE SYSTEM	555	REGIONAL ENTERITIS	16	$308,338.35	1.16%	43	427	$722.10	26.91	40.42
		SubTotal		**$308,338.35**	**1.16%**	**43**	**427**	**$722.10**	**26.91**	**40.42**
CIRCULATORY SYSTEM	401	ESSENTIAL HYPERTENSION	18	$300,048.55	1.13%	1707	3760	$79.80	236.96	51.18
		SubTotal		**$300,048.55**	**1.13%**	**1,707**	**3,760**	**$79.80**	**236.96**	**51.18**
NERVOUS SYSTEM/SENSE ORGAN	327	ORGANIC SLEEP DISORDERS	19	$235,399.95	0.89%	531	5039	$46.72	317.57	48.94
		SubTotal		**$235,399.95**	**0.89%**	**531**	**5,039**	**$46.72**	**317.57**	**48.94**
GENITOURINARY SYSTEM	626	DISORDERS OF MENSTRUATION AND OTHER ABNORMAL BLEEDING FROM FEMALE GENITAL TRACT	20	$234,006.33	0.88%	522	1698	$137.81	107.01	32.69
		SubTotal		**$234,006.33**	**0.88%**	**522**	**1,698**	**$137.81**	**107.01**	**32.69**
OTHER		OTHER DIAGNOSTICS		$17,505,590.26	65.97%	14299	137929	$126.92	8,692.55	36.69
		SubTotal		**$17,505,590.26**	**65.97%**	**14,299**	**137,929**	**$126.92**	**8,692.55**	**36.69**
Total				**$26,534,029.58**	**100.00%**	**37,997**	**218,756**	**$121.30**	**13,786.42**	**40.82**

			Total							
Diagnosis Category	Diagnosis Code	Diagnosis Description	Rank	Paid Amt	% of Total	# of Members	Adm/Vis/ Serv	Paid Per Adm/Vis/Serv	Adm/Vis/ Serv Per 1000	Avg Age
PREGNANCY/CHILDBIRTH	V30	SINGLE LIVEBORN	1	$2,280,323.26	3.42%	230	603	$3,781.63	38.00	0.10
	V31	TWIN BIRTH, MATE LIVEBORN	6	$1,282,907.79	1.92%	6	17	$75,465.12	1.07	0.00
		SubTotal		**$3,563,231.05**	**5.34%**	**236**	**620**	**$5,747.15**	**39.07**	**0.05**
MUSCULOSKELETAL SYSTEM	715	OSTEOARTHROSIS AND ALLIED DISORDERS	2	$1,541,689.59	2.31%	492	2069	$745.14	130.39	55.43
	722	INTERVERTEBRAL DISC DISORDERS	7	$1,219,126.85	1.83%	665	3180	$383.37	200.41	49.83
	724	OTHER AND UNSPECIFIED DISORDERS OF BACK	14	$879,750.00	1.32%	1169	4749	$185.25	299.29	44.79
	719	OTHER AND UNSPECIFIED DISORDERS OF JOINT	18	$615,071.12	0.92%	1500	4831	$127.32	304.46	42.01
	721	SPONDYLOSIS AND ALLIED DISORDERS	19	$601,441.85	0.90%	365	1523	$394.91	95.98	51.17
		SubTotal		**$4,857,079.41**	**7.28%**	**4,191**	**16,352**	**$297.03**	**1,030.53**	**48.65**
NEOPLASMS	174	MALIGNANT NEOPLASM OF FEMALE BREAST	3	$1,510,786.87	2.26%	101	2248	$672.06	141.67	53.39
	V76	SPECIAL SCREENING FOR MALIGNANT NEOPLASMS	8	$1,218,678.17	1.83%	2230	6382	$190.96	402.21	52.46
		SubTotal		**$2,729,465.04**	**4.09%**	**2,331**	**8,630**	**$316.28**	**543.88**	**52.93**
ILL-DEFINED CONDITIONS	786	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS	4	$1,451,302.91	2.18%	1804	5302	$273.73	334.14	39.30
	789	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS	5	$1,347,116.06	2.02%	1359	4321	$311.76	272.32	37.33
	780	GENERAL SYMPTOMS	9	$1,086,754.73	1.63%	1888	4752	$228.69	299.48	35.42
		SubTotal		**$3,885,173.70**	**5.82%**	**5,051**	**14,375**	**$270.27**	**905.94**	**37.35**
OTHER CONDITIONS	V20	HEALTH SUPERVISION OF INFANT OR CHILD	10	$1,066,518.70	1.60%	2644	16452	$64.83	1,036.84	7.33
	V70	GENERAL MEDICAL EXAMINATION	15	$860,971.58	1.29%	3203	8188	$105.15	516.02	44.17
	V72	SPECIAL INVESTIGATIONS AND EXAMINATIONS	17	$689,041.57	1.03%	3880	8017	$85.95	505.25	39.21
		SubTotal		**$2,616,531.85**	**3.92%**	**9,727**	**32,657**	**$80.12**	**2,058.11**	**30.24**
CIRCULATORY SYSTEM	427	CARDIAC DYSRHYTHMIAS	11	$1,063,424.74	1.59%	320	1243	$855.53	78.34	47.71
	414	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE	12	$933,115.76	1.40%	177	851	$1,096.49	53.63	59.82
		SubTotal		**$1,996,540.50**	**2.99%**	**497**	**2,094**	**$953.46**	**131.97**	**53.77**
INJURY/POISONING	996	COMPLICATIONS PECULIAR TO CERTAIN SPECIFIED PROCEDURES	13	$897,474.75	1.35%	69	274	$3,275.45	17.27	41.54
		SubTotal		**$897,474.75**	**1.35%**	**69**	**274**	**$3,275.46**	**17.27**	**41.54**
ENDOCRINE/METABOLIC	250	DIABETES MELLITUS	16	$766,327.67	1.15%	817	4127	$185.69	260.09	51.68
	278	OVERWEIGHT, OBESITY AND OTHER HYPERALIMENTATION	20	$558,661.34	0.84%	348	497	$1,124.07	31.32	40.76
		SubTotal		**$1,324,989.01**	**1.99%**	**1,165**	**4,624**	**$286.55**	**291.41**	**46.22**
OTHER		OTHER DIAGNOSTICS		$44,845,551.65	67.22%	14661	165364	$271.19	10,421.55	37.88
		SubTotal		**$44,845,551.65**	**67.22%**	**14,661**	**165,364**	**$271.19**	**10,421.55**	**37.88**
Total				**$66,716,036.96**	**100.00%**	**37,928**	**244,990**	**$272.32**	**15,439.74**	**39.59**

Top Drug Classes by Paid/Prescription

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014
Rank: 10
Rx Sort By: PAID

Drug Class	Drug	Current Rank	Prior Rank	Current Plan Paid Amt	Plan Paid Chg Pct	Formulary Pct	Substitution Pct	Avg Ingredient/ Rx	Avg Ingredient/ Brand	Avg Ingredient/ Generic	Cost Share Pct	# of Rx's	Rx Chg Pct	Total Rx Users	Current Util/1000	Current Util Chg Pct	Current Plan Paid PMPM	Plan Paid Chg	Paid PMPM Chg Pct
ANTIDIABETICS	NOVOLOG			$238,029.21	137.11%			$857.21	$857.21	$0.00	3.82%	288	50.00%	62	18.15	42.58%	$1.25	$0.70	125.39%
ANTIDIABETICS	NOVOLOG FLEXPEN			$233,728.98	99.21%			$633.70	$633.70	$0.00	5.07%	387	35.31%	87	24.39	28.62%	$1.23	$0.58	89.36%
ANTIDIABETICS	VICTOZA			$227,246.85	17.67%			$721.08	$721.08	$0.00	10.87%	349	-10.51%	75	21.99	-14.94%	$1.19	$0.13	11.85%
ANTIDIABETICS	LANTUS SOLOSTAR			$193,737.06	11.17%			$507.26	$507.26	$0.00	9.10%	416	-16.80%	84	26.22	-20.91%	$1.02	$0.05	5.68%
ANTIDIABETICS	INVOKANA			$163,362.76	98.29%			$429.33	$429.33	$0.00	20.09%	456	61.13%	84	28.74	53.16%	$0.86	$0.40	88.49%
ANTIDIABETICS	ALL OTHER			$1,069,240.75	26.21%			$232.24	$541.57	$30.59	16.06%	5,324	3.00%	857	335.53	-2.10%	$5.62	$0.93	19.97%
ANTIDIABETICS	**ANTIDIABETICS**	**1**	**1**	**$2,125,345.61**	**40.32%**	**90.30%**	**44.74%**	**$330.61**	**$572.53**	**$30.59**	**12.60%**	**7,220**	**5.87%**	**919**	**455.02**	**0.63%**	**$11.16**	**$2.79**	**33.38%**
ANALGESICS - ANTI-INFLAMMATORY	HUMIRA PEN			$526,178.93	17.66%			$3,566.69	$3,566.69	$0.00	1.68%	150	-5.06%	19	9.45	-9.76%	$2.76	$0.29	11.84%
ANALGESICS - ANTI-INFLAMMATORY	ENBREL SURECLICK			$261,648.36	70.12%			$3,172.26	$3,172.26	$0.00	1.85%	84	42.37%	13	5.29	35.33%	$1.37	$0.52	61.71%
ANALGESICS - ANTI-INFLAMMATORY	ENBREL			$213,013.14	36.21%			$3,608.20	$3,608.20	$0.00	1.64%	60	7.14%	7	3.78	1.84%	$1.12	$0.25	29.47%
ANALGESICS - ANTI-INFLAMMATORY	HUMIRA			$46,587.90	-17.95%			$3,158.80	$3,158.80	$0.00	1.72%	15	-31.82%	3	0.95	-35.19%	$0.24	($0.07)	-22.01%
ANALGESICS - ANTI-INFLAMMATORY	ORENCIA			$41,402.34	115.82%			$3,252.49	$3,252.49	$0.00	2.13%	13	85.71%	4	0.82	76.53%	$0.22	$0.11	105.15%
ANALGESICS - ANTI-INFLAMMATORY	ALL OTHER			$148,194.55	-25.69%			$40.06	$1,287.81	$21.00	41.32%	5,117	5.27%	2,638	322.48	0.06%	$0.78	($0.32)	-29.37%
ANALGESICS - ANTI-INFLAMMATORY	**ANALGESICS - ANTI-INFLAMMATORY**	**2**	**2**	**$1,237,025.22**	**19.78%**	**98.36%**	**93.06%**	**$241.34**	**$3,024.54**	**$21.00**	**6.48%**	**5,439**	**5.35%**	**2,662**	**342.78**	**0.14%**	**$6.50**	**$0.79**	**13.85%**
DERMATOLOGICALS	STELARA			$175,596.98	242.03%			$12,609.07	$12,609.07	$0.00	0.53%	14	250.00%	6	0.88	232.69%	$0.92	$0.64	225.12%
DERMATOLOGICALS	CLOBETASOL PROPIONATE			$81,075.18	169.61%			$239.73	$0.00	$239.73	8.93%	367	29.23%	218	23.13	22.83%	$0.43	$0.26	156.27%
DERMATOLOGICALS	ACZONE			$55,266.73	18.03%			$392.67	$392.67	$0.00	36.01%	191	18.63%	120	12.04	12.77%	$0.29	$0.03	12.19%
DERMATOLOGICALS	EPIDUO			$48,236.92	7.20%			$374.91	$374.91	$0.00	42.58%	183	-7.11%	113	11.53	-11.70%	$0.25	$0.00	1.90%
DERMATOLOGICALS	LIDOCAINE			$39,866.40	32.73%			$273.57	$0.00	$273.57	7.41%	156	30.00%	106	9.83	23.57%	$0.21	$0.04	26.16%
DERMATOLOGICALS	ALL OTHER			$572,807.51	29.17%			$168.32	$584.69	$97.25	19.17%	4,033	4.29%	2,403	254.17	-0.87%	$3.01	$0.56	22.78%
DERMATOLOGICALS	**DERMATOLOGICALS**	**3**	**5**	**$972,849.72**	**50.42%**	**84.93%**	**81.39%**	**$228.48**	**$680.26**	**$117.36**	**16.59%**	**4,944**	**6.71%**	**2,661**	**311.58**	**1.44%**	**$5.11**	**$1.54**	**42.99%**
ANTIVIRALS	HARVONI			$220,461.00	0.00%			$31,563.00	$31,563.00	$0.00	0.22%	7	0.00%	3	0.44	0.00%	$1.16	$1.16	0.00%
ANTIVIRALS	ATRIPLA			$125,569.83	-15.40%			$2,480.41	$2,480.41	$0.00	2.76%	52	-21.21%	8	3.28	-25.11%	$0.66	($0.16)	-19.58%
ANTIVIRALS	TRUVADA			$108,890.85	11.72%			$1,543.50	$1,543.50	$0.00	4.95%	74	0.00%	11	4.66	-4.95%	$0.57	$0.03	6.20%
ANTIVIRALS	COMPLERA			$86,904.13	4.57%			$2,365.50	$2,365.50	$0.00	3.47%	38	-2.56%	6	2.39	-7.38%	$0.46	($0.00)	-0.60%
ANTIVIRALS	STRIBILD			$84,048.80	213.99%			$2,610.21	$2,610.21	$0.00	2.52%	33	200.00%	4	2.08	185.16%	$0.44	$0.29	198.46%
ANTIVIRALS	ALL OTHER			$285,852.10	-40.87%			$157.67	$616.16	$40.65	26.10%	2,272	-10.41%	992	143.19	-14.84%	$1.50	($1.17)	-43.80%
ANTIVIRALS	**ANTIVIRALS**	**4**	**3**	**$911,726.71**	**8.64%**	**99.35%**	**73.49%**	**$403.23**	**$1,388.64**	**$40.65**	**9.77%**	**2,476**	**-9.17%**	**1,009**	**156.04**	**-13.66%**	**$4.79**	**$0.15**	**3.27%**
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	VYVANSE			$163,059.16	2.90%			$231.46	$231.46	$0.00	56.22%	1,096	2.05%	215	69.07	-3.00%	$0.86	($0.02)	-2.19%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	AMPHETAMINE/DEXTROAMPHETAMINE			$160,670.31	-3.31%			$86.95	$0.00	$86.95	29.44%	2,364	11.93%	386	148.98	6.40%	$0.84	($0.07)	-8.09%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	METHYLPHENIDATE HCL ER			$128,971.29	48.93%			$231.21	$237.21	$140.30	13.14%	629	12.93%	131	39.64	7.34%	$0.68	$0.20	41.56%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	NUVIGIL			$71,318.49	-0.75%			$577.49	$577.49	$0.00	14.34%	141	-11.88%	30	8.89	-16.23%	$0.37	($0.02)	-5.66%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	STRATTERA			$57,977.43	23.03%			$424.18	$424.18	$0.00	22.44%	167	-4.57%	35	10.52	-9.29%	$0.30	$0.04	16.94%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	ALL OTHER			$175,317.14	2.99%			$221.55	$334.56	$157.83	22.75%	968	5.56%	189	61.01	0.34%	$0.92	($0.02)	-2.11%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	**ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS**	**5**	**4**	**$757,313.82**	**8.12%**	**58.14%**	**64.13%**	**$181.06**	**$282.82**	**$102.16**	**28.92%**	**5,365**	**7.41%**	**811**	**338.11**	**2.10%**	**$3.98**	**$0.11**	**2.77%**
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	COPAXONE			$203,251.39	21.03%			$5,014.40	$5,014.40	$0.00	1.16%	41	17.14%	4	2.58	11.35%	$1.07	$0.14	15.04%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	GILENYA			$190,789.50	69.00%			$5,676.81	$5,676.81	$0.00	1.17%	34	47.83%	3	2.14	40.52%	$1.00	$0.38	60.64%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	XYREM			$100,694.51	0.00%			$7,816.89	$7,816.89	$0.00	0.92%	13	0.00%	2	0.82	0.00%	$0.53	$0.53	0.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	REBIF REBIDOSE			$69,737.57	0.00%			$5,422.12	$5,422.12	$0.00	1.08%	13	0.00%	1	0.82	0.00%	$0.37	$0.37	0.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	AVONEX			$56,013.20	-7.04%			$5,154.90	$5,154.90	$0.00	1.25%	11	-15.38%	1	0.69	-19.57%	$0.29	($0.04)	-11.64%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ALL OTHER			$109,500.82	11.46%			$449.68	$489.24	$149.22	13.15%	275	-13.25%	102	17.33	-17.54%	$0.58	$0.03	5.95%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	**PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.**	**6**	**8**	**$729,986.99**	**66.16%**	**50.90%**	**8.29%**	**$1,940.76**	**$2,102.25**	**$149.22**	**2.93%**	**387**	**-0.26%**	**112**	**24.39**	**-5.19%**	**$3.83**	**$1.41**	**57.94%**
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	GLEEVEC			$207,148.49	39.95%			$8,684.50	$8,684.50	$0.00	0.63%	24	4.35%	2	1.51	-0.81%	$1.09	$0.27	33.03%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	IMBRUVICA			$110,657.88	1158.31%			$11,135.79	$11,135.79	$0.00	0.63%	10	900.00%	2	0.63	850.54%	$0.58	$0.53	1096.08%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	TARCEVA			$99,334.12	34.88%			$6,682.16	$6,682.16	$0.00	0.90%	15	25.00%	2	0.95	18.82%	$0.52	$0.11	28.21%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	POMALYST			$40,611.26	0.00%			$8,122.25	$8,122.25	$0.00	0.00%	5	0.00%	1	0.32	0.00%	$0.21	$0.21	0.00%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	COMETRIQ			$40,606.77	258.75%			$13,535.59	$13,535.59	$0.00	0.00%	3	200.00%	1	0.19	185.16%	$0.21	$0.15	241.00%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	ALL OTHER			$94,239.88	17.01%			$138.47	$3,427.60	$59.64	13.75%	769	1.18%	179	48.46	-3.82%	$0.49	$0.05	11.23%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	**ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES**	**7**	**14**	**$592,598.40**	**83.86%**	**98.55%**	**92.26%**	**$735.74**	**$7,505.78**	**$59.64**	**2.68%**	**826**	**3.64%**	**186**	**52.06**	**-1.49%**	**$3.11**	**$1.33**	**74.77%**
ANTIHYPERLIPIDEMICS	CRESTOR			$242,800.93	14.69%			$307.78	$307.78	$0.00	39.82%	1,100	-17.60%	232	69.32	-21.68%	$1.28	$0.11	9.01%
ANTIHYPERLIPIDEMICS	ZETIA			$58,520.41	-3.80%			$292.20	$292.20	$0.00	30.20%	260	-26.55%	47	16.39	-30.19%	$0.31	($0.03)	-8.56%
ANTIHYPERLIPIDEMICS	OMEGA-3-ACID ETHYL ESTERS			$45,616.21	111.49%			$215.12	$0.00	$215.12	10.83%	234	122.86%	57	14.75	111.84%	$0.24	$0.12	101.03%
ANTIHYPERLIPIDEMICS	VYTORIN			$27,220.91	-3.27%			$270.44	$270.44	$0.00	43.52%	144	-25.77%	23	9.08	-29.44%	$0.14	($0.01)	-8.05%
ANTIHYPERLIPIDEMICS	WELCHOL			$27,033.79	-29.17%			$479.88	$479.88	$0.00	22.71%	69	-45.24%	31	4.35	-47.95%	$0.14	($0.07)	-32.67%
ANTIHYPERLIPIDEMICS	ALL OTHER			$128,687.37	-36.65%			$32.92	$367.53	$24.90	93.06%	7,346	-9.73%	1,450	462.96	-14.20%	$0.68	($0.45)	-39.78%
ANTIHYPERLIPIDEMICS	**ANTIHYPERLIPIDEMICS**	**8**	**6**	**$529,879.62**	**-5.97%**	**96.49%**	**81.52%**	**$85.08**	**$315.07**	**$30.91**	**48.51%**	**9,153**	**-10.72%**	**1,685**	**576.84**	**-15.14%**	**$2.78**	**($0.33)**	**-10.62%**
ANALGESICS - OPIOID	SUBOXONE			$108,727.31	23.49%			$421.91	$421.91	$0.00	18.23%	304	37.56%	37	19.16	30.75%	$0.57	$0.08	17.38%
ANALGESICS - OPIOID	OXYCONTIN			$100,957.02	0.64%			$516.06	$516.06	$0.00	12.65%	220	-3.93%	40	13.86	-8.68%	$0.53	($0.02)	-4.34%
ANALGESICS - OPIOID	OXYCODONE/ACETAMINOPHEN			$63,350.75	-9.21%			$43.55	$0.00	$43.55	45.43%	2,068	10.83%	950	130.33	5.34%	$0.33	($0.05)	-13.70%
ANALGESICS - OPIOID	NUCYNTA ER			$41,410.18	62.29%			$607.44	$607.44	$0.00	11.64%	76	16.92%	12	4.79	11.14%	$0.22	$0.08	54.26%
ANALGESICS - OPIOID	OPANA ER (CRUSH RESISTANT)			$22,785.17	-13.23%			$756.73	$756.73	$0.00	9.72%	33	-23.26%	4	2.08	-27.05%	$0.12	($0.03)	-17.52%
ANALGESICS - OPIOID	ALL OTHER			$191,631.01	-19.65%			$37.36	$544.42	$27.37	52.28%	7,606	-9.58%	2,829	479.34	-14.05%	$1.01	($0.31)	-23.62%
ANALGESICS - OPIOID	**ANALGESICS - OPIOID**	**9**	**7**	**$528,861.44**	**-3.57%**	**98.46%**	**94.16%**	**$66.67**	**$503.80**	**$30.88**	**31.88%**	**10,307**	**-4.88%**	**3,415**	**649.57**	**-9.59%**	**$2.78**	**($0.25)**	**-8.33%**
RESPIRATORY AGENTS - MISC.	KALYDECO			$216,655.65	-15.38%			$24,133.96	$24,133.96	$0.00	0.25%	9	-10.00%	1	0.57	-14.45%	$1.14	($0.28)	-19.57%
RESPIRATORY AGENTS - MISC.	PULMOZYME			$93,560.19	-2.41%			$4,098.95	$4,098.95	$0.00	0.78%	23	0.00%	4	1.45	-4.95%	$0.49	($0.04)	-7.24%
RESPIRATORY AGENTS - MISC.	OFEV			$48,600.00	0.00%			$8,160.00	$8,160.00	$0.00	0.74%	6	0.00%	1	0.38	0.00%	$0.26	$0.26	0.00%
RESPIRATORY AGENTS - MISC.	ORKAMBI			$39,805.86	0.00%			$19,962.93	$19,962.93	$0.00	0.30%	2	0.00%	1	0.13	0.00%	$0.21	$0.21	0.00%
RESPIRATORY AGENTS - MISC.	**RESPIRATORY AGENTS - MISC.**	**10**	**11**	**$398,621.70**	**13.27%**	**80.00%**	**0.00%**	**$10,009.19**	**$10,009.19**	**$0.00**	**0.44%**	**40**	**21.21%**	**6**	**2.52**	**15.22%**	**$2.09**	**$0.15**	**7.67%**
ALL OTHER	ALL OTHER			$5,059,771.35	-4.75%			$57.10	$252.76	$24.54	48.30%	129,585	-0.45%	12,459	8,166.69	-5.37%	$26.57	($2.78)	-9.46%
Total	**Total**			**$13,843,980.58**	**12.81%**	**91.74%**	**85.17%**	**$99.14**	**$437.73**	**$29.83**	**26.91%**	**175,742**	**-0.61%**	**13,346**	**11,075.59**	**-5.52%**	**$72.71**	**$4.91**	**7.24%**

Top Drug Classes by Paid/Prescription

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014
Rank: 10
Rx Sort By: PRESCRIPTION

Drug Class	Drug	Current Rank	Prior Rank	Current Plan Paid Amt	Plan Paid Chg Pct	Formulary Pct	Substitution Pct	Avg Ingredient/ Rx	Avg Ingredient/ Brand	Avg Ingredient/ Generic	Cost Share Pct	# of Rx's	Rx Chg Pct	Total Rx Users	Current Util/1000	Current Util Chg Pct	Current Plan Paid PMPM	Plan Paid Chg	Paid PMPM Chg Pct
ANTIDEPRESSANTS	SERTRALINE HCL			$146.33	-46.99%			$8.63	$0.00	$8.63	14882.72%	2,292	5.82%	494	144.45	0.58%	$0.00	($0.00)	-49.61%
ANTIDEPRESSANTS	BUPROPION HCL XL			$25,250.93	-3.52%			$41.16	$0.00	$41.16	149.21%	1,495	-2.92%	363	94.22	-7.72%	$0.13	($0.01)	-8.29%
ANTIDEPRESSANTS	ESCITALOPRAM OXALATE			$492.77	-54.44%			$9.97	$0.00	$9.97	3191.40%	1,489	4.34%	362	93.84	-0.82%	$0.00	($0.00)	-56.69%
ANTIDEPRESSANTS	FLUOXETINE HCL			$5,927.48	463.76%			$15.30	$198.32	$14.99	225.79%	1,191	5.40%	300	75.06	0.19%	$0.03	$0.03	435.88%
ANTIDEPRESSANTS	DULOXETINE HCL			$28,679.15	-82.57%			$47.17	$0.00	$47.17	85.72%	1,106	13.44%	230	69.70	7.83%	$0.15	($0.76)	-83.43%
ANTIDEPRESSANTS	ALL OTHER			$165,552.38	20.56%			$52.37	$318.18	$16.73	62.77%	5,058	-3.97%	1,116	318.76	-8.72%	$0.87	$0.11	14.60%
ANTIDEPRESSANTS	**ANTIDEPRESSANTS**	**1**	**1**	**$226,049.04**	**-31.60%**	**95.37%**	**96.03%**	**$34.16**	**$317.78**	**$20.01**	**96.02%**	**12,631**	**1.01%**	**2,333**	**796.03**	**-3.99%**	**$1.19**	**($0.64)**	**-34.98%**
ANTIHYPERTENSIVES	LISINOPRIL			$190.60	5.48%			$7.65	$0.00	$7.65	11722.83%	2,646	-0.23%	679	166.76	-5.16%	$0.00	$0.00	0.27%
ANTIHYPERTENSIVES	LOSARTAN POTASSIUM			$186.90	-2.04%			$9.03	$0.00	$9.03	8637.45%	1,641	8.39%	343	103.42	3.03%	$0.00	($0.00)	-6.88%
ANTIHYPERTENSIVES	LISINOPRIL/HYDROCHLOROTHIAZIDE			$27.15	20.56%			$9.19	$0.00	$9.19	38185.27%	1,034	0.58%	232	65.16	-4.39%	$0.00	$0.00	14.60%
ANTIHYPERTENSIVES	LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE			$51.98	-44.11%			$9.06	$0.00	$9.06	18667.95%	975	-9.22%	182	61.45	-13.71%	$0.00	($0.00)	-46.87%
ANTIHYPERTENSIVES	VALSARTAN/HYDROCHLOROTHIAZIDE			$503.49	-79.31%			$20.95	$0.00	$20.95	2058.38%	497	0.40%	113	31.32	-4.56%	$0.00	($0.01)	-80.33%
ANTIHYPERTENSIVES	ALL OTHER			$194,951.04	-24.44%			$75.56	$248.18	$32.92	70.68%	4,371	-7.59%	776	275.47	-12.16%	$1.02	($0.40)	-28.18%
ANTIHYPERTENSIVES	**ANTIHYPERTENSIVES**	**2**	**2**	**$195,911.16**	**-24.92%**	**92.32%**	**93.23%**	**$35.30**	**$248.18**	**$17.40**	**105.52%**	**11,164**	**-2.86%**	**2,095**	**703.58**	**-7.67%**	**$1.03**	**($0.41)**	**-28.63%**
ANALGESICS - OPIOID	HYDROCODONE/ACETAMINOPHEN			$19,066.16	92.69%			$16.08	$0.00	$16.08	270.93%	4,137	-8.35%	1,988	260.72	-12.88%	$0.10	$0.05	83.16%
ANALGESICS - OPIOID	OXYCODONE/ACETAMINOPHEN			$63,350.75	-9.21%			$43.55	$0.00	$43.55	45.43%	2,068	10.83%	950	130.33	5.34%	$0.33	($0.05)	-13.70%
ANALGESICS - OPIOID	TRAMADOL HCL			$144.80	-44.94%			$6.66	$0.00	$6.66	7050.68%	1,350	-9.70%	608	85.08	-14.16%	$0.00	($0.00)	-47.67%
ANALGESICS - OPIOID	OXYCODONE HCL			$7,583.79	-53.54%			$28.24	$0.00	$28.24	84.20%	478	0.84%	189	30.12	-4.14%	$0.04	($0.05)	-55.83%
ANALGESICS - OPIOID	SUBOXONE			$108,727.31	23.49%			$421.91	$421.91	$0.00	18.23%	304	37.56%	37	19.16	30.75%	$0.57	$0.08	17.38%
ANALGESICS - OPIOID	ALL OTHER			$329,988.63	-9.37%			$192.81	$556.09	$77.07	15.68%	1,970	-13.06%	646	124.15	-17.36%	$1.73	($0.28)	-13.85%
ANALGESICS - OPIOID	**ANALGESICS - OPIOID**	**3**	**3**	**$528,861.44**	**-3.57%**	**98.46%**	**94.16%**	**$66.67**	**$503.80**	**$30.88**	**31.88%**	**10,307**	**-4.88%**	**3,415**	**649.57**	**-9.59%**	**$2.78**	**($0.25)**	**-8.33%**
CONTRACEPTIVES	GILDESS FE 1/20			$8,852.92	-0.59%			$18.41	$0.00	$18.41	0.03%	460	6.73%	105	28.99	1.45%	$0.05	($0.00)	-5.51%
CONTRACEPTIVES	NUVARING			$16,410.95	19.06%			$116.89	$116.89	$0.00	172.07%	379	-7.11%	93	23.89	-11.70%	$0.09	$0.01	13.17%
CONTRACEPTIVES	LO LOESTRIN FE			$12,001.06	27.48%			$115.35	$115.35	$0.00	244.92%	356	20.27%	90	22.44	14.32%	$0.06	$0.01	21.18%
CONTRACEPTIVES	LARIN FE 1/20			$7,777.09	64.31%			$21.21	$0.00	$21.21	0.00%	351	69.57%	89	22.12	61.18%	$0.04	$0.01	56.19%
CONTRACEPTIVES	TRI-LINYAH			$6,736.75	-24.26%			$18.52	$0.00	$18.52	0.00%	346	-22.77%	73	21.81	-26.59%	$0.04	($0.01)	-28.00%
CONTRACEPTIVES	ALL OTHER			$286,740.18	3.77%			$44.73	$122.11	$35.92	23.66%	7,798	-7.02%	1,508	491.44	-11.62%	$1.51	($0.02)	-1.37%
CONTRACEPTIVES	**CONTRACEPTIVES**	**4**	**5**	**$338,518.95**	**5.11%**	**85.06%**	**85.13%**	**$47.11**	**$119.25**	**$33.56**	**37.06%**	**9,690**	**-4.79%**	**1,799**	**610.68**	**-9.49%**	**$1.78**	**($0.00)**	**-0.09%**
ANTIHYPERLIPIDEMICS	ATORVASTATIN CALCIUM			$916.97	26.50%			$11.07	$0.00	$11.07	3875.63%	3,044	3.43%	669	191.84	-1.68%	$0.00	$0.00	20.25%
ANTIHYPERLIPIDEMICS	SIMVASTATIN			$106.67	-44.56%			$7.59	$0.00	$7.59	14170.82%	1,793	-13.92%	372	113.00	-18.18%	$0.00	($0.00)	-47.30%
ANTIHYPERLIPIDEMICS	CRESTOR			$242,800.93	14.69%			$307.78	$307.78	$0.00	39.82%	1,100	-17.60%	232	69.32	-21.68%	$1.28	$0.11	9.01%
ANTIHYPERLIPIDEMICS	PRAVASTATIN SODIUM			$1,937.49	-15.57%			$21.28	$0.00	$21.28	934.19%	904	-6.51%	214	56.97	-11.14%	$0.01	($0.00)	-19.75%
ANTIHYPERLIPIDEMICS	FENOFIBRATE			$26,427.96	-42.60%			$62.53	$137.91	$61.35	72.60%	719	-12.53%	139	45.31	-16.86%	$0.14	($0.12)	-45.44%
ANTIHYPERLIPIDEMICS	ALL OTHER			$257,689.60	-14.84%			$206.35	$330.80	$124.07	28.10%	1,593	-24.22%	325	100.39	-27.96%	$1.35	($0.32)	-19.05%
ANTIHYPERLIPIDEMICS	**ANTIHYPERLIPIDEMICS**	**5**	**4**	**$529,879.62**	**-5.97%**	**96.49%**	**81.52%**	**$85.08**	**$315.07**	**$30.91**	**48.51%**	**9,153**	**-10.72%**	**1,685**	**576.84**	**-15.14%**	**$2.78**	**($0.33)**	**-10.62%**
ANTIDIABETICS	METFORMIN HCL			$1,243.90	152.06%			$8.49	$0.00	$8.49	757.31%	1,157	4.99%	366	72.92	-0.20%	$0.01	$0.00	139.60%
ANTIDIABETICS	METFORMIN HCL ER			$50,326.22	-5.76%			$55.24	$0.00	$55.24	21.81%	1,092	6.12%	253	68.82	0.87%	$0.26	($0.03)	-10.42%
ANTIDIABETICS	INVOKANA			$163,362.76	98.29%			$429.33	$429.33	$0.00	20.09%	456	61.13%	84	28.74	53.16%	$0.86	$0.40	88.49%
ANTIDIABETICS	LANTUS SOLOSTAR			$193,737.06	11.17%			$507.26	$507.26	$0.00	9.10%	416	-16.80%	84	26.22	-20.91%	$1.02	$0.05	5.68%
ANTIDIABETICS	NOVOLOG FLEXPEN			$233,728.98	99.21%			$633.70	$633.70	$0.00	5.07%	387	35.31%	87	24.39	28.62%	$1.23	$0.58	89.36%
ANTIDIABETICS	ALL OTHER			$1,482,946.69	36.45%			$448.50	$597.65	$29.22	12.48%	3,712	2.54%	511	233.94	-2.53%	$7.79	$1.78	29.70%
ANTIDIABETICS	**ANTIDIABETICS**	**6**	**6**	**$2,125,345.61**	**40.32%**	**90.30%**	**44.74%**	**$330.61**	**$572.53**	**$30.59**	**12.60%**	**7,220**	**5.87%**	**919**	**455.02**	**0.63%**	**$11.16**	**$2.79**	**33.38%**
ULCER DRUGS	OMEPRAZOLE			$865.18	-64.00%			$10.17	$0.00	$10.17	3681.53%	2,945	4.84%	791	185.60	-0.34%	$0.00	($0.01)	-65.78%
ULCER DRUGS	PANTOPRAZOLE SODIUM			$376.67	-7.34%			$8.20	$0.00	$8.20	3547.81%	1,505	5.39%	407	94.85	0.18%	$0.00	($0.00)	-11.92%
ULCER DRUGS	RANITIDINE HCL			$531.86	-3.75%			$9.41	$0.00	$9.41	968.97%	557	2.01%	261	35.10	-3.03%	$0.00	($0.00)	-8.51%
ULCER DRUGS	NEXIUM			$117,458.32	-46.12%			$409.02	$409.02	$0.00	16.55%	334	-58.20%	90	21.05	-60.27%	$0.62	($0.59)	-48.78%
ULCER DRUGS	LANSOPRAZOLE			$1,686.91	-79.68%			$25.24	$0.00	$25.24	357.25%	295	-26.80%	69	18.59	-30.42%	$0.01	($0.04)	-80.68%
ULCER DRUGS	ALL OTHER			$97,206.98	136.84%			$124.83	$238.84	$105.63	25.64%	971	26.27%	465	61.19	20.02%	$0.51	$0.28	125.13%
ULCER DRUGS	**ULCER DRUGS**	**7**	**7**	**$218,125.92**	**-19.42%**	**98.40%**	**96.31%**	**$47.34**	**$358.76**	**$23.28**	**46.19%**	**6,607**	**-2.18%**	**1,743**	**416.39**	**-7.01%**	**$1.15**	**($0.35)**	**-23.41%**
THYROID AGENTS	LEVOTHYROXINE SODIUM			$6,260.54	-33.34%			$21.43	$0.00	$21.43	1025.09%	3,167	4.73%	654	199.59	-0.45%	$0.03	($0.02)	-36.64%
THYROID AGENTS	SYNTHROID			$1,310.09	19.13%			$41.69	$41.69	$0.00	5992.59%	1,975	0.71%	344	124.47	-4.27%	$0.01	$0.00	13.23%
THYROID AGENTS	ARMOUR THYROID			$51.08	-11.64%			$27.87	$27.87	$0.00	19577.90%	350	11.46%	66	22.06	5.95%	$0.00	($0.00)	-16.01%
THYROID AGENTS	LIOTHYRONINE SODIUM			$2,624.56	-40.05%			$29.43	$0.00	$29.43	281.74%	330	-2.37%	69	20.80	-7.20%	$0.01	($0.01)	-43.02%
THYROID AGENTS	NATURE-THROID			$0.00	0.00%			$8.80	$8.80	$0.00	0.00%	84	236.00%	19	5.29	219.38%	$0.00	$0.00	0.00%
THYROID AGENTS	ALL OTHER			$2,777.52	18.30%			$50.59	$88.19	$15.77	237.91%	183	46.40%	51	11.53	39.16%	$0.01	$0.00	12.45%
THYROID AGENTS	**THYROID AGENTS**	**8**	**9**	**$13,023.79**	**-24.61%**	**58.99%**	**92.55%**	**$29.51**	**$40.29**	**$22.01**	**1286.06%**	**6,089**	**5.22%**	**1,006**	**383.74**	**0.01%**	**$0.07**	**($0.03)**	**-28.34%**
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	MONTELUKAST SODIUM			$2,543.18	-52.72%			$11.98	$0.00	$11.98	1195.55%	2,548	0.79%	744	160.58	-4.19%	$0.01	($0.02)	-55.05%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	PROAIR HFA			$2,760.25	-24.99%			$54.57	$54.57	$0.00	1372.30%	732	19.41%	644	46.13	13.51%	$0.01	($0.01)	-28.70%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	VENTOLIN HFA			$1,716.03	-34.87%			$50.85	$50.85	$0.00	1759.75%	617	-21.10%	416	38.88	-25.00%	$0.01	($0.01)	-38.09%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ALBUTEROL SULFATE			$1,461.60	-47.01%			$14.94	$0.00	$14.94	339.14%	405	-11.38%	332	25.52	-15.76%	$0.01	($0.01)	-49.63%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ADVAIR DISKUS			$100,376.53	-21.60%			$365.92	$365.92	$0.00	25.34%	343	-26.39%	117	21.62	-30.04%	$0.53	($0.18)	-25.48%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ALL OTHER			$227,178.42	6.82%			$233.20	$246.02	$150.99	34.49%	1,305	0.93%	465	82.24	-4.06%	$1.19	$0.02	1.54%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	**ANTIASTHMATIC AND BRONCHODILATOR AGENTS**	**9**	**8**	**$336,036.01**	**-5.39%**	**95.90%**	**52.78%**	**$90.38**	**$168.23**	**$20.18**	**61.67%**	**5,950**	**-3.08%**	**1,884**	**374.98**	**-7.87%**	**$1.76**	**($0.20)**	**-10.06%**
ANALGESICS - ANTI-INFLAMMATORY	IBUPROFEN			$163.96	-2.95%			$7.39	$0.00	$7.39	9716.19%	1,917	11.78%	1,361	120.81	6.25%	$0.00	($0.00)	-7.75%
ANALGESICS - ANTI-INFLAMMATORY	MELOXICAM			$27.76	-61.55%			$6.42	$0.00	$6.42	27431.56%	1,037	2.98%	499	65.35	-2.11%	$0.00	($0.00)	-63.45%
ANALGESICS - ANTI-INFLAMMATORY	DICLOFENAC SODIUM DR			$912.03	-45.23%			$15.52	$0.00	$15.52	1050.61%	639	-1.54%	341	40.27	-6.41%	$0.00	($0.00)	-47.94%
ANALGESICS - ANTI-INFLAMMATORY	CELECOXIB			$33,408.19	1319.95%			$96.87	$0.00	$96.87	27.07%	434	3000.00%	149	27.35	2846.69%	$0.18	$0.16	1249.73%
ANALGESICS - ANTI-INFLAMMATORY	NAPROXEN			$189.11	-35.00%			$8.15	$40.27	$7.92	1872.40%	414	-8.00%	300	26.09	-12.55%	$0.00	($0.00)	-38.22%
ANALGESICS - ANTI-INFLAMMATORY	ALL OTHER			$1,202,324.17	16.93%			$1,238.94	$3,047.15	$49.49	2.86%	998	-24.85%	378	62.90	-28.57%	$6.31	$0.63	11.15%
ANALGESICS - ANTI-INFLAMMATORY	**ANALGESICS - ANTI-INFLAMMATORY**	**10**	**12**	**$1,237,025.22**	**19.78%**	**98.36%**	**93.06%**	**$241.34**	**$3,024.54**	**$21.00**	**6.48%**	**5,439**	**5.35%**	**2,662**	**342.78**	**0.14%**	**$6.50**	**$0.79**	**13.85%**
ALL OTHER	ALL OTHER			$8,095,203.82	14.74%			$108.70	$515.88	$34.21	23.81%	91,492	0.67%	12,084	5,766.00	-4.31%	$42.51	$3.53	9.06%
Total	**Total**			**$13,843,980.58**	**12.81%**	**91.74%**	**85.17%**	**$99.14**	**$437.73**	**$29.83**	**26.91%**	**175,742**	**-0.61%**	**13,346**	**11,075.59**	**-5.52%**	**$72.71**	**$4.91**	**7.24%**

Top Drugs by Paid/Prescription

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014
Rank: 10
Rx Sort By: PAID

Total

	Rank		Paid Amt			Member Paid Amt			Total Paid Amt			Copay Amt		Deductible Amt		Co-Insurance Amt		Ingredient Cost		Dispense Fee	
Drug Name	**Current**	**Prior**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Current**	**Prior**	**Current**	**Prior**	**Current**	**Prior**	**Current**	**Prior**
HUMIRA PEN	1	1	$526,178.93	$447,189.59	17.66%	$8,853.91	$7,690.00	15.12%	$535,032.84	$454,879.59	17.62%	$7,500.00	$7,690.00	$1,353.91	$0.00	$0.00	$0.00	$535,003.94	$454,820.09	$28.90	$59.50
ENBREL SURECLICK	2	15	$261,648.36	$153,800.38	70.12%	$4,850.00	$2,820.00	71.99%	$266,498.36	$156,620.38	70.16%	$3,950.00	$2,820.00	$900.00	$0.00	$0.00	$0.00	$266,469.46	$156,592.03	$28.90	$28.35
CRESTOR	3	6	$242,800.93	$211,708.04	14.69%	$96,681.68	$82,415.03	17.31%	$339,482.61	$294,123.07	15.42%	$82,914.27	$82,415.03	$13,767.41	$0.00	$0.00	$0.00	$338,558.81	$292,914.62	$923.80	$1,208.45
NOVOLOG	4	22	$238,029.21	$100,385.91	137.12%	$9,090.00	$6,610.00	37.52%	$247,119.21	$106,995.91	130.96%	$7,890.00	$6,610.00	$1,200.00	$0.00	$0.00	$0.00	$246,876.41	$106,820.31	$242.80	$175.60
NOVOLOG FLEXPEN	5	20	$233,728.98	$117,325.14	99.21%	$11,842.22	$11,261.91	5.15%	$245,571.20	$128,587.05	90.98%	$10,880.00	$11,261.91	$962.22	$0.00	$0.00	$0.00	$245,240.35	$128,325.45	$330.85	$261.60
NORDITROPIN FLEXPRO	6	2	$228,190.92	$329,164.43	-30.68%	$3,630.00	$4,115.00	-11.79%	$231,820.92	$333,279.43	-30.44%	$2,930.00	$4,115.00	$700.00	$0.00	$0.00	$0.00	$231,804.77	$333,253.78	$16.15	$25.65
VICTOZA	7	8	$227,246.85	$193,122.03	17.67%	$24,703.43	$20,569.91	20.09%	$251,950.28	$213,691.94	17.90%	$21,346.83	$20,569.91	$3,356.60	$0.00	$0.00	$0.00	$251,655.78	$213,355.94	$294.50	$336.00
HARVONI	8	0	$220,461.00	$0.00	0.00%	$480.00	$0.00	0.00%	$220,941.00	$0.00	0.00%	$380.00	$0.00	$100.00	$0.00	$0.00	$0.00	$220,941.00	$0.00	$0.00	$0.00
KALYDECO	9	3	$216,655.65	$256,042.10	-15.38%	$550.00	$500.00	10.00%	$217,205.65	$256,542.10	-15.33%	$450.00	$500.00	$100.00	$0.00	$0.00	$0.00	$217,205.65	$256,542.10	$0.00	$0.00
ENBREL	10	14	$213,013.14	$156,384.43	36.21%	$3,500.00	$2,640.00	32.58%	$216,513.14	$159,024.43	36.15%	$3,000.00	$2,640.00	$500.00	$0.00	$0.00	$0.00	$216,491.89	$159,005.73	$21.25	$18.70
ALL OTHER			$11,236,026.61	$10,306,322.60	9.02%	$3,561,777.25	$3,268,967.78	8.96%	$14,797,803.86	$13,575,290.38	9.01%	$3,150,621.03	$3,268,967.78	$411,156.22	$0.00	$0.00	$0.00	$14,652,835.81	$13,407,679.74	$161,016.00	$175,972.15
Total			**$13,843,980.58**	**$12,271,444.65**	**12.81%**	**$3,725,958.49**	**$3,407,589.63**	**9.34%**	**$17,569,939.07**	**$15,679,034.28**	**12.06%**	**$3,291,862.13**	**$3,407,589.63**	**$434,096.36**	**$0.00**	**$0.00**	**$0.00**	**$17,423,083.87**	**$15,509,309.79**	**$162,903.15**	**$178,086.00**

Average

	Rank		Plan Avg Paid Amt			Member Avg Paid Amt			Total Avg Paid Amt			Copay Avg Amt		Deductible Avg Amt		Co-Insurance Avg Amt		Ingredient Avg Cost		Dispense Avg Fee	
Drug Name	**Current**	**Prior**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Current**	**Prior**	**Current**	**Prior**	**Current**	**Prior**	**Current**	**Prior**
HUMIRA PEN	1	1	$3,507.85	$2,830.31	23.92%	$59.02	$48.67	20.83%	$3,566.88	$2,878.98	23.87%	$50.00	$48.67	$9.02	$0.00	$0.00	$0.00	$3,566.69	$2,878.60	$0.19	$0.37
ENBREL SURECLICK	2	15	$3,114.86	$2,606.78	19.49%	$57.73	$47.79	19.15%	$3,172.59	$2,654.58	19.52%	$47.02	$47.79	$10.71	$0.00	$0.00	$0.00	$3,172.25	$2,654.10	$0.34	$0.48
CRESTOR	3	6	$220.72	$158.58	39.24%	$87.89	$61.73	42.62%	$308.62	$220.31	40.00%	$75.37	$61.73	$12.51	$0.00	$0.00	$0.00	$307.78	$219.41	$0.83	$0.90
NOVOLOG	4	22	$826.49	$522.84	58.05%	$31.56	$34.42	-5.88%	$858.05	$557.27	53.86%	$27.39	$34.42	$4.16	$0.00	$0.00	$0.00	$857.20	$556.35	$0.84	$0.91
NOVOLOG FLEXPEN	5	20	$603.95	$410.22	47.07%	$30.60	$39.37	-20.51%	$634.55	$449.60	40.98%	$28.11	$39.37	$2.48	$0.00	$0.00	$0.00	$633.69	$448.69	$0.85	$0.91
NORDITROPIN FLEXPRO	6	2	$3,803.18	$3,617.19	5.11%	$60.50	$45.21	33.33%	$3,863.68	$3,662.41	5.49%	$48.83	$45.21	$11.66	$0.00	$0.00	$0.00	$3,863.41	$3,662.12	$0.26	$0.28
VICTOZA	7	8	$651.13	$495.18	31.31%	$70.78	$52.74	34.62%	$721.92	$547.92	31.81%	$61.16	$52.74	$9.61	$0.00	$0.00	$0.00	$721.07	$547.06	$0.84	$0.86
HARVONI	8	0	$31,494.42	$0.00	0.00%	$68.57	$0.00	0.00%	$31,563.00	$0.00	0.00%	$54.28	$0.00	$14.28	$0.00	$0.00	$0.00	$31,563.00	$0.00	$0.00	$0.00
KALYDECO	9	3	$24,072.85	$25,604.21	-5.98%	$61.11	$50.00	22.00%	$24,133.96	$25,654.21	-5.93%	$50.00	$50.00	$11.11	$0.00	$0.00	$0.00	$24,133.96	$25,654.21	$0.00	$0.00
ENBREL	10	14	$3,550.21	$2,792.57	27.11%	$58.33	$47.14	23.40%	$3,608.55	$2,839.72	27.05%	$50.00	$47.14	$8.33	$0.00	$0.00	$0.00	$3,608.19	$2,839.38	$0.35	$0.33
ALL OTHER			$64.85	$59.15	8.47%	$20.55	$18.76	5.56%	$85.41	$77.91	9.09%	$18.18	$18.76	$2.37	$0.00	$0.00	$0.00	$84.57	$76.95	$0.92	$1.00
Total			**$78.77**	**$69.40**	**13.04%**	**$21.20**	**$19.27**	**5.26%**	**$99.97**	**$88.67**	**12.50%**	**$18.73**	**$19.27**	**$2.47**	**$0.00**	**$0.00**	**$0.00**	**$99.14**	**$87.71**	**$0.92**	**$1.00**

Utilization

	Rank		Number of Rx			Rx Users			Rx Per User		Avg Quantity		Avg Days Supply		Plan Paid PMPM Amt			Util/1000		
Drug Name	**Current**	**Prior**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Current**	**Prior**	**Current**	**Prior**	**Current**	**Prior**	**Chg %**	**Current**	**Prior**	**Chg %**
HUMIRA PEN	1	1	150	158	-5.06%	19	21	-9.52%	7.89	7.52	2.22	2.20	28.00	28.00	$2.76	$2.47	11.74%	9.45	10.48	-9.76%
ENBREL SURECLICK	2	15	84	59	42.37%	13	12	8.33%	6.46	4.92	3.92	3.92	28.00	28.00	$1.37	$0.84	63.10%	5.29	3.91	35.33%
CRESTOR	3	6	1,100	1,335	-17.60%	232	236	-1.69%	4.74	5.66	43.29	35.13	43.00	35.00	$1.27	$1.16	9.48%	69.32	88.51	-21.68%
NOVOLOG	4	22	288	192	50.00%	62	40	55.00%	4.65	4.80	39.09	30.05	43.00	32.00	$1.25	$0.55	127.27%	18.15	12.73	42.58%
NOVOLOG FLEXPEN	5	20	387	286	35.31%	87	65	33.85%	4.45	4.40	22.31	19.03	38.00	30.00	$1.22	$0.64	90.63%	24.39	18.96	28.62%
NORDITROPIN FLEXPRO	6	2	60	91	-34.07%	8	13	-38.46%	7.50	7.00	5.20	5.14	27.00	27.00	$1.19	$1.81	-34.25%	3.78	6.03	-37.33%
VICTOZA	7	8	349	390	-10.51%	75	76	-1.32%	4.65	5.13	10.09	8.61	35.00	31.00	$1.19	$1.06	12.26%	21.99	25.86	-14.94%
HARVONI	8	0	7	0	0.00%	3	0	0.00%	2.33	0.00	28.00	0.00	28.00	0.00	$1.15	$0.00	0.00%	0.44	0.00	0.00%
KALYDECO	9	3	9	10	-10.00%	1	1	0.00%	9.00	10.00	56.44	60.00	28.00	30.00	$1.13	$1.41	-19.86%	0.57	0.66	-14.46%
ENBREL	10	14	60	56	7.14%	7	7	0.00%	8.57	8.00	5.46	4.78	28.00	28.00	$1.11	$0.86	29.07%	3.78	3.71	1.84%
ALL OTHER			173,248	174,235	-0.57%	13,336	12,636	5.54%	12.99	13.79	50.81	48.37	32.00	29.00	$59.00	$56.94	3.62%	10,918.42	11,551.94	-5.48%
Total			**175,742**	**176,812**	**-0.61%**	**13,346**	**12,644**	**5.55%**	**13.17**	**13.98**	**50.50**	**48.02**	**32.00**	**29.00**	**$72.70**	**$67.80**	**7.23%**	**11,075.59**	**11,722.80**	**-5.52%**

Notes:
- * = Drug not found in prior period.
- TOTAL represents the summation of all Prescriptions for analysis period (including claims not ranked).
- ALL OTHER represents the difference between all prescriptions and prescriptions ranked for analysis period.
- Brand/Generic = (G) Generic, (MS) Multi-Source Brand, (SS) Single Source Brand.
- Plan Paid Amount does not include sales tax.

Top Drugs by Paid/Prescription

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014
Rank: 10
Rx Sort By: PRESCRIPTION

Total

	Rank		Paid Amt			Member Paid Amt			Total Paid Amt			Copay Amt		Deductible Amt		Co-Insurance Amt		Ingredient Cost		Dispense Fee	
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior
HYDROCODONE/ACETAMINOPHEN	1	1	$19,066.16	$9,894.67	92.69%	$51,655.72	$51,110.24	1.07%	$70,721.88	$61,004.91	15.93%	$51,655.72	$51,110.24	$0.00	$0.00	$0.00	$0.00	$66,516.58	$56,176.37	$4,205.30	$4,828.45
LEVOTHYROXINE SODIUM	2	2	$6,260.54	$9,392.38	-33.34%	$64,176.39	$38,342.18	67.38%	$70,436.93	$47,734.56	47.56%	$64,176.39	$38,342.18	$0.00	$0.00	$0.00	$0.00	$67,855.78	$44,860.51	$2,581.15	$2,874.05
ATORVASTATIN CALCIUM	3	3	$916.97	$724.87	26.52%	$35,538.41	$34,363.67	3.42%	$36,455.38	$35,088.54	3.89%	$35,538.41	$34,363.67	$0.00	$0.00	$0.00	$0.00	$33,701.18	$32,104.29	$2,768.00	$2,984.25
OMEPRAZOLE	4	4	$865.18	$2,403.33	-64.00%	$31,851.82	$34,578.87	-7.89%	$32,717.00	$36,982.20	-11.53%	$31,851.82	$34,578.87	$0.00	$0.00	$0.00	$0.00	$29,946.85	$34,114.70	$2,770.15	$2,867.50
AZITHROMYCIN	5	6	$3,145.70	$3,297.29	-4.58%	$29,277.20	$29,630.09	-1.19%	$32,422.90	$32,927.38	-1.53%	$28,972.28	$29,630.09	$304.92	$0.00	$0.00	$0.00	$29,476.60	$29,951.96	$2,949.00	$2,974.65
ALPRAZOLAM	6	5	$133.19	$470.34	-71.70%	$20,336.52	$19,579.55	3.86%	$20,469.71	$20,049.89	2.09%	$20,336.52	$19,579.55	$0.00	$0.00	$0.00	$0.00	$17,705.46	$17,059.54	$2,764.25	$2,990.35
LISINOPRIL	7	7	$190.60	$180.69	5.00%	$22,343.71	$18,720.61	19.35%	$22,534.31	$18,901.30	19.22%	$22,343.71	$18,720.61	$0.00	$0.00	$0.00	$0.00	$20,253.01	$16,287.36	$2,281.30	$2,613.85
MONTELUKAST SODIUM	8	8	$2,543.18	$5,378.51	-52.71%	$30,404.89	$36,196.82	-16.00%	$32,948.07	$41,575.33	-20.75%	$30,404.89	$36,196.82	$0.00	$0.00	$0.00	$0.00	$30,533.37	$38,989.62	$2,414.70	$2,585.55
AMPHETAMINE/DEXTROAMPHETAMINE	9	13	$160,670.31	$166,164.43	-3.31%	$47,299.69	$41,477.84	14.03%	$207,970.00	$207,642.27	0.16%	$47,299.69	$41,477.84	$0.00	$0.00	$0.00	$0.00	$205,558.75	$205,371.36	$2,411.25	$2,260.15
SERTRALINE HCL	10	12	$146.33	$276.03	-46.74%	$21,777.88	$17,969.84	21.19%	$21,924.21	$18,245.87	20.16%	$21,777.88	$17,969.84	$0.00	$0.00	$0.00	$0.00	$19,787.46	$15,941.37	$2,136.45	$2,304.50
ALL OTHER			$13,810,712.73	$12,239,426.54	12.84%	$3,418,595.95	$3,127,097.76	9.32%	$17,229,308.68	$15,366,524.30	12.12%	$2,984,804.51	$3,127,097.76	$433,791.44	$0.00	$0.00	$0.00	$17,107,307.58	$15,223,824.07	$138,032.85	$151,062.85
Total			**$13,843,980.58**	**$12,271,444.65**	**12.81%**	**$3,725,958.49**	**$3,407,589.63**	**9.34%**	**$17,569,939.07**	**$15,679,034.28**	**12.06%**	**$3,291,862.13**	**$3,407,589.63**	**$434,096.36**	**$0.00**	**$0.00**	**$0.00**	**$17,423,083.87**	**$15,509,309.79**	**$162,903.15**	**$178,086.00**

Average

	Rank		Plan Avg Paid Amt			Member Avg Paid Amt			Total Avg Paid Amt			Copay Avg Amt		Deductible Avg Amt		Co-Insurance Avg Amt		Ingredient Avg Cost		Dispense Avg Fee	
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior
HYDROCODONE/ACETAMINOPHEN	1	1	$4.60	$2.19	100.00%	$12.48	$11.32	9.09%	$17.09	$13.51	23.08%	$12.48	$11.32	$0.00	$0.00	$0.00	$0.00	$16.07	$12.44	$1.01	$1.06
LEVOTHYROXINE SODIUM	2	2	$1.97	$3.10	-33.33%	$20.26	$12.67	58.33%	$22.24	$15.78	40.00%	$20.26	$12.67	$0.00	$0.00	$0.00	$0.00	$21.42	$14.83	$0.81	$0.95
ATORVASTATIN CALCIUM	3	3	$0.30	$0.24	0.00%	$11.67	$11.67	0.00%	$11.97	$11.92	0.00%	$11.67	$11.67	$0.00	$0.00	$0.00	$0.00	$11.07	$10.90	$0.90	$1.01
OMEPRAZOLE	4	4	$0.29	$0.85	0.00%	$10.81	$12.31	-8.33%	$11.10	$13.16	-15.38%	$10.81	$12.31	$0.00	$0.00	$0.00	$0.00	$10.16	$12.14	$0.94	$1.02
AZITHROMYCIN	5	6	$1.10	$1.20	0.00%	$10.25	$10.85	0.00%	$11.36	$12.06	0.00%	$10.15	$10.85	$0.10	$0.00	$0.00	$0.00	$10.32	$10.97	$1.03	$1.08
ALPRAZOLAM	6	5	$0.04	$0.16	0.00%	$7.41	$6.99	0.00%	$7.46	$7.15	0.00%	$7.41	$6.99	$0.00	$0.00	$0.00	$0.00	$6.45	$6.09	$1.00	$1.06
LISINOPRIL	7	7	$0.07	$0.06	0.00%	$8.44	$7.05	14.29%	$8.51	$7.12	14.29%	$8.44	$7.05	$0.00	$0.00	$0.00	$0.00	$7.65	$6.14	$0.86	$0.98
MONTELUKAST SODIUM	8	8	$0.99	$2.12	-50.00%	$11.93	$14.31	-14.29%	$12.93	$16.44	-18.75%	$11.93	$14.31	$0.00	$0.00	$0.00	$0.00	$11.98	$15.42	$0.94	$1.02
AMPHETAMINE/DEXTROAMPHETAMINE	9	13	$67.96	$78.67	-12.82%	$20.00	$19.63	0.00%	$87.97	$98.31	-10.20%	$20.00	$19.63	$0.00	$0.00	$0.00	$0.00	$86.95	$97.24	$1.01	$1.07
SERTRALINE HCL	10	12	$0.06	$0.12	0.00%	$9.50	$8.29	12.50%	$9.56	$8.42	12.50%	$9.50	$8.29	$0.00	$0.00	$0.00	$0.00	$8.63	$7.35	$0.93	$1.06
ALL OTHER			$92.46	$81.24	13.58%	$22.88	$20.75	10.00%	$115.34	$102.00	12.75%	$19.98	$20.75	$2.90	$0.00	$0.00	$0.00	$114.53	$101.05	$0.92	$1.00
Total			**$78.77**	**$69.40**	**13.04%**	**$21.20**	**$19.27**	**5.26%**	**$99.97**	**$88.67**	**12.50%**	**$18.73**	**$19.27**	**$2.47**	**$0.00**	**$0.00**	**$0.00**	**$99.14**	**$87.71**	**$0.92**	**$1.00**

Utilization

	Rank		Number of Rx			Rx Users			Rx Per User		Avg Quantity		Avg Days Supply		Plan Paid PMPM Amt			Util/1000		
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %
HYDROCODONE/ACETAMINOPHEN	1	1	4,137	4,514	-8.35%	1,988	1,953	1.79%	2.08	2.31	51.81	53.23	15.00	15.00	$0.10	$0.05	100.00%	260.72	299.28	-12.88%
LEVOTHYROXINE SODIUM	2	2	3,167	3,024	4.73%	654	552	18.48%	4.84	5.48	49.09	41.03	48.00	40.00	$0.03	$0.05	-40.00%	199.59	200.49	-0.45%
ATORVASTATIN CALCIUM	3	3	3,044	2,943	3.43%	669	593	12.82%	4.55	4.96	46.32	39.74	46.00	39.00	$0.00	$0.00	0.00%	191.84	195.12	-1.68%
OMEPRAZOLE	4	4	2,945	2,809	4.84%	791	700	13.00%	3.72	4.01	48.27	43.36	42.00	38.00	$0.00	$0.01	-100.00%	185.60	186.24	-0.34%
AZITHROMYCIN	5	6	2,854	2,730	4.54%	2,290	2,169	5.58%	1.25	1.26	8.95	8.89	5.00	5.00	$0.01	$0.01	0.00%	179.86	181.00	-0.63%
ALPRAZOLAM	6	5	2,743	2,801	-2.07%	724	707	2.40%	3.79	3.96	53.60	53.56	27.00	26.00	$0.00	$0.00	0.00%	172.87	185.71	-6.91%
LISINOPRIL	7	7	2,646	2,652	-0.23%	679	623	8.99%	3.90	4.26	49.78	43.73	44.00	38.00	$0.00	$0.00	0.00%	166.76	175.83	-5.16%
MONTELUKAST SODIUM	8	8	2,548	2,528	0.79%	744	649	14.64%	3.42	3.90	39.11	35.34	39.00	35.00	$0.01	$0.02	-50.00%	160.58	167.61	-4.19%
AMPHETAMINE/DEXTROAMPHETAMINE	9	13	2,364	2,112	11.93%	386	344	12.21%	6.12	6.14	45.63	47.11	30.00	30.00	$0.84	$0.91	-7.69%	148.98	140.03	6.40%
SERTRALINE HCL	10	12	2,292	2,166	5.82%	494	440	12.27%	4.64	4.92	46.01	40.70	40.00	35.00	$0.00	$0.00	0.00%	144.45	143.61	0.58%
ALL OTHER			149,366	150,645	-0.85%	12,959	12,297	5.38%	11.53	12.25	51.64	49.25	31.00	29.00	$72.53	$67.62	7.26%	9,413.33	9,987.90	-5.75%
Total			**175,742**	**176,812**	**-0.61%**	**13,346**	**12,644**	**5.55%**	**13.17**	**13.98**	**50.50**	**48.02**	**32.00**	**29.00**	**$72.70**	**$67.80**	**7.23%**	**11,075.59**	**11,722.80**	**-5.52%**

Notes:
- * = Drug not found in prior period.
- TOTAL represents the summation of all Prescriptions for analysis period (including claims not ranked).
- ALL OTHER represents the difference between all prescriptions and prescriptions ranked for analysis period.
- Brand/Generic = (G) Generic, (MS) Multi-Source Brand, (SS) Single Source Brand.
- Plan Paid Amount does not include sales tax.

Top Provider Type by Paid

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014
Rank: 10

Inpatient

	Rank		Paid Amt			Members		Admits		Paid Per Admit			Admits/1000		Days		Days/1000		ALOS	
Provider Full Name	Current	Prior	Current	Prior	% Chg	Current	Prior	Current	Prior	Current	Prior	% Chg	Current	Prior	Current	Prior	Current	Prior	Current	Prior
BAPTIST MEDICAL CENTER	1	1	$16,248,973.15	$12,437,779.20	30.64%	884	826	971	908	$16,734.26	$13,697.99	22.17%	61.19	60.20	3,624	3,110	228.39	206.20	3.73	3.43
BAPTIST MED CTR - BCH	2	2	$1,055,315.82	$1,041,600.54	1.32%	106	94	114	99	$9,257.15	$10,521.21	-12.01%	7.18	6.56	293	264	18.47	17.50	2.57	2.67
MAYO CLINIC FLORIDA HOSPITAL	3	3	$782,161.94	$640,872.81	22.05%	19	11	19	15	$41,166.41	$42,724.85	-3.65%	1.20	0.99	85	55	5.36	3.65	4.47	3.67
SHANDS JACKSONVILLE MEDICAL CENTER INC	4	4	$577,535.09	$284,607.12	102.92%	23	18	22	16	$26,251.59	$17,787.94	47.58%	1.39	1.06	105	89	6.62	5.90	4.77	5.56
,	5	5	$508,686.82	$233,874.43	117.50%	30	15	19	25	$26,772.99	$9,354.97	186.19%	1.20	1.66	124	87	7.81	5.77	6.53	3.48
NEMOURS CHILDREN'S HOSPITAL	6	0	$297,305.55	$0.00	0.00%	1	0	1	0	$297,305.55	$0.00	0.00%	0.06	0.00	52	0	3.28	0.00	52.00	0.00
BAPTIST MEDICAL CENTER NASSAU	7	6	$245,570.95	$219,464.64	11.90%	32	24	30	25	$8,185.69	$8,778.58	-6.75%	1.89	1.66	71	64	4.47	4.24	2.37	2.56
BAPTIST MEDICAL CENTER (WOLFSON)	8	0	$229,832.30	$0.00	0.00%	40	0	43	0	$5,344.93	$0.00	0.00%	2.71	0.00	101	0	6.37	0.00	2.35	0.00
SHANDS AND UNIVERSITY OF FLORIDA HEALTH CARE NETWO	9	9	$200,619.84	$68,131.72	194.46%	6	7	6	7	$33,436.64	$9,733.10	243.54%	0.38	0.46	36	55	2.27	3.65	6.00	7.86
MEMORIAL HOSPITAL JACKSONVILLE	10	10	$124,558.51	$51,238.55	143.10%	15	11	15	7	$8,303.90	$7,319.79	13.44%	0.95	0.46	62	19	3.91	1.26	4.13	2.71
All Other			$807,286.80	$437,113.86	84.69%	126	85	108	78	$7,474.87	$5,604.02	33.38%	6.81	5.17	465	296	29.31	19.63	4.31	3.79
Total			**$21,077,846.77**	**$15,414,682.87**	**36.74%**	**1,209**	**1,044**	**1,348**	**1,180**	**$15,636.38**	**$13,063.29**	**19.70%**	**84.95**	**78.24**	**5,018**	**4,039**	**316.24**	**267.79**	**3.72**	**3.42**

Outpatient

	Rank		Paid Amt			Members		Visits		Paid Per Visit			Visits/1000	
Provider Full Name	Current	Prior	Current	Prior	% Chg	Current	Prior	Current	Prior	Current	Prior	% Chg	Current	Prior
BAPTIST MEDICAL CENTER	1	1	$13,417,513.15	$12,231,687.34	9.69%	7,067	7,147	18,230	18,108	$736.01	$675.49	8.96%	1148.89	1200.58
BAPTIST MED CTR - BCH	2	2	$1,713,113.12	$1,686,024.85	1.61%	1,174	1,086	2,552	2,470	$671.28	$682.60	-1.66%	160.83	163.76
BAPTIST MEDICAL CENTER NASSAU	3	3	$1,402,986.43	$1,461,379.93	-4.00%	493	486	1,160	1,161	$1,209.47	$1,258.73	-3.91%	73.11	76.98
,	4	4	$258,611.23	$237,438.88	8.92%	153	166	262	307	$987.07	$773.42	27.62%	16.51	20.35
BAPTIST HOME HEALTH CARE	5	5	$218,572.34	$183,362.68	19.20%	104	69	183	157	$1,194.38	$1,167.92	2.27%	11.53	10.41
MAYO CLINIC FLORIDA HOSPITAL	6	9	$217,376.93	$102,322.24	112.44%	60	42	86	68	$2,527.64	$1,504.74	67.98%	5.42	4.51
ST VINCENTS MEDICAL CENTER RIVERSIDE	7	15	$214,282.08	$56,741.93	277.64%	101	75	125	92	$1,714.26	$616.76	177.94%	7.88	6.10
SHANDS JACKSONVILLE MEDICAL CENTER INC	8	8	$196,479.13	$113,176.72	73.60%	127	90	201	132	$977.51	$857.40	14.01%	12.67	8.75
US DEPARTMENT OF VETERANS AFFAIRS	9	11	$189,166.41	$75,364.87	151.00%	82	75	370	301	$511.26	$250.38	104.19%	23.32	19.96
MEMORIAL HOSPITAL JACKSONVILLE	10	6	$171,004.75	$140,237.36	21.94%	113	98	138	120	$1,239.16	$1,168.64	6.03%	8.70	7.96
All Other			$1,105,055.04	$763,443.23	44.75%	1,072	622	1,579	1,148	$699.84	$665.02	5.24%	99.51	76.11
Total			**$19,104,160.61**	**$17,051,180.03**	**12.04%**	**8,781**	**8,503**	**24,886**	**24,064**	**$767.67**	**$708.58**	**8.34%**	**1568.36**	**1595.47**

Professional

	Rank		Paid Amt			Members		Services		Paid Per Service			Services/1000	
Provider Full Name	Current	Prior	Current	Prior	% Chg	Current	Prior	Current	Prior	Current	Prior	% Chg	Current	Prior
KALMADI, SAHANA R	1	4	$535,522.06	$278,272.75	92.45%	22	26	733	600	730.59	463.79	57.53%	46.20	39.78
FLEISHER, MARK R	2	2	$435,708.39	$394,037.53	10.58%	152	135	696	624	626.02	631.47	-0.86%	43.86	41.37
,	3	1	$403,130.23	$463,617.60	-13.05%	783	794	4,164	4,447	96.81	104.25	-7.14%	262.42	294.84
THOMAS, UNNI C	4	5	$309,791.07	$207,839.14	49.05%	39	41	907	862	341.56	241.11	41.66%	57.16	57.15
CAREMARK LLC	5	6	$228,287.12	$193,535.08	17.96%	74	83	167	150	1,366.99	1,290.23	5.95%	10.52	9.95
DESAI, ANKIT R	6	22	$196,539.09	$80,860.98	143.06%	30	36	106	98	1,854.14	825.11	124.71%	6.68	6.50
ASHRAF, SAFEER A	7	19	$185,141.64	$87,988.58	110.42%	33	24	596	291	310.64	302.37	2.74%	37.56	19.29
CZERKAWSKI, JOSEPH J	8	10	$161,815.44	$152,930.94	5.81%	456	464	1,835	1,785	88.18	85.68	2.93%	115.65	118.35
ELLISON, ROBERT G	9	8	$149,774.88	$153,784.89	-2.61%	120	111	595	565	251.72	272.19	-7.52%	37.50	37.46
NAOT, YUVAL Z	10	3	$142,732.83	$339,339.58	-57.94%	33	47	595	1,226	239.89	276.79	-13.33%	37.50	81.28
All Other			$23,785,586.83	$21,091,654.69	12.77%	15,583	14,799	208,362	196,144	114.16	107.53	6.16%	13,131.37	13,004.53
Total			**$26,534,029.58**	**$23,443,861.76**	**13.18%**	**15,825**	**15,000**	**218,756**	**206,792**	**121.30**	**113.37**	**7.00%**	**13,786.42**	**13,710.50**

Notes:
- ALOS = Average Length of Stay.
- Number of members are distinct within category.

Top Therapeutic Categories by Paid/Prescription

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014
Rank: 10
Rx Sort By: PAID

	Rank		Rx Users		# of RX's					Plan Paid					Member Paid					Total Paid				
Therapeutic Category	Current	Prior	Current	Prior	Current	% of Total	Prior	% of Total	% Chg	Current	% of Total	Prior	% of Total	% Chg	Current	% of Total	Prior	% of Total	% Chg	Current	% of Total	Prior	% of Total	% Chg
ANTIDIABETICS	1	1	919	860	7,220	4.11%	6,820	3.86%	5.87%	$2,125,345.61	15.35%	$1,514,649.15	12.34%	40.32%	$267,751.19	7.19%	$213,479.22	6.26%	25.42%	$2,393,096.80	13.62%	$1,728,128.37	11.02%	38.48%
ANALGESICS - ANTI-INFLAMMATORY	2	2	2,662	2,455	5,439	3.09%	5,163	2.92%	5.35%	$1,237,025.22	8.94%	$1,032,777.86	8.42%	19.78%	$80,122.71	2.15%	$84,394.44	2.48%	-5.06%	$1,317,147.93	7.50%	$1,117,172.30	7.13%	17.90%
DERMATOLOGICALS	3	5	2,661	2,501	4,944	2.81%	4,633	2.62%	6.71%	$972,849.72	7.03%	$646,735.55	5.27%	50.42%	$161,396.40	4.33%	$122,800.12	3.60%	31.43%	$1,134,246.12	6.46%	$769,535.67	4.91%	47.39%
ANTIVIRALS	4	3	1,009	1,105	2,476	1.41%	2,726	1.54%	-9.17%	$911,726.71	6.59%	$839,231.10	6.84%	8.64%	$89,077.49	2.39%	$86,853.48	2.55%	2.56%	$1,000,804.20	5.70%	$926,084.58	5.91%	8.07%
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	5	4	811	761	5,365	3.05%	4,995	2.83%	7.41%	$757,313.82	5.47%	$700,449.57	5.71%	8.12%	$219,050.49	5.88%	$173,845.24	5.10%	26.00%	$976,364.31	5.56%	$874,294.81	5.58%	11.67%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	6	8	112	135	387	0.22%	388	0.22%	-0.26%	$729,986.99	5.27%	$439,331.76	3.58%	66.16%	$21,362.18	0.57%	$20,275.60	0.59%	5.36%	$751,349.17	4.28%	$459,607.36	2.93%	63.48%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	7	14	186	164	826	0.47%	797	0.45%	3.64%	$592,598.40	4.28%	$322,310.82	2.63%	83.86%	$15,852.75	0.43%	$15,362.56	0.45%	3.19%	$608,451.15	3.46%	$337,673.38	2.15%	80.19%
ANTIHYPERLIPIDEMICS	8	6	1,685	1,656	9,153	5.21%	10,252	5.80%	-10.72%	$529,879.62	3.83%	$563,542.85	4.59%	-5.97%	$257,033.03	6.90%	$254,636.42	7.47%	0.94%	$786,912.65	4.48%	$818,179.27	5.22%	-3.82%
ANALGESICS - OPIOID	9	7	3,415	3,391	10,307	5.86%	10,836	6.13%	-4.88%	$528,861.44	3.82%	$548,412.91	4.47%	-3.57%	$168,586.55	4.52%	$159,478.23	4.68%	5.71%	$697,447.99	3.97%	$707,891.14	4.51%	-1.48%
RESPIRATORY AGENTS - MISC.	10	11	6	5	40	0.02%	33	0.02%	21.21%	$398,621.70	2.88%	$351,915.59	2.87%	13.27%	$1,764.41	0.05%	$1,190.00	0.03%	48.27%	$400,386.11	2.28%	$353,105.59	2.25%	13.39%
ALL OTHER	0	0	12,459	11,735	129,585	73.74%	130,169	73.62%	-0.45%	$5,059,771.35	36.55%	$5,312,087.49	43.29%	-4.75%	$2,443,961.29	65.59%	$2,275,274.32	66.77%	7.41%	$7,503,732.64	42.71%	$7,587,361.81	48.39%	-1.10%
TOTAL	**0**	**0**	**13,346**	**12,644**	**175,742**	**100.00%**	**176,812**	**100.00%**	**-0.61%**	**$13,843,980.58**	**100.00%**	**$12,271,444.65**	**100.00%**	**12.81%**	**$3,725,958.49**	**100.00%**	**$3,407,589.63**	**100.00%**	**9.34%**	**$17,569,939.07**	**100.00%**	**$15,679,034.28**	**100.00%**	**12.06%**

Top Therapeutic Categories by Paid/Prescription

Company:
Group:
Current Paid Period: From 01/2015 to 12/2015
Prior Paid Period: From 01/2014 to 12/2014
Rank: 10
Rx Sort By: PRESCRIPTION

	Rank		Rx Users		# of RX's					Plan Paid					Member Paid					Total Paid				
Therapeutic Category	Current	Prior	Current	Prior	Current	% of Total	Prior	% of Total	% Chg	Current	% of Total	Prior	% of Total	% Chg	Current	% of Total	Prior	% of Total	% Chg	Current	% of Total	Prior	% of Total	% Chg
ANTIDEPRESSANTS	1	1	2,333	2,097	12,631	7.19%	12,505	7.07%	1.01%	$226,049.04	1.63%	$330,462.28	2.69%	-31.60%	$217,061.26	5.83%	$183,588.61	5.39%	18.23%	$443,110.30	2.52%	$514,050.89	3.28%	-13.80%
ANTIHYPERTENSIVES	2	2	2,095	1,966	11,164	6.35%	11,493	6.50%	-2.86%	$195,911.16	1.42%	$260,936.98	2.13%	-24.92%	$206,715.91	5.55%	$217,760.09	6.39%	-5.07%	$402,627.07	2.29%	$478,697.07	3.05%	-15.89%
ANALGESICS - OPIOID	3	3	3,415	3,391	10,307	5.86%	10,836	6.13%	-4.88%	$528,861.44	3.82%	$548,412.91	4.47%	-3.57%	$168,586.55	4.52%	$159,478.23	4.68%	5.71%	$697,447.99	3.97%	$707,891.14	4.51%	-1.48%
CONTRACEPTIVES	4	5	1,799	1,676	9,690	5.51%	10,177	5.76%	-4.79%	$338,518.95	2.45%	$322,062.17	2.62%	5.11%	$125,466.64	3.37%	$128,715.10	3.78%	-2.52%	$463,985.59	2.64%	$450,777.27	2.88%	2.93%
ANTIHYPERLIPIDEMICS	5	4	1,685	1,656	9,153	5.21%	10,252	5.80%	-10.72%	$529,879.62	3.83%	$563,542.85	4.59%	-5.97%	$257,033.03	6.90%	$254,636.42	7.47%	0.94%	$786,912.65	4.48%	$818,179.27	5.22%	-3.82%
ANTIDIABETICS	6	6	919	860	7,220	4.11%	6,820	3.86%	5.87%	$2,125,345.61	15.35%	$1,514,649.15	12.34%	40.32%	$267,751.19	7.19%	$213,479.22	6.26%	25.42%	$2,393,096.80	13.62%	$1,728,128.37	11.02%	38.48%
ULCER DRUGS	7	7	1,743	1,604	6,607	3.76%	6,754	3.82%	-2.18%	$218,125.92	1.58%	$270,696.64	2.21%	-19.42%	$100,759.16	2.70%	$128,139.55	3.76%	-21.37%	$318,885.08	1.81%	$398,836.19	2.54%	-20.05%
THYROID AGENTS	8	9	1,006	880	6,089	3.46%	5,787	3.27%	5.22%	$13,023.79	0.09%	$17,275.85	0.14%	-24.61%	$167,493.68	4.50%	$117,451.21	3.45%	42.61%	$180,517.47	1.03%	$134,727.06	0.86%	33.99%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	9	8	1,884	1,783	5,950	3.39%	6,139	3.47%	-3.08%	$336,036.01	2.43%	$355,161.47	2.89%	-5.39%	$207,226.03	5.56%	$192,811.11	5.66%	7.48%	$543,262.04	3.09%	$547,972.58	3.49%	-0.86%
ANALGESICS - ANTI-INFLAMMATORY	10	12	2,662	2,455	5,439	3.09%	5,163	2.92%	5.35%	$1,237,025.22	8.94%	$1,032,777.86	8.42%	19.78%	$80,122.71	2.15%	$84,394.44	2.48%	-5.06%	$1,317,147.93	7.50%	$1,117,172.30	7.13%	17.90%
ALL OTHER	0	0	12,084	11,469	91,492	52.06%	90,886	51.40%	0.67%	$8,095,203.82	58.47%	$7,055,466.49	57.49%	14.74%	$1,927,742.33	51.74%	$1,727,135.65	50.68%	11.61%	$10,022,946.15	57.05%	$8,782,602.14	56.01%	14.12%
TOTAL	**0**	**0**	**13,346**	**12,644**	**175,742**	**100.00%**	**176,812**	**100.00%**	**-0.61%**	**$13,843,980.58**	**100.00%**	**$12,271,444.65**	**100.00%**	**12.81%**	**$3,725,958.49**	**100.00%**	**$3,407,589.63**	**100.00%**	**9.34%**	**$17,569,939.07**	**100.00%**	**$15,679,034.28**	**100.00%**	**12.06%**

Wellness Exam and Preventive Services

Company:
Group:
Current Paid Period: From 01/2015 to 01/2015
Prior Paid Period: From 01/2014 to 12/2015

Wellness		Current				Prior			
Procedure Code	Procedure Description	Paid Amt	Visits	Paid/Visit	Visits/ 1000 Mbrs	Paid Amt	Visits	Paid/Visit	Visits/ 1000 Mbrs
99381	NP Initial Preventive Exam	$628.25	6	$104.70	5	$22,010.86	183	$120.27	6
99382	NP Ages 1-4 Wellness Exam	$934.58	7	$133.51	5	$15,789.30	117	$134.95	4
99383	NP Ages 5-11 Wellness Exam	$758.65	5	$151.73	4	$25,096.65	175	$143.40	6
99384	NP Ages 12-17 Wellness Exam	$1,459.11	8	$182.38	6	$27,023.69	157	$172.12	5
99385	NP Ages 18-39 Wellness Exam	$4,581.20	27	$169.67	21	$168,708.33	976	$172.85	32
99386	NP Ages 40-64 Wellness Exam	$4,294.01	20	$214.70	15	$104,690.98	519	$201.71	17
99391	EP Periodic Preventive Exam	$8,675.96	81	$107.11	63	$222,388.22	2,032	$109.44	66
99392	EP Ages 1-4 Wellness Exam	$9,227.87	76	$121.41	59	$230,412.38	1,989	$115.84	64
99393	EP Ages 5-11 Wellness Exam	$5,180.01	46	$112.60	36	$203,940.09	1,742	$117.07	56
99394	EP Ages 12-17 Wellness Exam	$6,122.75	46	$133.10	36	$193,801.44	1,424	$136.09	46
99395	EP Ages 18-39 Wellness Exam	$19,496.41	130	$149.97	100	$575,115.90	3,790	$151.74	122
99396	EP Ages 40-64 Wellness Exam	$27,521.33	166	$165.79	128	$859,278.77	5,134	$167.37	166
99397	EP Ages 65 + Wellness Exam	$1,285.36	7	$183.62	5	$49,807.66	274	$181.77	9
99387	NP Ages 65 + Wellness Exam			$0.00		$2,649.29	12	$220.77	0
Total		**$90,165.49**	**625**	**$144.26**	**483**	**$2,700,713.56**	**18,524**	**$145.80**	**599**

Preventive	Current				Prior			
Preventive Service	Paid Amt	Visits	Paid/Visit	Visits/ 1000 Mbrs	Paid Amt	Visits	Paid/Visit	Visits/ 1000 Mbrs
Adult Preventive Visits	$57,178.31	350	$163.36	270	$1,760,250.93	10,705	$164.43	346
Colorectal Cancer Screening	$29,632.10	56	$529.14	43	$810,015.88	1,588	$510.08	51
Mammograms	$13,805.32	337	$40.96	260	$362,992.51	8,790	$41.29	284
PAP Smears	$1,675.81	82	$20.43	63	$39,411.98	1,834	$21.48	59
Total	**$102,291.54**	**825**	**$123.99**	**637**	**$2,972,671.30**	**22,917**	**$129.71**	**740**

SAMPLE

MyBlueInsight (MBI) Reports

Stop Loss Monthly

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Finance Monthly - Stop Loss

Company:
Group:
Invoice Month: 03/2016
Beginning Paid Date: 01/01/2015
Ending Paid Date: 03/31/2016
Beginning Service Date: 01/01/2015
Ending Service Date: 12/31/2015
Threshold: $125,000

Member ID	Member Name	Subscriber Name	HCC ID	Subscriber SSN	Claims Number	Product	Division	Location	Service Date	Paid Date	Paid Amt
										Total Paid Amt	**$157,830.02**
									Stoploss Credit	11/30/2015	($19,076.12)
									Stoploss Credit	12/31/2015	($13,409.40)
									Stoploss Credit	01/31/2016	($1,202.73)
									Stoploss Credit	03/31/2016	$858.23
										Total Stoploss Amt	**($32,830.02)**
										Member Total	**$125,000.00**

Note: This report is not considered final until you receive your invoice for the period covered.

As the incumbent carrier, The City will continue to receive the same reports as currently coordinated by the Account Management team.

BlueOptions

Group Master Policy

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueOptions
Large Group

60698 0107R SR

BlueOptions

Group Master Policy

Patrick J. Geraghty
Chief Executive Officer

For Customer Service Assistance: 800-FLA-BLUE

This Policy Contains Deductible Provisions

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueOptions
Large Group
60698 0107R SR

Table of Contents

Group Administrative Provisions

Introduction

Thank you for choosing Blue Cross and Blue Shield of Florida's ("BCBSF") **BlueOptions**. For over 50 years, BCBSF has been a leader in health care financing solutions. **BlueOptions** continues this tradition by combining the quality coverage and benefits you have come to expect with an innovative and affordable choice of Providers.

References to "we", "us", and "our" throughout this Group Master Policy refer to BCBSF. We may also refer to ourselves from time to time as "BCBSF."

If you are an employer and have purchased this coverage for your employees, and their covered dependents, you have established an employee welfare benefit plan ("Group Plan"). This document ("Group Master Policy" or "Policy") is evidence of the existence of the Group Plan and describes the rights and obligations which you and BCBSF have with respect to the coverage and benefits to be provided by BCBSF.

In exchange for your payment of the Premium, we agree to provide the coverage and benefits specified in the Benefit Booklet which is attached to and made a part of this Group Master Policy. The health care coverage and benefits to be provided under this Group Master Policy will be subject to all the requirements set forth in this Policy, including the Benefit Booklet and any Endorsements issued by BCBSF.

This Group Master Policy is divided into two parts. The first part contains various administrative and other provisions relating to your agreement with us. You should make sure that you read and understand these provisions as they describe important obligations applicable to you and us. The second part of the Group Master Policy is the Benefit Booklet. The Benefit Booklet describes the coverage, benefits, exclusions, and limitations under this Group Master Policy. The Benefit Booklet includes the Schedule of Benefits, any applicable Enrollment Forms, and any Endorsements to the Benefit Booklet or the Group Master Policy. Any Endorsements issued by us modifying the Benefit Booklet or the first part of this Group Master Policy are also part of this Group Master Policy.

Definitions

Certain terms defined in the first part of the Group Master Policy are also used and defined (for the convenience of Covered Persons) in the Benefit Booklet. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. In addition to the definitions set forth in the Benefit Booklet, the following terms apply to this Group Master Policy:

Anniversary Date means the date, one year after the Effective Date, stated on the Group Application and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties.

Covered Employee means an Eligible Employee, or other individual, who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Master Policy other than as a Covered Dependent (See the Eligibility Requirements for Covered Employees subsection of the Eligibility for Coverage section for further information).

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Master Policy other than as a Covered Employee (see the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage section for further information).

Covered Person means a Covered Employee or a Covered Dependent.

Effective Date means, with respect to the Group, 12:01 a.m. on the date specified on the Group Application. With respect to individuals covered under this Policy, 12:01 a.m. on the date the Group specifies that the coverage will commence as specified in the Enrollment and Effective Date of Coverage section of the Benefit Booklet.

Eligible Dependent means a Covered Employee's:

1. legal spouse under a legally valid, existing marriage; or
2. natural, newborn, Adopted, Foster, or step child(ren); or
3. a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian;

who meets and continues to meet all of the eligibility requirements set forth in the Eligibility for Coverage section in the Benefit Booklet.

Eligible Dependent also includes a newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child. Refer to the Eligibility for Coverage section for limits on eligibility.

Eligible Employee for purposes of this Group Master Policy means an individual who meets and continues to meet all of the eligibility requirements set forth in the Eligibility Requirements for Covered Employees subsection of the Eligibility for Coverage section in the Benefit Booklet and is eligible to enroll as a Covered Employee. Any individual who is an Eligible Employee is not a Covered Employee until such individual has actually enrolled and been accepted for coverage as a Covered Employee by us.

Enrollment Forms means those BCBSF forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under the Group Master Policy.

Grace Period means the ten (10) day period beginning on the date the Premium is due.

Group means the employer, labor union, trust, association, partnership, corporation, department, other organization or entity through which coverage and benefits are issued by us, and through which Covered Employees and Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

Note: References to "you" or "your" throughout the first part of the Group Master Policy also refer to the Group. References to "you" or "your" in the Benefit Booklet refer to Eligible Employees, Eligible Dependents, Covered Employees and/or Covered Dependents depending on the context and intent of the specific provision.

Group Master Policy means this document which is the agreement between the Group and us whereby coverage and benefits will be provided to Covered Persons. The Group Master Policy includes the Benefit Booklet (including the Schedule of Benefits), the Group Application, Enrollment Forms, and any Endorsements to the Benefit Booklet or the Group Master Policy.

Premium means the amount required to be paid by the Group to us in order for there to be coverage under this Policy.

Waiting Period means the period of time specified on the Group Application, if any, which must be met by an individual before that individual is eligible to enroll for coverage under this Policy.

Terms of the Group Master Policy

This Group Master Policy shall become effective as of the Effective Date provided that:

1. BCBSF accepts your Group Application; and
2. you pay the required initial Premium specified by us.

This Policy shall continue in effect until the first Anniversary Date following the Effective Date unless terminated earlier as permitted by its terms. After the initial term, this Policy shall automatically renew each succeeding year on the Anniversary Date for an additional one-year period unless:

1. at least 45 days prior to such Anniversary Date, you notify us that you do not want the Policy to automatically renew; or
2. it is terminated as permitted by its terms.

If this Policy renews as specified above, all of its terms and provisions (including the Premium due) shall govern coverage, as of the Anniversary Date, unless we give written notice of a modification or revision to you at least 45 days prior to the Anniversary Date. In the event that we give such written notification, you may elect not to renew this Policy effective as of the Anniversary Date by giving us written notice at least 10 days prior to the Anniversary Date. If you fail to give us written notice as required, this Policy shall renew on the Anniversary Date with the modified or revised terms. Nothing in this subsection shall prohibit us from amending, at the time of renewal, the coverage and benefits to be provided by us. We may modify the Premium at any time in accordance with the applicable provisions of this Policy.

Prior Carrier Responsibilities under an Extension of Benefits

Your prior carrier, if any, may be required to provide certain benefits to certain individuals covered by this Policy under an extension of benefits provision. We are not responsible for the payment of any claims which are payable under any extension of benefits provision in the prior carrier's plan.

Commencement of Coverage

Our coverage, in accordance with the terms of this Policy, begins on the Effective Date (see the Enrollment and Effective Date of Coverage section in the Benefit Booklet). We are not required to pay for health care expenses incurred prior to the Effective Date.

Voluntary Termination by the Group

The Group may terminate this Policy at any time by giving us at least 45 days prior written notice. Coverage will not be provided on or after such termination date. Nothing in this subsection shall affect a Covered Person's right to an extension of benefits, if applicable, in accordance with the Extension of Benefits section in the Benefit Booklet.

Conditions of Renewal and Termination

This Policy is conditionally renewable. This means that it automatically renews each year on your Anniversary Date unless terminated earlier in accordance with its terms. We may terminate this Policy or refuse to renew it if:

1. you fail to pay Premiums in accordance with its terms or we have not received timely Premium payments;
2. you perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact; or

3. you fail to comply with a material provision which relates to rules for Group contributions or Covered Employee participation.

If we decide to either terminate the Policy or not renew it, based on one or more of the circumstances mentioned above, we will give you at least 45 days advance written notice except in the case of failure to pay Premiums. Refer to the "Termination By Us for Non-Payment of Premium" subsection.

Termination Based on Discontinuation of Form

We may decide to discontinue this form, which means this Policy is terminated, but may do so only if:

1. we cease to offer this form in the large-group market in accordance with the Florida Insurance Code;
2. we provide notice to all groups and individuals having coverage under this form of the discontinuation of this form at least 90 days prior to the date of non-renewal; and
3. we offer to all groups having coverage under this form the option to purchase any other insurance form currently being offered for purchase by us in the large-group market.

Termination Based on Discontinuation of all Policies in Large-Group Market

We may terminate this Policy if we elect to terminate all of the policies we have issued in the large-group market in this state. In that case, we will provide notice, at least 180 days prior to the date of non-renewal, to the Florida Department of Insurance and to all large groups and each Covered Employee. If we terminate coverage pursuant to this provision, any unused Premium will be returned to you.

Termination by Us for Non-payment of Premium

This Policy will automatically terminate as of the applicable Premium due date if we do not receive the full Premium payment prior to the end of the Grace Period (see the Grace Period subsection of the Payment Provisions section). In the event of such a termination you are obligated to pay the following:

1. any portion of the Premium due for coverage provided by us prior to termination;
2. the amount of any payments made by us for health care expenses incurred by persons who were covered under the policy; and
3. any amounts otherwise due us.

We will mail to you a written notification prior to 45 days after the date the Premium is due that this Policy has terminated. This notification will tell you the reasons for termination.

Notification of Termination to Covered Employees

It is your responsibility to immediately notify each Covered Employee of termination of this Policy for any reason.

Representations Made By, and Obligations of, the Group

In agreeing to provide coverage in accordance with the terms of this Policy, we rely on the representations which you made when you applied for coverage with us and your representation that you have authority to act on behalf of all Covered Employees and Covered Dependents with respect to the Group Plan. Consequently, every act by, agreement with, or notice given to you, will be binding on all Covered Persons. You agree that you will offer to all Eligible Employees the opportunity to become a Covered Employee under the Group Plan. While you may require a Covered Employee to pay a portion

of the Premium due us, you agree that you will contribute toward the cost of coverage which you purchased.

You agree that, if requested by us, you will distribute to Covered Persons the Benefit Booklet (and any Endorsements to it) and other coverage materials.

Effective Date for Eligible Employees

Subject to the eligibility requirements set forth in the Eligibility for Coverage section in the Benefit Booklet (and any Endorsements), an Eligible Employee becomes eligible for coverage on the next Premium due date following the satisfaction of any Waiting Period established by you, provided the appropriate Enrollment Form is submitted to us within 30 days of the date the Eligible Employee first meets the applicable eligibility requirements. The designated Waiting Period is shown on the Group Application which you submitted to us.

Group Payment Provisions

Monthly Invoice

We will prepare a monthly invoice of the Premium which is due on or before the due date. This monthly Group invoice may also reflect any charges and credits resulting from changes in the number of Covered Persons and changes in the types of coverage that took place in the previous or current month.

If you become aware that a Covered Person will become ineligible, you must provide us with written notice of such ineligibility on or before the date that the individual is, or will become, ineligible. If a Covered Person becomes ineligible for coverage for any reason, you are specifically required to provide written notice to us of such ineligibility no later than 10 days after such ineligibility. In the event that you do not comply with the notice requirements, you shall be liable to us for the Premium due for any individual for which we make claims payments under this Group Master Policy.

You must pay the total amount of the Group invoice, minus any deletions for Covered Employees who became ineligible for coverage during the current month. Do not add names to a Group invoice, change coverage, or pay for an employee whose name does not appear on the invoice. No changes can be made to a Group invoice unless an applicable signed Enrollment Form is on file and submitted to us.

Other than as specifically set forth in this Group Master Policy, BCBSF is not obligated to provide coverage or benefits for any individual(s) for whom Premium has not been received by BCBSF in advance or to refund Premiums paid on behalf of any individual who was then listed on our Enrollment Records as a Covered Person.

Premium Payment Due Date

The first Premium payment is due before the Effective Date of the Policy. Each following Premium payment is due monthly unless you agree with us on some other method and/or frequency of Premium payment. The Premium is due and payable on or before the first day of each succeeding calendar month to which such payments apply, unless you agree with us to have the 15th day of each month as the Premium payment due date.

Grace Period

This Group Master Policy has a ten (10)-day Premium payment Grace Period which begins on the date the Premium payment is due. If we do not receive the required Premium payment on or before the date it is due, it may be paid during this Grace Period. Coverage will stay in force during the Grace Period. If Premium payments are not received by the end of the Grace Period, coverage will automatically terminate effective as of the applicable due date.

Changes in Premium

We may modify the amount of Premium at any time after the initial term. We shall provide at least 45 days prior written notice to you of any such change. Premium payments submitted to us following receipt of any such written notice of change constitutes your acceptance of any such change. You must immediately notify each Covered Employee of any such change which affects the Covered Employee's financial contribution requirement.

If an increase in Premium takes place on a date other than the Premium payment due date, a pro-rated increase will be applied from the date of the increase to the next payment due date. If a decrease in Premium takes place on a date other than the Premium payment due date, a pro-rated credit will be

granted. The pro-rated credit will apply for the decrease from the date of the decrease to the next Premium payment due date.

Other Rules Regarding the Payment of Premiums

1. In the event we do not receive Premium payment prior to the applicable due date, we reserve the right to suspend payment of claims for Health Care Services rendered to a Covered Person, on or after the applicable Premium due date.
2. We are not required to retroactively terminate this Policy or coverage for any Covered Person.

General Group Provisions

Administration

You must provide us with any information we need to administer the coverage and benefits to be provided or needed to compute the Premium due. While this coverage is in force, we have the right, at any reasonable time, to examine your records on any issues necessary to verify information provided by you.

Assignment and Delegation

You may not assign, delegate or otherwise transfer this Group Master Policy and the obligations hereunder without our written consent. Any assignment, delegation, or transfer made in violation of this provision shall be void. We may assign, delegate or otherwise transfer this Policy to our successor in interest or an affiliated entity without your consent at any time.

Membership Provision

As a holder of an insurance policy issued by us, you are a member of BCBSF. As such you have all the rights, privileges, and obligations provided in the Articles of Incorporation and our Bylaws currently in force and as may be amended from time to time.

The annual meeting of the members shall be held for the purpose of electing the Board of Directors and transacting such other business as may be properly brought before the meeting.

At all meetings of our members, each member shall be entitled to cast a number of votes equal to the amount of Premiums attributed to such member in the month of record, as determined by us (e.g., a Premium of $27.36 in that month will be equal to 27.36 votes). All proxies shall be filed with our Secretary before the meeting at which the proxy is to be voted.

Changes to the Group Master Policy

No person may change, modify, or revise the written terms or provisions of this Policy unless such change is made by a written Endorsement signed by a one of our duly authorized officers. This is the only manner in which a change may be made to this Policy. For example, no employee or agent of BCBSF or the Group can change or waive the written terms or provisions of this Policy except as stated in the first sentence of this paragraph.

Enrollment Records

1. Furnishing and Maintaining Enrollment Records:

   You must provide any information required by us for the purpose of creating and maintaining enrollment records, processing terminations, and recording changes in family status. In addition, you and each Eligible Employee must submit accurate and complete Enrollment Forms on a timely basis. You are responsible for collecting the Enrollment Forms, reviewing them for accuracy and completeness, and forwarding them to BCBSF, along with the applicable Premium payment. All enrollment record information, which is relevant to the eligibility or coverage status of any individual, must be made available to us for inspection and copying upon request.

2. Errors or Delays:

   Clerical errors or delays by us in maintaining enrollment records regarding Covered Persons will not invalidate coverage which would otherwise be validly in force, or continue coverage which would otherwise be validly terminated, provided you have furnished us with timely and accurate enrollment

information. Errors or delays by you in furnishing accurate enrollment information to us will not affect our right to strictly enforce any and all eligibility requirements. You are liable to us for any claims payments made by us on behalf of any individual who was not eligible for coverage at the time the Health Care Service was rendered.

Entire Agreement

This Group Master Policy sets forth the exclusive and entire understanding and agreement between the parties and shall be binding upon all Covered Persons, the parties, and any of their subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of the Group Master Policy, which includes the terms of coverage and/or benefits set forth in the Benefit Booklet, the Schedule of Benefits, and any Endorsements.

Financial Responsibilities of the Group

We reserve the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Our recovery efforts may relate to benefit payments made for Health Care Services rendered subsequent to the Covered Person's termination date and prior to the date notice of coverage termination is required to be made by you. Your cooperation and support of such recovery efforts is required.

Indemnification

You shall hold harmless and indemnify BCBSF against all claims, demands, liabilities, or expenses (including reasonable attorney's fees and court costs), which are related to, arise out of, or are in connection with, any of your acts or omissions, or acts or omissions of any of your employees or agents, in the performance of your obligations under this Policy. We are not your agent, nor are you our agent, for any purpose.

Benefit Booklet

We will provide a Benefit Booklet and Identification Card for each Covered Employee. The Benefit Booklet will describe the coverage and benefits to be provided to Covered Persons by us.

Representations on the Group Application and the Enrollment Forms

We rely on the information which you and your Eligible Employees provide to determine whether to issue coverage; the appropriate Rate and financing method; and eligibility for coverage. All such information must be accurate, truthful, and complete. Statements made on the Group Application and the Enrollment Forms are representations and not warranties.

We may cancel, terminate, or void this Policy if the information which you provide is fraudulent, or if you make an intentional misrepresentation.

Reservation of Right to Contract

We reserve the right to contract with any individuals, corporations, associations, partnerships, or other entities, for assistance with the servicing of coverage and benefits to be provided by us, or obligations due, under this Group Master Policy.

Service Mark

You, on behalf of the Group and your Covered Employees, hereby expressly acknowledge your understanding that the Group Master Policy constitutes a contract solely between you and us. We are an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans (the "Association"), permitting us to use the Blue Cross and Blue Shield Service Mark in the State of Florida and that we are not contracting as the agent for the Association. You further acknowledge and agree that you have not entered into this contract based upon representations by any person other than us and that no person, entity, or organization other than us shall be held accountable or liable to you for any of our obligations created under this Policy. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this Policy.

Third Party Beneficiary

The Group Master Policy under which this Benefit Booklet was issued was entered into solely and specifically for the benefit of BCBSF and the Group. The terms and provisions of the Group Master Policy shall be binding solely upon, and inure solely to the benefit of, BCBSF and the Group, and no other person shall have any rights, interest or claims thereunder, or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. BCBSF and the Group hereby specifically express their intent that health care Providers that have not entered into contracts with BCBSF to participate in BCBSF's Provider networks shall not be third-party beneficiaries under the Group Master Policy or this Benefit Booklet.

Group Medicare Secondary Payer Provisions

In order to ensure compliance with the applicable Medicare laws, you are required to advise us, without delay, of any Covered Person who will be, or is, covered under Medicare prior to or immediately following the date such Covered Person becomes so covered (e.g., prior to the Covered Person's 65th birthday). Additionally, you are required to advise us, without delay, of the Medicare status of any Medicare beneficiary who applies for coverage, prior to such individual's Effective Date. **You shall indemnify and hold us harmless to the extent of any liability, including attorneys' fees and costs, that results directly or indirectly from your failure to so advise us.**

In any circumstances under which the Medicare statute requires that coverage under the Policy be primary for any Covered Person, you MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such Covered Person. Also, you MAY NOT induce such Covered Person to decline or terminate his or her group health coverage and elect Medicare as primary payer.

Working Elderly

If you employ 20 or more persons for 20 or more weeks of the current or preceding Calendar Year, or if you are a member of a multi-employer group health plan that includes at least one employer with 20 or more employees, the Policy provides primary coverage for employees and/or their spouses, age 65 or older, who are covered under the Policy, pursuant to the following terms:

1. You shall provide us, without delay, the names of employees, age 65 or older:
   a) who are covered under the Policy;
   b) who are employed (not retired);
   c) who have not elected Medicare as primary payer of their health insurance claims; and
   d) who are not eligible for Medicare due to end stage renal disease (ESRD).
2. You shall also provide us, without delay, the names of spouses, age 65 or older, of current employees of any age:
   a) who are covered under the Policy;
   b) who have not elected Medicare as primary payer of their health insurance claims; and
   c) who are not eligible for Medicare due to ESRD.

   The names required to be provided as set forth above, along with any other identifying information requested by us, shall be provided to us on or before the 65th birthday of the employee or spouse or on or before such later date when the individual enrolls with us.
3. For an enrolled individual who meets one of the descriptions set out in paragraph 1 or 2 directly above, we will provide group health coverage, as set forth in the Benefit Booklet, on a primary basis beginning with the first day of the month in which the individual attains age 65 or the date of enrollment, if the individual is 65 or over at the time of enrollment.
4. Individual entitlement to primary coverage under this subsection will terminate automatically:
   a) for a current employee, age 65 or older, when he or she elects Medicare as the primary payer or when he or she becomes eligible for Medicare due to ESRD;
   b) for the spouse, age 65 or older, of a current employee of any age, when the spouse elects Medicare as the primary payer or when the spouse becomes eligible for Medicare due to ESRD.

You are required to provide us, without delay, the names of any current employees or spouses of such employees, age 65 or older, who choose Medicare as primary payer of their health insurance claims or who become eligible for Medicare due to ESRD.

Under Medicare, you MAY NOT offer, subsidize, procure or provide a Medicare supplement insurance policy to such individual. Also, you MAY NOT induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

5. Entitlement of the employee and/or spouse to primary coverage under this subsection will terminate automatically when:
   a) the employee retires; or
   b) the employee no longer meets the employer eligibility requirements.

   You are required to notify us, without delay, of the retirement or reduction to a part-time schedule of any employee who has received primary coverage pursuant to this subsection or whose spouse has received primary coverage pursuant to this Working Elderly subsection.
6. The primary coverage described in this subsection will not be provided in the case of a group that is a member of a multi-employer group health plan where that group has fewer than 20 employees and the plan has elected treatment of that group's employees under the exception for small employers described at 42 U.S.C. §1395y(b)(1) (A)(iii).

Note: You must immediately report to us changes in the number of employees to fewer than 20 employees or from fewer than 20 employees to 20 or more employees, including pertinent changes in multi-employer group health plans.

Individuals With End Stage Renal Disease

Primary coverage is provided for your current and former employees and/or their dependents who are covered under this Policy and who are entitled to Medicare coverage because of end stage renal disease ("ESRD"), pursuant to the following terms:

1. You are required to provide us, without delay, information, including, but not limited to, the following:
   a) the names of any individuals who are or will be undergoing a regular course of renal dialysis;
   b) the names of any individuals who will receive or already have received a kidney transplant;
   c) the beginning date of such dialysis or the date of such transplant;
   d) the individual's date of birth, sex, and social security number;
   e) health insurance claim number;
   f) relationship of each individual covered to the employee (i.e., employee, employee's spouse, or employee's dependent child);
   g) reason for Medicare entitlement;
   h) Medicare Part A effective date;
   i) employee's social security number;
   j) contract number;
   k) current employment status;
   l) coverage Effective Date;
   m) coverage termination date;
   n) group number;

o) benefits provided (i.e., hospital benefits only, medical benefits only, or all other); and,

p) type of coverage provided (i.e., self, family, etc.).

2. For an enrolled individual who is entitled to Medicare coverage because of ESRD, we will provide group health coverage, as set forth in the Benefit Booklet, on a primary basis for 30 months beginning with the earlier of:

   a) the month in which the individual became entitled to Medicare Part A ESRD benefits; or

   b) the first month in which the individual would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD, BCBSF will provide group health coverage, as set forth in the Benefit Booklet, on a primary basis for 30 months.

Under Medicare, you MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such individual or induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

Disabled Active Individuals

We provide primary coverage to Covered Persons who are covered under this Policy if:

1. you are a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50 percent or more of its regular business days during the previous Calendar Year; and
2. the Covered Persons are entitled to Medicare coverage because of disability (unless they have ESRD).

Primary coverage, if any, under this subsection of this Policy is also subject to the following terms:

1. You are required to provide us, without delay, with the names of any Covered Persons covered under this Policy, who are entitled to Medicare coverage because of disability (other than those with ESRD), and who have not elected Medicare as primary payer of their health insurance claims, along with any other identifying information requested.
2. For such a Covered Person, we will provide group health coverage, as set forth in the Benefit Booklet, on a primary basis during any month in which that individual meets the description set out in paragraph 1 directly above.
3. Individual entitlement to primary coverage under this subsection will terminate automatically when:

   a) the individual turns 65 years of age; or

   b) the individual no longer qualifies for Medicare coverage because of disability; or

   c) the individual elects Medicare as the primary payer. Coverage will terminate as of the day of such election.

You are required to notify us, without delay, of the occurrence of any of the above events.
Under Medicare, you MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such individual or induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

Entitlement of the Covered Person to primary coverage under this subsection will terminate automatically if the Covered Employee no longer qualifies as such under applicable Medicare regulations and instructions.

You shall notify us, without delay, of any such change in status.

Note: You must immediately report to us changes in the number of employees to fewer than 100 employees or from fewer than 100 employees to 100 or more employees.

Miscellaneous

1. This Medicare Secondary Payer Provisions section shall be subject to, modified if necessary to conform to or comply with, and interpreted with reference to, the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Policy.
2. We will not be liable to you or to any individual covered under this Policy due to any nonpayment of primary benefits resulting from any failure of performance of your obligations as set forth in this section.
3. If we should elect to make primary payments covering services rendered to Covered Persons described in this section in a period prior to receipt of the information required by the terms of this section, we may require you to reimburse us for such payments. Alternatively, we may require you to pay as additional Premium the rate differential that resulted from your failure to provide us with the required information in a timely manner.
4. You shall indemnify and hold us harmless to the extent of any liability that we may be charged with on account of improper primary Medicare payments that were made as a result of any failure of performance of your obligations as set forth in this section.

Note: You are subject to the federal laws described in this section. Individuals with questions regarding their rights under those laws should direct their questions to you.

COBRA Administrative Services Provisions

The following rules apply if the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, apply to you.

Your Obligations

1. You are responsible for all aspects of the administration of COBRA with respect to the group health coverage provided by the Group Plan.
2. You specifically delegate to us the right to designate an administrator (COBRA Administrator) to perform COBRA administration responsibilities as provided in the Obligations of the COBRA Administrator subsection set out below.
3. You delegate the COBRA administration responsibilities to the COBRA Administrator designated by us as specified in such Obligations of the COBRA Administrator subsection.
4. **You retain responsibility for the following COBRA administrative duties:**
   a) You will complete and provide all notices and Enrollment Forms to the Covered Persons (including the initial notice of COBRA rights) required under COBRA, using forms or sample forms provided by the COBRA Administrator.
   b) You will provide a copy of the Enrollment Form to the COBRA Administrator at the same time that it is sent to the beneficiary(ies).
   c) You will determine the applicable Premium for qualified beneficiaries in accordance with this Policy with us.
   d) You will remit Premiums to us on behalf of the qualified beneficiary until we receive notice from the Group that such beneficiary is no longer entitled to COBRA coverage.
5. By entering into the Policy, you agree to indemnify and hold us and the COBRA Administrator, including any directors, officers, employees, and agents harmless against any and all claims, lawsuits, settlement, judgments, costs, taxes, and expenses, including reasonable attorneys' fees directly resulting from or arising out of your failure to perform COBRA administration responsibilities not delegated to the COBRA Administrator.
6. Upon receipt of notice from us that a COBRA Administrator is not designated pursuant to the Obligations of the COBRA Administrator subsection to then perform COBRA administration for the Group, you shall resume responsibility for all COBRA administration.

Our Obligations

1. On behalf of the Group, we may designate a COBRA Administrator to perform the COBRA administration responsibilities specified in the Obligations of the COBRA Administrator subsection and may enter into a contract with the COBRA Administrator for that purpose. In this event, it is understood that:
   a) The COBRA Administrator is not our agent.
   b) We are not responsible for the COBRA Administrator's performance of the duties as specified in the Obligations of the COBRA Administrator subsection.
2. We, on behalf of the Group, will allocate part of the fees charged to the Group to the COBRA Administrator for the services provided in the Obligations of the COBRA Administrator subsection, and will authorize the COBRA Administrator to retain the COBRA administration fee charged to the qualified beneficiaries.

3. We are not the plan administrator or plan sponsor for purposes of COBRA and have no responsibility for your COBRA administration obligations except for the designation of a COBRA Administrator pursuant to Paragraph 2 of the Your Obligations subsection.
4. To the extent required by COBRA, and upon timely receipt of Premiums and proper Enrollment Forms, we will provide coverage to the qualified beneficiaries after the period that their coverage would normally cease under the Group Plan.
5. We will not be responsible for determining whether a Covered Person is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by the COBRA Administrator if then designated.
6. If you or the Covered Person fails to meet any obligations under the Group Plan and COBRA, we will not be liable for any claims of the Covered Person after his/her termination of coverage.

Obligations of the COBRA Administrator

1. The person or entity designated by us to be the COBRA Administrator pursuant to Paragraph 2 of the Your Obligations subsection shall be responsible for the following functions:
   a) Determining application of COBRA to the Group;
   b) Receiving COBRA election forms from beneficiaries;
   c) Maintaining records of COBRA continuation coverage Premiums;
   d) Billing and collecting Premiums from COBRA beneficiaries;
   e) Providing notification of nonpayment of COBRA continuation coverage Premiums;
   f) Providing notification of conversion rights, if any, on termination of COBRA coverage;
   g) Remitting COBRA continuation coverage Premiums to the Group;
   h) Establishing and maintaining records of COBRA continuation coverage;
   i) Providing necessary forms, materials, and manuals to the Group;
   j) Establishing procedures to verify eligibility for COBRA coverage;
   k) Developing all correspondence and notices to COBRA beneficiaries;
   l) Providing a reasonable level of customer service with respect to its COBRA responsibilities;
   m) Retaining and maintaining confidentiality of records, as required by law, providing an adequate disaster recovery program, and providing reasonable access to the records by the Group;
   n) On termination of its responsibilities as COBRA Administrator for the Group, furnishing to the Group or its agent all records necessary for continued administration of the Group's COBRA responsibilities.
2. The COBRA Administrator is not responsible for notifying Covered Persons or any other parties entitled to notices with regard to COBRA continuation coverage rights, or for providing them with Enrollment Forms.
3. The COBRA Administrator designated pursuant to Paragraph 2 of the Your Obligations subsection shall agree to indemnify the Group and us, and their directors, officers, employees and agents against any and all claims, lawsuits, settlements, judgments, costs, taxes and expenses, including reasonable attorneys' fees, directly resulting from or arising out of the failure of the COBRA Administrator to perform the obligations specified in this Obligations of the COBRA Administrator subsection.

Obligations of the Covered Persons

1. A Covered Person must contact you to determine if he or she is entitled to COBRA continuation of coverage.
2. Covered Persons may elect, if COBRA applies to the Group, to continue their group health coverage if they qualify under one of the circumstances specified in COBRA and satisfy all of the requirements for such coverage including payment of required Premiums.
3. The Covered Person must provide you with all required notices, in the form and within the time period required by COBRA, the Group, and the COBRA Administrator, including but not limited to, notice of:
   a) Medicare entitlement, divorce or legal separation, or the failure of a Dependent child to meet eligibility requirements of the Group Plan;
   b) coverage under another group health plan; and
   c) with respect to the Covered Person's ability to receive additional periods of coverage under COBRA in the event that the Covered person is disabled, a determination by the Social Security Administration that the Covered Person is disabled, or a determination by the Social Security Administration that the Covered Person has ceased to be disabled.

This section shall not be interpreted to grant to any Covered Person any continuation rights in excess of those required by COBRA. Additionally, this section shall be interpreted so as to comply with COBRA and any changes to COBRA that are mandatory with respect to the Group.

BlueCard®

Like all Blue Cross and Blue Shield Licensees, BCBSF participates in a program called “BlueCard”. Whenever a Covered Person accesses Health Care Services outside the geographic area we serve, the claim for those Services may be processed through BlueCard® and presented to us for payment in conformity with network access rules of the BlueCard® Policies then in effect (“Policies”). Under BlueCard®, when a Covered Person receives Covered Health Care Services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee (“Host Blue”), we will remain responsible to you for fulfilling our contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard® Policies, if any, for providing such services as contracting with its participating Providers and handling all interaction with its participating Providers. The financial terms of BlueCard® are described generally below.

Liability Calculation Method per Claim

The calculation of a Covered Person’s liability on claims for Covered Health Care Services incurred outside the geographic area we serve and processed through BlueCard® will be based on the lower of the Provider's billed charges or the negotiated price we pay the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue’s Provider contracts. The negotiated price paid to a Host Blue by us on a claim for Health Care Services processed through BlueCard® may represent:

i. the actual price paid on the claim by the Host Blue to the health care Provider (“Actual Price”), or

ii. an estimated price, determined by the Host Blue in accordance with BlueCard® Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue’s health care Providers or one or more particular Providers (“Estimated Price”), or

iii. an average price, determined by the Host Blue in accordance with BlueCard® Policies, based on a billed charges discount representing the Host Blue’s average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers (“Average Price”). An Average Price may result in greater variation to you and the Covered Person from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard® Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Covered Person is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating the Covered Person’s liability for Covered Health Care Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate the Covered Person’s liability for any Covered Health Care Services in accordance with the applicable Host Blue state statute in effect at the time the Covered Person received those services.

Return of Overpayments

Under BlueCard®, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third

party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard® Policies, which generally require correction on a claim-by-claim or prospective basis.

BCBSF Health Care Reform Master Policy Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Master Policy including any Endorsements attached thereto. If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

Administrative Provisions

The following new subsection is added:

Employer Obligation to Report Contribution Rate and Changes

If one or more of your plans is considered a "grandfathered health plan" as that term is used under the federal law known as the Patient Protection and Affordable Care Act (PPACA), you agree to provide us with the following information regarding each plan:

- Your current contribution rates by tier of coverage;
- Your contribution rates by tier of coverage that were effective on March 23, 2010; and
- Any changes you make to your contribution rates by tier at any time during the term of this Master Policy. You must report any such contribution rate change to us with at least 30 days advance written notice.

This information is required by PPACA so that we can verify that you continue to maintain grandfathered status. Remember, any change that results in a reduction in contribution by tier of greater than 5 percentage points will cause a loss in grandfathered health plan status.

Employer agreement to transfer upon termination of grandfathered health plan status

You understand and agree that upon loss of grandfathered health plan status we shall, at our sole discretion, either, 1) modify your current health plan to comply with the provisions of PPACA applicable to non-grandfathered health plans; or 2) transfer your health plan to a comparable health plan that is already non-grandfathered. Such modification or transfer shall take place at the date specified by us and may include modified rates.

You agree that any action you take that causes a loss in grandfathered health plan status constitutes automatic consent for us to modify your coverage or transfer your group health plan to a comparable group health plan, as described in the paragraph above. You further agree to any rate change associated with the change in your coverage as a result of the loss of grandfathered health plan status.

General Provisions

The following new subsections are added:

Grandfathered Health Plan Indemnification

There are certain actions that are solely within your control, as the employer, that can cause a loss in grandfathered health plan status. As such, if you wish to retain grandfathered health plan status, please recognize that we make no representations that your group health plan will retain grandfathered health plan status where you take unilateral action that may cause a loss in grandfathered health plan status. For example, if you:

- Reduce your contribution percentage by more than 5%;
- Acquire another corporation, or merge another corporation into your health plan solely to add enrollees to your health plans; and/or
- Transfer employees from one health plan to another with no bona fide employment-based reason for the transfer;

You will likely lose your grandfathered health plan status. Since we have no control over the above actions and other such unilateral actions identified in the grandfathering health plan interim final regulations found at 75 FR 34537 (June 17, 2010), as may be amended from time to time, we disclaim all responsibility for compliance with grandfathering health plan rules for such unilateral actions.

You agree to indemnify BCBSF for any and all penalties and/or fines and costs associated therewith for such unilateral actions taken by you that cause a loss in grandfathered health plan status. We encourage you to read the grandfathering health plan rules and work with your attorney to ensure compliance with such rules.

Medical Loss Ratio – Rebates

Federal law requires that BSBSF return that portion of premiums where BCBSF's claims and quality improvement costs fall below a specified minimum Medical Loss Ratio (MLR) for the entire large group market. This return of premium is known as a "rebate". MLR is determined by the federal government and sets a minimum percentage of total premiums that must be attributed to claims and quality improvement expenses. This is calculated in accordance with Section 2718 of the Public Health Services Act ("PHSA"), as added by the Patient Protection and Affordable Care Act (the "ACA" or the "Act") and any promulgated regulations. While we make every effort to meet such MLR, there may be times when we will rebate a portion of the Premium amount to you and/or your Covered Employees in accordance with federal law. Currently, such rebates, if any, are payable by August of the year following the Calendar Year in which our MLR exceeds the then current federal threshold required by Section 2718 of the Act.

In order to properly rebate that portion of Premiums due under federal law you and/or your Covered Employees agree to the following:

1. You, or your authorized representative (e.g., agent, broker, etc.), shall timely cooperate with us in determining that portion of rebate due you and provide all required information for determining your employer size under federal law. This may require you, or your authorized representative, to complete written or electronic questionnaires and report on amounts you may be required to rebate to Covered Employees under paragraph 3, below. Required information may include, but is not limited to, your employee and former employee addresses, whether Premium contributions are collected pre or post tax, and employee social security numbers.
2. You agree that we have the sole right to determine to whom rebates are due and how such rebates shall be provided, e.g., in the form of future Premium credits, by check, or debit card.
3. You agree that BCBSF has the sole right to choose to whom the rebate will be paid. As such, we may rebate the entire amount due to you or choose to rebate the entire amount to your Covered Employees, including your portion of the rebate based upon your contribution toward coverage. Should we choose to rebate the entire amount due to you, you agree to the following:

a) If the Group Plan is subject to the Employee Retirement Income Security Act of 1972 ("ERISA"), then you will use the rebate in accordance with the terms of your Plan Document as that term is defined in ERISA, and treat the rebated amount as a Plan Asset as that term is defined in ERISA;

b) If the Group Plan is not subject to ERISA, you attest, acknowledge and agree that you shall use the rebates for the benefit of the Covered Employees of your Group Plan. You agree to use the rebates in one of the following three ways:

   i. To reduce subscribers' portion of the annual premium for the subsequent policy year for all subscribers covered under any group health plan offered by the group;

   ii. To reduce subscribers' portion of the annual premium for the subsequent policy year for only those subscribers covered by the group health plan on which the rebate was based; or

   iii. To provide a cash refund only to subscribers that were covered by the group health plan on which the rebate is based.

c) You shall timely cooperate with any data reporting requirements that we may have for reporting to the federal government the amounts rebated to you and your employees.

4. If we choose to rebate to your Covered Employees directly, you agree that you shall not contest in any formal way, e.g. litigation, our choice to rebate to employees directly. Furthermore, you agree that BCBSF may, in its sole discretion, choose to treat amounts that may be due you as "unclaimed" as that term is defined under any promulgated regulations related to Section 2718 of the Act. If we choose to treat the amount due as "unclaimed", you shall have the right, at any time prior to escheat to the state, to provide the information in paragraph 1 to allow for proper return of such amounts as required by Section 2718 of the Act.

5. You acknowledge and agree that you, or your authorized representative, shall certify all information as true and correct as may be required by us on any forms provided for provision of the requested information in paragraphs 1 through 4 above.

You recognize and agree that this section shall apply to all rebates returned to you on or after June 1, 2012, regardless of which Calendar Year the rebate reflects.

You recognize that appropriately rebating amounts due you and your employees under this section is both complex and requires significant support from you. Failure to correctly rebate may result in fines and/or other penalties being imposed on us. If we are fined for failure to provide rebates, failure to provide rebates in a timely fashion, or failure to provide the appropriate rebates and such fines and/or penalties result from your failure to comply with the provisions of paragraphs 1 through 4, above, you agree to indemnify BCBSF for any such fines, penalties, interest or other amounts due, including any additional rebates due as a result of improper rebating based upon information you provided or failed to provide in accordance with this process. You agree to provide such amounts to us in accordance with any required timeframe imposed upon us by the government for such failure.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in your Master Policy, 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 your Master Policy, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

Rescissions Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Master Policy and any Endorsements attached thereto. If you have any questions concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

GENERAL PROVISIONS

The following new subsection is added:

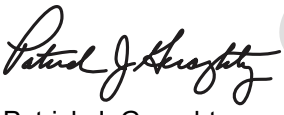
Rescissions

You represent that any eligibility and status changes you request are compliant with and permissible under applicable state and federal law, including the Patient Protection and Affordable Care Act ("ACA") and subsequent regulations. For example, Section 2712 of the Public Health Services Act ("PHSA"), as added by the ACA prohibits canceling the policy of an employee and/or their dependent(s) for any period during which a premium was collected from the employee and/or their dependent.

You hereby agree not to collect any premium from an employee and/or their dependent(s) for a coverage period occurring after the date their policy terminates. When submitting cancellation requests to us, you represent that you have not collected any premium from the canceled employee(s) and/or their dependent(s) for coverage after the requested termination date.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Master Policy, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Master Policy, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.



Patrick J. Geraghty
Chief Executive Officer

Summary of Benefits and Coverage Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Master Policy and any Endorsements attached thereto. If you have any questions concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

GENERAL PROVISIONS

The following **new** subsection is added.

Summary of Benefits and Coverage

Section 2715 of the Public Health Services Act ("PHSA"), as added by the Patient Protection and Affordable Care Act and any promulgated regulations and guidance ("SBC Rules") require group health plans, group health plan administrators, and health insurers offering group health coverage to provide a Summary of Benefits and Coverage ("SBC"). An SBC must be provided to your employees and their dependents, at the following times, and under the following circumstances:

1. upon application for coverage;
2. by the first day of coverage (if there are changes to the SBC after application);
3. to special enrollees;
4. upon renewal; or
5. upon request for an SBC or summary information about health coverage.

Additionally, when a material modification (as defined under section 102 of ERISA) is made to the terms of a plan or coverage occurring outside a renewal or reissuance that would affect the most recently provided SBC, notice must be provided to each person covered under such plan 60 days in advance of the change.

BCBSF will provide you or your designated representative or agent with an SBC for each BCBSF benefit plan you offer for you to distribute to your Eligible Employees and their dependents in accordance with the following:

1. You agree to provide an SBC to your Eligible Employees and their dependents as required by the SBC Rules, within the required time frames, and in compliance with the delivery rules including electronic delivery requirements. The SBC Rules only require providing an SBC to dependents if they live at a different address than the employee.
2. You agree to distribute the SBC in the manner and appearance as specified in the SBC Rules. For example, the SBC must be provided either (1) as a stand-alone document; or (2) in combination with other summary materials (such as a Summary Plan Description (SPD)). The SBC must be intact and prominently displayed at the beginning of any other summary materials (such as immediately after the table of contents in an SPD).
3. You agree to provide a complete and accurate SBC with respect to each benefit plan you offer to your eligible employees and their dependents. For example, you are responsible for creating an SBC for any benefits not insured by BCBSF. To the extent the SBC Rules require you to incorporate such information into a single SBC document you are responsible for incorporating all such information into a single SBC and providing it to your Covered and Eligible Employees and their dependents.

SBC MP END Large Group

4. You agree to provide notice to your Covered Employees and their dependents 60 days prior to a material modification that affects the most recently provided SBC.
5. You agree to retain records related to the delivery of the SBCs and compliance with the SBC Rules. These records must be made available to BCBSF for inspection and copying upon request.
6. You agree to indemnify and hold BCBSF harmless from any damages, loss, action, claim or suit, including court costs and attorney's fees, arising from, or related to, your failure to provide a complete, accurate and timely SBC to your Covered and Eligible Employees and their dependents in accordance with the SBC Rules.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Master Policy, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Master Policy, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2014 Health Care Reform Master Policy Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Group Master Policy and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

GENERAL PROVISIONS

The **Medical Loss Ratio Rebates** subsection is amended by deleting the first paragraph in its entirety and replacing it with the following:

Medical Loss Ratio Rebates

Federal law requires that BSBSF return that portion of premiums where BCBSF's administrative cost exceeds a specified Medical Loss Ratio (MLR) for the entire large group market. This return of premium is known as a "rebate". MLR is set by the federal government at 80% for medical expenses and 20% for administrative expenses of total premiums as calculated in accordance with Section 2718 of the Public Health Services Act ("PHSA"), as added by the Patient Protection and Affordable Care Act (the "ACA" or the "Act") and any promulgated regulations. While we make every effort to meet such MLR, there may be times when we will rebate such amount to you and/or your Covered Employees in accordance with federal law. Currently, such rebates, if any, are payable by the date specified by the federal government of the year following the Calendar Year in which our MLR exceeds the then current federal threshold required by Section 2718 of the Act.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Group Master Policy, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Group Master Policy, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions Eligible Dependent Definition Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Group Master Policy and any Endorsements attached thereto. The Group Master Policy is amended as described below.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

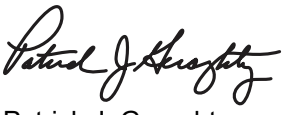
GROUP ADMINISTRATIVE PROVISIONS

The **Definitions** subsection is amended by deleting the definition for **Eligible Dependent** in its entirety and replacing it with the following:

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the ELIGIBILITY FOR COVERAGE section of the Benefit Booklet.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Group Master Policy, 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 Master Policy, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.



Patrick J. Geraghty
Chief Executive Officer

BlueOptions COBRA Administration Master Policy Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Group Master Policy and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective on **December 1, 2014**.

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The **Obligations of the COBRA Administrator** section is deleted in its entirety.

COBRA ADMINISTRATIVE SERVICES PROVISIONS

The **COBRA Administrative Services Provisions** section is deleted in its entirety and replaced with the following:

The following rules apply if the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, apply to you.

Your Obligations

1. You are responsible for all aspects of the administration of COBRA with respect to the group health coverage provided by the Group Plan.
2. You specifically delegate to us the right to perform COBRA administration responsibilities as provided in the Our Obligations subsection set out below.
3. **You retain responsibility for the following COBRA administrative duties:**
   a) You will provide a general notice of COBRA Continuation Coverage Rights or a similar notice you created to all new enrollees; and
   b) You will be required to provide us with the notices of qualifying events.
4. By entering into the Policy, you agree to indemnify and hold us, including any directors, officers, employees, and agents harmless against any and all claims, lawsuits, settlement, judgments, costs, taxes, and expenses, including reasonable attorneys' fees directly resulting from or arising out of your failure to perform COBRA administration responsibilities not specifically delegated to us.
5. Upon receipt of notice from us that we are no longer the COBRA Administrator performing COBRA administration for the Group, you shall resume responsibility for all COBRA administration.

Our Obligations

1. We, or the person or entity designated by us to be the COBRA Administrator pursuant to Paragraph two of the Your Obligations subsection, shall be responsible for the following functions:
   a) Determining application of COBRA to the Group;
   b) Receiving COBRA election forms from beneficiaries;

c) Maintaining records of COBRA continuation coverage Premiums;

d) Billing and collecting Premiums from COBRA beneficiaries;

e) Providing notification of nonpayment of COBRA continuation coverage Premiums;

f) Providing notification of conversion rights, if any, on termination of COBRA coverage;

g) Remitting COBRA continuation coverage Premiums to the Group for policies other than the health coverage under this Policy;

h) Establishing and maintaining records of COBRA continuation coverage;

i) Providing necessary forms, materials, and manuals to the Group;

j) Establishing procedures to verify eligibility for COBRA coverage;

k) Developing all correspondence and notices to COBRA beneficiaries;

l) Retaining and maintaining confidentiality of records, as required by law, providing an adequate disaster recovery program, and allowing the Group reasonable access to the records;

m) On termination of its responsibilities as COBRA Administrator for the Group, furnishing to the Group or its agent upon request, all records reasonably necessary for continued administration of the Group's COBRA responsibilities.

2. On behalf of the Group, we may designate a COBRA Administrator to perform the COBRA administration responsibilities as specified in this subsection and may enter into a contract with the COBRA Administrator. We may designate ourselves as the COBRA Administrator.
3. We are not the plan sponsor for purposes of COBRA and have no responsibility for the COBRA administration obligations not specified in this Policy.
4. If you or the Covered Person fails to meet any obligations under the Group Plan and COBRA, we will not be liable for any claims of the Covered Person after his/her termination of coverage.

Obligations of the Covered Persons

1. A Covered Person must contact you to determine if he or she is entitled to COBRA continuation of coverage.
2. If COBRA applies to the Group, Covered Persons may elect to continue their group health coverage if they qualify under one of the circumstances specified in COBRA and satisfy all of the requirements for such coverage including payment of required Premiums.
3. The Covered Person must provide you with all required notices, in the form and within the time period required by COBRA, the Group, and the COBRA Administrator, including but not limited to, notice of:

   a) Medicare entitlement, divorce or legal separation, or the failure of a Dependent child to meet eligibility requirements of the Group Plan;

   b) coverage under another group health plan; and

   c) with respect to the Covered Person’s ability to receive additional periods of coverage under COBRA in the event that the Covered person is disabled, a determination by the Social Security Administration that the Covered Person is disabled, or a determination by the Social Security Administration that the Covered Person has ceased to be disabled.

This section shall not be interpreted to grant to any Covered Person any continuation rights in excess of those required by COBRA. Additionally, this section shall be interpreted so as to comply with COBRA and any changes to COBRA that are mandatory with respect to the Group.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Group Master Policy, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Group Master Policy, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions General Group Provisions 2016 Large Group Master Policy Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Master Policy and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 1, 2016** or first Anniversary Date occurring on or after **January 1, 2016** whichever occurs first.

GENERAL GROUP PROVISIONS

The **Membership Provision** category is amended by deleting the Membership Provision in its entirety and replacing it with the following:

Membership Provision

As a holder of an insurance policy issued by us, you are a member of our parent company, GuideWell Mutual Holding Corporation ("GuideWell"). As such you have all the rights, privileges, and obligations provided in the Articles of Incorporation and Bylaws of GuideWell as currently in force and as may be amended from time to time, including the right to elect GuideWell's Board of Directors. You will not be able to transfer your membership interest in GuideWell and your membership interest in GuideWell will terminate automatically upon the lapse or termination of your insurance policy. Separate certificates evidencing your membership interests in GuideWell will not be issued.

An annual meeting of the members shall be held for the purpose of electing the Board of Directors and transacting such other business as may be properly brought before the meeting. At all meetings of our members, each member shall be entitled to cast a number of votes equal to the amount of Premiums attributed to such member in the month immediately preceding the meeting's record date, as determined by us (e.g., a Premium of $27.36 in that month will be equal to 27.36 votes). Members may vote in person or by submitting a proxy in accordance with the voting instructions provided by us before the meeting.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Master Policy, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Master Policy, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2019 Master Policy Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Group Master Policy ("Policy") and any Endorsements attached thereto.

The Policy is amended as described below. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's initial Effective Date occurring on or after **January 01, 2019** or first Anniversary Date occurring on or after **January 01, 2019** whichever occurs first.

BLUECARD® PROGRAM

The **BCBS Global Core Program** subsection is deleted in its entirety and replaced with the following.

Blue Cross Blue Shield Global® Core Program

If Covered Persons are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists Covered Persons with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the BlueCard Service Area, Covered Persons will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these Services.

Inpatient Services

In most cases, if Covered Persons contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Covered Persons to pay for inpatient Covered Services, except for their Cost Share amounts. In such cases, the hospital will submit Covered Person claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the Covered Person paid in full at the time of Service, the Covered Person must submit a claim to obtain reimbursement for Covered Services. **Covered Persons must notify us of any non-emergency inpatient Services.**

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require Covered Persons to pay in full at the time of Service. Covered Persons must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Covered Persons should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If Covered Persons need assistance with their

claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

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

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueCard Program Master Policy Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Master Policy and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2018** or first Anniversary Date occurring on or after **January 01, 2018** whichever occurs first.

GROUP ADMINISTRATIVE PROVISIONS

The following definition is added:

Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

BLUECARD® PROGRAM

The Master Policy is amended by deleting the BlueCard section in its entirety and replacing it with the following:

Out-of-Area Services Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Covered Persons access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter- Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside Florida, Covered Persons obtain care from Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Covered Persons may obtain care from Providers in the Host Blue geographic area that do not have a contractual agreement ("Nonparticipating Providers") with the Host Blue. We remain responsible for fulfilling our contractual obligations to the Group. Our payment practices in both instances are described below.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific Service or Services.

BlueCard Program

The BlueCard Program is an Inter-Plan Arrangement. Under this Arrangement, when Covered Persons access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar Copayment, the calculation of the Covered Person's liability on claims for Covered Services will be based on the lower of the Participating Provider's billed charges for Covered Services or the negotiated price made available to us by the Host Blue.
Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Provider contracts. The negotiated price made available to us by the Host Blue may be represented by one of the following:

1. **An actual price**. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
2. **An estimated price**. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or
3. **An average price**. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to Providers or refunds received or anticipated to be received from Providers). However, the BlueCard Program requires that the amount paid by the Covered Person is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by us in determining the Group's premiums.

Special Cases: Value-Based Programs

We have included a factor for bulk distributions from Host Blues in the Group's premium for Value-Based Programs when applicable under this Master Policy. Additional information is available upon request.

Return of Overpayments

Recoveries from a Host Blue or its Participating and Nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to us, they will be credited to the Group's account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to the Group as a percentage of the recovery.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee in determining the Group's premium.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, our payment will be based on the Allowed Amount, as defined in the DEFINITIONS section of the Benefit Booklet.

BCBS Global™ Core Program

If Covered Persons are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), they may be able to take advantage of the BCBS Global Core Program when accessing Covered Services. The BCBS Global Core Program is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the BCBS Global Core Program assists Covered Persons with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the BlueCard Service Area, Covered Persons will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these Services.

Inpatient Services

In most cases, if Covered Persons contact the BCBS Global Core Service Center for assistance, hospitals will not require Covered Persons to pay for inpatient Covered Services, except for their Cost Share amounts. In such cases, the hospital will submit Covered Person claims to the BCBS Global Core Service Center to initiate claims processing. However, if the Covered Person paid in full at the time of Service, the Covered Person must submit a claim to obtain reimbursement for Covered Services. **Covered Persons must notify us of any non-emergency inpatient Services.**

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require Covered Persons to pay in full at the time of Service. Covered Persons must submit a claim to obtain reimbursement for Covered Services.

Submitting a BCBS Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Covered Persons should complete a BCBS Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the BCBS Global Core Service Center address on the form to initiate claims processing. The claim form is available from the BCBS Global Core Service Center or online at www.bcbsglobalcore.com. If Covered Persons need assistance with their claim submissions, they should call the BCBS Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Master Policy, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Master Policy, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2024 Master Policy Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Group Master Policy ("Policy") and any Endorsements attached thereto.

The Policy is amended as described below. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at the Group Plan's initial Effective Date occurring on or after **January 01, 2024** or first Anniversary Date occurring on or after **January 01, 2024** whichever occurs first.

GENERAL PROVISIONS

The following **new** subsection is added**:**

Special Federal Reporting and Disclosures

Transparency in Coverage – Machine Readable Files

BCBSF will produce the data required at 45 CFR 147.212(b) to the extent that BCBSF processes this data and will publish this information on its website. The group health plan may link to this data at https://www.floridablue.com/members/tools-resources/transparency/machine-readable-files.

Prescription Drug and Health Care Spending (RxDC) Reporting

BCBSF will produce the data and perform the reporting required by 45 CFR 149.720(a) to the extent that BCBSF processes this data on behalf of the Group during the time period for which the reporting is required. In addition, BCBSF will perform the reporting of the data in support of employer / employee share of premium only to the extent that the Group has supplied the information needed for BCBSF to perform this reporting. You agree that your group will provide any needed supplemental data requested by BCBSF to support RxDC Reporting upon request, in a timely manner. If your group does not supply the information needed to support the RxDC Reporting upon request, BCBSF will not perform the reporting for which we do not have the information, and BCBSF does not take responsibility for this reporting as defined in 45 CFR 149.720(d).

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

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions

Benefit Booklet

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

BlueOptions
Large Group
22603-0107 BCA

BlueOptions

Benefit Booklet

Robert I. Lufrano, M.D.

Chairman of the Board and Chief Executive Officer

This Benefit Booklet Contains Deductible Provisions

For Customer Service Assistance: (800) 664-5295

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

Table of Contents

Section 1: How to Use Your Benefit Booklet

This is your Benefit Booklet ("Booklet"). You should read it carefully before you need Health Care Services. It contains valuable information about:

- your BlueOptions benefits
- what is covered
- what is excluded or not covered
- our coverage and payment rules
- our Blueprint for Health Programs
- how and when to file a claim
- how much, and under what circumstances, we will pay
- what you will have to pay as your share
- and other important information including when benefits may change; how and when coverage stops; how to continue coverage if you are no longer eligible; how we will coordinate benefits with other policies or plans; our subrogation rights; and our right of reimbursement.

Refer to the Schedule of Benefits included in this booklet to determine how much you have to pay for particular Health Care Services.

When reading your Booklet, please remember that:

- you should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered.
- the headings of sections contained in this Benefit Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- references to "you" or "your" throughout refer to you as the Covered Employee and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Covered Employee or solely to your Covered Dependent(s) will be noted as such.
- references to "we", "us", and "our" throughout refer to Blue Cross and Blue Shield of Florida, Inc. We may also refer to ourselves as "BCBSF."
- if a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the Definitions section or defined within the particular section where it is used.

Where do you find information on…

- **what particular types of Health Care Services are covered?**

  Read the "What Is Covered?" and "What Is Not Covered?" sections.

- **how much does BCBSF pay and how much do you have to pay?**

  Read the "Understanding Your Share of Health Care Expenses" section along with the Schedule of Benefits.

- **how to take advantage of the BlueCard® (Out-of-State) Program when you receive Services out-of-state?**

  Read the "BlueCard® (Out-of-State) Program" section.

- **how to add or remove a Dependent?**

  Read the "Enrollment and Effective Date of Coverage" section.

- **what happens if you are covered under BlueOptions and another health plan?**

  Read the “Duplication of Coverage Under Other Health Plans /Programs” section.

- **what happens when your coverage ends?**

  Read the “Termination of Coverage” section.

- **what the terms used throughout this Booklet mean?**

  Read the Definitions section.

Overview of How BlueOptions Works

Whenever you need care, you have a choice. If you visit an:	
In-Network Provider	**Out-of-Network Provider**
You receive In-Network benefits, the highest level of coverage available.	You receive the Out-of-Network level of benefits – you will share more of the cost of your care.
You do not have to file a claim; the claim will be filed by the In-Network Provider for you.	You may be required to submit a claim form.
The In-Network Provider* is responsible for Admission Notification if you are admitted to the Hospital.	You should notify BCBSF of inpatient admissions.

*For Services rendered by an In-Network Provider located outside of Florida, you should notify us of inpatient admissions.

Section 2: What Is Covered?

Introduction

This section describes the Health Care Services that are covered under this Benefit Booklet. All benefits for Covered Services are subject to your share of the cost and the benefit maximums listed on your Schedule of Benefits, the applicable Allowed Amount, any limitations and/or exclusions, as well as other provisions contained in this Booklet, and any Endorsement(s) in accordance with our Medical Necessity coverage criteria and benefit guidelines then in effect.

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included along with the benefit description in this section. Additional exclusions and limitations that may apply can be found in the "What Is Not Covered?" section. More than one limitation or exclusion may apply to a specific Service or a particular situation.

Expenses for the Health Care Services listed in this section will be covered under this Booklet only if the Services are:

1. within the Health Care Services categories in this "What Is Covered?" section;
2. actually rendered (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment by us and for which we receive an itemized statement or description of the procedure or Service, which was rendered, including any applicable procedure code, diagnosis code and other information we require in order to process a claim for the Service;
3. Medically Necessary, as defined in this Booklet and determined by us in accordance with our Medical Necessity coverage criteria then in effect, except as specified in this section;
4. in accordance with our benefit guidelines listed below;
5. rendered while your coverage is in force; and
6. not specifically or generally limited (e.g., Pre-existing Condition exclusionary period) or excluded under this Booklet.

We will determine whether Services are Covered Services under this Booklet after you have obtained the Services and we have received a claim for the Services. In some circumstances we may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, we may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. We are not obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service.

In determining whether Health Care Services are Covered Services under this Booklet, no written or verbal representation by any employee or agent of BCBSF, or by any other person shall waive or otherwise modify the terms of this Booklet and, therefore, neither you, nor the Group, nor any health care Provider or other person should rely on any such written or verbal representation.

Our Benefit Guidelines

In providing benefits for Covered Services, we may apply the benefit guidelines listed below as well as any other applicable payment rules specific to particular categories of Services:

1. Our payment for certain Health Care Services is included within the Allowed

Amount for the primary procedure, and therefore no additional amount is payable by us for any such Services.

2. Our payment is based on the Allowed Amount for the actual Service rendered (i.e., payment is not based on the Allowed Amount for a Service which is more complex than that actually rendered), and is not based on the method utilized to perform the Service nor the day of the week nor the time of day the procedure is performed.
3. Our payment for a Service includes all components of the Health Care Service when the Service can be described by a single procedure code, or when the Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

Covered Services Categories

Accident Care

Health Care Services to treat an injury resulting from an Accident not related to your job or employment are covered.

Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded except for Services (not otherwise excluded) when you are not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by you.

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization serum are covered. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based upon the type and number of doses.

Ambulance Services

Ambulance Services provided by a ground vehicle may be covered provided it is necessary to transport you from:

1. a Hospital which is unable to provide proper care to the nearest Hospital that can provide proper care;
2. a Hospital to your nearest home, or to a Skilled Nursing Facility; or
3. the place a medical emergency occurs to the nearest Hospital that can provide proper care.

Expenses for Ambulance Services by boat, airplane, or helicopter shall be limited to the Allowed Amount for a ground vehicle unless:

1. the pick-up point is inaccessible by ground vehicle;
2. speed in excess of ground vehicle speed is critical; or
3. the travel distance involved in getting you to the nearest Hospital that can provide proper care is too far for medical safety, as determined by us.

Please refer to your Schedule of Benefits for the separate per-day maximums for ground transportation and air/water transportation.

Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center are covered and include:

1. use of operating and recovery rooms;
2. respiratory, or inhalation therapy (e.g., oxygen);
3. drugs and medicines administered (except for take home drugs) at the Ambulatory Surgical Center;
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;

7. administration of, including the cost of, whole blood or blood products;
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and
10. chemotherapy treatment for proven malignant disease.

Anesthesia Administration Services

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, our payment for Covered Services, if any, will be made for both the CRNA and the Physician Health Care Services at the lower directed-services Allowed Amount in accordance with our payment program for such Covered Services then in effect.

Exclusion:

Coverage does not include anesthesia Services by an operating Physician, his or her partner or associate.

Breast Reconstructive Surgery

Surgery to reestablish symmetry between two breasts and implanted prostheses incident to Mastectomy is covered. In order to be covered, such surgery must be provided in a manner chosen by your Physician, consistent with prevailing medical standards, and in consultation with you.

Child Cleft Lip and Cleft Palate Treatment

Treatment and Services for Child Cleft Lip and Cleft Palate, including medical, dental, Speech Therapy, audiology, and nutrition Services for treatment of a child under the age of 18 who has cleft lip or cleft palate are covered. In order for such Services to be covered, your Covered Dependent's Physician must specifically prescribe such Services and such Services must be consequent to treatment of the cleft lip or cleft palate.

Concurrent Physician Care

Concurrent Physician care Services are covered, provided: (a) the additional Physician actively participates in your treatment; (b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and (c) the Physicians have different specialties or have the same specialty with different sub-specialties.

Consultations

Consultations provided by a Physician are covered if your attending Physician requests the consultation and the consulting Physician prepares a written report.

Contraceptive Injections

Medication by injection is covered when provided and administered by a Physician, for the purpose of contraception, and is limited to the medication and administration.

Payment Guidelines for Medication and Administration by Injection for Contraception

Physician office Services, rendered on the same day, in connection with the administration by injection of the contraceptive medication, for well or preventive Services, are not reimbursed separately unless the Group has purchased the adult wellness benefit.

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.

3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you or your Covered Dependent in a Hospital or Ambulatory Surgical Center if:

    a) the Covered Dependent is under 8 years of age and it is determined by a dentist and the Covered Dependent's Physician that:

        i. dental treatment is necessary due to a dental Condition that is significantly complex; or

        ii. the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or

    b) you have one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Exclusion:

1. Dental Services provided more than 62 days after the date of an Accidental Dental Injury regardless of whether or not such services could have been rendered within 62 days; and
2. Dental Implants.

Diabetes Outpatient Self-Management

Diabetes outpatient self-management training and educational Services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes, if your treating Physician or a Physician who specializes in the treatment of diabetes certifies that such Services are Medically Necessary, are covered. In order to be covered, diabetes outpatient self-management training and educational Services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. Additionally, in order to be covered, nutrition counseling must be provided by a licensed Dietitian. Covered Services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Notwithstanding the above, if your Benefit Booklet was amended by a BCBSF Pharmacy Program Endorsement which covers diabetes equipment and supplies, then diabetes equipment and supplies will be covered in accordance with the terms and conditions of such Pharmacy Program Endorsement.

Diagnostic Services

Diagnostic Services when ordered by a Physician are limited to the following:

1. radiology, ultrasound and nuclear medicine, Magnetic Resonance Imaging (MRI);
2. laboratory and pathology Services;
3. Services involving bones or joints of the jaw (e.g., Services to treat temporomandibular joint [TMJ] dysfunction) or facial region if, under accepted medical standards, such diagnostic Services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. approved machine testing (e.g., electrocardiogram [EKG], electroencephalograph [EEG], and other electronic diagnostic medical procedures); and
5. genetic testing for the purposes of explaining current signs and symptoms of a possible hereditary disease.

Dialysis Services

Dialysis Services including equipment, training, and medical supplies, when provided at any location by a Provider licensed to perform dialysis including a Dialysis Center are covered.

Durable Medical Equipment

Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed by a Physician, limited to the most cost effective equipment as determined by us is covered.

Payment Guidelines for Durable Medical Equipment

Supplies and service to repair medical equipment may be Covered Services only if you own the equipment or you are purchasing the equipment. Our payment for Durable Medical Equipment will be based on the lowest of the following: 1) the purchase price; 2) the lease/purchase price; 3) the rental rate; or 4) our Allowed Amount. Our Allowed Amount for such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Note: Repair or replacement of Durable Medical Equipment due to growth of a child or significant change in functional status is a Covered Service.

Exclusion:

Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used are excluded.

Enteral Formulas

Prescription and non-prescription enteral formulas for home use when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period are covered.

Coverage to treat inherited diseases of amino acid and organic acids, for you up to your 25th birthday, shall include coverage for food products modified to be low protein.

Eye Care

Coverage includes the following Services:

1. Physician Services, soft lenses or sclera shells, for the treatment of aphakic patients;
2. initial glasses or contact lenses following cataract surgery; and
3. Physician Services to treat an injury to or disease of the eyes.

Exclusion:

Health Care Services to diagnose or treat vision problems which are not a direct consequence of trauma or prior ophthalmic surgery; eye examinations; eye exercises or visual training; eye glasses and contact lenses and their fitting are excluded. In addition to the above, any surgical procedure performed primarily to correct or improve myopia or other refractive disorders (e.g., radial keratotomy, PRK and LASIK) are also excluded.

Home Health Care

The Home Health Care Services listed below are covered when the following criteria are met:

1. you are unable to leave your home without considerable effort and the assistance of another person because you are: bedridden or chairbound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition; and
2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan which has been reviewed and renewed by the prescribing Physician every 30 days. We reserve the right to request a copy of any written treatment plan in order to determine whether such Services are covered under this Booklet.
3. the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

1. part-time (i.e., less than 8 hours per day and less than a total of 40 hours in a calendar week) or intermittent (i.e., a visit of up to, but not exceeding, 2 hours per day) nursing care by a Registered Nurse, Licensed Practical Nurse and/or home health aide Services;
2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and rendered under the supervision of a Registered Nurse;
3. medical social services;
4. nutritional guidance;
5. respiratory, or inhalation therapy (e.g., oxygen); and
6. Physical Therapy by a Physical Therapist, Occupational Therapy by a Occupational Therapist, and Speech Therapy by a Speech Therapist.

Exclusions:

1. homemaker or domestic maid services;
2. sitter or companion services;
3. Services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility;
4. Speech Therapy provided for a diagnosis of developmental delay;
5. Custodial Care;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is approved by your Physician. We reserve the right to request that your Physician certify in writing your life expectancy.

Hospital Services

Covered Hospital Services include:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;

5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. drugs and medicines administered (except for take home drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, and Cardiac Therapies; and
14. transplants as described in the Transplant Services subsection.

Exclusion:

Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital: 1) room and board provided during the admission; 2) Physician visits provided while you were an inpatient; 3) Occupational Therapy, Speech Therapy, Physical Therapy, and Cardiac Therapy; and 4) other Services provided while you were an inpatient.

In addition, expenses for the following and similar items are also excluded:

1. gowns and slippers;
2. shampoo, toothpaste, body lotions and hygiene packets;
3. take-home drugs;
4. telephone and television;
5. guest meals or gourmet menus; and
6. admission kits.

Inpatient Rehabilitation

Inpatient Rehabilitation Services are covered when the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is limited to the specific acute, catastrophic target diagnoses of severe stroke, multiple trauma, brain/spinal injury, severe neurological motor disorders, and/or severe burns;
4. the individual must be able to actively participate in at least 2 rehabilitative therapies and be able to tolerate at least 3 hours per day of skilled Rehabilitation Services for at least 5 days a week and their Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration as to make it impractical for the individual to receive services in a less intensive setting.

Inpatient Rehabilitation Services are subject to the inpatient facility Copayment, if applicable, and the benefit maximum set forth in the Schedule of Benefits.

Exclusion:

All Substance Dependency, drug and alcohol related diagnoses, Pain Management, and respiratory ventilator management Services are excluded.

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment

registered with the appropriate Florida regulatory agencies (or those of another state) for diagnostic purposes or breast cancer screening are Covered Services.

Benefits for mammograms may not be subject to the Calendar Year Deductible, Coinsurance, or Copayment (if applicable). Please refer to your Schedule of Benefits for more information.

Mastectomy Services

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards as determined by you and your attending Physician are covered. Outpatient post-surgical follow-up care for Mastectomy Services shall be covered when provided by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or your home. The treating Physician, after consultation with you, may choose the appropriate setting.

Maternity Services

Health Care Services, including prenatal care, delivery and postpartum care and assessment, provided to you, by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Hospital, Birth Center, Midwife or Certified Nurse Midwife may be Covered Services. Care for the mother includes the postpartum assessment.

In order for the postpartum assessment to be covered, such assessment must be provided at a Hospital, an attending Physician's office, an outpatient maternity center, or in the home by a qualified licensed health care professional trained in care for a mother. Coverage under this Booklet for the postpartum assessment includes coverage for the physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards.

Exclusion:

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all expenses for prenatal, intra-partal, and post-partal Maternity/Obstetrical Care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

For the definition of Gestational Surrogate and Gestational Surrogacy Contract see the "Definitions" section of this Benefit Booklet.

Mental Health Services

Diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy provided to you by a Physician, Psychologist, or Mental Health Professional for the treatment of a Mental and Nervous Disorder may be covered. These Health Care Services include inpatient, outpatient, and Partial Hospitalization services.

Partial Hospitalization is a Covered Service when provided under the direction of a Physician and in lieu of inpatient hospitalization and is combined with the inpatient Hospital benefit. Two days of Partial Hospitalization will count as one day toward the inpatient Mental and Nervous Disorder benefit.

Exclusion:

1. Services rendered in connection with a Condition not classified in the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation;
3. Services extended beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation;

4. Services for marriage counseling, when not rendered in connection with a Condition classified in the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;
5. Services for pre-marital counseling;
6. Services for court-ordered care or testing, or required as a condition of parole or probation;
7. Services for testing of aptitude, ability, intelligence or interest;
8. Services for testing and evaluation for the purpose of maintaining employment;
9. Services for cognitive remediation;
10. inpatient confinements that are primarily intended as a change of environment; and
11. inpatient (over night) mental health Services received in a residential treatment facility.

Newborn Care

A newborn child will be covered from the moment of birth provided that the newborn child is eligible for coverage and properly enrolled. Covered Services shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

Newborn Assessment:

An assessment of the newborn child is covered provided the Services were rendered at a Hospital, the attending Physician's office, a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife, and the performance of any necessary clinical tests and immunizations are within prevailing medical standards. These Services are not subject to the Calendar Year Deductible.

Ambulance Services, when necessary to transport the newborn child to and from the nearest appropriate facility which is staffed and equipped to treat the newborn child's Condition, as determined by us and certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child, are covered.

Orthotic Devices

Orthotic Devices including braces and trusses for the leg, arm, neck and back, and special surgical corsets are covered when prescribed by a Physician and designed and fitted by an Orthotist.

Benefits may be provided for necessary replacement of an Orthotic Device which is owned by you when due to irreparable damage, wear, a change in your Condition, or when necessitated due to growth of a child.

Payment for splints for the treatment of temporomandibular joint ("TMJ") dysfunction is limited to payment for one splint in a six-month period unless a more frequent replacement is determined by us to be Medically Necessary.

Exclusion:

1. Expenses for arch supports**,** shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease;
2. Expenses for orthotic appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g. dynamic orthotic cranioplasty or molding helmets); and
3. Expenses for devices necessary to exercise, train, or participate in sports, e.g. custom-made knee braces.

Osteoporosis Screening, Diagnosis, and Treatment

Screening, diagnosis, and treatment of osteoporosis for high-risk individuals is covered, including, but not limited to:

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;
3. individuals who are receiving long-term glucocorticoid (steroid) therapy; or
4. individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulation Services

1. Outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such Services. The outpatient therapies listed in this category are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.
    a) **Cardiac Therapy** Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.
    b) **Occupational Therapy** Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition are covered.
    c) **Speech Therapy** Services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition are covered.
    d) **Physical Therapy** Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition are covered.
    e) **Massage Therapy** Massage provided by a Physician, Massage Therapist, or Physical Therapist when the Massage is prescribed as being Medically Necessary by a Physician licensed pursuant to Florida Statutes Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry) is covered. The Physician's prescription must specify the number of treatments.

Payment Guidelines for Physical and Massage Therapy

Massage or a combination of Massage and Physical Therapy Services are limited to four (4) modalities per day not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.

Exclusion:

Application or use of the following or similar techniques or items for the purpose of aiding in the provision of a Massage: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; contrast baths are excluded.

2. **Spinal Manipulations:** Services by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray are covered.

   Payment Guidelines for Spinal Manipulations

   We will cover up to 26 spinal manipulations per Calendar Year, or the maximum benefit listed in the Schedule of Benefits, whichever occurs first.

   The Schedule of Benefits sets forth the maximum amount that we will pay for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, you may have only utilized two (2) of your spinal manipulations for the Calendar Year, but if you have already met the combined therapy maximum with other Services, this Benefit Booklet will not cover any additional spinal manipulations for that Calendar Year.

Oxygen

Expenses for oxygen, the equipment necessary to administer it, and the administration of oxygen are covered.

Physician Services

Medical or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office, in an outpatient facility, or electronically through a computer via the Internet.

Payment Guidelines for Physician Services Provided by Electronic Means through a Computer:

Expenses for online medical Services provided electronically through a computer by a Physician via the Internet will be covered only if such Services:

1. were provided to a covered individual who was, at the time the Services were provided, an established patient of the Physician rendering the Services;
2. were in response to an online inquiry received through the Internet from the covered individual with respect to which the Services were provided; and
3. were provided by a Physician through a secure online healthcare communication services vendor that, at the time the Services was rendered, was under contract with BCBSF.

The term "established patient," as used herein, shall mean that the covered individual has received professional services from the Physician who provided the online medical Services, or another physician of the same specialty who belongs to the same group practice as that Physician, within the past three years.

Exclusion:

Expenses for online medical Services provided electronically through a computer by a Physician via the Internet other than through a healthcare communication services vendor that has entered into contract with BCBSF. Expenses for online medical Services provided by a health care provider that is not a Physician and expenses for Health Care Services rendered by telephone are also excluded.

Preventive Adult Wellness Services

If the preventive adult wellness category is listed on your Schedule of Benefits, Covered Services for preventive adult wellness Services may be covered under your Benefit Booklet. Please refer to your Schedule of Benefits for any applicable preventive adult wellness Services benefit maximums or limitations.

Preventive Child Health Supervision Services

Periodic Physician-delivered or Physician-supervised Services from the moment of birth up to the 17th birthday are covered as follows:

1. periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;
2. oral and/or injectable immunizations; and
3. laboratory tests normally performed for a well child.

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

Expenses for these Services are not subject to the Calendar Year Deductible, but are subject to the Coinsurance or the Copayment (if applicable).

Prosthetic Devices

The following Prosthetic Devices are covered when prescribed by a Physician and designed and fitted by a Prosthetist:

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers, and prosthetic devices incident to a Mastectomy;
2. appliances needed to effectively use artificial limbs or corrective braces; or
3. penile prosthesis.

Covered Prosthetic Devices (except cardiac pacemakers, and prosthetic devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition.

Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by you when due to irreparable damage, wear, or a change in your Condition, or when necessitated due to growth of a child.

Exclusion:

1. Expenses for microprocessor controlled or myoelectric artificial limbs (e.g. C-legs); and
2. Expenses for cosmetic enhancements to artificial limbs.

Self-Administered Injectable Prescription Drugs

Unless otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet, only Self-Administered Injectable Prescription Drugs used in the treatment of diabetes, cancer, conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis are covered.

Skilled Nursing Facilities

The following Health Care Services may be Covered Services when you are an inpatient in a Skilled Nursing Facility:

1. room and board;
2. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
3. drugs and medicines administered while an inpatient (except take-home drugs);
4. intravenous solutions;
5. administration of, including the cost of, whole blood or blood products;
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. chemotherapy treatment for proven malignant disease; and
10. Physical, Speech, and Occupational Therapies;

We reserve the right to request a treatment plan for determining coverage and payment.

Exclusion:

Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other Service primarily for the convenience of you and/or your family members or the Provider are excluded. Expenses for any inpatient days beyond the per person per Calendar Year maximum number of days listed on the Schedule of Benefits are also excluded.

Substance Dependency Care and Treatment

Care and treatment for Substance Dependency includes the following:

1. Health Care Services (inpatient and outpatient or any combination thereof) provided by a Physician, Psychologist or Mental Health Professional in a program accredited by the Joint Commission of the Accreditation of Healthcare Organizations or approved by the state of Florida for Detoxification or Substance Dependency.
2. Physician, Psychologist and Mental Health Professional outpatient visits for the care and treatment of Substance Dependency as listed in the Schedule of Benefits.

Exclusion:

Expenses for prolonged care and treatment of Substance Dependency in a specialized inpatient or residential facility or inpatient confinements that are primarily intended as a change of environment are excluded.

Surgical Assistant Services

Services rendered by a Physician, Registered Nurse First Assistant or Physician Assistant when acting as a surgical assistant (provided no intern, resident, or other staff physician is available) when the assistant is necessary are covered.

Payment Guidelines for Surgical Assistant Services

The Allowed Amount is limited to 20 percent of the surgical procedure's Allowed Amount.

Surgical Procedures

Surgical procedures performed by a Physician may be covered including the following:

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
3. oral surgical procedures for excision of tumors, cysts, abscesses, and lesions of the mouth;
4. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint [TMJ]) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury; and
5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic services to help determine the need for surgery.

Payment Guidelines for Surgical Procedures

1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed and the Coinsurance or Copayment (if any) indicated in your Schedule of Benefits. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.

2. Payment for Incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "incidental surgical procedure" includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (i.e., there is no payment for the removal of the normal appendix in the example).
3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount of the surgical procedure.

Transplant Services

Transplant Services, limited to the procedures listed below, may be covered when performed at a facility acceptable to us, subject to the conditions and limitations described below.

Transplant includes pre-transplant, transplant and post-discharge Services, and treatment of complications after transplantation. We will pay benefits only for Services, care and treatment received or provided in connection with a:

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-127.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Centers for Medicare and Medicaid Services. We will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);
3. heart-lung combination transplant;
4. liver transplant;
5. kidney transplant;
6. pancreas;
7. pancreas transplant performed simultaneously with a kidney transplant; or
8. lung-whole single or whole bilateral transplant.

We will cover donor costs and organ acquisition for transplants, other than Bone Marrow Transplants, provided such costs are not covered in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.

You may call the customer service phone number indicated in this Booklet or on your Identification Card in order to determine which Bone Marrow Transplants are covered under this Booklet.

<u>Exclusion:</u>

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);

2. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-127.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;
8. any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility; or
9. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Section 3: What Is Not Covered?

Introduction

Your Booklet expressly excludes the following Health Care Services, supplies, drugs or charges. The following exclusions are in addition to any exclusions specified in the "What Is Covered?" section.

Abortions which are elective.

Adult Wellness preventive care or routine screening Services, except as specified under the Preventive Adult Wellness Services category on the Schedule of Benefits.

Arch Supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Assisted Reproductive Therapy (Infertility) including, but not limited to, associated Services, supplies, and medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI); embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; and infertility treatment medication.

Autopsy or postmortem examination services, unless specifically requested by us.

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Complications of Non-Covered Services, including the diagnosis or treatment of any Condition which is a complication of a non-covered Health Care Service (e.g., Health Care Services to treat a complication of cosmetic surgery are not covered).

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered, under the adult wellness benefit, on the Schedule of Benefits (when selected by the Group), or otherwise covered in the "What Is Covered?" section.

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

Costs related to telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Custodial Care and any service of a custodial nature, including and without limitation: Health Care Services primarily to assist in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; respite care; and provision of services which are for the sole purposes of allowing a family member or caregiver of a Covered Person to return to work.

Dental Care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion also applies to Phase II treatments (as defined by the American Dental Association) for TMJ dysfunction. This exclusion does not apply to an Accidental Dental Injury and the Child Cleft Lip and Cleft Palate Treatment Services category as described in the "What Is Covered?" section.

Diabetic Equipment and Supplies used for the treatment of diabetes which are otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet.

Drugs

1. Prescribed for uses other than the Food and Drug Administration (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 your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All drugs dispensed to, or purchased by, you from a pharmacy. This exclusion does not apply to drugs dispensed to you when: (a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility; (b) you are in the outpatient department of a Hospital; (c) dispensed by a pharmacy under contract with us to provide injectable medications, indicated as covered under the "What Is Covered?" section of this Benefit Booklet, to you at home for self-administration, or to your Physician for administration to you in the Physician's office; or (d) you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for such drugs.
3. Any non-Prescription medicine, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods.
4. Any drug which is indicated or used for sexual dysfunction (e.g., Viagra, Muse, Edex, Caverject, papaverine, Yocon, and phentolamine).
5. Any Self-Administered Injectable Prescription Drug which is otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet except for a Self-Administered Injectable Prescription Drug indicated as covered in the "What Is Covered?" section of this Benefit Booklet.

Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category, and except for any drug prescribed for the treatment of cancer that has been approved by the Federal Food and Drug Administration (FDA) for at least one indication, provided the drug is recognized for treatment of the particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

Food and Food Products prescribed or not, except as covered in the Enteral Formulas subsection of the "What Is Covered?" section.

Foot Care which is routine, including any Health Care Service, in the absence of disease. This exclusion includes, but is not limited to: non-surgical treatment of bunions; flat feet; fallen arches; chronic foot strain; trimming of toenails; corns; or calluses.

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to your Effective Date or after the date your coverage terminates;
2. any Health Care Services not within the service categories described in the "What is Covered?" section, any rider, or Endorsement attached hereto, unless such services are specifically required to be covered by applicable law;
3. any Health Care Services provided by a Physician or other health care Provider related to you by blood or marriage;
4. any Health Care Service which is not Medically Necessary as determined by us and defined in this Booklet. The ordering of a Service by a health care Provider does not in itself make such Service Medically Necessary or a Covered Service;
5. any Health Care Services rendered at no charge;
6. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
7. any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    a) war or an act of war, whether declared or not;
    b) your participation in, or commission of, any act punishable by law as a misdemeanor or felony, or which constitutes riot, or rebellion;
    c) your engaging in an illegal occupation;
    d) Services received at military or government facilities; or
    e) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard;
8. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Benefit Booklet; and
9. any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

Genetic Screening including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition.

Hearing Aids (external or implantable) and Services related to the fitting or provision of

hearing aids, including tinnitus maskers, batteries, and cost of repair.

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all expenses for prenatal, intra-partal, and post-partal Maternity/Obstetrical Care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

For the definition of Gestational Surrogate and Gestational Surrogacy Contract see the "Definitions" section of this Benefit Booklet.

Oral Surgery except as provided under the "What Is Covered?" section.

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

Personal Comfort, Hygiene or Convenience Items and Services deemed to be not Medically Necessary and not directly related to your treatment including, but not limited to:

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses (other than Medically Necessary Ambulance Services);
8. motel/hotel accommodations;
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment;
13. hand rails and grab bars; and
14. Massages except as covered in the "What Is Covered?" section of this Booklet.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided on an inpatient or outpatient basis, except as provided in the Hospital, Skilled Nursing Facility, Home Health Care, and Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations categories of the "What Is Covered?" section. Rehabilitative Therapies provided for the purpose of maintaining rather than improving your Condition are also excluded.

Reversal of Voluntary, Surgically-Induced Sterility including the reversal of tubal ligations and vasectomies.

Sexual Reassignment, or Modification Services including, but not limited to, any Health Care Services related to such treatment, such as psychiatric Services.

Smoking Cessation Programs including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

Sports-Related devices and services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.

Training and Educational Programs, or materials, including, but not limited to programs

or materials for pain management and vocational rehabilitation, except as provided under the Diabetes Outpatient Self Management category of the “What Is Covered?” section.

Travel or vacation expenses even if prescribed or ordered by a Provider.

Volunteer Services or Services which would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayment (if applicable) requirements which are waived by a health care Provider.

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food.

Wigs and/or cranial prosthesis.

Work Related Health Care Services to treat a work related Condition to the extent you are covered; or required to be covered by Workers’ Compensation law. Any Service to diagnose or treat any Condition resulting from or in connection with your job or employment will be excluded, except for Medically Necessary services (not otherwise excluded) for an individual who is not covered by Workers’ Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

Section 4: Medical Necessity

In order for Health Care Services to be covered under this Booklet, such Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as defined by us.

It is important to remember that any review of Medical Necessity we undertake is solely for the purposes of determining coverage, benefits, or payment under the terms of this Booklet and not for the purpose of recommending or providing medical care. In conducting our review of Medical Necessity, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining whether a Health Care Service provided or proposed meets the definition of Medical Necessity in this Booklet. In applying the definition of Medical Necessity in this Booklet to a specific Health Care Service, we may apply our coverage and payment guidelines then in effect.

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical services, are solely your responsibility and that of your treating Physicians and health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. We are solely responsible for determining whether expenses incurred for medical care are covered under this Booklet. In making coverage decisions, we will not be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care Providers.

Examples of hospitalization and other Health Care Services that are not Medically Necessary include, but are not limited to:

1. staying in the Hospital because arrangements for discharge have not been completed;
2. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment;
3. staying in the Hospital because supervision in the home, or care in the home, is not available or inconvenient; or being hospitalized for any Service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department); or
4. inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other Service primarily for the convenience of the patient or his or her family members or a Provider.

Note: Whether or not a Health Care Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the Service is Medically Necessary (as defined by us) or a Covered Service. Please refer to the "Definitions" section for the definitions of "Medically Necessary or Medical Necessity".

Section 5: Understanding Your Share of Health Care Expenses

This section explains what your share of the health care expenses will be for Covered Services you receive. In addition to the information explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

Calendar Year Deductible

1. Individual Calendar Year Deductible:

   This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Calendar Year, before any payment will be made. Only those charges indicated on claims we receive for Covered Services will be credited toward the Individual Calendar Year Deductible and only up to the applicable Allowed Amount. Covered Services, which are subject to a Copayment are not subject to the Calendar Year Deductible.

2. Family Calendar Year Deductible:

   Once your family has met the family Calendar Year Deductible, neither you nor your Covered Dependents will have any additional Calendar Year Deductible responsibility for the remainder of that Calendar Year. The maximum amount that any one Covered Person in your family can contribute toward the family Calendar Year Deductible is the amount applied toward the Individual Calendar Year Deductible.

   Note: Please see your Schedule of Benefits for more information.

Copayment Requirements

Covered Services rendered by certain Providers or at certain locations or settings will be subject to a Copayment requirement. This is the dollar amount you have to pay when you receive these Services. Please refer to your Schedule of Benefits for the specific Covered Services, which are subject to a Copayment. Listed below is a brief description of some of the Copayment requirements that may apply to your plan. If our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you must pay the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service.

1. Office Services Copayment:

   If your plan is a Copayment plan, the Copayment for Covered Services rendered in the office (when applicable) must be satisfied by you, for each office Service before any payment will be made. The office Services Copayment applies regardless of the reason for the office visit and applies to all Covered Services rendered in the office, with the exception of Durable Medical Equipment, Prosthetics, and Orthotics.

   Generally, if more than one Covered Service that is subject to a Copayment is rendered during the same office visit, you will be responsible for a single Copayment which will not exceed the highest Copayment specified in the Schedule of Benefits for the particular Health Care Services rendered.

2. Copayment for inpatient facility Services:

   The Copayment for Inpatient Facility Services, if applicable to your plan, must be

satisfied by you, for each inpatient admission to a Hospital, Psychiatric Facility, or Substance Abuse Facility, before any payment will be made by us for any claim for inpatient Covered Services. The Copayment for inpatient facility Services, if applicable to your plan, applies regardless of the reason for the admission, and applies to all inpatient admissions to a Hospital, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals for inpatient admissions.

Note: Copayments for inpatient facility Services vary depending on the facility chosen. (Please see the Schedule of Benefits for more information).

3. Copayment for Outpatient Facility Services:

   The Copayment for outpatient facility Services, if applicable to your plan, must be satisfied by you, for each outpatient visit to a Hospital, Ambulatory Surgical Center, Independent Diagnostic testing Facility, Psychiatric Facility or Substance Abuse Facility, before any payment will be made by us for any claim for outpatient Covered Services. The Copayment for Outpatient Facility Services, if applicable to your plan, applies regardless of the reason for the visit, and applies to all outpatient visits to a Hospital, Ambulatory Surgical Center, Independent Diagnostic testing Facility, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida. Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other healthcare professionals.

   Note: Copayments for outpatient facility Services vary depending on the facility chosen and the Services received. (Please see the Schedule of Benefits for more information).

4. Copayment for Emergency Room Facility Services:

   The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Coinsurance amount, and applies to emergency room facility Services in or outside the state of Florida. The Copayment for emergency room facility Services, if applicable to your plan, must be satisfied by you for each visit. If you are admitted to the Hospital as an inpatient at the time of the emergency room visit, the Copayment for emergency room facility Services, if applicable to your plan, will be waived, but you will still be responsible for your share of the expenses for inpatient facility Services as listed in your Schedule of Benefits.

Coinsurance Requirements

All applicable Calendar Year Deductible or Copayment amounts must be satisfied before we will pay any portion of the Allowed Amount for Covered Services. For Services that are subject to Coinsurance, the Coinsurance percentage of the applicable Allowed Amount you are responsible for is listed in the Schedule of Benefits.

Note: If a particular Covered Service is not available from any In-Network Provider, the Coinsurance percentage that we will base payment on for that Covered Service will not be less than ten (10%) percentage points lower than the Coinsurance percentage we would have based payment on had the Covered Services been available from an In-Network Provider.

Out-of-Pocket Calendar Year Maximum

Out-of-Pocket Maximum Amount

1. Individual out-of-pocket Calendar Year maximum:

   Once you have reached the individual out-of-pocket Calendar Year maximum amount listed in the Schedule of Benefits, you will have no additional out-of-pocket responsibility for the remainder of the Calendar Year and we will pay for Covered Services rendered during the remainder of that Calendar Year at 100 percent of the Allowed Amount.

2. Family out-of-pocket Calendar Year maximum:

   Once your family has reached the family out-of-pocket Calendar Year maximum amount listed in the Schedule of Benefits, neither you nor your covered family members will have any additional out-of-pocket responsibility for the remainder of that Calendar Year and we will pay for Covered Services rendered during the remainder of that Calendar Year at 100 percent of the Allowed Amount. The maximum amount any one Covered Person in your family can contribute toward the family out-of-pocket Calendar Year maximum is the amount applied toward the individual out-of-pocket Calendar Year maximum. Please see your Schedule of Benefits for more information.

Note: The Calendar Year Deductible, any applicable Copayments and Coinsurance amounts will accumulate towards the Calendar Year out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate towards the out-of-pocket Calendar Year maximums. If the Group has purchased prescription drug coverage, any applicable Deductible, Coinsurance or Copayments, under the prescription drug coverage, will not apply to the Calendar Year Deductible or the out-of-pocket Calendar Year maximums under this Booklet.

Prior Coverage Credit

We will give you credit for the satisfaction or partial satisfaction of any Calendar Year Deductible and Calendar Year Coinsurance maximums met by you under a prior group insurance, blanket insurance, franchise insurance or group Health Maintenance Organization (HMO) policy maintained by the Group if the Group Master Policy replaces such a policy. This provision only applies if the prior group insurance, blanket insurance, franchise insurance or HMO coverage purchased by the Group was in effect immediately preceding the Effective Date of this Group policy. This provision is only applicable for you during the initial Calendar Year of coverage under the Group Master Policy and the following rules apply:

1. Prior Coverage Credit for Deductible:

   For the initial Calendar Year of coverage under the Group Master Policy only**,** charges credited by the Group's prior insurer, towards your Deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of the Group Master Policy, will be credited to the Calendar Year Deductible requirement under this Booklet.

2. Prior Coverage Credit for Coinsurance:

   Charges credited by the Group's prior insurer, towards your Coinsurance Calendar Year Maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of the Group Master Policy, will be credited to your out-of-

pocket Calendar Year maximum under this Booklet.

3. Prior coverage credit towards the Calendar Year Deductible or out-of-pocket Calendar Year maximums will only be given for Health Care Services, which would have been Covered Services under this Booklet.
4. Prior coverage credit under this Booklet only applies at the initial enrollment of the entire Group. You and/or the Group are responsible for providing us with any information necessary for us to apply this prior coverage credit.

Benefit Maximum Carryover

If immediately before the Effective Date of the Group, you were covered under a prior group policy issued by BCBSF to the Group, amounts applied to your Calendar Year benefit maximums and lifetime maximums under the prior BCBSF policy, will be applied toward your Calendar Year benefit maximums and lifetime maximums under this Booklet. Unless otherwise specified on your Schedule of Benefits.

Additional Expenses You Must Pay

In addition to your share of the expenses described above, you are also responsible for:

1. any applicable Copayments;
2. expenses incurred for non-covered Services;
3. charges in excess of any maximum benefit limitation listed in the Schedule of Benefits (e.g., the lifetime maximums and Calendar Year maximums);
4. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept our Allowed Amount as payment in full;
5. any benefit reductions;
6. payment of expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and
7. charges for Health Care Services which are excluded.

Additionally, you are responsible for any Premium contribution amount required by your Group.

How we will Credit Calendar Year Benefit Maximums and the Total Maximum Benefit per Person

Except as described below, only amounts actually paid by us for Covered Services will be credited towards any applicable Calendar Year benefit maximums and the total maximum benefit per person (lifetime maximum). The amounts we pay which are credited towards your Calendar Year benefit maximums and your total maximum benefit per person will be based on our Allowed Amount for the Covered Services provided.

Section 6: Physicians, Hospitals and Other Provider Options

Introduction

It is important for you to understand how the Provider you select and the setting in which you receive Health Care Services affects how much you are responsible for paying under this Booklet. This section, along with the Schedule of Benefits and our Provider Directory, describes the health care Provider options available to you and our payment rules for Services you receive.

As used throughout this section "out-of-pocket expenses" or "out-of-pocket" refers to the amounts you are required to pay including any applicable Copayments, the Calendar Year Deductible and/or Coinsurance amounts for Covered Services.

You are entitled to preferred provider type benefits when you receive Covered Services from In-Network Providers. You are entitled to traditional program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard® (Out-of-State) Traditional Program Providers, in conformity with Section 7: BlueCard® (Out-of-State) Program.

Provider Participation Status

In order to help control health care costs, we have entered into contracts with certain Providers to participate in NetworkBlue, one of our preferred provider networks. We have also entered into contracts with certain Providers to participate in our Traditional Program. We negotiate with these Providers to establish maximum allowances and payment rules for Covered Services as one way to control health care costs. The allowances we establish are called our Allowed Amounts. The amount you are responsible for paying out-of-pocket for a particular Covered Service is based on our Allowed Amount for that Covered Service.

Your Schedule of Benefits designates the panel of NetworkBlue Providers who are participating for your specific plan of coverage. This is important because these Providers are considered your In-Network Providers for purposes of this Benefit Booklet.

With BlueOptions, you may choose to receive Services from any Provider. However, you will be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider. Although you have the option to select any Provider you choose, we encourage you to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician. Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs. Developing and continuing a relationship with a Family Physician allows the physician to become knowledgeable about you and your family's health history. A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific healthcare needs. Types of Family Physicians are Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians. Additionally, care rendered by Family Physicians usually results in lower out-of-pocket expenses for you. Whether you select a Family Physician or another type of Physician to render Health Care Services, please remember that using In-Network Providers will result in lower out-of-pocket expenses for you. You should always determine whether a Provider is In-Network or

Out-of-Network prior to receiving Services to determine the amount you are responsible for paying out-of-pocket.

Location of Service

In addition to the participation status of the Provider, the location or setting where you receive Services can affect the amount you pay. For example, the amount you are responsible for paying out-of-pocket will vary whether you receive Services in a Hospital, a Provider's office, or an Ambulatory Surgical Center. Please refer to your Schedule of Benefits for specific information regarding your out-of-pocket expenses for such situations. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the "What Is Covered?" section and your Schedule of Benefits to find out if the specific Health Care Services are covered and how much you will have to pay. You should also consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

To verify if a Provider is In-Network for your plan you can:

1. review your current BlueOptions Provider Directory;
2. access the BlueOptions Provider directory at our web-site at www.bcbsfl.com; and/or
3. call the customer service phone number in this Booklet or on your Identification Card.

In-Network Providers

When you use In-Network Providers, your out-of-pocket expenses for Covered Services will be lower. We will base our payment on the Allowed Amount at the Coinsurance percentage listed in the Schedule of Benefits. Consult your Schedule of Benefits to determine what panel of Providers in the BlueOptions Provider directory is designated as In-Network for your plan.

Out-of-Network Providers

When you use Out-of-Network Providers your out-of-pocket expenses for Covered Services will be higher. We will base our payment on the Allowed Amount at the Coinsurance percentage listed in the Schedule of Benefits. [Further, if the Out-of-Network Provider is a Traditional Program Provider or a BlueCard® (Out-of-State) Traditional Program Provider, our payment to such Provider may be under the terms of that Provider's contract.] If your Schedule of Benefits and BlueOptions Provider directory do not include a Provider as In-Network under your benefit plan, the Provider is considered Out-of-Network.

	In-Network	Out-of-Network
What expenses are you responsible for paying?	• Any applicable Copayments, Deductible(s) and/or Coinsurance requirements; • Expenses for Services which are not covered; • Expenses for Services in excess of any benefit maximum limitations; • Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and • Expenses for Services which are excluded.	
Who is responsible for filing your claims?	• The Provider will file the claim for you and payment will be made directly to the Provider.	• You are responsible for filing the claim and payment will be made directly to the Covered Employee. If you receive Services from a Provider who participates in our Traditional Program or is a BlueCard® (Out-of-State) Traditional Program Provider, the Provider will file the claim for you. In those instances payment will be made directly to the Provider.
Can you be billed the difference between what we pay the Provider and the Provider's charge?	• **NO**. You are protected from being billed for the difference in our Allowed Amount and the Provider's charge when you use In-Network Providers. The Provider will accept our Allowed Amount as payment in full for Covered Services except as otherwise permitted under the terms of the Provider's contract and this Booklet.	• **YES**. You are responsible for paying the difference between what we pay and the Provider's charge. However, if you receive Services from a Provider who participates in our Traditional Program, the Provider will accept our Allowed Amount as payment in full for Covered Services since such Traditional Program Providers have agreed not to bill you for the difference. Further, under the BlueCard® (Out-of-State) Program, when you receive Covered Services from a BlueCard® (Out-of-State) Traditional Program Provider, you may be responsible for paying the difference between what the Host Blue pays and the Provider's billed charge.

Note: You are solely responsible for selecting a Provider when obtaining Health Care Services and for verifying whether that Provider is In-Network or Out-of-Network at the time Health Care Services are rendered. You are also responsible for determining the corresponding payment options, if any, at the time the Health Care Services are rendered.

Physicians

When you receive Covered Services from a Physician you will be responsible for a Copayment and/or the Calendar Year Deductible and the applicable Coinsurance. Several factors will determine your out-of-pocket expenses including your Schedule of Benefits, whether the Physician is In-Network or Out-of-Network, the location of service, the type of service rendered, and the Physician's specialty.

Remember that the location or setting where a Service is rendered can affect the amount you are responsible for paying out-of-pocket. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the Schedule of Benefits and consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

Refer to your Schedule of Benefits to determine the applicable Copayments, Coinsurance percentage and/or Calendar Year Deductible amount you are responsible for paying for Physician Services.

Hospitals

Each time you receive inpatient or outpatient Covered Services at a Hospital, in addition to any out-of-pocket expenses related to Physician Services, you will be responsible for out-of-pocket expenses related to Hospital Services.

We are able to negotiate lower payment amounts with some Hospitals than with others. Because of this, In-Network Hospitals have been divided into two groups, which are referred to as "options" on the Schedule of Benefits. The amount you are responsible for paying out-of-pocket is different for each of these options. Remember that there are also different out-of-pocket expenses for Out-of-Network Hospitals.

Since not all Physicians admit patients to every Hospital, it is important when choosing a Physician that you determine the Hospitals where your Physician has admitting privileges. You can find out what Hospitals your Physician admits to by contacting the Physician's office. This will provide you with information that will help you determine a portion of what your out-of-pocket costs may be in the event you are hospitalized.

Refer to your Schedule of Benefits to determine the applicable out-of-pocket expenses you are responsible for paying for Hospital Services.

Other Providers

With BlueOptions you have access to other Providers in addition to the ones previously described in this section. Other Providers include facilities that provide alternative outpatient settings or other persons and entities that specialize in a specific Service(s). While these Providers may be recognized for payment, they may not be included as In-Network Providers for your plan. Additionally, all of the Services that are within the scope of certain Providers' licenses may not be Covered Services under this Booklet. Please refer to the "What Is Covered?" and "What Is Not Covered?" sections of this Booklet and your Schedule of Benefits to determine your out-of-pocket expenses for Covered Services rendered by these Providers.

You may be able to receive certain outpatient Services at a location other than a Hospital. The amount you are responsible for paying for Services rendered at some alternative facilities is generally less than if you had received those same Services at a Hospital.

Remember that the location of Service can impact the amount you are responsible for paying out-of-pocket. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer

to the Schedule of Benefits and consult with your Physician to determine the most appropriate setting based on your health care and financial needs. When Services are rendered at an outpatient facility other than a Hospital there may be an out-of-pocket expense for the facility Provider as well as an out-of-pocket expense for other types of Providers.

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this section, we will not honor any of the following assignments, or attempted assignments, by you to any Provider:

- an assignment of the benefits due to you for Covered Services under this Benefit Booklet;
- an assignment of your right to receive payments for Covered Services under this Benefit Booklet; or
- an assignment of a claim for damage resulting from a breach, or an alleged breach, of the Group Master Policy.

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is In-Network under your plan of coverage; 2) is a NetworkBlue Provider even if that Provider is not in the panel for your plan of coverage; 3) is a Traditional Program Provider; 4) is a BlueCard® (Out-of-State) PPO Program Provider; or 5) is a BlueCard® (Out-of-State) Traditional Program Provider.

Section 7: BlueCard® (Out-of-State) Program

Providers Outside the State of Florida

When you obtain Health Care Services from BlueCard® participating Providers outside the geographic area we serve, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be prospectively adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating a covered individual's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard® method noted above in paragraph one of this section or require a surcharge, we will then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

Section 8: Blueprint for Health Programs

Introduction

We have established (and from time to time establish) various customer-focused health education and information programs as well as benefit utilization management and utilization review programs. These programs, collectively called the Blueprint For Health Programs, are designed to 1) provide you with information that will help you make more informed decisions about your health, 2) help us facilitate the management and review of coverage and benefits provided under our policies; and 3) present opportunities, as explained below, to mutually agree upon alternative benefits or payment alternatives for cost-effective medically appropriate Health Care Services.

Admission Notification

Our admission notification requirements vary depending on whether you are admitted to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility which is In-Network or Out-of-Network. To find out about the participation status of any of these providers, you can:

1. review the Provider Directory then in effect;
2. access our web-site at www.bcbsfl.com; and/or
3. call the customer service phone number in this Booklet or on your Identification Card.

In-Network

Under the admission notification requirement, we must be notified of all inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospitals, Psychiatric Facilities, Substance Abuse Facilities or Skilled Nursing Facilities. While it is the sole responsibility of the In-Network Provider located in Florida to comply with our admission notification requirements, you should ask the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) if we have been notified of your admission. For an admission outside of Florida, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) should notify us of the admission. Making sure that we are notified of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility (as applicable) may notify us of your admission by calling the toll free customer service number on your ID card.

Out-of-Network

For admissions to an Out-of-Network Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility, you or the Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility should notify us of the admission. Notifying us of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the Hospital may notify us of your admission by calling the toll free customer service number on your Identification Card.

Inpatient Facility Program

Under the inpatient facility program, we may review Hospital stays, Skilled Nursing Facility (SNF) Services, and other Health Care Services rendered during the course of an inpatient stay or treatment program. We may conduct this review while you are inpatient or after your discharge. The review is conducted solely to determine whether we should provide coverage and/or payment for a particular admission or

Health Care Services rendered during that admission. Using our established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals. We will provide notification to your Physician when inpatient coverage criteria is no longer met. In administering the inpatient facility program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Benefit Booklet and not for the purpose of recommending or providing medical care.

In anticipation of your needs following an inpatient stay, we may provide you and your Physician with information about other Blueprint for Health Programs, which may be beneficial to you, and help you and your Physician identify health care resources, which may be available in your community. Upon request, we will answer questions your Physician has regarding your coverage or benefits following discharge from the Hospital.

Provider Focused Utilization Management Program

Certain NetworkBlue Providers have agreed to participate in our focused utilization management program. This pre-service review program is intended to promote the efficient delivery of medically appropriate Health Care Services by NetworkBlue Providers. Under this program we may perform focused prospective reviews of all or specific Health Care Services proposed for you. In order to perform the review, we may require the Provider to submit to us specific medical information relating to Health Care Services proposed for you. NetworkBlue Providers have agreed not to bill, or collect, any payment whatsoever from you or us, or any other person or entity, with respect to Health Care Services if: 1) we perform a focused review under the focused utilization management program; and 2) we determine that the Health Care Services are not Medically Necessary in accordance with our Medical Necessity criteria or inconsistent with our benefit guidelines then in effect.

Member Focused Programs

The Blueprint for Health Programs may include voluntary programs for certain members. These programs may address health promotion, prevention and early detection of disease, chronic illness management programs, case management programs and other member focused programs.

Personal Case Management Program

The personal case management program focuses on members who suffer from a catastrophic illness or injury. In the event you have a catastrophic or chronic Condition, we may, in our sole discretion, assign a Personal Case Manager to you to help coordinate coverage, benefits, or payment for Health Care Services you receive. Your participation in this program is completely voluntary.

Under the personal case management program, we may elect to offer alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available by us on a case-by-case basis when you meet our case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing.

The fact that we may offer to pay for, or that we have paid for certain Health Care Services under the personal case management program in no way obligates us to continue to provide or pay for the same or similar Services. Nothing contained in this section shall be deemed a waiver of our right to enforce this Benefit Booklet in strict accordance with its terms. The terms of this Booklet will continue to apply, except as specifically modified in writing by us in accordance with the personal case management program rules then in effect

Health Information, Promotion, Prevention and Illness Management Programs

These Blueprint for Health Programs may include health information that supports member education and choices for healthcare issues. These programs focus on keeping you well, help to identify early preventive measures of treatment and help members with chronic problems to enjoy lives that are as productive and healthy as possible. These programs may include prenatal educational programs and illness management programs for Conditions such as diabetes, cancer and heart disease. These programs are voluntary and are designed to enhance your ability to make informed choices and decisions for your unique health care needs. You may call the toll free customer service number on your Identification Card for more information. Your participation in this program is completely voluntary.

IMPORTANT INFORMATION RELATING TO BCBSF'S BLUEPRINT FOR HEALTH PROGRAMS

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical services, are solely your responsibility and the responsibility of your Physicians and other health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. We are solely responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this Booklet. In fulfilling this responsibility, we will not be deemed to participate in or override the medical decisions of your health care Provider.

You, a treating Physician, Hospital, or other Provider may request that we review a Blueprint for Health Program coverage or payment decision, provided such a request is received by us, in writing, within 90 days of the date of the decision. The review request must include all information deemed relevant or necessary by us. We will review the decision in light of such information and notify you or your representative, the Hospital and/or the Physician of the review decision.

Please note that we reserve the right to discontinue or modify the Hospital admission notification requirement and any Blueprint for Health Program at any time without consent from you or the Group.

Section 9: Pre-existing Conditions Exclusion Period

Introduction

Generally, there is no coverage under this Booklet for Health Care Services to treat a Pre-existing Condition, or Conditions arising from a Pre-existing Condition, until you have been continuously covered under this Booklet for a 12-month period. This 12-month Pre-existing Condition exclusionary period begins on the first day of the Waiting Period if you are an initial enrollee; or your Effective Date of coverage under the Booklet if you are a special or annual enrollee. This exclusionary period also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

This Pre-existing Condition exclusionary period does not apply to:

1. the Covered Employee and each Covered Dependent who was covered under the Group's prior medical plan on the date immediately preceding the Effective Date of coverage under this Booklet;
2. you if you were enrolled during the Initial Enrollment Period prior to the Effective Date of the Group; or
3. you when the Group has elected to waive, in writing, at the time of Group Application the Pre-existing Conditions exclusionary period for all subsequent Eligible Employees and/or Eligible Dependents;
4. pregnancy;
5. a newborn child or an adopted newborn child properly enrolled under this Booklet;
6. an adopted child that has Creditable Coverage;
7. Genetic Information in the absence of a diagnosis of the Condition;
8. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
9. Conditions arising from domestic violence; or
10. inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

Genetic Information, as used above, means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Pre-existing Condition Definition

A Pre-existing Condition means any Condition related to a physical or mental Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately preceding:

1. the first day of your Waiting Period for initial enrollees; or
2. your Effective Date of coverage under the Group Master Policy for special and annual enrollees.

Reducing the Pre-existing Conditions Exclusionary Period

No matter whether you enroll when first eligible or at a later date (such as an Annual Open Enrollment Period or as a result of special enrollment), you may be able to reduce or even eliminate the Pre-existing Conditions exclusionary period if you have prior Creditable Coverage.

If you are enrolling when you are first eligible for coverage and you have no more than a 63-day break in Creditable Coverage as of your Enrollment Date under this Booklet, your Pre-existing Conditions exclusionary period will be reduced by the amount of prior Creditable Coverage you have.

If, on the other hand, you are enrolling under this Booklet at any other time as allowed under its terms, such as during an Annual Open Enrollment Period or a Special Enrollment Period, your Pre-existing Conditions exclusionary period will be reduced by the amount of any Creditable Coverage you have; provided there is no more than a 63-day break in coverage prior to your Enrollment Date in this Booklet.

If you have no Creditable Coverage or none that can reduce the Pre-existing Conditions exclusionary period, the full 12-month Pre-existing Conditions exclusionary period will apply.

Creditable Coverage

Creditable Coverage is health care coverage that may include any of the following:

1. a group health insurance plan;
2. individual health insurance;
3. Medicare Part A and Part B;
4. Medicaid;
5. benefits to members and certain former members of the uniformed services and their dependents;
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a State health benefits risk pool;
8. a health plan offered under chapter 89 of Title 5, United States Code;
9. a public health plan;
10. a health benefit plan of the Peace Corps;
11. State Children's Health Insurance Program (S-CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

Proving Creditable Coverage

You may provide a Prior/Concurrent Coverage Affidavit or Certification of Creditable Coverage to prove the amount of time you were covered under Creditable Coverage. Prior health insurers and/or group health plans are required to provide a certification of Creditable Coverage to you upon termination of your coverage and at any time upon request up to 24 months after termination of your prior health coverage. If you do not provide a certification, then you must provide us some other evidence of Creditable Coverage such as a copy of an ID card or health insurance bill from a prior carrier and attest to the amount of time you were covered under the Creditable Coverage.

Section 10: Eligibility for Coverage

Each employee or other individual who is eligible to participate in the Group Plan, and who meets and continues to meet our eligibility requirements described in this Booklet, shall be entitled to apply for coverage with us under this Booklet. These eligibility requirements are binding upon you and/or your eligible family members as well as the Group. No changes in our eligibility requirements will be permitted unless we have been notified of and have agreed in writing to any such change in advance. We may require acceptable documentation that an individual meets and continues to meet the eligibility requirements such as a court order naming the Covered Employee as the legal guardian or appropriate adoption documentation described in the "Enrollment and Effective Date of Coverage" section.

Eligibility Requirements for Covered Employees

In order to be eligible to enroll as a Covered Employee, an individual must be an Eligible Employee. An Eligible Employee must meet each of the following requirements:

1. The employee must be a bona fide employee;
2. The employee's job must fall within a job classification identified on the Group Application;
3. The employee must have completed any applicable Waiting Period identified on the Group Application; and
4. The employee must meet any additional eligibility requirement(s) identified on the Group Application.

The Covered Employee eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of the Group, provided such companies and the Group are under common control; and
4. other individuals as determined by us and the Group (e.g., members of associations or labor unions).

Any expansion of the Covered Employee eligibility class must be approved in writing by us and the Group prior to such expansion, and may be subject to different Rates.

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this Booklet:

1. The Covered Employee's spouse under a legally valid existing marriage;
2. The Covered Employee's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year in which the child reaches age 25 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), and who is:
    a) dependent upon the Covered Employee for financial support; and
        i. living in the household of the Covered Employee or a full-time or part-time student; or
        ii. the child does not live in the household of the Covered Employee

and is not enrolled as a full or part-time student because the child has not met the age requirement to begin elementary school education; or

b) in the case of a handicapped dependent child, such child is eligible to continue coverage, beyond the limiting age of 25, as a Covered Dependent if the child is:

i. otherwise eligible for coverage under the Group Master Policy;

ii. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

iii. chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 25th birthday.

This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

or

3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is your sole responsibility as the Covered Employee to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Section 11: Enrollment and Effective Date of Coverage

Eligible Employees and Eligible Dependents may enroll for coverage according to the provisions below.

Any Eligible Employee or Eligible Dependent who is not properly enrolled with us will not be covered under this Booklet. We will have no obligation whatsoever to any individual who is not properly enrolled.

General Rules for Enrollment

1. Any Employee and/or Eligible Dependent who is eligible for coverage under this Booklet may apply for coverage by completing and submitting an Enrollment Form to the Group.
2. All factual representations on the Enrollment Forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) we may have, in disqualification for, termination of, or rescission of coverage.
3. We will not provide coverage and benefits to any individual who would not have been entitled to enrollment with us, had accurate and complete information been provided on a timely basis on the Enrollment Forms. In such cases, we may require you or an individual legally responsible for you, to reimburse us for any payments we made on your behalf.

Enrollment Forms/Electing Coverage

To apply for coverage, you as the Eligible Employee must:

1. complete and submit, through your Group, the Enrollment Form;
2. provide any additional information needed to determine eligibility, at our request;
3. agree to pay your portion of the required Premium; and
4. complete and submit, through your Group, an Enrollment Form to add Eligible Dependents or delete Covered Dependents.

When making application for coverage, you must elect one of the types of coverage available under your Group's program. Such types may include:

Employee Only Coverage - This type of coverage provides coverage for the Eligible Employee only.

Employee/Spouse Coverage - This type of coverage provides coverage for the Eligible Employee and the employee's spouse under a legally valid existing marriage.

Employee/Child(ren) Coverage - This type of coverage provides coverage for the Eligible Employee and the employee's eligible child(ren) only.

Employee/Family Coverage - This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

There may be an additional Premium charge for each Covered Dependent based on the coverage selected by the Group.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in the Group's health benefit program. The period is established by us, occurs annually, and will take place prior to the Anniversary Date.

Special Enrollment Period is the 30-day period of time immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for coverage. Special circumstances are described in the Special Enrollment Period subsection.

Employee Enrollment

1. An Eligible Employee must enroll during the Initial Enrollment Period in order to become covered as of the Effective Date of the Group. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) will be the same as the Covered Employee's Effective Date.
2. An individual who becomes an Eligible Employee after the Group's Effective Date (for example, newly-hired employees) must enroll before or within the Initial Enrollment Period. The Effective Date of coverage for such individual will begin on the date specified on the Group Application.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Covered Employee. Below are special rules for certain Eligible Dependents.

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must submit an Enrollment Form to us through the Group. The Effective Date of coverage for a newborn child will be the date of birth. We must be notified, in writing, and the following guidelines will be applied when enrolling a newborn child:

a) If we receive written notice within 30 days after the date of birth, the Effective Date of coverage will be the date of birth and no Premium will be charged for the newborn child for the first 30 days of coverage.

b) If we receive written notice 31 to 60 days after the date of birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.

c) If we receive written notice more than 60 days after the date of birth and Annual Open Enrollment **has not** occurred since the date of birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.

d) If we receive written notice more than 60 days after the date of birth and Annual Open Enrollment **has** occurred, the newborn child may not be added until the next Annual Open Enrollment Period or Special Enrollment Period.

Note: The guidelines above only apply to newborns born after the Effective Date of the Covered Employee. If a child is born before the Effective Date of the Covered Employee and was not added during the Initial Enrollment

Period, we must receive an Enrollment Form. If the Enrollment Form is received within 30 days after the birth of the child, no Premium will be charged for the first 30 days of coverage. If the Enrollment Form is received 31-60 days after the birth of the child, any applicable Premium must be paid back to the Effective Date of coverage of the Covered Employee. In the event we are not notified within 60 days of the birth of the newborn child, the Covered Employee must make application during an Annual Open Enrollment Period or Special Enrollment Period.

Note: Coverage for a newborn child of a Covered Dependent child will automatically terminate 18 months after the birth of the newborn child.

Adopted Newborn Child – To enroll an adopted newborn child, the Covered Employee must submit an Enrollment Form through the Group to us. The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Employee prior to the birth of such child, whether or not such an agreement is enforceable. We may require the Covered Employee to provide any information and/or documents which we deem necessary in order to administer this provision. The following guidelines will be applied when enrolling an adopted newborn child:

a) If we receive written notice within 30 days after the birth, the Effective Date of coverage will be the date of birth and no Premium will be charged for the first 30 days of coverage for the adopted newborn child.

b) If we receive written notice 31 to 60 days after the birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.

c) If we receive written notice more than 60 days after the date of birth and Annual Open Enrollment **has not** occurred, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.

d) If we receive written notice more than 60 days after the date of birth and Annual Open Enrollment **has** occurred, the adopted newborn child may not be added until the next Annual Open Enrollment Period or Special Enrollment Period.

Note: The guidelines above only apply to adopted newborns born after the Effective Date of the Covered Employee. If a child is born before the Effective Date of the Covered Employee and was not added during the Initial Enrollment Period, we must receive an Enrollment Form. If the Enrollment Form is received within 30 days after the birth of the child, no Premium will be charged for the first 30 days of coverage. If the Enrollment Form is received 31-60 days after the birth of the adopted newborn child, any applicable Premium must be paid back to the Effective Date of coverage of the Covered Employee. In the event we are not notified within 60 days of the birth of the adopted newborn child, the Covered Employee must make application during an Annual Open Enrollment Period or Special Enrollment Period.

If the adopted newborn child is not ultimately placed in the residence of the Covered Employee, there shall be no coverage for the adopted newborn child. It is your responsibility as the Covered Employee to notify us within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

Adopted/Foster Children – To enroll an adopted child or Foster Child, the Covered Employee must submit an Enrollment Form during the 30-day period immediately following

the date of placement and pay the additional Premium, if any. The Effective Date for an adopted child or Foster Child (other than an adopted newborn child) will be the date such adopted or Foster Child is placed in the residence of the Covered Employee in compliance with Florida law. If timely notice is given, no additional Premium will be charged for coverage of the adopted child for the duration of the notice period. Any Pre-existing Condition exclusionary period will not apply to an adopted child but will apply to a Foster Child. We may require the Covered Employee to provide any information and/or documents we deem necessary, in order to properly administer this section.

In the event we are not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as the Covered Employee provides notice to the Group, and we receive the Enrollment Form within 60 days of the placement, and any applicable Premium is paid back to the date of placement. In the event we are not notified within 60 days of the date of placement, the Covered Employee must make application during an Annual Open Enrollment Period or Special Enrollment Period in order for the adopted child or Foster Child to be covered.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child. It is the responsibility of the Covered Employee to notify us if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child upon receipt of the written notice.

If the Covered Employee's status as a foster parent is terminated, coverage will end for any Foster Child. It is the responsibility of the Covered Employee to notify us in writing that the Foster Child is no longer in the Covered Employee's care. Upon receipt of this notification, we will terminate the coverage of the child on the date provided by the Group or on the first billing date following receipt of the written notice.

Marital Status –The Covered Employee may apply for coverage of an Eligible Dependent due to a legally valid marriage. To apply for coverage, the Covered Employee must complete the Enrollment Form through the Group and forward it to us. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

Court Order – The Covered Employee may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under their plan. To apply for coverage, the Covered Employee must complete an Enrollment Form through the Group and forward it to us. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court or the next billing date.

Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Enrollment Form during the Annual Open Enrollment Period.

The Effective Date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the first billing date following the Annual Open Enrollment Period.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period, must wait until the next Annual Open Enrollment Period, unless the Eligible Employee or the Eligible Dependent is enrolled due to a special circumstance as outlined in the Special Enrollment Period subsection of this section.

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependents may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependents must complete the applicable Enrollment Form and forward it to the Group within 30 days of the date of the special enrollment event. For purposes of this subsection, the following are the special enrollment events:

1. you lose your coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance, or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:

   a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and

   b) you lost your other coverage under a group health benefit plan or health insurance coverage as a result of termination of employment, reduction in the number of hours you work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated.

   Note: Loss of coverage for failure to pay your portion of the required Premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

2. you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption.

The Effective Date of coverage for you and your Eligible Dependents added as a result of a special enrollment event is the date of the special enrollment event. Eligible Employees who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Employee).

Other Provisions Regarding Enrollment and Effective Date of Coverage

1. Rehired Employees:

   Individuals who are rehired as employees of the Group are considered newly hired employees for purposes of this section. The provisions of the Group Master Policy (which includes this Booklet), which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, Pre-existing Condition exclusionary period, and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

2. Premium Payments:

   In those instances where an individual is to be added to coverage (e.g., a new Eligible Employee or a new Eligible Dependent, including a newborn or adopted child), that individual's coverage shall be effective, as described in this section, provided we receive the applicable additional Premium payment within 30 days of the date we notified the Group of such amount. In no event shall an individual be covered under this Group Master Policy if we do not receive the applicable Premium payment within such time period.

Section 12: Termination of Coverage

Termination of a Covered Employee's Coverage

A Covered Employee's coverage will automatically terminate at 12:01 a.m.:

1. on the date the Group Master Policy terminates;
2. on the last day of the first month that the Covered Employee fails to continue to meet any of the applicable eligibility requirements;
3. on the date the Covered Employee's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or
4. on the date specified by the Group that the Covered Employee's coverage terminates.

Termination of a Covered Dependent's Coverage

A Covered Dependent's coverage will automatically terminate at 12:01 a.m.:

1. on the date the Group Master Policy terminates;
2. on the date Covered Employee's coverage terminates for any reason;
3. on the last day of the first month that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Covered Employee);
4. on the date we specify that the Covered Dependent's coverage is terminated by us for cause; or
5. on the date specified by the Group that the Covered Dependent's coverage terminates.

In the event you as the Covered Employee wish to delete a Covered Dependent from coverage, an Enrollment Form should be forwarded to us through the Group.

In the event you as the Covered Employee wish to terminate a spouse's coverage, (e.g., in the case of divorce), you must submit an Enrollment Form to the Group, prior to the requested termination date or within 10 days of the date the divorce is final, whichever is applicable.

Termination of an Individual's Coverage for Cause

If, in our opinion, any of the following events occur, we may terminate an individual's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits;
2. the knowing misrepresentation, omission or the giving of false information on Enrollment Forms or other forms completed for us, by or on your behalf; or
3. misuse of the Identification Card.

Note: Only fraudulent misstatements on the Enrollment Form may be used by us to void coverage or deny any claim for loss incurred or disability, if discovered after two years from your Effective Date.

Notice of Termination

It is the Group's responsibility to immediately notify you of termination of the Group Master Policy for any reason.

Responsibilities of BCBSF Upon Termination of Your Coverage

Upon termination of coverage for you or your Covered Dependents for any reason, we will have no further liability or responsibility with respect to such individual, except as otherwise specifically described in this Booklet.

Certification of Creditable Coverage

In the event coverage terminates for any reason, we will issue a written certification of Creditable Coverage to you.

The certification of Creditable Coverage will indicate the period of time you were enrolled with us. Creditable Coverage may reduce the length of any Pre-existing Condition exclusionary period by the length of time you had prior Creditable Coverage.

Upon request, we will send you another certification of Creditable Coverage within a 24-month period after termination of coverage.

The succeeding carrier will be responsible for determining if our coverage meets the qualifying Creditable Coverage guidelines (e.g., no more than a 63-day break in coverage).

Section 13: Continuing Coverage Under COBRA

A Federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to the Group. If COBRA applies to the Group, you or your Covered Dependents may be entitled to continue coverage for a limited period of time, if you meet the applicable requirements, make a timely election, and pay the proper amount required to maintain coverage.

You must contact the Group to determine if you or your Covered Dependent are entitled to COBRA continuation of coverage. The Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Covered Persons of their rights under COBRA. If the Group or you fail to meet your obligations under COBRA and this Group Master Policy, we will not be liable for any claims incurred by you or your Covered Dependent(s) after termination of coverage.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Group are met by the purchase of the Group Master Policy; the duty to meet such obligations remains with the Group.

The following is a summary of what you may elect, if COBRA applies to the Group and you are eligible for such coverage:

1. You may elect to continue their coverage for a period not to exceed 18 months* in the case of:
    a) termination of employment of the Covered Employee other than for gross misconduct; or
    b) reduced hours of employment of the Covered Employee.

    ***Note:** You and your Covered Dependents are eligible for an 11 month extension of the 18 month COBRA continuation option above (to a total of 29 months) if you or your Covered Dependent is totally disabled (as defined by the Social Security Administration (SSA)) at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. The Covered Person must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.
2. Your Covered Dependent(s) may elect to continue their coverage for a period not to exceed 36 months in the case of:
    a) the Covered Employee's entitlement to Medicare;
    b) divorce or legal separation of the Covered Employee;
    c) death of the Covered Employee;
    d) the employer files bankruptcy (subject to bankruptcy court approval); or
    e) a Dependent child may elect the 36 month extension if the Dependent child ceases to be an Eligible Dependent under the terms of the Group's coverage.

Children born to or placed for adoption with the Covered Employee during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

If you are eligible to continue group health insurance coverage pursuant to COBRA, the following conditions must be met:

1. The Group must notify you of your continuation of coverage rights under COBRA within 14 days of the event, which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify the Group, in writing, within 60 days of any of these events. The Group's 14-day notice requirement runs from the date of receipt of such notice.
2. You must elect to continue the coverage within 60 days of the later of:
    a) the date that the coverage terminates; or
    b) the date the notification of continuation of coverage rights is sent by the Group.
3. COBRA coverage will terminate if you become covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect your coverage.
4. COBRA coverage will terminate if you become entitled to Medicare.
5. If you are totally disabled and eligible and elect to extend your continuation of coverage, you may not continue such extension of coverage more than 30 days after a determination by the Social Security Administration that you are no longer disabled. You must inform the Group of the Social Security Administration's determination within 30 days of such determination.
6. You must meet all Premium payment requirements, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, in the Group Master Policy.
7. The Group must continue to provide group health coverage to its employees.

An election by an Covered Employee or Covered Dependent spouse shall be deemed to be an election for any other qualified beneficiary related to that Covered Employee or Covered Dependent spouse, unless otherwise specified in the election form.

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Group Master Policy shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Group.

Section 14: Conversion Privilege

Eligibility Criteria for Conversion

You are entitled to apply for a BCBSF individual policy (hereinafter referred to as a "converted policy" or "conversion policy") if:

1. you were continuously covered for at least three months under the Group Master Policy, and/or under another group policy with your Group, that provided similar benefits immediately prior to the Group Master Policy; and
2. your coverage was terminated for any reason, including discontinuance of the Group Master Policy in its entirety and termination of continued coverage under COBRA.

Notify us in writing or by telephone if you are interested in a conversion policy. Within 14 days of such notice, we will send you a conversion policy application, premium notice and outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

We must receive a completed application for a converted policy, and the applicable premium payment, within the 63-day period beginning on the date the coverage under the Group Master Policy terminated. If coverage has been terminated, due to the non-payment of premium by the Group, we must receive the completed converted policy application and the applicable premium payment within the 63-day period beginning on the date notice was given that the Group Master Policy terminated.

In the event we do not receive the converted policy application and the initial premium payment within such 63-day period, your converted policy application will be denied and you will not be entitled to a converted policy.

Additionally, you are not entitled to a converted policy if:

1. you are eligible for or covered under the Medicare program;
2. you failed to pay, on a timely basis, the contribution required by the Group for coverage under this Group Master Policy;
3. the Group Master Policy was replaced within 31 days after termination by any group policy, contract, plan, or program, including a self-insured plan or program, that provides benefits similar to the benefits provided under this Booklet; or
4. a) you fall under one of the following categories and meet the requirements of 4.b. below:
    i. you are covered under any Hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits which are similar to the benefits provided under this Booklet; or
    ii. you are eligible, whether or not covered, under any arrangement of coverage for individuals in a group, whether on an insured, uninsured, or partially insured basis, for benefits similar to those provided under this Booklet; or
    iii. benefits similar to the benefits provided under this Booklet are provided for or are available to you pursuant to or in accordance with the requirements of any state or

federal law (e.g., COBRA, Medicaid); and

b) the benefits provided under the sources referred to in paragraph 4.a.i or the benefits provided or available under the source referred to in paragraph 4.a.ii. and 4.a.iii. above, together with the benefits provided by our converted policy would result in over insurance in accordance with our over insurance standards, as determined by us.

We have no obligation to notify you of this conversion privilege when your coverage terminates or at any other time. It is your sole responsibility to exercise this conversion privilege by submitting a BCBSF converted policy application and the initial premium payment to us on a timely basis. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under the Group Master Policy terminated.

Note: Our converted policies are not a continuation of coverage under COBRA or any other states' similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this Booklet. When applying for our converted policy, you have two options: 1) a converted policy providing major medical coverage meeting the requirements of 627.6675(10) Florida Statutes or 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan pursuant to Section 627.6699(12) Florida Statutes. In any event, we will not be required to issue a converted policy unless required to do so by Florida law. We may have other options available to you. Call the telephone number on your Identification card for more information.

Section 15: Extension of Benefits

Extension of Benefits

In the event the Group Master Policy is terminated, we will not provide coverage for any Service rendered on or after the termination date. The extension of benefits provisions described below only apply when the entire Group Master Policy is terminated. The extension of benefits described in this section do not apply when your coverage terminates if the Group Master Policy remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is your sole responsibility to provide acceptable documentation to us showing that you are entitled to an extension of benefits.

1. In the event you are totally disabled on the termination date of the Group Master Policy as a result of a specific Accident or illness incurred while you were covered under this Booklet, as determined by us, we will provide a limited extension of benefits for the disabled individual only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted. In any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Master Policy.

   For purposes of this section, you will be considered "totally disabled" only if, in our opinion, you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a Physician. You are totally disabled only if, in our opinion, you are unable to perform those normal day-to-day activities which you would otherwise perform and you require regular care and attendance by a Physician.

2. In the event you are receiving covered dental treatment as of the termination date of the Group Master Policy, we will provide a limited extension of such covered dental treatment provided:

   a) a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while you were covered under the Group Master Policy;

   b) the dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and

   c) the dental procedures were performed within 90 days after the Group Master Policy terminated.

   This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of the Group Master Policy or on the date you become covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or Services for similar dental procedures. You are not required to be totally disabled in order to be eligible for this extension of benefits.

   Please refer to the Dental Care category of the "What Is Covered?" section for a

description of the dental care Services covered under this Booklet.

3. In the event you are pregnant as of the termination date of the Group Master Policy, we will provide a limited extension of the maternity expense benefits provided by this Booklet, provided the pregnancy commenced while the pregnant individual was covered under the Group Master Policy, as determined by us. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. You are not required to be totally disabled in order to be eligible for this extension of benefits.

Section 16: The Effect of Medicare Coverage / Medicare Secondary Payer Provisions

When you become covered under Medicare and continue to be eligible and covered under the Group Master Policy, our coverage will be primary and the Medicare benefits will be secondary, but only to the extent required by law. In all other instances, our coverage will be secondary to any Medicare benefits. To the extent we are the primary payer, claims for Covered Services should be filed with us first.

Under Medicare, your Group MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, your Group MAY NOT induce you to decline or terminate your group health insurance coverage and elect Medicare as primary payer.

If you become 65 or become eligible for Medicare due to End Stage Renal Disease ("ESRD"), you must notify your Group.

Individuals With End Stage Renal Disease

If you are entitled to Medicare coverage because of ESRD, we will provide group health coverage on a primary basis for 30 months beginning with the earlier of:

1. the month in which you became entitled to Medicare Part A ESRD benefits; or
2. the first month in which you would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the time you became eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health insurance coverage was primary prior to ESRD entitlement, then the group health insurance coverage will remain primary for the ESRD coordination period. If you become eligible for Medicare due to ESRD, we will provide group health coverage, as described in this section, on a primary basis for 30 months.

Disabled Active Individuals

We will provide primary coverage to you if:

1. the Group is a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50 percent or more of its regular business days during the previous Calendar Year; and
2. you are entitled to Medicare coverage because of disability (unless you have ESRD).

Primary coverage under the Group Master Policy is subject to the following terms:

1. For a Covered Person, we will provide coverage on a primary basis during any month in which that individual meets the description set out in the above paragraphs.
2. Individual entitlement to primary coverage under this subsection will terminate automatically when:
    a) the Covered Person turns 65 years of age; or
    b) the Covered Person no longer qualifies for Medicare coverage because of disability; or
    c) the Covered Person elects Medicare as the primary payer. Coverage will terminate as of the day of such election.

3. Entitlement of the Covered Person to primary coverage under this subsection will terminate automatically if the Covered Employee no longer qualifies as such under applicable Medicare regulations and instructions. The Group must notify us, without delay, of any such change in status.

Miscellaneous

1. This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under the Group Master Policy.
2. We will not be liable to the Group or to any individual covered under the Group Master Policy on account of any nonpayment of primary benefits resulting from any failure of performance of the Group's obligations as described in this section.
3. If we should elect to make primary payments for Covered Services rendered to an employee or Dependent described in this section in a period prior to receipt of the information required by the terms of this section, we may require the Group to reimburse us for such payments. Alternatively, we may require the Group to pay the Rate differential that resulted from the Group's failure to provide us with the required information in a timely manner.

Section 17: Duplication of Coverage Under Other Health Plans/Programs

Coordination of Benefits

Coordination of Benefits ("COB") is a limitation of coverage and/or benefits to be provided by us. This provision is required by and subject to applicable federal and/or Florida law concerning coordination of health insurance benefits and will be modified to the extent necessary to enable us to comply with such laws.

COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. It is your responsibility to provide us and your Physician with information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If we do not receive the information we request from you, we may deny your claims and you will be responsible for payment of any expenses related to denied claims.

Health plans, programs or policies which may be subject to COB include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. any group or non-group health insurance, group-type self-insurance, or HMO plan;
2. any group plan issued by any Blue Cross and/or Blue Shield organization(s);
3. any other plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage which the law permits us to coordinate benefits with;
4. Medicare, as described in "The Effect of Medicare Coverage/Medicare Secondary Payer Provisions" section; and
5. to the extent permitted by law, any other government sponsored health insurance program.

The amount of our payment, if any, when we coordinate benefits under this section, is based on whether or not we are the primary payer. When we are primary, we will pay for Covered Services without regard to coverage under other plans. When we are not primary, our payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, in the event you receive Covered Services from a NetworkBlue Provider or an Out-of-Network Provider who participates in our Traditional Program, "total reasonable expenses" shall mean the amount we are obligated to pay to the Provider pursuant to the applicable agreement we have with such Provider. **In the event that the primary payer's payment exceeds our Allowed Amount, no payment will be made for such Services**.

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. When we cover you as a Covered Dependent and the other plan covers you as

other than a dependent, we will be secondary.

2. When we cover a dependent child whose parents are not separated or divorced:
   a) the plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary; or
   b) if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than us, we will be secondary.
3. When we cover a dependent child whose parents are separated or divorced:
   a) if the parent with custody is not remarried, the plan of the parent with custody is primary;
   b) if the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody pays last;
   c) regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is primary.
4. When we cover a dependent child and the dependent child is also covered under another plan:
   a) the plan of the parent who is neither laid off nor retired will be primary; or
   b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered you the longest shall be primary.

   We will not coordinate benefits against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.
6. If you are covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group plan, the following order of benefits applies:
   a) first, the plan covering the person as an employee, or as the employee's Dependent; and
   b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.
7. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

Facility of Payment

Whenever payments which are payable by us under this Booklet are made by any other person, plan, or organization, we will have the right, exercisable alone and in our sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts we determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under this Booklet and, to the extent of such payments, we will be fully discharged from liability.

Non-Duplication of Government Programs and Workers' Compensation

The benefits under this Booklet shall not duplicate any benefits to which you or your Covered Dependents are entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) or Workers' Compensation to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program which may be provided or required by law.

Section 18: Subrogation

If you are injured or become ill as a result of another person's or entity's intentional act, negligence or fault, you must notify us concerning the circumstances under which you were injured or became ill. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. If you recover money to compensate for the cost/expense of Health Care Services to treat your illness or injury, we are legally entitled to recover payments made on your behalf to the doctors, hospitals, or other providers who treated you. Our legal right to recover money we have paid in such cases is called "subrogation". We may recover the amount of any payments we made on your behalf minus our pro rata share for any costs and attorney fees incurred by you in pursuing and recovering damages. We may subrogate against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although we may, but are not required to, take into consideration any special factors relating to your specific case in resolving our subrogation claim, we will have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of the recovery or settlement.

You must do nothing to prejudice our right of subrogation hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Section 19: Right of Reimbursement

If any payment under this Booklet is made to you or on your behalf with respect to any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, we will have a right to be reimbursed by you (out of any settlement or judgment proceeds you recover) one dollar ($1.00) for each dollar paid under the terms of this Booklet minus a pro rata share for any costs and attorney fees incurred in pursuing and recovering such proceeds.

Our right of reimbursement will be in addition to any subrogation right or claim available to us, and you must execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by us to exercise our right of reimbursement hereunder. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. You must do nothing to prejudice our right of reimbursement hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Section 20: Claims Processing

Introduction

This section is intended to:

- help you understand what you or your treating Providers must do, under the terms of this Benefit Booklet, in order to obtain payment for expenses for Covered Services they have rendered or will render to you; and
- provide you with a general description of the applicable procedures we will use for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying you when we deny benefits.

If your Group Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), your plan administrator is solely responsible for complying with ERISA. While the benefit determination timeliness standards set forth in this section are generally consistent with ERISA, we are not legally responsible for notifying you of any rights you may have under ERISA. If you are not sure of your rights under ERISA, you should contact your plan administrator or an attorney of your choice. We will follow the claim determination procedures and notice requirements set forth in this section even if your Group Plan is not subject to ERISA.

Under no circumstances will we be held responsible for, nor will we accept liability relating to, the failure of your Group Plan's sponsor or plan administrator to: 1) comply with ERISA's disclosure requirements; 2) provide you with a Summary Plan Description (SPD) as that term is defined by ERISA; or 3) comply with any other legal requirements. You should contact your plan sponsor or administrator if you have questions relating to your Group Plan's SPD. We are not your Group Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims

For purposes of this Benefit Booklet, there are three types of claims: 1) Pre-Service Claims; 2) Post-Service Claims; and 3) Claims Involving Urgent Care. It is important that you become familiar with the types of claims that can be submitted to us and the timeframes and other requirements that apply.

Post-Service Claims

How to File a Post-Service Claim

We have defined and described the three types of claims that may be submitted to us. Our experience shows that the most common type of claim we will receive from you or your treating Providers will likely be Post-Service Claims.

In-Network Providers have agreed to file Post-Service Claims for Services they render to you. In the event a Provider who renders Services to you does not file a Post-Service Claim for such Services, it is your responsibility to file it with us.

We must receive a Post-Service Claim within 90 days of the date the Health Care Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if we do not receive it at the address indicated on your Identification Card within one year of the date the Service was rendered unless you were legally incapacitated.

For Post-Service Claims, we must receive an itemized statement from the health care Provider for the Service rendered along with a completed claim form. The itemized statement must contain the following information:

1. the date the Service was provided;
2. a description of the Service including any applicable procedure code(s);
3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis code(s);
5. the Provider's name and address;
6. the name of the individual who received the Service; and
7. the Covered Employee's name and contract number as they appear on the Identification Card.

The itemized statement and claim form must be received by us at the address indicated on your Identification Card.

Note: If your Group purchased retail pharmacy prescription drug coverage, please refer to the pharmacy program Endorsement for information on the processing of prescription drug claims. Further, special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard® Program (See the *BlueCard® (Out-of-State) Program* section of this Booklet).

The Processing of Post-Service Claims

We will use our best efforts to pay, contest, or deny all Post-Service Claims for which we have all of the necessary information, as determined by us. Post-Service Claims will be paid, contested, or denied within the timeframes described below.

- Payment for Post-Service Claims

When payment is due under the terms of this Benefit Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more or additional information, we may contest the claim within the timeframes set forth below.

- Contested Post-Service Claims

In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event we contest a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. Our notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that we reasonably expect to notify you of the decision. The notice may also indicate whether additional information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of our request for the information. **If we do not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in our possession at the time and may be denied.** Upon receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- Denial of Post-Service Claims

In the event we deny a Post-Service Claim submitted electronically, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event we deny a paper Post-Service Claim, we will use our best efforts to

provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is your responsibility to ensure that we receive all information determined by us as necessary to adjudicate a Post-Service Claim. **If we do not receive the necessary information, the claim or a portion of the claim may be denied.**

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards and appeal procedures described in this section.

Additional Processing Information for Post-Service Claims

In any event, we will use our best efforts to pay or deny all: 1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and 2) Post-Service paper claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by us or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by us within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

We will investigate any allegation of improper billing by a Provider upon receipt of written notification from you. If we determine that you were billed for a Service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested. In such a case, if payment to the Provider is reduced due solely to the notification from you, we will pay you 20 percent of the amount of the reduction, up to a total of $500.

Pre-Service Claims

How to File a Pre-Service Claim

This Benefit Booklet may condition coverage, benefits, or payment (in whole or in part), for a specific Covered Service, on the receipt by us of a Pre-Service Claim as that term is defined herein. In order to determine whether we must receive a Pre-Service Claim for a particular Covered Service, please refer to the "What Is Covered?" section and other applicable sections of this Benefit Booklet. You may also call the customer service number on your ID card for assistance.

We are not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to you unless the terms of this Benefit Booklet require (or condition payment upon) approval by us for the Service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

1. For a Pre-Service Claim Involving Urgent Care, we will use our best efforts to provide notice of our determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a determination, we will use our best efforts to provide notice within 24 hours of: 1) the need for additional information; 2) the specific information that you or your Provider may need to provide; and 3) the date that we reasonably expect to provide notice of the decision. If we request additional information, we must receive it within 48 hours of our request. We will use our best efforts to provide notice of the decision on your Pre-Service Claim within 48 hours after the earlier of: 1) receipt of the requested information; or 2) the end of the period you

were afforded to provide the specified additional information as described above.

2. Benefit Determinations on Pre-Service Claims that Do Not Involve Urgent Care
3. We will use our best efforts to provide notice of a decision on a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. This 15-day determination period may be extended by us one time for up to an additional 15 days. If such an extension is necessary, we will use our best efforts to provide notice of the extension and reasons for it. We will use our best efforts to provide notification of the decision on your Pre-Service claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by us.
4. If additional information is necessary to make a determination, we will use our best efforts to: 1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period; 2) identify the specific information that you or your Provider may need to provide; and 3) inform you of the date that we reasonably expect to notify you of our decision. If we request additional information, we must receive it within 45 days of our request for the information. We will use our best efforts to provide notification of the decision on your Pre-Service Claim within 15 days of receipt of the requested information.
5. A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards and appeal procedures described in this section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

A reduction or termination of coverage or benefits for Services will be considered an Adverse Benefit Determination when:

- we have approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of Services; and
- the reduction or termination of coverage or benefits by us was not due to an amendment of this Benefit Booklet or termination of your coverage as provided by this Benefit Booklet.

We will use our best efforts to notify you of such reduction or termination in advance so that you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Services.

Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of your request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our

best efforts to notify you within 24 hours if: 1) we need additional information; or 2) you or your representative failed to follow proper procedures in your request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for extension of Services is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure below.

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

We will use our best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to you free of charge upon request):

- the specific reason or reasons for the Adverse Benefit Determination;
- a reference to the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

If your claim is a Claim Involving Urgent Care, we may notify you orally within the proper timeframes, provided we follow-up with a written or electronic notification meeting the requirements of this subsection no later than three days after the oral notification.

How to Appeal an Adverse Benefit Determination

You, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. We will review your appeal through the review process described below. Your appeal must be submitted in writing to us within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

- We must receive your appeal of an Adverse Benefit Determination in person or in writing;
- You may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;
- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational limitations and exclusions or other similar exclusions or limitations, you may request, free of charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this Benefit Booklet to your medical circumstances;

- During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination;
- We may consult with appropriate Physicians, as necessary;
- Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request; and
- If your claim is a Claim Involving Urgent Care, you may request an expedited appeal orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method.

Your request for appeal should be sent to the address below:

Blue Cross and Blue Shield of Florida, Inc.
Attention PPO Appeals / DC4
P.O. Box 44197
Jacksonville, Florida 32231-4197

Timing of Our Appeal Review on Adverse Benefit Determinations

We will use our best efforts to review your appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

- Pre-Service Claims -- within 30 days of the receipt of your appeal; or
- Post-Service Claims -- within 60 days of the receipt of your appeal; or
- Claims Involving Urgent Care (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services) -- within 72 hours of receipt of your request. If additional information is necessary we will notify you within 24 hours and we must receive the requested additional information within 48 hours of our request. After we receive the additional information, we will have an additional 48 hours to make a final determination.

Note: The nature of a claim for Services (i.e. whether it is "urgent care" or not) is judged as of the time of the benefit determination on review, not as of the time the Service was initially reviewed or provided.

You, or a Provider acting on your behalf, who has had a claim denied as not Medically Necessary has the opportunity to appeal the claim denial. The appeal may be directed to an employee of BCBSF who is a licensed Physician responsible for Medical Necessity reviews. The appeal may be by telephone and the Physician will respond to you, within a reasonable time, not to exceed 15 business days.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

   In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in our effort to obtain such information by, among other ways, signing any release of information form at our request. Failure by you to fully cooperate with us may result in a denial of the pending claim and we will have no liability for such claim.

2. Physical Examination:

   In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a health care Provider of our choice as often as is reasonably necessary while a claim is pending. Failure by you to fully cooperate with such examination shall result in a denial of the pending claim and we shall have no liability for such claim.

3. Legal Actions:

   No legal action arising out of or in connection with coverage under this Benefit Booklet may be brought against us within the 60-day period following our receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

   We rely on the information provided on the itemized statement and the claim form when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy we may have, in denial of the claim or cancellation or rescission of your coverage.

5. Explanation of Benefits Form:

   All claims decisions, including denial and claims review decisions, will be communicated to you in writing either on an explanation of benefits form or some other written correspondence. This form may indicate:

   a) The specific reason or reasons for the Adverse Benefit Determination;

   b) Reference to the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

   c) A description of any additional information that would change the initial determination and why that information is necessary;

   d) A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and

   e) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond Our Control:

   To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of claims for Covered Services, except that we will make a good faith effort to make payment for such Services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

ERISA Civil Action Provision

A federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, may apply to the Group Plan. If ERISA applies to the Group Plan, you or your Covered Dependents are entitled, after exhaustion of the appeal procedures provided for in this section, to pursue civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

Section 21: Relationships Between the Parties

BCBSF and Health Care Providers

Neither BCBSF nor any of its officers, directors or employees provides Health Care Services to you. Rather, we are engaged in making coverage and benefit decisions under this Booklet. By accepting our coverage and benefits, you agree that making such coverage and benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering those Services are not our employees or agents. **In this regard, we hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** We do not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care Provider. Any decisions we make concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such Services are covered, and not for purposes of recommending any treatment or non-treatment. Neither BCBSF nor the Group will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and the Group

Neither the Group nor any person covered under this Booklet is our agent or representative, and neither shall be liable for any acts or omissions by our agents, servants, employees, or us. Additionally, we will not be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which we have made or hereafter make arrangements for the provision of Covered Services. We are not your agent, servant, or representative nor are we an agent, servant, or representative of the Group and we will not be liable for any acts or omissions, or those of the Group, its agents, servants, employees, or any person or organization with which the Group has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Medical Treatment Decisions - Responsibility of Your Physician, Not BCBSF

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for medical services or supplies, must be made solely by your family 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 procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Section 22: General Provisions

Access to Information

We have the right to receive, from you and any health care Provider rendering Services to you, information that is reasonably necessary, as determined by us, in order to administer the coverage and benefits we provide, subject to all applicable confidentiality requirements listed below. By accepting coverage, you authorize every health care Provider who renders Services to you, to disclose to us or to entities affiliated with us, upon request, all facts, records, and reports pertaining to your care, treatment, and physical or mental Condition, and to permit us to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and benefits, we may, without the consent of, or notice to, any person, plan, or organization, obtain from any person, plan, or organization any information with respect to any person covered under this Booklet or applicant for enrollment which we deem to be necessary.

Amendment

The terms of coverage and benefits to be provided by us may be amended at renewal of the Group Master Policy, without the consent of the Group, you or any other person, upon 45 days prior written notice to the Group. In the event the amendment is unacceptable to the Group, the Group may terminate the Group Master Policy upon at least ten days prior written notice to us. Any such amendment will be without prejudice to claims filed with us and related to Covered Services prior to the date of such amendment. No agent or other person, except a duly authorized officer of BCBSF, has the authority to modify the terms of the Group Master Policy, or to bind us in any manner not expressly described herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The terms of coverage and benefits to be provided by us may not be amended by the Group; unless such amendment is evidenced in writing and signed by a duly authorized officer of BCBSF. The Group shall immediately notify you of any such amendment and/or shall assist us in notifying you at our request.

Assignment and Delegation

Your obligations arising hereunder may not be assigned, delegated or otherwise transferred by you without the written consent of BCBSF. We may assign our coverage and/or benefit obligations to our successor in interest or an affiliated entity without the consent of the Group at any time. **Any assignment, delegation, or transfer made in violation of this provision shall be void.**

Changes in Premium

We may modify the Rates at any time, without your consent, upon at least 45 days prior notice to the Group. It is the Group's responsibility to immediately notify you if your financial contribution requirement is changed due to a change in Rates.

Right to Recovery

Whenever we have made payments in excess of the maximum provided for under this Booklet**,** we will have the right to recover any such payments, to the extent of such excess, from you or any person, plan, or other organization that received such payments.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided by us under the Group Master Policy shall be deemed to have been modified and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with Rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received by Providers, shall be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including our quality assurance and Blueprint for Health Programs. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist in providing coverage, benefits or services under this Booklet. Further, any documents or information, which are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

Our arrangements with a Provider may require that we release certain claims and medical information about persons covered under this Booklet to that Provider even if treatment has not been sought by or through that Provider. By accepting coverage, you hereby authorize us to release to Providers claims information, including related medical information, pertaining to you in order for any such Provider to evaluate your financial responsibility under this Booklet.

Evidence of Coverage

You have been provided with this Benefit Booklet and an Identification Card as evidence of coverage under the Group Master Policy issued by us to the Group.

Governing Law

The terms of coverage and benefits to be provided hereunder, and the rights of the parties hereunder, shall be construed in accordance with the laws of the state of Florida and/or the United States, when applicable.

Identification Cards

The Identification Cards issued to you in no way creates, or serves to verify, eligibility to receive coverage and benefits under this Booklet. Identification cards are our property and must be destroyed or returned to us immediately following termination of your coverage.

Modification of Provider Network and the Participation Status

NetworkBlue, and the participation status of individual Providers available under this Booklet, are subject to change at any time without prior notice to you or your approval or that of the Group. Additionally, we may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to, or approval of, the Group or you. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time the Health Care Service is rendered. Under this Booklet, your financial responsibility may vary depending upon a Provider's participation status.

Cooperation Required of You and Your Covered Dependents

You must cooperate with us, and must execute and submit to us any consents, releases, assignments, and other documents we may request in order to administer, and exercise our rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause by us (See the Termination of an Individual's Coverage for Cause subsection in the "Termination of Coverage" section).

Non-Waiver of Defaults

Any failure by us at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will not affect our right at any time to enforce or avail ourselves of any such remedies as we may be entitled to under applicable law, the Group Master Policy, or this Benefit Booklet.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

If to us:

To the address printed on the Group Application and/or the Identification Card.

If to you:

To the latest address provided by you or to your latest address on Enrollment Forms actually delivered to us.

You must notify us immediately of any address change.

If to Group:

To the address indicated on the Group Application.

Our Obligations upon Termination

Upon termination of your coverage for any reason, we will have no further liability or responsibility to you under the Group Master Policy, except as specifically described herein.

ERISA

We are not the plan sponsor or plan administrator, as defined by ERISA. If the group health plan under which you are covered is subject to the Employee Retirement Income Security Act (ERISA), the Group, as either plan sponsor or plan administrator of an employee welfare benefit plan subject to ERISA, is responsible for ensuring compliance with ERISA.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Booklet.

Florida Agency for Health Care Administration (AHCA) Performance Outcome and Financial Data

The performance outcome and financial data published by AHCA, pursuant to Florida Statute 408.05, or any successor statute, located at the web site address www.floridahealthstat.com, may be accessed through the link provided on the Blue Cross and Blue Shield of Florida's corporate web site at www.bcbsfl.com.

Third Party Beneficiary

The Group Master Policy under which this Benefit Booklet was issued was entered into solely and specifically for the benefit of BCBSF and the Group. The terms and provisions of the Group Master Policy shall be binding solely upon, and inure solely to the benefit of, BCBSF and the Group, and no other person shall have any rights, interest or claims thereunder, or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. BCBSF and the Group hereby specifically express their intent that health care Providers that have not entered into contracts with BCBSF to participate in BCBSF's Provider networks shall not be third-party beneficiaries under the Group Master Policy or this Benefit Booklet.

Section 23: Definitions

The following definitions are used in this Benefit Booklet. Other definitions may be found in the particular section or subsection where they are used.

Accident means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.

Accidental Dental Injury means an injury to sound natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Benefit Booklet with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this section, shall also constitute an Adverse Benefit Determination.

Allowed Amount means the maximum amount upon which payment will be based for Covered Services. The Allowed Amount may be changed at any time without notice to you or your consent.

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard® (Out-of-State) Program section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard® (Out-of-State) Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard® (Out-of-State) Program section for more details.
5. In the case of Out-of-Network Providers that have not entered into any agreement with BCBSF, or with another Blue Cross and/or Blue Shield organization to provide access to Provider discounts under the BlueCard® Program, the Allowed Amount will be the lesser of the Provider's actual charge or an amount established by BCBSF based on several factors including (but not necessarily limited to): BCBSF's medical, payment, and/or administrative guidelines; pre-negotiated payment amounts; diagnostic related grouping(s) (DRG); payment for such services under the Medicare program; relative value scales; the charge(s) of the

Provider; the charge(s) of similar Providers within a particular geographic area established by BCBSF; and/or the cost of providing the Covered Service.

If a particular Covered Service is not available from any provider that is in NetworkBlue, as determined by us, the Allowed Amount, whenever Florida Statute §627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular services by calling the customer service telephone number included in this Booklet or on your Identification Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in your Booklet apply. You should refer to the "What is Covered?" section of your Booklet and the Schedule of Benefits to determine what is covered and how much we will pay.

Ambulance means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the Florida Statutes, or a similar applicable law in another state.

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

Anniversary Date means the date, one year after the Effective Date, stated on the Group Application and subsequent annual anniversaries.

Artificial Insemination (AI) means a medical procedure in which sperm is placed into the female reproductive tract by a qualified health care provider for the purpose of producing a pregnancy.

Benefit Booklet or **Booklet** means the certificate of coverage, which is evidence of coverage under the Group Master Policy.

Birth Center means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to Chapter 383 of the Florida Statutes, or a similar applicable law of another state, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

BlueCard® (Out-of-State) PPO Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the BlueCard® (Out-of-State) PPO Program discounts of other participating Blue Cross and/or Blue Shield plans.

BlueCard® (Out-of-State) PPO Program Provider means a Provider designated as a BlueCard® (Out-of-State) PPO Program Provider by the Host Blue.

BlueCard® (Out-of-State) Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the Provider discounts of other participating Blue Cross and/or Blue Shield plans.

BlueCard® (Out-of-State) Traditional Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the BlueCard® (Out-of-State) Traditional Program discounts of other

participating Blue Cross and/or Blue Shield plans.

BlueCard® (Out-of-State) Traditional Program Provider means a Provider designated as a BlueCard® (Out-of-State) Traditional Program Provider by the Host Blue.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary services).

Calendar Year begins January 1st and ends December 31st.

Cardiac Therapy means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Certified Nurse Midwife means a person who is licensed pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state, as an advanced nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced registered nurse practitioner within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has not yet been provided to you with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize your life or health or your ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of your Condition, would subject you to severe pain that cannot be adequately managed without the proposed Services being rendered.

Coinsurance means the sharing of health care expenses for Covered Services between BCBSF and you. After your Deductible requirement is met, BCBSF will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Concurrent Care Decision means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the personal case management Program as described in the “Blueprint for Health Programs” section of this Benefit Booklet.

Condition means a disease, illness, ailment, injury, or pregnancy.

Convenient Care Center means a properly licensed ambulatory center that: 1) treats a limited number of common, low-intensity illnesses when ready access to the patient's primary physician is not possible; 2) shares clinical information about the treatment with the patient's primary physician; 3) is usually housed in a retail business; and 4) is staffed by at least one master’s level nurse (ARNP) who operates under a set of clinical protocols that strictly circumscribe the conditions the ARNP can treat. Although no physician is present at the Convenient Care Center, medical oversight is based on a written collaborative agreement between a supervising physician and the ARNP.

Copayment means the dollar amount established solely by us, which is required to be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Master Policy other than as a Covered Employee (See the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage section).

Covered Employee means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Master Policy other than as a Covered Dependent (See Eligibility Requirements for Covered Employees subsection of the “Eligibility for Coverage” section).

Covered Person means a Covered Employee or a Covered Dependent.

Covered Services means those Health Care Services which meet the criteria listed in the “What Is Covered?” section.

Custodial or **Custodial Care** means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services, which you must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Booklet, before our payment for Covered Services begins.

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, individual is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the individual at a minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or a similar applicable law of another state, to supervise diabetes outpatient self-management training and educational services.

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services (CMMS) and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis services and support.

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management services.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law (or a similar applicable law of another state) to provide home medical equipment, oxygen therapy services, or dialysis supplies in the patient's home under a Physician's prescription.

Effective Date means, with respect to the Group, 12:01 a.m. on the date specified on the Group Application. With respect to individuals covered under this Group Master Policy, 12:01 a.m. on the date the group specifies that the coverage will commence as further described in the "Enrollment and Effective Date of Coverage" section of this Benefit Booklet.

Eligible Dependent means a Covered Employee's:

1. legal spouse under a legally valid, existing marriage; or
2. natural, newborn, adopted, Foster, or step child(ren); or
3. a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian;
4. who meets and continues to meet all of the eligibility requirements described in the "Eligibility for Coverage" section in this Benefit Booklet.

Eligible Dependent also includes a newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child. Refer to the "Eligibility for Coverage" section for limits on eligibility.

Eligible Employee means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Covered Employees subsection of the "Eligibility for Coverage" section in this Benefit Booklet and is eligible to enroll as a Covered Employee. Any individual who is an Eligible Employee is not a Covered Employee until such individual has actually enrolled with, and been accepted for coverage as a Covered Employee by us.

Endorsement means an amendment to the Group Master Policy or this Booklet issued by BCBSF.

Enrollment Date means the date of enrollment of the individual under the Group Master Policy or, if earlier, the first day of the Waiting Period of such enrollment.

Enrollment Forms means those BCBSF forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under the Group Master Policy.

Experimental or **Investigational** means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by us:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you; or
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations; or
4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Reliable evidence" shall mean (as determined by us):

1. records maintained by Physicians or Hospitals rendering care or treatment to you or other patients with the same or similar Condition;
2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
4. the written protocol or protocols relied upon by the treating physician or institution or the protocols of another Physician or institution

studying substantially the same evaluation, treatment, therapy, or device;

5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Health Care Services, which are determined by BCBSF to be Experimental or Investigational, are excluded (see the "What Is Not Covered?" section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

Foster Child means a person who is placed in your residence and care under the Foster Care Program by the Florida Department of Health & Rehabilitative Services in compliance with *Florida Statutes* or by a similar regulatory agency of another state in compliance with that state's applicable laws.

Gamete Intrafallopian Transfer (GIFT*)* means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube.

Gestational Surrogate means a woman, regardless of age, who contracts, orally or in writing, to become pregnant by means of Assisted Reproductive Technology without the use of an egg from her body.

Gestational Surrogacy Contract or Arrangement means an oral or written agreement, regardless of the state or jurisdiction where executed, between the Gestational Surrogate and the intended parent or parents.

Group means the employer, labor union, trust, association, partnership, or corporation, department, other organization or entity through which coverage and benefits are issued by us, and through which you and your Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

Group Application means the BCBSF form, electronic (where available) or paper, including the underwriting questionnaire form, if any, that the Group must submit to BCBSF when requesting the issuance of the Group Master Policy.

Group Master Policy means the written document, which is the agreement between the Group and us whereby coverage and benefits will be provided to you and any Covered Dependents. The Group Master Policy includes this Benefit Booklet (including the Schedule of Benefits), the Group Application, Enrollment Forms, and any Endorsements to this Benefit Booklet or the Group Master Policy.

Group Plan means the employee welfare benefit plan established by the Group.

Health Care Service or Services includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied, by or at the direction of, Providers.

Home Health Agency means a properly licensed agency or organization, which provides

health services in the home pursuant to Chapter 400 of the *Florida Statutes*, or a similar applicable law of another state.

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individuals home or residence.

Hospice means a public agency or private organization, which is duly licensed by the state of Florida under applicable law, or a similar applicable law of another state, to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.

Hospital means a facility properly licensed pursuant to Chapter 395 of the *Florida Statutes*, or a similar applicable law of another state, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

Identification (ID) Card means the card(s) we issue to Covered Employees. The card is our property, and is not transferable to another person. Possession of such card in no way verifies that a particular individual is eligible for, or covered under, the Group Master Policy.

Independent Clinical Laboratory means a laboratory properly licensed pursuant to Chapter 483 of the *Florida Statutes*, or a similar applicable law of another state, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

Independent Diagnostic Testing Facility means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable Florida law or laws of the

state in which it operates. Further, such an entity must meet our criteria for eligibility as an Independent Diagnostic Testing Facility.

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on the Schedule of Benefits under the heading "In-Network". Otherwise, In-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is an In-Network Provider under the terms of this Benefit Booklet.

In-Network Provider means any health care Provider who, at the time Covered Services were rendered to you, was under contract with BCBSF to participate in BCBSF's NetworkBlue and included in the panel of providers designated by BCBSF as "In-Network" for your specific plan. (Please refer to your Schedule of Benefits). For payment purposes under this Benefit Booklet only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the state of Florida who or which, at the time Health Care Services were rendered to you, participated as a BlueCard® (Out-of-State) PPO Program Provider under the Blue Cross Blue Shield Association's BlueCard® (Out-of-State) Program.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus.

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the *Florida Statues*, or a similar applicable law of another state.

Massage Therapist means a person properly licensed to practice Massage, pursuant to Chapter 480 of the *Florida Statutes*, or a similar applicable law of another state.

Massage or Massage Therapy means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Benefit Booklet, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medically Necessary or **Medical Necessity** means, in accordance with our guidelines and criteria then in effect, for coverage and payment purposes only, that a Health Care Service is required for the identification, treatment, or management of a Condition, and is, in the opinion of BCBSF:

1. consistent with the symptom, diagnosis, and treatment of the Condition being treated;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
3. universally accepted in clinical use such that omission of the service in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. not Experimental or Investigational;
5. not for cosmetic purposes;
6. not primarily for the convenience of, the Covered Person's family, the Physician or other provider;

7. the most appropriate level of service or care which can safely be provided to the Covered Person; and
8. in the case of inpatient care, the Health Care Service(s) cannot be provided safely in an alternative setting.

Note: It is important to remember that any review of Medical Necessity by us is solely for the purposes of determining coverage or benefits under this Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Booklet as determined by us. In applying the definition of Medical Necessity in this Booklet**,** we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

Medicare means the federal health insurance provided under Title XVIII of the Social Security Act and all amendments thereto.

Mental Health Professional means a person properly licensed to provide Mental Health Services, pursuant to Chapter 491 of the *Florida Statutes*, or a similar applicable law of another state. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination who provide counseling services.

Mental and Nervous Disorder means any and all disorders listed in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the *Florida Statutes,* or a similar applicable law of another state.

Morbid Obesity is a Condition where an individual is 100 pounds over their ideal body weight and/or Body Mass Index (BMI) of equal to or greater than 40.

NetworkBlue means, or refers to, the preferred provider network established and so designated by BCBSF, which is available to BlueOptions members under this Benefit Booklet. Please note that BCBSF's Preferred Patient Care (PPC) preferred provider network is not available to BlueOptions members under this Benefit Booklet.

Occupational Therapist means a person properly licensed to practice Occupational Therapy pursuant to Chapter 468 of the *Florida Statutes*, or a similar applicable law of another state.

Occupational Therapy means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Out-of-Network means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on the Schedule of Benefits under the heading "Out-of-Network". Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is not an In-Network Provider under the terms of this Benefit Booklet.

Out-of-Network Provider means a Provider who, at the time Health Care Services were rendered:

1. did not have a contract with us to participate in NetworkBlue but was participating in our Traditional Program; or
2. did not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard® (Out-of-State) PPO Program but was participating, for purposes of the BlueCard® (Out-of-State) Program, as a BlueCard® (Out-of-State) Traditional Program Provider; or
3. did have a contract to participate in NetworkBlue but was not included in the panel of Providers designated by us to be In-Network for your Plan; or
4. did not have a contract with us to participate in NetworkBlue or our Traditional Program; or
5. did not have a contract with a Host Blue to participate for purposes of the BlueCard® (Out-of-State) Program as a BlueCard® (Out-of-State) Traditional Program Provider.

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient Physical Therapy; outpatient Speech Therapy; outpatient Occupational Therapy; outpatient cardiac rehabilitation therapy; and outpatient Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet our criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59A, Florida Administrative Code or the similar law or laws of another state.

Pain Management includes, but is not limited to, Services for pain assessment, medication, physical therapy, biofeedback, and/or counseling. Pain rehabilitation programs are programs featuring multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

Physical Therapy means the treatment of disease or injury by physical or mechanical means as defined in Chapter 486 of the *Florida Statutes* or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or heat therapy.

Physical Therapist means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the *Florida Statutes*, or a similar applicable law of another state.

Physician means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

Physician Assistant means a person properly licensed pursuant to Chapter 458 of the *Florida Statutes*, or a similar applicable law of another state.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to you (not just proposed or recommended) that is received by us on a properly completed claim form or electronic format acceptable to us in accordance with the provisions of the "Claims Processing" section.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of this Benefit Booklet condition payment for the Service (in whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Benefit Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

Premium means the amount required to be paid by the Group to BCBSF in order for there to be coverage under the Group Master Policy.

Prior/Concurrent Coverage Affidavit means the form that an Eligible Employee can submit to us as proof of the amount of time the Eligible Employee was covered under Creditable Coverage.

Prosthetist/Orthotist means a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs prescribed by a Physician.

Prosthetic Device means a device, which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

Provider means any facility, person or entity recognized for payment by BCBSF under this Booklet.

Psychiatric Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the care and treatment of Mental and Nervous Disorders. For purposes of this Booklet, a Psychiatric Facility is not a Hospital or a Substance Abuse Facility, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the *Florida Statutes*, or a similar applicable law of another state.

Rate means the amount BCBSF charges the Group for each type of coverage under the Group Master Policy (e.g., Employee Only Coverage).

Registered Nurse means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state.

Registered Nurse First Assistant (RNFA*)* means a person properly licensed to perform surgical first assisting services pursuant to Chapter 464 of the *Florida Statutes* or a similar applicable law of another state.

Rehabilitation Services means Services for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to Cardiac Rehabilitation, Pulmonary Rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage Therapy.

Rehabilitative Therapies means therapies the primary purpose of which is to restore or improve bodily or mental functions impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech

Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

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.

Skilled Nursing Facility means an institution or part thereof which meets BCBSF's criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the state of Florida or a similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by BCBSF.

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not Sound Natural Teeth.

Speech Therapy means the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy services.

Speech Therapist means a person properly licensed to practice Speech Therapy pursuant to Chapter 468 of the *Florida Statutes*, or a similar applicable law of another state.

Standard Reference Compendium means: 1) the United States Pharmacopoeia Drug Information; 2) the American Medical Association Drug Evaluation; or 3) the American Hospital Formulary Service Hospital Drug Information.

Substance Abuse Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For the purposes of this Booklet a Substance Abuse Facility is not a Hospital or a Psychiatric Facility, as defined herein.

Substance Dependency means a Condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Traditional Program means, or refers to, BCBSF 's provider contracting programs called Payment for Physician Services (PPS) and Payment for Hospital Services (PHS).

Traditional Program Providers means, or refers to, those health care Providers who are not NetworkBlue Providers, but who, or which, have entered into a contract, then in effect, to participate in BCBSF's Traditional Program as applicable in Florida or in certain counties outside of Florida when such programs exist.

Urgent Care Center means a facility properly licensed that: 1) is available to provide services to patients at least 60 hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the Urgent Care Center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and 4) maintains and operates basic diagnostic

radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

For purposes of this Benefit Booklet, an Urgent Care Center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

Waiting Period means the length of time specified on the Group Application, which must be met by an individual before that individual becomes eligible for coverage under this Benefit Booklet.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the resulting zygote is transferred to the fallopian tube at the pronuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day.

BlueScript® Pharmacy Program Endorsement

This Endorsement and the BlueScript Pharmacy Program Schedule of Benefits are to be attached to, and made a part of, your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet. The Benefit Booklet is hereby amended by adding the following BlueScript Pharmacy Program provisions.

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

References to "you" or "your" throughout refer to you as the Covered Employee and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any reference that refers solely to you as the Covered Employee or solely to your Covered Dependent(s) will be noted as such.

References to "we", "us", and "our" throughout refer to BCBSF.

Introduction

Under this Endorsement, we provide coverage to you for certain 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 percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, as applicable, indicated on the BlueScript Pharmacy Program Schedule of Benefits.

A Formulary list is contained in the Closed Formulary Medication Guide (referred to as "Medication Guide" hereafter), where you will find lists of Generic Prescription Drugs and Brand Name Prescription Drugs. Generic Prescription Drugs not included on the Formulary List are covered, unless specifically listed in the Exclusions subsection in this Endorsement. In order to be covered under this BlueScript Pharmacy Program, Brand Name Prescription Drugs must be included on the Formulary List. You may be able to reduce your out-of-pocket expenses by using Participating Pharmacies and by choosing Generic Prescription Drugs.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com or call the customer service number on your Identification Card.

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 Brand Name Prescription Drug, included on the Formulary List in the Medication Guide;
5. 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;
6. in the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide

7. a Prescription Drug contained in an anaphylactic kit (e.g., Epi-Pen, Epi-Pen Jr., Ana-Kit);
8. authorized for coverage by us, if prior coverage authorization is required by us as indicated with a unique identifier in the Medication Guide, then in effect;
9. not specifically or generally limited or excluded herein or in the Benefit Booklet; and
10. 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/her license;
3. Medically Necessary, and
4. not specifically or generally limited or excluded herein or in 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 are covered (unless listed as not covered on the BlueScript 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, etc.) inserted for purposes of contraception, 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 your 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 on our website at www.floridablue.com, or you may call the customer service number on your Identification Card and one will be mailed to you upon request.

Diabetic Coverage

All Covered Prescription Drugs and Supplies used in the treatment of diabetes are covered (unless indicated as not covered on the BlueScript Pharmacy Program Schedule of Benefits), 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/or syringes and needles.

Exclusion

All Supplies used in the treatment of diabetes except those that are Covered Prescription

Supplies are excluded from coverage under this Endorsement.

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/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

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

Limitations

1. We will not cover more than the Maximum supply, as set forth in the BlueScript 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 its 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 subsection of the "What Is Covered?" section of your 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 if 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 BlueScript Pharmacy Program Endorsement or on the BlueScript Pharmacy Program Schedule of Benefits;

    b. furnished to you without cost;

    c. Experimental or Investigational;

    d. indicated or used for the treatment of infertility (except when indicated as covered on the BlueScript Pharmacy Program Schedule of Benefits);

    e. used for cosmetic purposes including, but not limited to, Minoxidil, Rogaine, Renova;

    f. prescribed by a Pharmacist;

    g. used for smoking cessation, except when indicated as covered on the BlueScript Pharmacy Program Schedule of Benefits;

    h. listed in the Homeopathic Pharmacopoeia;

    i. not Medically Necessary;

    j. indicated or used for sexual dysfunction, except when indicated as covered on the BlueScript Pharmacy Program Schedule of Benefits. The exception described in item number 12 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. Brand Name Prescription Drugs, Supplies and 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. Non-Formulary Drugs, unless approved through the exception process described below:

   Exception Process: Exceptions may be considered when designated Brand Name Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, we must receive an Exception Request Form from your Physician.

   You can obtain an Exception Request Form on our website at www.bcbsfl.com, or you may call the customer service number on your Identification Card and one will be mailed to you upon request.

9. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection.

10. Any appetite suppressant and/or Drug indicated, or used, for purposes of weight reduction or control (except when indicated as covered on the BlueScript Pharmacy Program Schedule of Benefits).

11. Immunization agents, biological sera, blood and blood plasma.

12. 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.

13. Drugs that have not been approved by the FDA as required by federal law for distribution or delivery into interstate commerce.

14. 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.

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: i) the American Medical Association; ii) the National Heart Lung and Blood Institute; iii) the American Cancer Society; iv) the American Heart Association; v) the National Institutes of Health; vi) the American Gastroenterological Association; vii) the Agency for Health Care Policy and Research; or

c. we, in our sole discretion, waive 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:

    a. the American Medical Association;

    b. the National Heart Lung and Blood Institute;

    c. the American Cancer Society;

    d. the American Heart Association;

    e. the National Institutes of Health;

    f. the American Gastroenterological Association;

    g. the Agency for Health Care Policy and Research;

    unless we, in our sole discretion, decide 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 BlueScript Pharmacy Program Schedule of Benefits.

18. Any benefit penalty reductions or any charges in excess of the Participating Pharmacy Allowance or the Non-Participating Pharmacy Allowance.

19. Self-prescribed 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.

Payment Rules

Under this Endorsement, the amount you must pay for Covered Prescription Drugs and Supplies or a Covered OTC Drug may vary depending on:

1. the participation status of the Pharmacy where purchased (e.g., Participating Pharmacy versus Non-Participating Pharmacy);

2. the terms of our agreement with the Pharmacy selected;

3. whether you have satisfied the Pharmacy Deductible, if any, and the amount of Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, as

applicable, set forth in the BlueScript Pharmacy Program Schedule of Benefits;

4. whether the Prescription Drug is a Generic Prescription Drug, a Brand Name Prescription Drug or a Covered OTC Drug;
5. whether the Brand Name Prescription Drug is on the Formulary List;
6. whether the Prescription Drug is purchased from the Mail Order Pharmacy;
7. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug.

We reserve the right to add, remove or reclassify any Prescription Drug or OTC Drug in the Medication Guide at any time.

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 BlueScript Pharmacy Program, or the National Network Pharmacy belonging to our Pharmacy Benefit Manager, at the time you purchase Covered Prescription Drugs and Supplies and/or Covered OTC Drugs. Participating Pharmacies have agreed not to charge, or collect from you, for each Covered Prescription Drug, Covered Prescription Supply or Covered OTC, more than the amount set forth in the BlueScript Pharmacy Program Schedule of Benefits.

With BlueScript, there are four types of Participating Pharmacies:

1. Pharmacies in Florida that have signed a BlueScript 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 access the Pharmacy Program Provider Directory on our website at www.bcbsfl.com or call the customer service number included in your Benefit Booklet or on your Identification Card.

Prior to purchase, you must present your BCBSF Identification Card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that we, in fact, cover you.

When charges for Covered Prescription Drugs and Supplies or Covered OTC Drugs by a Participating Pharmacy are less than the required Copayment, if applicable, the amount you will 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 BlueScript 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 additional details on how to obtain Covered Prescription Drugs and Supplies and OTC Drugs from the Mail Order Pharmacy, refer to the Medication Guide or the Mail Order Pharmacy Brochure.

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

Non-Participating Pharmacies

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

Our reimbursement to you for Covered Prescription Drugs and Supplies is based upon the Non-Participating Pharmacy Allowance. Non-Participating Pharmacies have **not** agreed to accept our Participating Pharmacy Allowance or our Pharmacy Benefit Manager's Participating Pharmacy Allowance as payment in full less any applicable cost-sharing amounts (e.g., Deductible, Copayment, percentage of the Participating Pharmacy Allowance) due from you.

You may be responsible for paying the full cost of the Covered Prescription Drugs and Supplies at the time of purchase and must submit a claim to us for reimbursement. Our reimbursement for Covered Prescription Drugs and Supplies will be based on the Non-Participating Pharmacy Allowance less the Pharmacy Deductible, if any, and the Copayment or percentage of the Out-of-Network member cost-share set forth in the BlueScript Pharmacy Program Schedule of Benefits.

In order to obtain reimbursement for Covered Prescription Drugs and Supplies purchased at a Non-Participating Pharmacy, you must obtain an itemized paid receipt and submit it with a properly completed claim form (with any required documentation) to:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Prescription Drug Program
P. O. Box 1798
Jacksonville, Florida 32231

Pharmacy Utilization Review Programs

Our pharmacy utilization review programs are intended to encourage the responsible use of Prescription Drugs and Supplies and Covered 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 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 we will not cover or pay for the Prescription Drug, Supply or OTC Drug. You are always free to purchase the Prescription Drug, Supply or OTC Drug at your 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 your Prescription, your Physician may, but is not required to, 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, or you may call the customer service number on your Identification Card. Your Pharmacist may also advise you if a Prescription 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 concerning whether a 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 in the Benefit Booklet that this Endorsement amends.

Average Wholesale Price ("AWP") means the average wholesale price of a Prescription Drug at the time a claim is processed, as established in the BCBSF price file and updated no less than weekly by Medi-Span or by such other national drug database designated solely by BCBSF.

Brand Name Prescription Drug means a Prescription Drug which 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.

Closed Formulary Medication Guide means the guide then in effect issued by us that contains the Formulary List which designates the following categories of Prescription Drugs: Generic Prescription Drugs and Brand Name Prescription Drugs.

Note: The Closed Formulary Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service number on your Identification Card.

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); or
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 (unless indicated as not covered on the BlueScript Pharmacy Program Schedule of Benefits).

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 a fee that every Pharmacist is paid for filling a Prescription in addition to the cost of 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.

Formulary List means a list of Brand Name Prescription Drugs then in effect, for which we provide coverage and benefits, subject to the

exclusions of this Endorsement. The Formulary List is contained within the Closed Formulary Medication Guide.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either (i) has been approved by the 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 (ii) 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 Order Copayment means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug and Covered Prescription Supply and/or Covered OTC Drug as set forth in the BlueScript 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.

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-Formulary Drug means a Brand Name Prescription Drug that is not included on the Formulary List then in effect.

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

Non-Participating Pharmacy Allowance means the maximum amount upon which payment will be based for Covered Prescription Drugs and Supplies:

1. In the case of Generic Prescription Drugs and Supplies and OTC Drugs, the maximum is based on 33 percent of AWP plus a $1.00 Dispensing Fee.
2. In the case of Brand Name Prescription Drugs and Supplies, the maximum is based on 82 percent of AWP plus a $1.00 Dispensing Fee.

It is further provided, however, that if either: 1) a national drug database then used by BCBSF makes a “material modification” to its AWP data (as determined by BCBSF), or; 2) BCBSF elects to utilize a new national drug database, BCBSF may modify the 33 percent of AWP figure and/or the 82 percent of AWP figure set out above so that the applicable modified figure sets out a replacement percent figure that is between: 1) the percent figure calculated to approximate the applicable Non-Participating Pharmacy Allowance in effect immediately prior to the applicable AWP database change, and; 2) the 33 percent of AWP figure or the 82 percent of AWP figure, whichever is applicable.

One-Month Supply means a Maximum quantity per Prescription, up to a 30-day supply as defined by the Drug manufacturer's dosing recommendations. 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 a Participating Pharmacy Provider Agreement with us to participate in the BlueScript Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

Participating Pharmacy Allowance means the maximum amount allowed to be charged by a Participating Pharmacy per Prescription for a Covered Prescription Drug or Covered Prescription Supply under this Endorsement.

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 a network and/or programs available to you.

Pharmacy Deductible means, when applicable, the amount of allowed charges for Covered Prescription Drugs and Supplies and Covered OTC Drugs that you must actually pay per Benefit Period, in addition to any applicable Copayment or percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, as applicable, to a Pharmacy, who is recognized for payment under this Endorsement, before our payment for Covered Prescription Drugs and Supplies and OTC Drugs begins.

Pharmacy Out-of-Pocket Maximum means the maximum amount you will be required to pay per Benefit Period for Covered Prescription Drugs and Supplies and OTC Drugs. Any benefit penalty reductions, non-covered charges or any charges in excess of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance will not accumulate toward the pharmacy out-of-pocket maximum.

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

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". For purposes of this Endorsement, insulin is considered a Prescription Drug because, in order to be covered hereunder, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

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 BlueScript 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.

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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and Chief Executive Officer

BlueOptions Bone Marrow Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueOptions Benefit Booklet, BlueOptions Hospital and Surgical Coverage Benefit Booklet and BlueOptions with Integrated Prescription Drug Coverage Benefit Booklet (herein “Benefit Booklet”), including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

The “Definitions” section is amended as follows:

The **Bone Marrow Transplant** definition is deleted in its entirety and replaced with the following:

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary Services).

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions 2008 Omnibus Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueOptions Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

This Endorsement is effective upon receipt unless specifically stated otherwise within this Endorsement.

The "What Is Covered?" section is amended as follows:

The **Orthotic Devices** category is amended by deleting the **Exclusion** provision in its entirety and replacing it with the following:

Exclusion:

1. Expenses for arch supports**,** shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease;
2. Expenses for orthotic appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g. dynamic orthotic cranioplasty or molding helmets) except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and
3. Expenses for devices necessary to exercise, train, or participate in sports, e.g. custom-made knee braces.

The **Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulation Services** category is amended as follows:

The **Payment Guidelines for Physical and Massage Therapy** subsection is deleted in its entirety and replaced with the following:

Payment Guidelines for Massage and Physical Therapy

a. Payment for covered Massage Services is limited to no more than four (4) 15-minute Massage treatments per day, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.

b. Payment for a combination of covered Massage and Physical Therapy Services rendered on the same day is limited to no more than four (4) 15-minute treatments per day for combined Massage and Physical Therapy treatment, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.

c. Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day not to exceed fifteen (15) minutes in length.

The **Payment Guidelines for Spinal Manipulations** subsection is deleted in its entirety and replaced with the following:

Payment Guidelines for Spinal Manipulation

a. Payment for spinal manipulation is limited to no more than 26 spinal manipulations per Calendar Year, **or** the maximum benefit listed in the Schedule of Benefits, whichever occurs first.

b. Payment for Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day, not to exceed fifteen (15) minutes in length.

The Schedule of Benefits sets forth the maximum dollar amount that we will pay for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, even if you may have only been administered two (2) of your spinal manipulations for the Calendar Year, any additional spinal manipulations for that Calendar Year will not be covered if you have already met the combined therapy dollar maximum with other Services.

The second to the last paragraph of the **Preventive Child Health Supervision Services** category is deleted in its entirety and replaced with the following:

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics, the U.S. Preventive Services Task Force, or the Advisory Committee on Immunization Practices established under the Public Health Service Act.

The "BlueScript® Pharmacy Program" section is amended as follows:

The **BlueScript® Pharmacy Program Limitations and Exclusions** subsection is amended by deleting items 7j and 11 in their entirety and replacing them with the following under **Exclusions**:

7. Prescription Drugs and Supplies and OTC Drugs that are:

   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.

11. Drugs prescribed for uses other than the Food and Drug Administration (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 your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

The "What Is Not Covered?" section is amended as follows:

The **Introduction** paragraph is deleted in its entirety and replaced with the following:

Your Booklet expressly excludes expenses for the following Health Care Services, supplies, Drugs or charges. The following exclusions are in addition to any exclusions specified in the "What Is Covered?" and "BlueScript® Pharmacy Program" sections or any other section of the Booklet.

The **Drugs** exclusion is amended by deleting item numbers one and four in their entirety and replacing them with the following:

1. Prescribed for uses other than the Food and Drug Administration (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 your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
4. Any Drug which is indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction Drugs excluded under this paragraph.

The **Experimental or Investigational Services** exclusion is deleted in its entirety and replaced with the following:

Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category.

The exclusion titled **General Exclusions** is amended by adding the following to item number seven:

f) Services that are not patient-specific, as determined solely by us.

The following exclusions are added:

Immunizations except those covered under the Preventive Child Health Supervision Services or Preventive Adult Wellness Services categories of the "What Is Covered?" section.

Oversight of a medical laboratory by a Physician or other health care Provider. "Oversight" as used in this exclusion shall, include, but is not limited to, the oversight of:

1. the laboratory to assure timeliness, reliability, and/or usefulness of test results;
2. the calibration of laboratory machines or testing of laboratory equipment;
3. the preparation, review or updating of any protocol or procedure created or reviewed by a Physician or other health care Provider in connection with the operation of the laboratory; and
4. laboratory equipment or laboratory personnel for any reason.

Prescription Drug Copayments, Coinsurance and Deductibles, or any part thereof, you are obligated to pay under any plan or policy.

The "Blueprint for Health Programs" section is amended as follows:

The **Inpatient Facility Program** subsection is amended by deleting the **Provider Focused Utilization Management Program** provision in its entirety and replacing it with the following:

Certain NetworkBlue Providers have agreed to participate in our focused utilization management program. This pre-service review program is intended to promote the efficient delivery of medically appropriate Health Care Services by NetworkBlue Providers. Under this program we may perform focused prospective reviews of all or specific Health Care Services proposed for you. In order to perform the review, we may require the Provider to submit to us specific medical information relating to Health Care Services proposed for you. These NetworkBlue Providers have agreed not to bill, or collect, any payment whatsoever from you or us, or any other person or entity, with respect to a specific Health Care Service if:

1. they fail to submit the Health Care Service for a focused prospective review when required under the terms of their agreement with us; **or**
2. we perform a focused review under the focused utilization management program and we determine that a Health Care Service is not Medically Necessary in accordance with our Medical Necessity criteria or inconsistent with our benefit guidelines then in effect unless the following exception applies.

Exception for Certain NetworkBlue Physicians

Certain NetworkBlue Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.) only may bill you for Services determined to be not Medically Necessary by BCBSF under this focused utilization management program if, **before** you receive the Service:

a. they give you a written estimate of your financial obligation for the Service;
b. they specifically identify the proposed Service that BCBSF has determined not to be Medically Necessary; and
c. you agree to assume financial responsibility for such Service.

The "Duplication of Coverage Under Other Health Plans/Programs" section is amended as follows:

The following exclusion is added:

Coordination of Benefits Exclusion

Prescription Drug Copayments, Coinsurance and Deductibles, or any part thereof, you are obligated to pay under any plan or policy.

The "Claims Processing" section is amended as follows:

The **How to Appeal an Adverse Benefit Determination** subsection is amended as follows:

The first paragraph is deleted in its entirety and replaced with the following:

Except as described below, only you, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using the review process described below. Your appeal must be submitted to us in writing for an internal appeal within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

The third guideline is deleted in its entirety and replaced with the following:

- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request, free of charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this Benefit Booklet to your medical circumstances;

The following guidelines are added:

- If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.bcbsfl.com or by calling the number on the back of your BCBSF ID Card.
- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service, or the Experimental or Investigational nature of a Service, you have the right to an independent external review through the External Review Organization designated in the How to Request External Review of Our Appeal Decision subsection of this section. Your right to an External Review applies only when the Service is actually rendered by Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.).

The **How to Appeal an Adverse Benefit Determination** subsection is further amended by replacing the address information with the following:

Requests for an internal appeal should be sent to the address below:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Member Appeals
P.O. Box 44197
Jacksonville, Florida 32231-4197

Effective **April 21, 2009**, the following subsection is added at the end of the **How to Appeal an Adverse Benefit Determination** subsection.

How to Request External Review of Our Appeal Decision

If you are not satisfied with our internal review of your appeal of an Adverse Benefit Determination based on the lack of Medical Necessity or Experimental or Investigational nature of a Service you received from Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.), you may appeal our decision through an External Review Organization. Our denial letter will provide information regarding this External Review Organization.

Only Adverse Benefit Determinations based on the lack of Medical Necessity or Experimental or Investigational nature of a Service you actually received will be reviewed by the External Review Organization.

The External Review Organization's determination with respect to your appeal shall be binding upon you, your Physician, and us.

The "Definitions" section is amended as follows:

The term "reliable evidence" shall be replaced with the words "credible scientific evidence" in the definition of **Experimental or Investigational.**

The definition of **Allowed Amount** is amended as follows:

Subparagraph number five is deleted in its entirety and replaced with the following:

5. In the case of an Out-of-Network Provider that has not entered into an agreement with

BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by BCBSF that may be based on several factors including (but not necessarily limited to): (i) payment for such Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that BCBSF determines are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by BCBSF, with BCBSF's provider network strategies (e.g., does not result in payment that encourages Providers participating in a BCBSF network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard (Out-of-State) Program, the Allowed Amount for the specific Covered Services provided to you may be based upon the amount provided to BCBSF by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay non-participating Providers in its geographic area for such Services.

The following paragraph is added at the end of the definition of **Allowed Amount**:

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider, the Allowed Amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services. You will be responsible for any difference between such Allowed Amount and the amount billed for such Services by any such Out-of-Network Provider.

The following definitions are deleted in their entirety and replaced with the following:

Medically Necessary or **Medical Necessity** means that, with respect to a Health Care Service, a Physician, exercising prudent clinical judgment, provided the Health Care Service to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that the Health Care Service was:

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease; and
3. not primarily for your convenience, or that of your Physician or other health care Provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness.

Note: It is important to remember that any review of Medical Necessity by us is solely for the purpose of determining coverage or benefits

under this Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Booklet as determined by us. In applying the definition of Medical Necessity in this Booklet, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM) or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

The following definitions are added:

External Review Organization means an external organization that is chosen by BCBSF in its sole discretion to conduct external reviews as described herein.

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Physician Specialty Society means a United States medical specialty society that represents diplomates certified by a board recognized by the American Board of Medical Specialties.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Mental Health Services Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

This Endorsement is effective upon your Group's next renewal, which occurs on or after 10/15/09.

What is Covered?

The **Mental Health Services** subsection is amended as follows:

The second paragraph is deleted in its entirety and replaced with the following:

Partial Hospitalization is a Covered Service when provided under the direction of a Physician and in lieu of inpatient hospitalization.

Blueprint for Health Programs

The following new subsection is added:

Prior Coverage Authorization/Pre-Service Notification Programs for Mental Health Services

You or your Physician will be required to obtain prior coverage authorization from us for Mental Health Services.

In-Network Providers

It is the In-Network Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore you will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

Once we have received the necessary medical documentation from the Provider, we will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. The Provider will be notified of the prior coverage authorization decision.

Out-of-Network Providers

It is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network Provider **before** Mental Health Services are provided. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Services**.

For additional details on how to obtain prior coverage authorization for Mental Health Services, please call the customer service phone number on the back of your ID Card.

Once the necessary medical documentation has been received from you and/or the Out-of-Network Provider, BCBSF will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

See the "Claims Processing" section for information on what you can do if prior coverage authorization is denied.

Note: Prior coverage authorization is not required when Covered Services are provided for the treatment of a Medical Emergency.

Definitions

The following definition is added:

Medical Emergency means the sudden and unexpected onset of a medical or psychiatric Condition or an injury that in the absence of medical care could reasonably be expected to endanger your life or result in serious injury or disability.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Autism Spectrum Disorder Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

This Endorsement is effective upon your Group's renewal, which occurs on or after 4/1/09.

Schedule of Benefits

The Schedule of Benefits is amended to the following benefit maximums:

Autism Spectrum Disorder Services

Per BP……..$36,000
Per Lifetime……...$200,000

What Is Covered?

The **What is Covered?** section of the Benefit Booklet is amended as follows:

The following new subsection is added:

Autism Spectrum Disorder

Autism Spectrum Disorder Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by an individual certified pursuant to Section 393.17 of the *Florida Statutes* or licensed under Chapters 490 or 491 of the *Florida Statutes*; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Guidelines for Autism Spectrum Disorder

1. All Covered Services for Autism Spectrum Disorder will be applied to the Benefit Period and lifetime benefit maximums for Autism Spectrum Disorder Services indicated in your Schedule of Benefits.
2. Upon your Group's renewal, which occurs on or after 10/15/09, the Applied Behavior Analysis Services outlined in paragraph two above will continue to be eligible for coverage once the Benefit Period and/or lifetime benefit maximums for Autism Spectrum Disorder have been met, up to the Total Lifetime Maximum Benefit or Benefit Period maximum, when applicable, set forth in your Schedule of Benefits.
3. The covered therapies provided in the treatment of Autism Spectrum Disorder outlined in paragraph three above will be applied to the Benefit Period and lifetime benefit maximums for Autism Spectrum Disorder **and**

   the Outpatient Therapies Benefit Period maximum set forth in your Schedule of Benefits. Once the lifetime benefit maximum for Autism Spectrum Disorder has been met,

there will be no coverage for therapies described in paragraph three above.

Exclusion:

Any Services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this section.

Note: In order to determine whether Autism Spectrum Disorder Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

You or your Physician will be required to obtain prior coverage authorization from us for Autism Spectrum Disorder Services before such Services are rendered. Refer to the "Blueprint for Health Programs" section of this Booklet for additional information.

The **Mental Health Services** subsection is amended as follows:

Exclusion #7 is deleted in its entirety and replaced with the following:

7. Services for testing of aptitude, ability, intelligence or interest except as covered under the Autism Spectrum Disorder subsection;

Blueprint for Health Programs

The following new subsection is added:

Prior Coverage Authorization/Pre-Service Notification Programs for Autism Spectrum Disorder

You or your Physician will be required to obtain prior coverage authorization from us for Autism Spectrum Disorder Services.

In-Network Providers

It is the In-Network Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore you will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

Once we have received the necessary medical documentation from the Provider, we will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. The Provider will be notified of the prior coverage authorization decision.

Out-of-Network Providers

It is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network Provider **before** Autism Spectrum Disorder Services are provided. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Services**.

Once the necessary medical documentation has been received from you and/or the Provider, BCBSF will review the information and make a prior coverage authorization decision, based on BCBSF's established criteria then in effect. You will be notified of the prior coverage authorization decision.

For additional details on how to obtain prior coverage authorization for Autism Spectrum Disorder Services please call the customer service phone number on the back of your ID Card.

See the "Claims Processing" section for information on what to do if prior coverage authorization is denied.

Note: Prior coverage authorization is not required when Covered Services are provided for the treatment of a Medical Emergency.

Definitions

The **Definitions** section is amended by adding the following terms:

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;
2. Asperger's syndrome;
3. Pervasive developmental disorder not otherwise specified; and
4. Childhood Disintegrative Disorder.

Medical Emergency means the sudden and unexpected onset of a medical or psychiatric Condition or an injury that in the absence of medical care could reasonably be expected to endanger your life or result in serious injury or disability.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Substance Dependency Care and Treatment Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

This Endorsement is effective upon your Group's next renewal, which occurs on or after 10/15/09.

What is Covered?

The **Substance Dependency Care and Treatment** subsection is amended by deleting item #2 in its entirety and replacing it with the following:

2. Physician, Psychologist and Mental Health Professional outpatient visits for the care and treatment of Substance Dependency.

Blueprint for Health Programs

The following new subsection is added:

Prior Coverage Authorization/Pre-Service Notification Programs for Substance Dependency Care and Treatment

You or your Physician will be required to obtain prior coverage authorization from us for Substance Dependency Care and Treatment.

In-Network Providers

It is the In-Network Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore you will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

Once we have received the necessary medical documentation from the Provider, we will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. The Provider will be notified of the prior coverage authorization decision.

Out-of-Network Providers

It is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network Provider **before** Substance Dependency Care and Treatment Services are provided. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Services**.

For additional details on how to obtain prior coverage authorization for Substance Dependency Care and Treatment, please call the customer service phone number on the back of your ID Card.

Once the necessary medical documentation has been received from you and/or the Out-of-Network Provider, BCBSF will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

See the "Claims Processing" section for information on what you can do if prior coverage authorization is denied.

Note: Prior coverage authorization is not required when Covered Services are provided for the treatment of a Medical Emergency.

Definitions

The following definition is added:

Medical Emergency means the sudden and unexpected onset of a medical or psychiatric Condition or an injury that in the absence of medical care could reasonably be expected to endanger your life or result in serious injury or disability.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Special Enrollment Period Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below.

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

References to the "State Children's Health Insurance Program (S-CHIP)" in your Benefit Booklet are hereby changed to "Children's Health Insurance Program (CHIP)."

The **Enrollment and Effective Date of Coverage** section is amended by deleting the "Special Enrollment Period" subsection in its entirety and replacing it with the following:

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependent(s) must complete the applicable Enrollment Form and forward it to the Group within the time periods noted below for each special enrollment event.

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage if one of the following special enrollment events occurs and the applicable Enrollment Form is submitted to the Group within the indicated time periods:

1. If you lose your coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance (except in the case of loss of coverage under a Children's Health Insurance Program (CHIP) or Medicaid, see #3 below), or COBRA continuation coverage that you were covered under at the time of initial enrollment provided that:

   a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and

   b) you lost your other coverage under a group health benefit plan or health insurance coverage (except in the case of loss of coverage under a CHIP or Medicaid, see #3 below) as a result of termination of employment, reduction in the number of hours you work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated; and

   c) you submit the applicable Enrollment Form to the Group within 30 days of the date your coverage was terminated

   Note: Loss of coverage for failure to pay your portion of the required Premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

   or

2. If when offered coverage under this plan at the time of initial eligibility, you stated, in

writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption and you submit the applicable Enrollment Form to the Group within 30 days of the date of the event.

or

3. If you or your Eligible Dependent(s) lose coverage under a CHIP or Medicaid due to loss of eligibility for such coverage or become eligible for the optional state premium assistance program and you submit the applicable Enrollment Form to the Group within 60 days of the date such coverage was terminated or the date you become eligible for the optional state premium assistance program.

The Effective Date of coverage for you and your Eligible Dependents added as a result of a special enrollment event is the date of the special enrollment event. Eligible Employees who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Employee).

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Prior Coverage Authorization and Eligibility Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions with Integrated Prescription Drug Coverage Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

This Endorsement is effective upon your Group's renewal, which occurs on or after 10/15/09.

Blueprint for Health Programs

Prior Coverage Authorization/Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these requirements and ultimately how much you are responsible for paying under this Benefit Booklet.

You or your Physician will be required to obtain prior coverage authorization from us for:

1. certain **Provider-administered Drugs**, as denoted with a special symbol in the Medication Guide;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging; and
3. **other Health Care Services** that are or may become subject to a prior coverage authorization program or a pre-service notification program as defined and administered by us.

Prior coverage authorization requirements vary, depending on whether Services are rendered by an In-Network Provider or an Out-of-Network Provider, as described below:

In-Network Providers

It is the In-Network Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore you will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

Once we have received the necessary medical documentation from the Provider, we will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. The Provider will be notified of the prior coverage authorization decision.

Out-of-Network Providers

1. In the case of **Provider-administered Drugs**, it is your sole responsibility to comply with our prior coverage authorization requirements when you use an Out-of-Network Provider **before** the Drug is purchased or administered. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Drug, including any Service related to the Drug or its administration.**

   For additional details on how to obtain prior coverage authorization, and for a list of Provider-administered Drugs that require prior coverage authorization, please refer to the Medication Guide.

2. In the case of **advanced diagnostic imaging Services** such as CT scans, MRIs,

MRA and nuclear imaging, it is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network Provider **before** the advanced diagnostic imaging Services are provided. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Services**.

For additional details on how to obtain prior coverage authorization for advanced diagnostic imaging Services, please call the customer service phone number on the back of your ID Card.

3. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, it is your sole responsibility to comply with our prior coverage authorization or pre-service notification requirements when rendered or referred by an Out-of-Network Provider, **before** the Services are provided. **Failure to obtain prior coverage authorization or provide pre-service notification may result in denial of the claim or application of a financial penalty assessed at the time the claim is presented for payment to us.** The penalty applied will be the lesser of $500 or 20% of the total Allowed Amount of the claim. The decision to apply a penalty or deny the claim will be made uniformly and will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

Once the necessary medical documentation has been received from you and/or the Out-of-Network Provider, BCBSF or a designated vendor, will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

BCBSF will provide you information for any Out-of-Network Health Care Service subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service not already listed here. This information will be provided to you upon enrollment, or at least 30 days prior to such Out-of-Network Services becoming subject to a prior coverage authorization or pre-service notification program.

See the "Claims Processing" section for information on what you can do if prior coverage authorization is denied.

Note: Prior coverage authorization is not required when Covered Services are provided for the treatment of a Medical Emergency

Eligibility for Coverage

The following paragraph is added at the end of the **Eligibility Requirements for Dependent(s)** subsection:

Exception for Students on Medical Leave of Absence from School

A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a physician certified medically necessary leave of absence from school, will still be considered a student for eligibility purposes under this Booklet for the earlier of 12 months from the first day of the leave of absence or the date the Covered Dependent would otherwise no longer be eligible for coverage under this Booklet.

Definitions

The following definition is added:

Medical Emergency means the sudden and unexpected onset of a medical or psychiatric Condition or an injury that in the absence of medical care could reasonably be expected to endanger your life or result in serious injury or disability.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Hospital Per Admission Deductible Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

Understanding Your Share of Health Care Expenses

The **Understanding Your Share of Health Care Expenses** section is amended by adding the following new subsection:

Hospital Per Admission Deductible

The Hospital per admission Deductible, when applicable to your plan, must be satisfied by each you for each Hospital admission before any payment will be made by us for any claim for inpatient Services. The Hospital per admission Deductible applies regardless of the reason for the admission, is in addition to the Deductible requirement, and applies to all Hospital admissions in or outside the State of Florida.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Product Enhancement Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions Benefit Booklet including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

This Endorsement is effective beginning **January 1, 2010** and effective on your plan's first Anniversary Date occurring after this date.

All references to the terms or phrases in the chart below are changed as indicated throughout the Benefit Booklet:

Current	New
Calendar Year Deductible	Deductible
Calendar Year Coinsurance	Coinsurance
Per person per Calendar Year	Per person per Benefit Period
Calendar Year maximums	Benefit Period maximums

What Is Covered?

The **Introduction** subsection is amended as follows:

The second to the last paragraph is deleted in its entirety and replaced with the following:

We will determine whether Services are Covered Services under this Booklet after you have obtained the Services and we have received a claim for the Services.

In some circumstances we may determine whether Services might be Covered Services under this Booklet before such Services are rendered. For example, we may determine whether a proposed transplant would be a Covered Service under this Booklet before the transplant is provided. We are not obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service unless we have specifically designated that a Service is subject to a prior authorization requirement as described in the "Blueprint for Health Programs" section. We are also not obligated to cover or pay for any Service that has not actually been rendered to you.

The **Ambulatory Surgical Centers** category is amended as follows:

Item number seven is deleted in its entirety and replaced with the following:

7. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);

The **Hospital Services** category is amended as follows:

Item number eight is deleted in its entirety and replaced with the following:

8. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);

The **Maternity Services** category is amended by adding the following paragraph before the exclusion:

Under Federal law, your Group Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the

mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your Group Plan can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

The following **Covered Service Category** is added:

Medical Pharmacy

Physician-administered Prescription Drugs which are rendered in a Physician's office are subject to a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to the Prescription Drug and does not include the administration of the Prescription Drug.

Your plan may also include a maximum monthly amount you will be required to pay out-of-pocket for Medical Pharmacy, when such Services are provided by an In-Network Provider or Specialty Pharmacy. If your plan includes a Medical Pharmacy out-of-pocket monthly maximum, it will be listed on your Schedule of Benefits and only applies after you have met your Deductible, if applicable.

Please refer to your Schedule of Benefits for the additional Cost Share amount and/or monthly maximum out-of-pocket applicable to Medical Pharmacy for your plan.

Note: For purposes of this benefit, allergy injections and immunizations are not considered Medical Pharmacy.

The **Newborn Care** category is amended by adding the following paragraph at the end of the category:

Under Federal law, your Group Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your Group Plan can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

The **Self-Administered Injectable Prescription Drug** category is deleted in its entirety and replaced with the following:

Self-Administered Prescription Drugs

The following Self-Administered Drugs are covered:

1. Self-Administered Prescription Drugs used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis; and
2. Self-Administered Prescription Drugs identified as Specialty Drugs with a special symbol in the Medication Guide when delivered to you at home and purchased at a Specialty Pharmacy or an Out-of-Network Provider that provides Specialty Drugs; and
3. Specialty Drugs used to increase height or bone growth (e.g., growth hormone), must meet the following criteria in order to be covered:

a. Must be prescribed 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.

b. Continuation of growth hormone therapy only covered 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.

The **Skilled Nursing Facilities** category is amended as follows:

Item number five is deleted in its entirety and replaced with the following:

5. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the "What Is Not Covered?" section);

The **Surgical Assistant Services** category is amended by deleting the following in its entirety:

Payment Guidelines for Surgical Assistant Services

The Allowed Amount for surgical assistant Services is limited to 20 percent of the Allowed Amount for the surgical procedure.

What Is Not Covered?

The **Drugs** exclusion is amended as follows:

Exclusion numbers two and five are deleted in their entirety and replaced with the following:

2. All drugs dispensed to, or purchased by, you from a pharmacy. This exclusion does not apply to drugs dispensed to you when:

   a. you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;

   b. you are in the outpatient department of a Hospital;

   c. dispensed to your Physician for administration to you in the Physician's office and prior coverage authorization has been obtained (if required);

   d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit; and

   e. defined by, and covered under, a BCBSF Pharmacy Program Endorsement to this Booklet.

5. Any Self-Administered Prescription Drug except when indicated as covered in the "What Is Covered?" section of this Benefit Booklet.

The following **exclusions** are added:

6. Blood or blood products used to treat hemophilia, except when provided to you for:

   a. emergency stabilization;

   b. during a covered inpatient stay, or

   c. when proximately related to a surgical procedure.

   The exceptions to the exclusion for drugs purchased or dispensed by a pharmacy described in subparagraph number two do not apply to hemophilia drugs excluded under this subparagraph.

7. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.

8. Specialty 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. (See "What Is Covered?" section for additional information.)

Understanding Your Share of Health Care Expenses

The **Calendar Year Deductible** subsection is deleted in its entirety and replaced with the following:

Deductible Requirement

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by us. Only those charges indicated on claims we receive for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount. Please see your Schedule of Benefits for more information.

Family Deductible

If your plan includes a family Deductible, after the family Deductible has been met by your family, neither you nor your Covered Dependents will have any additional Deductible responsibility for the remainder of that Benefit Period. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible, if applicable, is the amount applied toward the individual Deductible. Please see your Schedule of Benefits for more information.

The **Copayment Requirements** subsection is amended by deleting number one in its entirety and replacing it with the following:

1. Office Services Copayment

   If your plan is a Copayment plan, the Copayment for Covered Services rendered in the office must be paid by you, for each office visit before any payment will be made by us. The office Services Copayment applies regardless of the reason for the

office visit and applies to all Covered Services rendered during that visit, with the exception of Durable Medical Equipment, Medical Pharmacy, Orthotics and Prosthetics, which may require Cost Share amounts in addition to the Office Services Copayment, as set forth on your Schedule of Benefits.

The **Out-of-Pocket Calendar Year Maximums** subsection is deleted in its entirety and replaced with the following:

Out-of-Pocket Maximums

Individual out-of-pocket maximum

Once you have reached the individual out-of-pocket maximum amount listed in the Schedule of Benefits, you will have no additional out-of-pocket responsibility for the remainder of that Benefit Period and we will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period.

Family out-of-pocket maximum

If your plan includes a family out-of-pocket maximum, once your family has reached the family out-of-pocket maximum amount listed in the Schedule of Benefits, neither you nor your covered family members will have any additional out-of-pocket responsibility for the remainder of that Benefit Period and we will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period. The maximum amount any one Covered Person in your family can contribute toward the family out-of-pocket maximum, if applicable, is the amount applied toward the individual out-of-pocket maximum. Please see your Schedule of Benefits for more information.

Note: The Deductible, any applicable Copayments and Coinsurance amounts will accumulate toward the out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate toward the out-of-pocket maximums. If the Group has purchased Prescription Drug coverage, any applicable Cost Share under the Prescription Drug coverage, will not apply to the Deductible or the out-of-pocket maximums under this Booklet.

The **Prior Coverage Credit** subsection is deleted in its entirety and replaced with the following:

Prior Coverage Credit

We will give you credit for the satisfaction or partial satisfaction of any Deductible and Coinsurance maximums met by you under a prior group insurance, blanket insurance, franchise insurance or group Health Maintenance Organization (HMO) policy maintained by the Group if the Group Master Policy replaces such policy. This provision only applies if the prior group insurance, blanket insurance, franchise insurance or HMO coverage purchased by the Group was in effect immediately preceding the Effective Date of this Group policy. This provision is only applicable for you during the initial Benefit Period of coverage under the Group Master Policy and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage under the Group Master Policy only, charges credited by the Group's prior insurer, toward your Deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of the Group Master Policy, will be credited to the Deductible requirement under this Booklet.

Prior Coverage Credit for Coinsurance

Charges credited by the Group's prior insurer, toward your Coinsurance maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of the Group

Master Policy, will be credited to your out-of-pocket maximum under this Booklet.

Prior coverage credit toward the Deductible or out-of-pocket maximums will only be given for Health Care Services, which would have been Covered Services under this Booklet.

Prior coverage credit under this Booklet only applies at the initial enrollment of the entire Group. You and/or the Group are responsible for providing us with any information necessary for us to apply this prior coverage credit.

The **How We Will Credit Calendar Year Benefit Maximums and the Total Maximum Benefit Per Person** subsection is amended as follows:

The subsection title is hereby changed to:

"How we will Credit Benefit Maximums"

Physicians, Hospitals and Other Provider Options

The following subsection is added after the **Hospitals** subsection:

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 the Specialty Pharmacy to provide these Specialty Drugs, if applicable on your plan, should lower the amount you have to pay for these medications, while helping to preserve your benefits. Please refer to the Medication Guide for a list of Specialty Pharmacies.

Blueprint for Health Programs

The **Inpatient Facility Program** subsection is amended by deleting the first paragraph it its entirety and replacing it with the following:

Under the inpatient facility program, we may review Hospital stays, Hospice, Inpatient Rehabilitation, LTAC and Skilled Nursing Facility (SNF) Services, and other Health Care Services rendered during the course of an inpatient stay or treatment program. We may conduct this review while you are inpatient, after your discharge, or as part of a review of an episode of care when you are transferred from one level of inpatient care to another for ongoing treatment. The review is conducted solely to determine whether we should provide coverage and/or payment for a particular admission or Health Care Services rendered during that admission. Using our established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals, including in advance of a transfer from one inpatient facility to another. We will provide notification to your Physician when inpatient coverage criteria are no longer met. In administering the inpatient facility program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Benefit Booklet and not for the purpose of recommending or providing medical care.

The following subsection, added to your Benefit Booklet with Endorsement 24200 0709 BCA, is deleted in its entirety and replaced with the following:

Prior Coverage Authorization/Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these requirements and ultimately how much you are responsible for paying under this Benefit Booklet.

You or your Provider will be required to obtain prior coverage authorization from us for:

1. certain **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging; and
3. **other Health Care Services** that are or may become subject to a prior coverage authorization program or a pre-service notification program as defined and administered by us.

Prior coverage authorization requirements vary, depending on whether Services are rendered by an In-Network Provider or an Out-of-Network Provider, as described below:

In-Network Providers

It is the In-Network Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore you will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

Once we have received the necessary medical documentation from the Provider, we will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. The Provider will be notified of the prior coverage authorization decision.

Out-of-Network Providers

1. In the case of **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization, it is your sole responsibility to comply with our prior coverage authorization requirements when you use an Out-of-Network Provider **before** the Prescription Drug is purchased or administered. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Prescription Drug, including any Service related to the Prescription Drug or its administration.**

   Exception: Self-Administered Prescription Drugs, identified as Specialty Drugs with a special symbol in the Medication Guide, do not require prior authorization when purchased from an Out-of-Network Provider for delivery to you at home.

   For additional details on how to obtain prior coverage authorization, and for a list of Prescription Drugs that require prior coverage authorization, please refer to the Medication Guide.

2. In the case of **advanced diagnostic imaging Services** such as CT scans, MRIs, MRA and nuclear imaging, it is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network Provider **before** the advanced diagnostic imaging Services are provided.

Your failure to obtain prior coverage authorization will result in denial of coverage for such Services.

For additional details on how to obtain prior coverage authorization for advanced diagnostic imaging Services, please call the customer service phone number on the back of your ID Card.

3. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, it is your sole responsibility to comply with our prior coverage authorization or pre-service notification requirements when rendered or referred by an Out-of-Network Provider, **before** the Services are provided. **Failure to obtain prior coverage authorization or provide pre-service notification may result in denial of the claim or application of a financial penalty assessed at the time the claim is presented for payment to us.** The penalty applied will be the lesser of $500 or 20% of the total Allowed Amount of the claim. The decision to apply a penalty or deny the claim will be made uniformly and will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

Once the necessary medical documentation has been received from you and/or the Out-of-Network Provider, BCBSF or a designated vendor, will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

BCBSF will provide you information for any Out-of-Network Health Care Service subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service not already listed here. This information will be provided to you upon enrollment, or at least 30 days prior to such Out-of-Network Services becoming subject to a prior coverage authorization or pre-service notification program.

See the "Claims Processing" section for information on what you can do if prior coverage authorization is denied.

Note: Prior coverage authorization is not required when Covered Services are provided for the treatment of a Medical Emergency.

Eligibility for Coverage

The following paragraph is added at the end of the **Eligibility Requirements for Dependent(s)** subsection:

Exception for Students on Medical Leave of Absence from School

A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a physician certified medically necessary leave of absence from school, will still be considered a student for eligibility purposes under this Booklet for the earlier of 12 months from the first day of the leave of absence or the date the Covered Dependent would otherwise no longer be eligible for coverage under this Booklet.

Termination of Coverage

The following sentence is added to the third paragraph of the **Certification of Creditable Coverage** subsection:

You may call the call the customer service phone number indicated in this Booklet or on your ID Card to request the certification.

General Provisions

The following **subsection** is added:

Customer Rewards Programs

From time to time, we may offer programs to our customers that provide rewards for following the terms of the program. We will tell you about any available rewards programs in general mailings, member newsletters and/or on our website. Your participation in these programs is completely voluntary and will in no way affect the coverage available to you under this Benefit Booklet. We reserve the right to offer rewards in excess of $25 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Definitions

The following definitions are added:

Benefit Period means a consecutive period of time, specified by BCBSF and the Group, in which benefits accumulate toward the satisfaction of Deductibles, out-of-pocket maximums and any applicable benefit maximums. Your Benefit Period is listed on your Schedule of Benefits, and will not be less than 12 months unless indicated as such.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by you at the time Covered Services are rendered by that Provider. Cost Share may include, but is not limited to Coinsurance, Copayment, Deductible and/or Per Admission Deductible (PAD) amounts. Applicable Cost Share amounts are identified in your Schedule of Benefits.

FDA means the United States Food and Drug Administration.

Medical Emergency means the sudden and unexpected onset of a medical or psychiatric Condition or an injury that in the absence of medical care could reasonably be expected to endanger your life or result in serious injury or disability.

Medication Guide for the purpose of this Benefit Booklet means the guide then in effect issued by us where you may find information about Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan.

Note: The Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service phone number on your Identification Card for current information.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed with 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".

Specialty Drug means an FDA-approved Prescription Drug that has been designated, solely by us, as a Specialty Drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty Drugs may be Provider administered or self-administered and 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 provide specific Prescription Drug products, as determined by us. In-Network Specialty Pharmacies are listed in the Medication Guide.

The fact that a pharmacy is a participating pharmacy does not mean that it is a Specialty Pharmacy.

The definition of **Self-Administered Injectable Prescription Drug** is deleted in its entirety and replaced with the following:

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

24736 0910 BCA
BlueOptions II LG

BlueOptions Dependent Eligibility Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueOptions Benefit Booklet, BlueOptions Hospital and Surgical Coverage Benefit Booklet and BlueOptions with Integrated Prescription Drug Coverage Benefit Booklet (herein "Benefit Booklet"), including any Endorsements attached thereto. The Benefit Booklet is amended as described below:

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

This Endorsement is effective at the group plan's initial effective date or first Anniversary occurring on or after **October 1, 2010** whichever occurs first.

Eligibility for Coverage

The **Eligibility Requirements for Dependent(s)** subsection is deleted in its entirety and replaced with the following:

Eligibility Requirements for Dependents

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this Booklet:

1. The Covered Employee's spouse under a legally valid existing marriage;
2. The Covered Employee's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 30 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Employee, whether the dependent child resides with the Covered Employee, or whether the dependent child is eligible for or enrolled in any other health plan.
3. The newborn child of a Covered Dependent child**.** Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is the Covered Employee's sole responsibility to establish that a child meets the applicable requirements for eligibility.

Handicapped Children

In the case of a handicapped dependent child, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 30, if the child is:

1. otherwise eligible for coverage under the Group Plan;
2. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
3. chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 30th birthday.

This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a handicapped child.

Enrollment and Effective Date of Coverage

The **Dependent Enrollment** subsection is amended by deleting the note at the end of the Newborn Child subsection in its entirety and replacing it with the following:

Note: Coverage for a newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 30 will automatically terminate 18 months after the birth of the newborn child.

Termination of Coverage

The **Termination of a Covered Dependent's Coverage** subsection is deleted in its entirety and replaced with the following:

A Covered Dependent's coverage will automatically terminate

1. at 12:01 a.m. on the date the Group Master Policy terminates;
2. at 12:01 a.m. on the date the Covered Employee's coverage terminates for any reason;
3. If the Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
4. The last day of the Calendar Year that the Covered Dependent child no longer meets any of the applicable eligibility requirements;
5. the Dependent's coverage is terminated for cause (see the Termination of Individual Coverage for Cause subsection).

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of your Blue Cross and Blue Shield of Florida, Inc. BlueOptions Benefit Booklet including any Endorsements attached thereto. If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE. The Benefit Booklet is amended as described below to comply with the Patient Protection and Affordable Care Act (PPACA), H.R. 3590, otherwise known as the Affordable Care Act.

This Endorsement is effective at your group plan's initial effective date or first Anniversary Date occurring on or after **September 23, 2010** whichever occurs first.

All references to the term **Emergency Services and Care** are changed to **Emergency Services** throughout the Benefit Booklet. Additionally, all references to the term **Medical Emergency** are changes to **Emergency Medical Condition.**

What Is Covered?

The **Autism Spectrum Disorder Category** is amended by deleting the **Payment Guidelines for Autism Spectrum Disorder** in its entirety and replacing it with the following:

Coverage Access Rules for Autism Spectrum Disorder

Autism Spectrum Disorder Services must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Benefit Booklet, we reserve the right to request a formal written treatment plan signed by the treating physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

The **Hospice Services** category is deleted in its entirety and replaced with the following:

Hospice Services

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is:

1. approved by your Physician; and
2. your doctor has certified to us in writing that your life expectancy is 12 months or less.

Recertification is required every six months.

The **Outpatient Cardiac, Occupational, Physical, Speech and Massage Therapies and Spinal Manipulation Services** subsection is amended by deleting the last paragraph of the Payment Guidelines for Spinal Manipulation subsection in its entirety and replacing it with the following:

Your Schedule of Benefits sets forth the maximum number of visits covered under this plan for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, even if you may have only been administered two (2) of your spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if you have already

met the combined therapy visit maximum with other Services.

The **Preventive Adult Wellness Services** category is deleted in its entirety and replaced with the following.

Preventive Adult Wellness Services

Preventive adult wellness Services are covered under your plan. For purposes of this benefit, an adult is 17 years or older.

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved; and
3. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Exclusion:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph number one above.

The **Preventive Child Health Supervision Services** category is deleted in its entirety and replaced with the following:

Preventive Child Health Supervision Services

Preventive Child Health Supervision Services from the moment of birth up to the 17th birthday are covered.

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence- informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

The following new category is added:

Emergency Services

Emergency Services and care for an Emergency Medical Condition are covered In-Network and Out-of-Network without the need for any prior authorization determination by us.

When Emergency Services and care for an Emergency Medical Condition are rendered by an Out-of-Network Provider, any Copayment and/or Coinsurance amount applicable to In-Network Providers for Emergency Services and care will also apply to such Out-of-Network Provider.

What Is Not Covered?

The **Drugs** exclusion is amended by deleting exclusion number three in its entirety and replacing it with the following:

3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods, except as described in the Preventive Adult Wellness Services and Preventive Child Health Supervision Services categories of the "What Is Covered?" section.

The **Genetic Screening** exclusion is deleted in its entirety and replaced with the following:

Genetic screening, including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a Condition, except as provided under the Preventive Adult Wellness Services and Preventive Child Health Supervision Services categories of the "What Is Covered?" section.

Pre-existing Conditions Exclusion Period

The list of exceptions in the **Introduction** is deleted in its entirety and replaced with the following:

This Pre-existing Condition exclusionary period does not apply to

1. the Covered Employee and each Covered Dependent who was covered under the Group's prior medical plan on the date immediately preceding the Effective Date of coverage under this Booklet;
2. you if you were enrolled during the Initial Enrollment Period prior to the Effective Date of the Group;
3. you when the Group has elected to waive, in writing, at the time of Group Application the Pre-existing Conditions exclusionary period for all subsequent Eligible Employees and/or Eligible Dependents
4. the Covered Dependent child who is under the age of 19 as of the effective date of this Endorsement, or if enrolled thereafter, is under the age of 19 at the time of enrollment;
5. pregnancy;
6. Genetic Information in the absence of a diagnosis of the Condition;
7. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
8. Conditions arising from domestic violence; or
9. inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

Termination of Coverage

Rescission of Coverage

We reserve the right to Rescind the coverage under this Group Master Policy for any individual covered under this Group Master policy as permitted by law.

We may only Rescind the coverage under this Group Master Policy if you, or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

We will provide at least 45 days advance written notice our intent to Rescind coverage.

Rescission of coverage is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure described in the "Claims Processing" section of this Benefit Booklet.

Claims Processing

The **Standards for Adverse Benefit Determinations** subsection is deleted in its entirety and replaced with the following:

Manner and Content of a Notification of an Adverse Benefit Determination:

We will use our best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to you free of charge upon request):

- the date the Service or supply was provided;
- the Provider's name
- the dollar amount of the claim, if applicable;
- the diagnosis codes included on the claim (e.g., ICD-9, DSM-IV), including a description of such codes;
- the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
- the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;
- a description of the specific Benefit Booklet provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and,
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how to obtain the specific explanation of the scientific or clinical judgment for the determination.

If the claim is a Claim Involving Urgent Care, we may notify you orally within the proper timeframes, provided we follow-up with a written or electronic notification meeting the requirements of this subsection no later than three days after the oral notification.

The **How to Appeal an Adverse Benefit Determination** is amended by deleting the section in its entirety and replacing it with the following:

You have the right to an independent external review through an external review organization for certain appeals, as provided in the Patient Protection and Affordable Care Act of 2010.

The **How to Request External Review of Our Appeal Decision** subsection is deleted in its entirety and replaced with the following:

How to Request External Review of Our Appeal Decision

If you are not satisfied with our internal review of your appeal of an Adverse Benefit Determination, please refer to the Adverse Benefit Determination notice or call the customer service phone number on your ID Card for information on how to request an external review.

Definitions

The definition of **Adverse Benefit Determination** is deleted in its entirety and replaced with the following:

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Contract in connection with:

1. a Pre-Service Claim or a Post-Service Claim;
2. a Concurrent Care Decision, as described in the "Claims Processing" section; or
3. Rescission of coverage, as described in the "Termination of Coverage" section;

The definition of **Emergency Services and Care** is deleted in its entirety and replaced with the following:

Emergency Services means, with respect to an Emergency Medical Condition:

1. a medical screening examination (as required under Section 1867 of the Social Security Act) that is within the capability of the emergency department of a Hospital, including ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under Section 1867 of such Act to Stabilize the patient.

The definition of **Medical Emergency** is deleted in its entirety and replaced with the following:

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

The following definitions are added:

Rescission or **Rescind** refers to BCBSF's action to retroactively cancel or discontinue coverage under the Group Health. Plan. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premiums

Stabilize shall have the same meaning with regard to Emergency Services as the term is defined in Section 1867 of the Social Security Act.

The following definition is deleted:

External Review Organization

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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions Autism Spectrum Disorder Amendment

This document amends the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueOptions Autism Spectrum Disorder Endorsement to the BlueOptions Benefit Booklet issued to you. The BlueOptions Autism Spectrum Disorder Endorsement is hereby amended as described below:

If you have any questions concerning this amendment, please call Blue Cross and Blue Shield of Florida toll free at 800-FLA-BLUE.

The Autism Spectrum Disorder Services benefit maximums added to your Schedule of Benefits with Endorsement 24013 0709 BCA, are hereby changed to unlimited.

This amendment 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 the provisions contained in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Benefit Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Robert I. Lufrano, M.D.
Chairman of the Board and
Chief Executive Officer

BlueOptions 2012 Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") BlueOptions Benefit Booklet including any Endorsements attached thereto. If you have any questions concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

Except as otherwise noted, your Booklet is amended as described below to comply with the Patient Protection and Affordable Care Act (PPACA), H.R. 3590, otherwise known as the Affordable Care Act. The provisions contained in this Endorsement are effective at your Group's initial effective on or after **August 1, 2012** or first Anniversary Date occurring on or after **August 1, 2012,** whichever occurs first.

All references to the "**Preventive Adult Wellness Services**" and "**Preventive Child Health Supervision Services**" categories throughout the Booklet are hereby replaced with **"Preventive Health Services".**

WHAT IS COVERED?

The following is added at the end of the **Emergency Services** category:

Special Payment Rules for Non-Grandfathered Plans

The Patient Protection and Affordable Care Act (PPACA) requires that non-grandfathered health plans apply a specific method for determining the allowed amount for Emergency Services rendered for an Emergency Medical Condition by Providers who do not have a contract with us.

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider will be the greater of:

1. the amount equal to the median amount negotiated with all BCBSF In-Network Providers for the same Services;
2. the Allowed Amount as defined in the Booklet;
3. the usual and customary Provider charges for similar Services in the community where the Services were provided; or
4. what Medicare would have paid for the Services rendered.

In no event will Out-of-Network Providers be paid more than their charges for the Services rendered. **If your plan is a grandfathered health plan under PPACA, these payment guidelines do not apply to your plan.** If you are not sure whether or not your health plan is grandfathered, please contact your Group.

The **Preventive Adult Wellness Services** and **Preventive Child Health Supervision Services** categories are deleted in their entirety and replaced with the following:

Preventive Health Services

Preventive Services are covered for both adults and children based on prevailing medical standards and recommendations which are explained further below. Some examples of preventive health Services include, but are not limited to, periodic routine health exams, routine gynecological exams, immunizations and related preventive Services such as Prostate Specific Antigen (PSA), routine mammograms and pap smears. In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. with respect to infants, children, and adolescents, evidence- informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph number one as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Women's preventive coverage under this category includes:
    a. well-woman visits;
    b. screening for gestational diabetes;
    c. human papillomavirus testing;
    d. counseling for sexually transmitted infections;

e. counseling and screening for human immune-deficiency virus;

f. contraceptive methods and counseling unless indicated as covered under a BlueScript Pharmacy Program Endorsement;

g. screening and counseling for interpersonal and domestic violence; and

h. breastfeeding support, supplies and counseling. Breastfeeding supplies are limited to one manual breast pump per pregnancy.

Exclusion:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph number one above. Sterilization procedures covered under this section are limited to tubal ligations only. Contraceptive implants are limited to Intra-uterine devices (IUD) only, including insertion and removal.

CLAIMS PROCESSING

The **Standards for Adverse Benefit Determinations** subsection is amended as follows (these changes are not related to the Affordable Care Act):

The **Manner and Content of a Notification of an Adverse Benefit Determination** is amended by deleting the numbered list in its entirety and replacing it with the following:

Manner and Content of a Notification of an Adverse Benefit Determination

We will use our best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to you free of charge upon request):

1. the date the Service or supply was provided;
2. the Provider's name;
3. the dollar amount of the claim, if applicable;
4. the diagnosis codes included on the claim (e.g., ICD-9, DSM-IV), including a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;
7. a reference to the specific Booklet provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
8. a description of any additional information that might change the determination and why that information is necessary;
9. a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
10. if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueScript® Contraceptive Amendment

This amendment is to be attached to, and made a part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet ("Booklet"). Your BlueScript® Pharmacy Program Endorsement is amended as described below.

This amendment is effective at your Group plan's initial effective date occurring on or after **August 1, 2012** or first Anniversary Date occurring on or after **August 1, 2012** whichever occurs first.

If you have any questions concerning this amendment, please call us toll free at 800-FLA-BLUE.

COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

Number 1 is deleted in its entirety and replaced with the following:

1. Prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;

COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The Co**ntraceptive Coverage** category is deleted in its entirety and replaced with the following:

Contraceptive Coverage

All Prescription diaphragms, oral contraceptives and contraceptive patches are covered under this Endorsement unless indicated as not covered on the BlueScript® Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this Endorsement.

The following are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

   Exceptions may be considered for Brand Name oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, we must receive an "Exception Request Form" from your Physician.

   You can obtain an Exception Request Form on our website at www.floridablue.com, or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.

2. Diaphragms indicated as covered in the Medication Guide; and
3. Emergency contraceptives indicated as covered in the Medication Guide.

Exclusion

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

LIMITATIONS AND EXCLUSIONS

The **Limitations** subsection is amended by deleting exclusion number 5 in its entirety and replacing it with the following:

6. Retinoids (e.g., Retin-A) and their generic or therapeutic equivalents are excluded after age 26.

The **Exclusions** subsection is amended by deleting exclusions 3, 11 and 21 in their entirety and replacing them with the following:

3. Any Drug or Supply which can be purchased over-the-counter without a Prescription, even though a written Prescription is provided (i.e., Drugs which do not require a Prescription) except for emergency contraceptives, insulin and Covered OTC Drugs listed in the Medication Guide.

11. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection.

21. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:

    a. the Drug is a Repackaged Drug;

    b. the Drug is no longer marketed;

    c. the Drug has been shown to have excessive adverse effects and/or safer alternatives;

    d. the Drug is available Over-the-Counter (OTC);

    e. the Drug has a preferred formulary alternative;

    f. the Drug has a widely available/ distributed AB rated generic equivalent formulation;

    g. the Drug has shown limited effectiveness in relation to alternative Drugs on the formulary; or

    h. 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.

DEFINITIONS

The **Brand Name Prescription Drug** definition is deleted in its entirety and replaced with the following:

Brand Name Prescription Drug means a Prescription Drug which 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. For purposes of this Endorsement, compound drugs are also considered Brand Name Prescription Drugs.

The **Covered Prescription Supply(ies)** definition is deleted in its entirety and replaced with the following:

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

1. diaphragms indicated as covered in the Medication Guide;
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; or
4. 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 (unless indicated as not covered on the BlueScript® Pharmacy Program Schedule of Benefits).

The **Prescription Drug** definition is deleted in its entirety and replaced with the following:

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". For purposes of this Endorsement, emergency contraceptives and insulin are considered a Prescription Drug because, in order to be covered, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

The following **new** definition is added:

Repackaged Drug(s) means a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

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

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2014 Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 1, 2014** or first Anniversary Date occurring on or after **January 1, 2014** whichever occurs first.

TABLE OF CONTENTS

The **Table of Contents** is amended by deleting **Pre-Existing Conditions Exclusion Period** in its entirety.

WHAT IS COVERED?

The **Introduction** is amended as follows:

Item number six is deleted in its entirety and replaced with the following:

6. not specifically or generally limited or excluded under this Booklet.

The **Clinical Trials** category is added:

Clinical Trials

Clinical trials are research studies in which Physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial.

If you are eligible to participate in an Approved Clinical Trial, routine patient care for Services furnished in connection with your participation in the Approved Clinical Trial may be covered when:

1. An In-Network Provider has indicated such trial is appropriate for you, or
2. you provide us with medical and scientific information establishing that your participation in such trial is appropriate.

Routine patient care includes all Medically Necessary Services that would otherwise be covered under this Booklet, such as doctor visits, lab tests, x-rays and scans and hospital stays related to treatment of your Condition and is subject to the applicable Cost Share(s) on the Schedule of Benefits.

Even though benefits may be available under this Booklet for routine patient care related to an Approved Clinical Trial you may not be eligible for inclusion in these trials or there may not be any trials available to treat your Condition at the time you want to be included in a clinical trial.

Exclusion

1. Costs that are generally covered by the clinical trial, including, but not limited to:
    a. Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
    b. The investigational item, device or Service itself.
    c. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.
2. Services related to an Approved Clinical Trial received outside of the United States.

The Special Payment Rules for Non-Grandfathered Plans at the end of the **Emergency Services** category is deleted in its entirety and replaced with the following:

Special Payment Rules for Non-Grandfathered Plans

The Patient Protection and Affordable Care Act (PPACA) requires that non-grandfathered health plans apply a specific method for determining the allowed amount for Emergency Services rendered for an Emergency Medical Condition by Providers who do not have a contract with us.

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider will be the greater of:

1. the amount equal to the median amount negotiated with all BCBSF In-Network Providers for the same Services;
2. the Allowed Amount as defined in the Booklet; or
3. what Medicare would have paid for the Services rendered.

In no event will Out-of-Network Providers be paid more than their charges for the Services rendered. **If your plan is a grandfathered health plan under PPACA, these payment guidelines do not apply to your plan.** If you are not sure whether or not your health plan is grandfathered, please contact your Group.

The **Inpatient Rehabilitation** category is amended by deleting numbers three and five in their entirely and replacing them with the following:

3. coverage is subject to our Medical Necessity coverage criteria then in effect;
5. the Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

The **Mental Health Services** category is amended by deleting the first two paragraphs in their entirety and replacing them with the following:

Diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy rendered to you by a Physician, Psychologist or Mental Health Professional for the treatment of a Mental and Nervous Disorder may be covered. Covered Services may include:

1. Physician office visits;
2. Intensive Outpatient Treatment (rendered in a facility), as defined in this Booklet; and

3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician.

The **Exclusion** is amended by deleting numbers one through four in their entirely and replacing them with the following:

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability;
4. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;

The **Preventive Health Services** category is amended by deleting the exclusion in its entirety and replacing it with the following:

Exclusion

Routine vision and hearing examinations and screenings are not covered as Preventive Health Services, except as required under paragraph number one and/or number three above. Sterilization procedures covered under this category are limited to tubal ligations only. Contraceptive implants are limited to Intra-uterine devices (IUD) indicated as covered in the Medication Guide only, including insertion and removal.

MEDICAL NECESSITY

Item number three is deleted in its entirety and replaced with the following:

3. staying in the Hospital because supervision in the home, or care in the home, is not available or is inconvenient; or being hospitalized for any Service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department or at home with Home Health Care Services); or

PRE-EXISTING CONDITIONS EXCLUSION PERIOD

The **Pre-Existing Conditions Exclusion Period** Section is deleted in its entirety.

BLUEPRINT FOR HEALTH PROGRAMS

The **Prior Coverage Authorization/Pre-Service Notificaton Programs** subsection is deleted in its entirety and replaced with the following:

Prior Coverage Authorization/ Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these requirements and ultimately how much you will have to pay under this Booklet.

You or your Physician will be required to obtain prior coverage authorization from us for:

1. **Prescription Drugs**, as denoted with a special symbol in the Medication Guide;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging;
3. **Autism Spectrum Disorder** Services; and
4. **Substance Dependency Care and Treatment** Services; and
5. **Mental Health Services**; and
6. Services rendered in connection with **Approved Clinical Trials**; and
7. **other Health Care Services** that are or may become subject to a prior coverage authorization program or a pre-service notification program as defined and administered by us.

You are solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider.

1. In the case of **Prescription Drugs**, it is your sole responsibility to obtain our prior coverage authorization when you use a Provider **before** the drug is purchased or administered. **If you do not obtain prior coverage authorization, we will deny coverage for the Prescription Drug and not make any payment for the drug or any Service related to the drug or its administration.**

   All Prescription Drugs covered under the Medical Pharmacy category in the WHAT IS COVERED? section, require prior authorization. For a list of other medications that require prior coverage authorization and details on how to get an authorization, please refer to the Medication Guide.

2. In the case of **advanced diagnostic imaging Services** such as CT scans, MRIs, MRA and nuclear imaging, you must obtain authorization when rendered or referred by a Provider **before** the advanced diagnostic imaging Services are provided. **If you do not obtain prior coverage authorization we will deny coverage for the Services and not make any payment for such Services**.

   For details on how to obtain prior coverage authorization for advanced diagnostic imaging Services, please call the customer service phone number on the back of your ID Card.

3. In the case of **Autism Spectrum Disorder Services**, you must obtain an authorization when rendered or referred by a Provider **before** Autism Spectrum Disorder Services are provided. **If you do not obtain prior coverage authorization we will not make any payment for such Services**.

For details on how to obtain prior coverage authorization for Autism Spectrum Disorder Services, please call the customer service phone number on your ID Card.

4. In the case of **Substance Dependency Care and Treatment Services**, you must obtain an authorization when rendered or referred by a Provider **before** Substance Dependency Care and Treatment Services are provided. **If you do not obtain prior coverage authorization we will not make any payment for such Services**.

   For details on how to obtain prior coverage authorization for Substance Dependency Care and Treatment Services, please call the customer service phone number on your ID Card.

5. In the case of **Mental Health Services**, you must obtain an authorization when rendered or referred by a Provider **before** Mental Health Services are provided. **If you do not obtain prior coverage authorization we will not make any payment for such Services**.

   For details on how to obtain prior coverage authorization for Mental Health Services, please call the customer service phone number on your ID Card.

6. In the case of Services rendered in connection with **Approved Clinical Trials**, you must obtain an authorization when rendered or referred by a Provider **before** you obtain routine patient care provided in connection with an Approved Clinical Trial. **If you do not obtain prior coverage authorization we will not make any payment for such Services.**

7. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, you must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

If you do not obtain authorization or provide pre-service notification, we may:

1. deny payment of the claim; or
2. apply a benefit penalty when the claim is presented to us for payment consisting of one of the following:
   a. $500
   b. 20% of the total Allowed Amount of the claim;or
   c. The lesser of $500 or 20% of the total Amount of the claim.

The decision to apply a penalty or deny the claim will be made uniformly and the applicable denial/penalty will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

We will inform you of any Health Care Service that is or will become subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to you upon enrollment, or at least 30 days prior to such Services becoming subject to a prior coverage authorization or pre-service notification program. Such information may be provided to you electronically, if you have elected the delivery of notifications from us in that manner. Changes to the list of other Health Care Services that require prior authorization shall occur no more frequently than twice in a Calendar Year.

Once the necessary medical documentation has been received from you and/or the Provider, BCBSF or a designated vendor, will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

Note: Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.

See the CLAIMS PROCESSING section for information on what you can do if prior coverage authorization is denied.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

The **Dependent Enrollment** subsection is amended by deleting the first paragraph of the **Adopted/Foster Children** subsection in its entirety and replacing it with the following:

Adopted/Foster Children – To enroll an adopted child (other than an adopted newborn child) or Foster Child, the Covered Employee must submit an Enrollment Form during the 30-day period immediately following the date of placement and pay the additional Premium, if any. The Effective Date for an adopted or Foster Child (other than an adopted newborn child) shall be the date such adopted or Foster Child is placed in the residence of the Covered Employee pursuant to Florida law. If timely notice is given, no additional Premium will be charged for coverage of the adopted child or Foster Child for the duration of the notice period. We may require the Covered Employee to provide any information and/or documents deemed necessary by us in order to properly administer this section.

The **Other Provisions Regarding Enrollment and Effective Date of Coverage** subsection is amended by deleting the **Rehired Employees** subsection in its entirely and replacing it with the following:

Rehired Employees

Individuals who are rehired as employees of the Group are considered newly-hired employees for purposes of this section. The provisions of the Group Master Policy (which includes this Booklet), applicable to newly-hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

CLAIMS PROCESSING

The Standards for Adverse Benefit Determinations subsection is amended by deleting **How to Request External Review of Our Appeal Decision** in its entirety and replacing it with the following:

How to Request External Review of Our Appeal Decision

If we deny your appeal and our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational, you are entitled to request an independent, external review of our decision.

Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with us. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the External Review Request form within four months after receipt of your denial to the below address:

Blue Cross and Blue Shield of Florida
Attention: Member External Reviews DCC9-5
Post Office Box 44197
Jacksonville, FL 32231-4197

If you have a medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you may file a request for an expedited external review. Generally, an urgent situation is one in which your health may be in serious jeopardy, or in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. Moreover expedited external reviews may be requested for an admission, availability of care, continued stay or Health Care Service for which you received Emergency Services, but have not been discharged from a facility. Please be sure your treating Physician completes the appropriate form to initiate this request type. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to the External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. If you believe your situation is urgent, you may request an expedited review by sending your request to the address above or by fax to 904-565-6637.

If the External Reviewer decides to overturn our decision, we will provide coverage or payment for your health care item or Service.

You or someone you name to act for you may file a request for external review. To appoint someone to act on your behalf, please complete an Appointment of Representative form.

You are entitled to receive, upon written request and free of charge, reasonable access to, and copies of all documents relevant to your appeal including a copy of the actual benefit provision, guideline protocol or other similar criterion on which the appeal decision was based.

You may request and we will provide the diagnosis and treatment codes, as well as their corresponding meanings, applicable to this notice, if available.

GENERAL PROVISIONS

The following **subsection** is added:

Care Profile Program – A Payer-Based Health Record Program

A care profile is available to treating Physicians for each person covered under this Booklet. This care profile allows a secure, electronic view of specific claims information for Services rendered by Physicians, Hospitals, labs, pharmacies, and other health care Providers. Unless you have chosen to opt out, here are a few of the benefits of participation in the Care Profile Program:

1. All authorized treating Physicians will have a consolidated view – or history – of your Health Care Services, assisting them in improved decision-making in the delivery of health care.
2. In times of catastrophic events or Emergency Services, the care profile will be accessible from any location by authorized Physicians so that appropriate treatment and Service can still be delivered.
3. Safe and secure transmission of claim information. Only authorized health care Providers or authorized members of the Provider's staff will have access to your information.
4. Coordination of care among your authorized treating health care Providers.
5. More efficient health care delivery for you.

Keeping your health information private is extremely important, so your care profile will not include certain health information that pertains to "sensitive" medical conditions, for which the law provides special protection. Health care Providers access the care profile using the same secure, electronic channel they use to file claims. In addition, only authorized members of the Provider's staff will have access to the information. Remember, this will help your Physician in obtaining important information concerning your health history.

However, if for some reason you, or any of your Covered Dependents, choose not to provide your treating Physician access to your claim history, the use of this information may be restricted. Should you choose not to participate call the customer service phone number on your ID Card and inform a service associate of your decision.

DEFINITIONS

The definition of **Aproved Clinical Trial** is added:

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and meets one of the following criteria:

1. The study or investigation is approved or funded by one or more of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare and Medicaid Services.

e. cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. Any of the following if the conditions described in paragraph (2) are met:

i. The Department of Veterans Affairs.

ii. The Department of Defense.

iii. The Department of Energy.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For a study or investigation conducted by a Department the study or investigation must be reviewed and approved through a system of peer review that the Secretary determines: (1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

For purposes of this definition, the term “Life-Threatening Disease or Condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The definition of **Intensive Outpatient Treatment** is added:

Intensive Outpatient Treatment means treatment in which an individual receives at least 3 clinical hours of institutional care per day (24-hour period) for at least 3 days a week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

The definition of **Medically Necessary** or **Medical Necessity** is deleted in its entirety and replaced with the following:

Medically Necessary or **Medical Necessity** means that, with respect to a Health Care Service, a Provider, exercising prudent clinical judgment, provided, or is proposing or recommending to provide the Health Care Service to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that the Health Care Service was/is:

1. in accordance with Generally Accepted Standards of Medical Practice;

2. clinically appropriate, in terms of type, frequency, extent, site of Service, duration, and considered effective for your illness, injury, or disease or symptoms;

3. not primarily for your convenience, your family’s convenience, your caregiver’s convenience or that of your Physician or other health care Provider, and

4. not more costly than the same or similar Service provided by a different Provider, by way of a different method of administration, an alternative location (e.g., office vs. inpatient), and/or an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms.

   When determining whether a Service is not more costly than the same or similar Service as referenced above, we may, but are not required to, take into consideration various factors including, but not limited to, the following:

   a. the Allowed Amount for Service at the location for the delivery of the Service versus an alternate setting;

   b. the amount we have to pay to the proposed particular Provider versus the Allowed Amount for a Service by another Provider including Providers of the same and/or different licensure and/or specialty; and/or,

   c. an analysis of the therapeutic and/or diagnostic outcomes of an alternate treatment versus the recommended or performed procedure including a comparison to no treatment. Any such analysis may include the short and/or long-term health outcomes of the recommended or performed treatment versus alternate treatments including an analysis of such outcomes as the ability of the proposed procedure to treat comorbidities, time to disease recurrence, the likelihood of additional Services in the future, etc.

   Note: The distance you have to travel to receive a Health Care Service, time off from work, overall recovery time, etc. are not factors that we are required to consider when evaluating whether or not a Health Care Service is not more costly than an alternative Service or sequence of Services.

   Reviews we perform of Medical Necessity may be based on comparative effectiveness research, where available, or on evidence showing lack of superiority of a particular Service or lack of difference in outcomes with respect to a particular Service. In performing Medical Necessity reviews, we may take into consideration and use cost data which may be proprietary.

It is important to remember that any review of Medical Necessity by us is solely for the purpose of determining coverage or benefits under this Booklet and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Booklet as determined by us. In applying the definition of Medical Necessity in this Booklet, we may apply our coverage and payment guidelines then in effect. You are free to obtain a Service even if we deny coverage because the Service is not Medically Necessary; however, you will be solely responsible for paying for the Service.

The definition of **Mental and Nervous Disorder** is deleted in its entirety and replaced with the following:

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Disease (ICD-9 CM or ICD 10 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

The definition of **Partial Hospitalization** is deleted in its entirety and replaced with the following:

Partial Hospitalization means treatment in which an individual receives at least 6 clinical hours of institutional care per day (24-hour period) for at least 5 days per week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueScript® Specialty Pharmacy: Split Fill Option Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript® Pharmacy Program Endorsement is amended as described below.

This amendment is effective at your Group plan's initial Effective Date occurring on or after **January 1, 2014** or first Anniversary Date occurring on or after **January 1, 2014** whichever occurs first.

If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

COVERGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The following subsection is added:

Specialty Pharmacy: Split Fill Option

Some types of medication may be difficult to tolerate for patients who are new to certain forms of treatment, such as oral oncology medication. To reduce waste and help avoid cost for medications that will go unused, the Specialty Pharmacy may split the first fill for certain medications identified in the Medication Guide. The applicable Cost Share would also be split between the two fills.

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

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2014 Compliance Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **July 1, 2014** or first Anniversary Date occurring on or after **July 1, 2014** whichever occurs first.

All references to "**Substance Dependency Care and Treatment**" throughout this Booklet are replaced with "**Substance Dependency**".

WHAT IS COVERED?

The **Mental Health Services** and **Substance Dependency Care and Treatment** categories are deleted in their entirety and replaced with the following:

Behavioral Health Services

Mental Health Services

Diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy rendered to you by a Physician, Psychologist or Mental Health Professional for the treatment of a Mental and Nervous Disorder may be covered. Covered Services may include:

1. Physician office visits;
2. Intensive Outpatient Treatment (rendered in a facility), as defined in this Booklet;
3. Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician; and
4. Residential Treatment Services, as defined in this Booklet.

Exclusion

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability;
4. Services for educational purposes;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;

7. Services for court-ordered care or testing, or required as a condition of parole or probation;
8. Services to test aptitude, ability, intelligence or interest;
9. Services required to maintain employment;
10. Services for cognitive remediation; and
11. inpatient stays that are primarily intended as a change of environment.

Substance Dependency Treatment Services

When there is a sudden drop in consumption after prolonged heavy use of a substance a person may experience withdrawal, often causing both physiologic and cognitive symptoms. The symptoms of withdrawal vary greatly, ranging from minimal changes to potentially life threatening states. Detoxification Services can be rendered in different types of locations, depending on the severity of the withdrawal symptoms.

Care and treatment for Substance Dependency includes the following:

1. Inpatient and outpatient Health Care Services rendered by a Physician, Psychologist or Mental Health Professional in a program accredited by The Joint Commission or approved by the state of Florida for Detoxification or Substance Dependency.
2. Physician, Psychologist and Mental Health Professional outpatient visits for the care and treatment of Substance Dependency.

We may provide you with information on resources available to you for non-medical ancillary services like vocational rehabilitation or employment counseling, when we are able to. We don't pay for any services that are provided to you by any of these resources; they are to be provided solely at your expense. You acknowledge that we do not have any Contractual or other formal arrangements with the Provider of such services.

Exclusion

Long term Services for alcoholism or drug addiction, including specialized inpatient units or inpatient stays that are primarily intended as a change of environment.

The **Preventive Health Services** category is amended by deleting number h under item number 4 in its entirety and replacing it with the following:

h. breastfeeding support, supplies and counseling. Breastfeeding supplies are limited to breast pumps. **You must obtain prior coverage authorization from us before you get the breast pump**. Breast pumps must be obtained through a Durable Medical Equipment Provider who must be able to verify that you are either scheduled for delivery or have delivered within 9 months. In-Network benefits are only available through our preferred Durable Medical Equipment Provider. If you do not obtain prior coverage authorization we will not make any payment for such Service.

The following **Note** is added after number h:
Note: From time to time medical standards that are based on the recommendations of the entities listed in numbers 1 through 4 above change. Services may be added to the recommendations and sometimes may be removed. It is important to understand that your coverage for these preventive Services is based

on what is in effect on your Effective Date. If any of the recommendations or guidelines change after your Effective Date, your coverage will not change until your Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

For example, if the USPSTF adds a new recommendation for a preventive Service that we do not cover and you are already covered under this Benefit Booklet; that new Service will not be a Covered Service under this category right away. The coverage for a new Service will start on your Group's Anniversary Date one year after the new recommendation goes into effect.

The **Exclusion** is deleted in its entirety and replaced with following:

Routine vision and hearing examinations and screenings are not covered as Preventive Services, except as required under paragraph number one and/or number three above. Sterilization procedures covered under this category are limited to those procedures indicated as covered in the Medication Guide only. Contraceptive implants are limited to Intra-uterine devices (IUD) indicated as covered in the Medication Guide only, including insertion and removal.

The following limitations are added after the **Exclusion**:

Limitations

Breast pumps are limited to:

a. one manual or electric breast pump per pregnancy, in connection with childbirth;

b. the most cost-effective pump, as determined by us (please see the Durable Medical Equipment category in this section for additional information);

c. hospital-grade breast pumps are not covered except when Medically Necessary during an inpatient stay, in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided.

DEFINITIONS

The following definitions are added:

Psychiatric Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Booklet, a psychiatric facility is not a Hospital or a Substance Abuse Facility, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes, or a similar applicable law of another state.

Residential Treatment Facility means a facility properly licensed under Florida law or a similar applicable law of another state, to provide care and treatment of Mental and Nervous Disorders and Substance Dependency and meets all of the following requirements:

- Has Mental Health Professionals on-site 24 hours per day and 7 days per week;
- Provides access to necessary medical services 24 hours per day and 7 days per week;

- Provides access to at least weekly sessions with a behavioral health professional fully licensed for independent practice for individual psychotherapy;
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Is not a wilderness treatment program or any such related or similar program, school and/or education service.

With regard to Substance Dependency treatment, in addition to the above, must meet the following:

- If Detoxification Services are necessary, provides access to necessary on-site medical services 24 hours per day and 7 days per week, which must be actively supervised by an attending physician;
- Ability to assess and recognize withdrawal complications that threaten life or bodily function and to obtain needed Services either on site or externally;
- Is supervised by an on-site Physician 24 hours per day and 7 days per week with evidence of close and frequent observation.

Residential Treatment Services means treatment in which an individual is admitted by a Physician overnight to a Hospital, Psychiatric Hospital or Residential Treatment Facility and receives daily face to face treatment by a Mental Health Professional for at least 8 hours per day, each day. The Physician must perform the admission evaluation with documentation and treatment orders within 48 hours and provide evaluations at least weekly with documentation. A multidisciplinary treatment plan must be developed within 3 days of admission and must be updated weekly.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions Creditable Coverage Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE. This Endorsement is effective on **December 1, 2014**.

TERMINATION OF COVERAGE

The **Certification of Creditable Coverage** subsection is deleted in its entirety.

DEFINITIONS

The **Prior/Concurrent Coverage Affidavit** definition is deleted in its entirety

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueScript® Oral Chemotherapy Drug Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"), including any Endorsements attached thereto. This document specifically amends the BlueScript® Pharmacy Program Endorsement as described below.

This amendment is effective at your Group plan's initial Effective Date occurring on or after **July 1, 2014** or first Anniversary Date occurring on or after **July 1, 2014** whichever occurs first.

If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The following subcategory is added:

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed $50 per One-Month Supply when purchased from a Participating Pharmacy.

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

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueCard® Program Endorsement

This Endorsement is to be attached to and made a part of your current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto. If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 1, 2016** or first Anniversary Date occurring on or after **January 1, 2016** whichever occurs first.

BLUECARD® PROGRAM

The Benefit Booklet is amended by deleting the BlueCard (Out-of-State) Program section in its entirety and replacing it with the following:

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific Service or Services.

BlueCard Program

Under the BlueCard Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations to you. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or

- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, our payment will be based on the Allowed Amount, as defined in the DEFINITIONS section of the Benefit Booklet.

BlueCard Worldwide® Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), you may be able to take advantage of the BlueCard Worldwide Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these Services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for inpatient Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Covered Services. **You must notify us of any non-emergency inpatient Services.**

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Worldwide Claim

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

DEFINITIONS

The following definitions are added:

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's health care needs across the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

Provider Incentive means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2016** or first Anniversary Date occurring on or after **January 01, 2016** whichever occurs first.

TABLE OF CONTENTS

The **Table of Contents** is amended by deleting the "Subrogation" and "Right of Reimbursement" sections in their entirety.

WHAT IS COVERED?

The **Medical Pharmacy** category is amended by deleting the first paragraph in its entirety and replacing it with the following:

Physician-administered Prescription Drugs which are rendered in a Physician's office may be subject to a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to each Prescription Drug and does not include the administration of the Prescription Drug.

The **Preventive Health Services** category is amended by deleting the last sentence in item number 4 and items number "a – h" in their entirety then adding the following after item number 4:

More detailed information, such as medical management programs or limitations, on Services that are covered under the Preventive Health Services category is available in the Preventive Services Guide located on our website at www.FloridaBlue.com/healthresources. Drugs or Supplies covered as Preventive Services are described in the Medication Guide. In order to be covered as a Preventive Health Service under this section the Service must be provided as described in the Preventive Services Guide or, for Drugs and Supplies, in the Medication Guide.

The Exclusion is deleted in its entirety and replaced with the following:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph one above.

The Limitations are deleted in their entirety.

WHAT IS NOT COVERED?

The **General Exclusions** subsection is amended by deleting item number 3 in its entirety and replacing it with the following:

3. Any Health Care Service you render to yourself or those renedered by a Physician or other health care Provider related to you by blood or marriage.

It is further amended by deleting items number "b - d" under item number 7 in their entirety and replacing them with the following:

b) your participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical condition;

c) your engaging in an illegal occupation, except for an injury resulting from an act of domestic violence or a medical condition;

d) Services received at military or government facilities to treat a condition arising out of your service in the armed forces, reserves and/or National Guard; or

The following **Exclusion** is added:

Motor Vehicle Accidents including any costs you incur due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.

UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Copayment Requirements** subsection is amended by deleting item number 4 in its entirety and replacing it with the following:

4. Copayment for Emergency Room Facility Services:

   The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Coinsurance amount, and applies to emergency room facility Services in or outside the state of Florida. The Copayment for emergency room facility Services, if applicable to your plan, must be satisfied by you for each visit.

   - If you are admitted to an In-Network Hospital as an inpatient at the time of the emergency room visit, the Copayment for emergency room facility Services, if applicable to your plan, will be waived, but you will still be responsible for your share of the expenses for inpatient facility Services as listed in your Schedule of Benefits.

   - If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility, the Out-of-network Deductible, In-Network Coinsurance and/or Emergency Room Copayment will apply to that admission. Please see your Schedule of Benefits for the applicable Cost Share.

BLUEPRINT FOR HEALTH PROGRAMS

The **Prior Coverage Authorization/Pre-Service Notification Programs** subsection is amended by deleting numbers 4 and 5, in the first and second set of numbered lists, in their entirety.

DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS/PROGRAMS

The **Coordination of Benefits** subsection is amended by deleting the fifth paragraph and subsequent numbered list in their entirety and replacing them as follows:

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. This plan always pays secondary to any medical payment, personal injury protection (PIP) coverage or no-fault coverage under any automobile policy available to you.
2. When we cover you as a Covered Dependent and the other plan covers you as other than a dependent, we will be secondary.
3. When we cover you as a dependent child and your parents are married (not separated or divorced):
    a. the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;
    b. if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than us, we will be secondary.
4. When we cover you as a dependent child whose parents are not married, or are separated or divorced:
    a. if the parent with custody is not remarried, the plan of the parent with custody is primary;
    b. if the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody is last;
    c. regardless of which parent has custody, when a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When we cover you as a dependent child and the other plan covers you as a dependent child:
    a. the plan of the parent who is neither laid off nor retired will be primary;
    b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
6. If you have continuation of coverage under COBRA as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group plan, the following order of benefits applies:
    a. first, the plan covering the person as an employee, or as the employee’s Dependent; and

b. second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.

7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary, unless you are age 65 or older and covered under Medicare Parts A and B. In that case, this Booklet will be secondary to Medicare.

8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

We will not coordinate benefits against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare Supplement policy.

SUBROGATION

The **Subrogation** section is deleted in its entirety.

RIGHT OF REIMBURSEMENT

The **Right of Reimbursement** section is deleted in its entirety.

GENERAL PROVISIONS

The following subsection is added:

Subrogation and Right of Reimbursement

As used herein, the term "Third Party," means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care or treatment of Third Party Injuries.

If benefits are paid under this Booklet for expenses incurred due to Third Party Injuries, then we retain the right to repayment of the full cost of all benefits provided under this Booklet on your behalf that are associated with the Third Party Injuries. Our subrogation and reimbursement rights of recovery apply to any claim or potential claim made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and

- Any other payments from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

By accepting benefits under this Booklet, you specifically acknowledge our right of subrogation. In the event you suffer injuries for which a Third Party is responsible (such as someone injuring you in an accident), and we pay benefits under this Booklet as a result of those injuries, we will be subrogated and succeed to the right of recovery against such Third Party to the extent of the benefits we have paid. This means that we have the right, independently of you, to proceed against the Third Party responsible for your injuries to recover the benefits we have paid. In order to secure our recovery rights, you agree to assign to us any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of our subrogation and reimbursement claims. This assignment allows us to pursue any claim you may have, whether or not you choose to pursue the claim.

By accepting benefits under this Booklet, you also specifically acknowledge our right of reimbursement. This right of reimbursement attaches when we have paid health care benefits for expenses incurred due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Booklet, we are granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided under this Booklet. Our right of reimbursement is cumulative with and not exclusive of our subrogation right and we may choose to exercise either or both rights of recovery.

By accepting benefits under this Booklet, you or your representatives further agree to:

- Notify us promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by you;
- Cooperate with us and do whatever is necessary to secure our right of subrogation and reimbursement under this Booklet;
- Give us a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party Injuries provided under this Booklet (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement);
- Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation, any and all amounts due to us as reimbursement for the full cost of all benefits associated with Third Party Injuries paid under this Booklet (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by us in writing;
- Do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid under this Booklet; and
- Serve as a constructive trustee for the benefits under this Booklet over any settlement.

We may recover the full cost of all benefits paid by us under this Booklet without regard to any claim of fault on your part, whether by comparative negligence or otherwise. In the event you or your representative fails to cooperate with us, you shall be responsible for all benefits provided by us under this Booklet in addition to costs and attorney's fees incurred by us in obtaining repayment.

DEFINITIONS

The following definition is added:

Preventive Services Guide means the guide then in effect issued by us that contains a listing of Preventive Health Services covered under your plan. **Note**: The Preventive Services Guide is subject to change Please refer to our website at www.FloridaBlue.com/healthresources for the most current guide.

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's health care needs across the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program.

Provider Incentive means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueScript® Pharmacy Program New Drug Addition Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2016** or first Anniversary Date occurring on or after **January 01, 2016,** whichever occurs first.

COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Covered Prescription Drugs and Supplies and Covered OTC Drugs** section is amended by deleting item number 10 in its entirety and replacing it, then adding item number 11 as follows:

10. approved by the FDA and assigned a National Drug Code; except for New Prescription Drugs; and

11. reviewed by our Pharmacy and Therapeutics Committee.

COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The following subsection is added:

Preventive Medications

Certain medications may be available at no Cost Share when purchased from a Participating Pharmacy if they are considered a Preventive Service as outlined in the WHAT IS COVERED? section of the Benefit Booklet . Please see the Medication Guide for a list of these medications.

LIMITATIONS AND EXCLUSIONS

The **Limitations and Exclusions** section is amended by adding item number 22 under the "Exclusions" subsection numbered list.

22. New Prescription Drugs.

DEFINITIONS

The **Definitions** section is amended by adding and/or replacing the following definitions:

New Prescription Drug(s) means an FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee resulting in a final coverage determination. New Prescription Drugs includes a new dosage form of a previously FDA approved Prescription Drug. All New Prescription Drugs will be reviewed by the Pharmacy and Therapeutics Committee within 6 months of FDA approval.

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

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2017 Health Care Reform Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2017** or first Anniversary Date occurring on or after **January 01, 2017** whichever occurs first.

WHAT IS COVERED?

The **Ambulance Services** category is amended by deleting it in its entirety and replacing it with the following:

Ambulance Services

Ambulance Services for Emergency Medical Conditions and limited non-emergency ground transport may be covered only when:

1. For Emergency Medical Conditions – it is Medically Necessary to transport you by air, ground or water, from the place an Emergency Medical Condition occurs to the nearest Hospital that can provide the Medically Necessary level of care. If it is determined that the nearest Hospital is unable to provide the Medically Necessary level of care for the Emergency Medical Condition, then coverage for Ambulance Services shall extend to the next nearest Hospital that can provide Medically Necessary care; or
2. For limited non-emergency ground Ambulance transport – it is Medically Necessary to transport you by ground:
    a. from an Out-of-Network Hospital to the nearest In-Network Hospital that can provide care;
    b. to the nearest In-Network or Out-of-Network Hospital for a Condition that requires a higher level of care that was not available at the original Hospital;
    c. to the nearest more cost-effective acute care facility as determined solely by us; or
    d. from an acute facility to the nearest cost-effective sub-acute setting.

Note: Non-emergency Ambulance transportation meets the definition of Medical Necessity only when the patient's Condition requires treatment at another facility and when another mode of transportation, whether by Ambulance or otherwise (regardless of whether covered by us or not) would endanger the patient's medical Condition. If another mode of transportation could be used safely and effectively, regardless of time, or mode (e.g. air, ground, water) then Ambulance transportation is not Medically Necessary.

Limitations:

Air Ambulance coverage is specifically limited to transport due to an Emergency Medical Condition when the patient's destination is an acute care Hospital, and:

1. the pick-up point is not accessible by ground Ambulance, or
2. speed in excess of the ground vehicle is critical for your health or safety.

Air Ambulance transport for non-emergency transport is excluded unless it is specifically approved by us in advance of the transport.

Exclusions:

Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

1. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
2. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
    a. the crew renders aid until a helicopter can be sent;
    b. the patient refuses care or transport; or
    c. only basic first aid is rendered.
3. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
4. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
5. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
    a. patient wants to be at a certain Hospital or facility for personal/preference reasons;
    b. patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment, or for continued treatment, including patients who have recently been discharged from inpatient care; or
    c. patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for and/or find such transportation.
6. Air Ambulance Services in the absence of an Emergency Medical Condition,unless such Services are authorized by us in advance.

The **Autism Spectrum Disorder** category is amended by deleting the Coverage Access Rules for Autism Spectrum Disorder in its entirety and replacing it with the following:

Payment Guidelines for Autism Spectrum Disorder

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization

will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition**.**

Note: In order to determine whether such Services are covered under this Benefit Booklet, we reserve the right to request a formal written treatment plan signed by the treating physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

The **Dental** category is amended by deleting list item "b" in its entirety and replacing it with the following:

b) you or your Covered Dependent has one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

The Maternity Services category is amended by deleting the **Exclusion** in its entirety.

The **Payment Guidelines for Physician Services Provided by Electronic Means through a Computer** category is amended by deleting the **Exclusion** in its entirety and replacing it with the following:

Expenses for online medical Services provided electronically through a computer by a Physician via the Internet other than through a healthcare communication services vendor that has entered into contract with BCBSF are excluded. Expenses for online medical Services provided by a health care provider that is not a Physician and expenses for Health Care Services rendered by telephone (except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section) are also excluded.

The **Self-Administered Prescription Drugs** category is amended by deleting number 2 in its entirety.

The **Surgical Procedures** category is amended by adding item number 6 as follows:

6. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

   Exclusions:

   The following Services, which are considered cosmetic in nature, are not covered when used to improve the gender-specific appearance of an individual. Examples of Services which are considered cosmetic include, but are not limited to:

   a. reduction thyroid chondroplasty;

   b. liposuction;

   c. rhinoplasty;

   d. facial bone reconstruction;

   e. face lift;

   f. blepharoplasty;

   g. voice modification surgery;

   h. hair removal/hairplasty; or

   i. breast augmentation.

The following category is added:

Down Syndrome

Down syndrome Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older is attending high school, consisting of:

1. Applied Behavior Analysis, when rendered by an individual certified per Section 393.17 of the Florida Statutes; and
2. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Down syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Guidelines for Down Syndrome

Applied Behavior Analysis Services for Down syndrome must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required for Emergency Services provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

WHAT IS NOT COVERED?

The **General Exclusions** subsection is amended by deleting the following **Exclusions** in their entirety and replacing them with the following:

7b. your participation in, or commission of, any act punishable by law as a felony whether or not you are charged or convicted, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical condition;

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants,or services used to improve the gender specific appearance of an individual including, but not limited to reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty, breast augmentation.

Costs related to telephone consultations (except as indicated as covered under the Preventive Health Services category of the COVERED SERVICES section) , failure to keep a scheduled appointment, or completion of any form and /or medical information.

Smoking Cessation Programs including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products

(e.g., gum, transdermal patches, etc.),except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section.

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition, except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food.

The **Motor Vehicle Accidents Exclusion** is deleted in its entirety and replaced with the following:

Motor Vehicle Accidents Injuries and Services you incur due to an accident involving any motor vehicle for which no-fault insurance is available.

The following Exclusions are deleted in their entirety: item number 2d. under the **Drugs** exclusion, **Maternity Services** and the **Sexual Reassignment, or Modification Services.**

UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Understanding Your Share of Health Care Expenses** section has been amended by adding the following after the first paragraph:

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly.

PHYSICIANS, HOSPITALS AND OTHER PROVIDER OPTIONS

The **Physician, Hospital and Other Provider Options** section has been amended by adding the following new subsection:

Value Choice Providers

Some Providers, designated by us, may provide Services other than advanced imaging, maternity and Medical Pharmacy at a lower cost share. The DED will be waived for these Services and are available at a lower cost share of $5 when they are rendered in the Value Choice Provider's office. To find a Value Choice Provider you may access the most recent provider directory at www.floridablue.com. These

Providers will be designated under the heading Value Choice Providers. Advanced imaging, maternity and Medical Pharmacy Services will remain at the cost share listed on your Schedule of Benefits.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

The **Other Provisions Regarding Enrollment and Effective Date of Coverage** subsection is amended by deleting number 1 in its entirety and replacing it with the following:

1. Rehired Employees:

Individuals who are rehired as employees of the Group are considered newly hired employees for purposes of this section, unless the employer has indicated that the employee qualifies for the exception as described in the federal regulations. The provisions of the Group Master Policy (which includes this Booklet), which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, Pre-existing Condition exclusionary period, and Waiting Period) are applicable to rehired employees and their Eligible Dependents if the employee does not qualify for the federal exception.

DEFINITIONS

The following definition is added:

Down syndrome means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

The following definitions are deleted in their entirety: **Gestational Surrogate** and the **Gestational Surrogacy Contract or Arrangement**.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueScript® Pharmacy Program 2017 Amendment

This amendment is to be attached to and made part of your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet ("Booklet"). Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2017** or first Anniversary Date occurring on or after **January 01, 2017,** whichever occurs first.

COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Covered Prescription Drugs and Supplies and Covered OTC Drugs** section is amended by deleting the following numbered items in their entirety and replacing them with the following:

3. Medically Necessary, as defined in this Booklet and determined by us in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;

7. a Prescription Drug contained in an anaphylactic kit;

The following is added to the numbered list:

12 within the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs category listed in this Endorsement.

COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Contraceptive Coverage** category is amended by deleting the first paragraph in its entirety and replacing it with the following:

Contraceptive Coverage

Prescription diaphragms, oral contraceptives and contraceptive patches will be covered under this Endorsement unless indicated as not covered on the BlueScript Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this Endorsement.

LIMITATIONS AND EXCLUSIONS

The **Limitations** section is amended adding the following numbered item:

6. We reserve the right to cover the Biosimilar Prescription Drug as an alternative to coverage of the referenced Brand Name Prescription Drug.

The **Exclusions** section is amended by deleting the following numbered items in their entirety and replacing them with the following:

7g. used for smoking cessation, except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section in the Booklet or on the BlueScript Pharmacy Program Schedule of Benefits;

19. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage;

21d. The Drug, or an effective alternative, is available Over-the-Counter (OTC);

Item number 23. is deleted in its entirety and replaced with the following:

23. We reserve the right not to apply manufacturer or provider cost share assistance program payments (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket maximums.

DEFINITIONS

The **Definitions** section is amended by deleting the following definition in its entirety and replacing it with the following:

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee. Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee, resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee, or
2. December 31st of the following Calendar Year.

The following definition is added:

Biosimilar Prescription Drug is a biological product that is approved by the FDA because it is highly similar to an already FDA-approved biological product (know as a reference product). A Biosimilar Prescription Drug has no clinically meaningful difference in terms of safety and effectiveness from the reference product it is compared to.

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

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2018 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") BlueOptions Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group Plan's initial Effective Date occurring on or after **January 01, 2018** or first Anniversary Date occurring on or after **January 01, 2018** whichever occurs first.

WHAT IS COVERED?

The **Ambulance Services** category is deleted it in its entirety and replaced with the following:

Ambulance Services

Ground Ambulance

Ground Ambulance Services for Emergency Medical Conditions and limited non-emergency ground transport may be covered only when:

1. For Emergency Medical Conditions – it is Medically Necessary to transport you from the place an Emergency Medical Condition occurs to the nearest Hospital that can provide the Medically Necessary level of care. If it is determined that the nearest Hospital is unable to provide the Medically Necessary level of care for the Emergency Medical Condition, then coverage for Ambulance Services shall extend to the next nearest Hospital that can provide Medically Necessary care; or
2. For limited non-emergency ground Ambulance transport – it is Medically Necessary to transport you by ground:
    a. from an Out-of-Network Hospital to the nearest In-Network Hospital that can provide care;
    b. to the nearest In-Network or Out-of-Network Hospital for a Condition that requires a higher level of care that was not available at the original Hospital;
    c. to the nearest more cost-effective acute care facility as determined solely by us; or
    d. from an acute facility to the nearest cost-effective sub-acute setting.

Note: Non-emergency Ambulance transportation meets the definition of Medical Necessity only when the patient's Condition requires treatment at another facility and when another mode of transportation, whether by Ambulance or otherwise (regardless of whether covered by us or not) would endanger the patient's medical Condition. If another mode of transportation could be used safely and effectively, regardless of time, or mode (e.g. air, ground, water) then Ambulance transportation is not Medically Necessary.

Air and Water Ambulance

Air and water Ambulance coverage is specifically limited to transport due to an Emergency Medical Condition when the patient's destination is an acute care Hospital, and:

1. the pick-up point is not accessible by ground Ambulance, or
2. speed in excess of the ground vehicle is critical for your health or safety.

Air and water Ambulance transport for non-emergency transport is excluded unless it is specifically approved by us in advance of the transport.

Exclusion

Ground, air and water Ambulance Services for situations that are not Medically Necessary because they do not require Ambulance transportation including but not limited to:

1. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
2. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
    a. the crew renders aid until a helicopter can be sent;
    b. the patient refuses care or transport; or
    c. only basic first aid is rendered.
3. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
4. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
5. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
    a. patient wants to be at a certain Hospital or facility for personal/preference reasons;
    b. patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment), or after being discharged from inpatient care; or
    c. patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.
6. Air or water Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

The **Emergency Services** category is deleted in its entirety and replaced with the following:

Emergency Services and Urgent Care Services

Emergency Services

Emergency Services for treatment of an Emergency Medical Condition are covered In-Network and Out-of-Network without the need for any prior authorization from us.

Urgent Care Services

For non-critical but urgent care needs, you may be able to reduce your out-of-pocket expenses and, in many cases, your wait time for care by using an Urgent Care Center. All Urgent Care Centers maintain extended weekday and weekend hours. Urgent Care Centers treat non-emergency conditions such as:

- Animal bites
- Cuts, scrapes and minor wounds
- Minor burns
- Minor eye irritations or infections
- Rash, poison ivy
- Sprains, strains, dislocations and minor fractures

The **Physician Services** category is deleted in its entirety and replaced with the following:

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility. Certain Physician Services can be rendered electronically through a computer via the Internet (E-Visits). E-Visits are covered when rendered in accordance with the Payment Rules below.

Payment Rules for E-Visits

Expenses for E-Visits are covered only if:

1. you are an established patient of the Physician rendering the Services at the time the Services are provided; and
2. the Services are provided in response to an online inquiry you sent to the Physician.

The term "established patient", as used in this category, shall mean that the covered individual has received professional Services from the Physician who provided the E-Visit, or another Physician of the same specialty who belongs to the same group practice as that Physician, within the past three years.

Exclusion

1. Expenses for failure to keep a scheduled appointment or scheduled E-visit and for telephone consultations (except as indicated as covered under the Preventive Service category of this section).
2. Telemedicine Services, as defined in this Benefit Booklet.
3. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

The **Prosthetic Devices** category is amended by deleting the exclusion in its entirety and replacing it with the following:

Exclusion

Expenses for cosmetic enhancements to artificial limbs.

WHAT IS NOT COVERED?

The **Drugs** exclusion is amended by adding the following:

5. New Prescription Drug(s), as defined in the DEFINITIONS section.
6. Convenience Kits, as defined in the DEFINITIONS section of the Booklet.
7. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Medical Policy Committee or any other nationally recognized source.

The following exclusion is added:

Telemedicine Services, as defined in this Benefit Booklet.

UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Additional Expenses You Must Pay** subsection is amended by adding the following:

Special Payment Rules

Emergency Services in an Emergency Room

Payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered.

Additionally, payments for Emergency Services by an Out-of-Network Provider will comply with any applicable federal law.

Non-Emergency Services

Payment for Services rendered by an Out-of-Network Provider will comply with section 627.64194(4) of the Florida Statutes when:

- such Services are rendered in an In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center; and
- you do not have the ability and opportunity to choose an In-Network Provider at the In-Network Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center who is available to treat you; and,
- section 627.64194(3) of the Florida Statutes is applicable to the Services rendered.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

BLUEPRINT FOR HEALTH

The note at the end of the **Prior Coverage Authorization /Pre-Service Notification Programs** section is deleted it in its entirety and replaced with the following:

Note:

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior coverage authorizations expire on the earlier of, but not to exceed 12 months:
   a. the termination date of your plan, or
   b. the period authorized by us, as indicated in the letter you receive from us.

   Subject to our review and approval, we may authorize continued coverage of a previously approved Service. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS/PROGRAMS

The **Coordination of Benefits** subsection is amended by deleting list numbers 4 through 7 of the second numbered list in the section and replacing them with the following:

4. When we cover a dependent child whose parents are not married, or are separated or divorced:
   a. the plan of the parent with custody is primary;
   b. the plan of the remarried parent with custody is primary; the step-parent's plan is secondary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; and
   c. the plan of the parent without custody is last;
   d. regardless of which parent has custody, when a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:
   a. the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;
   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

6. If you have continuation of coverage under COBRA or Florida Health Insurance Coverage Continuation Act (FHICCA or mini COBRA), and also under another group plan, the following order of benefits applies:

   a. first, the plan covering the person as an employee, or as the employee's dependent; and

   b. second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA or FHICCA.

7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the Covered Person the longest shall be primary.

DEFINITIONS

The following definitions are added:

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

E-Visit, for purposes of the Benefit Booklet, means online assessment and management Services provided to an established patient by a Physician or other qualified health care professional; that does not originate from a related Physician Service rendered within the previous 7 days; using the internet or similar electronic communications network.

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The New Prescription Drug Coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination).

   or

2. December 31st of the following Calendar Year.

Telemedicine means the practice of medicine by a licensed Florida Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of Health Care Services solely through (1) audio-only telephone; (2) email messages; (3) text messages; (4) facsimile transmission; (5) U.S. Mail or other parcel service; or (6) any combination thereof.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2019 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2019** or first Anniversary Date occurring on or after **January 01, 2019** whichever occurs first.

WHAT IS COVERED?

The **Prosthetic Devices** category is amended by deleting the exclusion in its entirety replacing it with the following.

Exclusion

Expenses for cosmetic enhancements to artificial limbs.

The **Self-Administered Prescription Drugs** category is amended by deleting item number 3 in its entirety.

The **Transplant Services** category is amended as follows:

Item number 3 in the coverage list is deleted in its entirety and replaced with the following:

3. Hearth transplant;

Item numbers 2 and 4 are deleted in their entirety and replaced with the following:

2. Transplant procedures involving the transplantation of any non-human animal organ or tissue.
4. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.

Item number 9 is deleted in its entirety.

WHAT IS NOT COVERED?

The **Drugs** exclusion is amended by deleting item number 8 in its entirety.

The **Complications of Non-Covered Services** and **Weight Control Services** exclusions are deleted in their entirety and replaced with the following:

Services to Treat Complications of Non-Covered Services, including any Services(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities

as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this Booklet or another BCBSF/HOI policy. It also applies if the non-Covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) were covered under the prior carrier or self-funded plan.

Weight Control Services including any Service to lose, gain or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition ,(except as indicated as covered under the Preventive Health Services category of the WHAT IS COVERED? section). This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food. Complications of any kind arising from, or related to, weight control surgery, as determined by us, are not covered. Complications of weight control surgery are excluded when the preceding weight control surgery was not a Covered Service under this Booklet or another BCBSF/HOI policy and it also applies if the surgery was performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) was/were covered under the prior carrier or self-funded plan.

PHYSICIANS, HOSPITALS AND OTHER PROVIDER OPTIONS

The **Provider Participation Status** subsection is amended by deleting the third paragraph in its entirety and replacing it with the following:

With BlueOptions, you may choose to receive Services from any Provider. However, you will be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider.

Family Physician Program

We encourage you to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician (Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians)

- Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs.
- Developing and continuing a relationship with a Family Physician allows the Physician to become knowledgeable about you and your family's health history.
- A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific healthcare needs.
- Care rendered by Family Physicians usually results in lower out-of-pocket expenses for you.

We will check our records periodically to see if you have visited a Family Physician. If not, we may provide your name and contact information to an In-Network Family Physician who will call you and offer to schedule a wellness visit. This program is completely voluntary and although we encourage you to schedule this visit, you are not obligated to do so. The applicable Family Physician Cost Share will apply to this visit.

You are responsible for checking to see if a Provider is In-Network for your plan prior to receiving Services. To find out if a Provider is In-Network, refer to the current Provider directory at www.floridablue.com or call the customer service phone number on your ID Card.

UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The following **new** subsection is added:

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 627.6385 of the Florida Statutes.

BLUECARD® PROGRAM

The **BCBS Global Core Program** subsection is deleted in its entirety and replaced with the following:

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these Services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Covered Services. **You must notify us of any non-emergency inpatient Services**.

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

ELIGIBILITY FOR COVERAGE

The **Handicapped Children** subsection is deleted in its entirety and replaced with the following:

Children with Disabilities

In the case of a dependent child with an intellectual or physical disability, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 30, if the child is:

1. otherwise eligible for coverage under the Group Plan;
2. incapable of self-sustaining employment by reason of intellectual or physical disability; and
3. chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of the child's intellectual or physical disability existed prior to the child's 30th birthday.

This eligibility will terminate on the last day of the month in which the dependent child no longer meets these requirements.

TERMINATION OF COVERAGE

The **Covered Dependent** section is amended by deleting the first paragraph after the numbered list in its entirety and replacing it with the following:

If you as the Covered Employee wish to delete a Covered Dependent from coverage, you must complete an Enrollment Form and submit it to the Group prior to the termination date requested.

CLAIMS PROCESSING

The **Standards for Adverse Benefit Determinations** is amended by deleting the **How to Appeal an Adverse Benefit Determination** subsection in its entirety and replacing it with the following:

How to Appeal an Adverse Benefit Determination

Except as described below, you, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using

the process described below. Your appeal must be submitted in writing to us for an internal appeal, within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

1. You must cooperate fully with us in our effort to promptly review and resolve an appeal. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the appeal processed within the time frames set forth in this section.
2. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The expedited appeal process only applies to Pre-Service Claims or requests for extension of concurrent care Services made within 24 hours before the authorization for such Services expires. An expedited appeal will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
3. We must receive your appeal of an Adverse Benefit Determination in person or in writing.
4. You may review pertinent documents, upon request and free of charge, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date.
6. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request.
10. If the claim is a Claim Involving Urgent Care, you may request an expedited review orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method.
11. If your request for expedited review arises out of a concurrent review determination by us that a continued hospitalization is not Medically Necessary, coverage for the hospitalization will continue until you have been notified of the determination.

12. We will review the appeal and may make a decision based on medical records, additional information and input from health care professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review.

13. We will advise you of all appeal decisions in writing, as outlined in the Timing of Our Appeal Review on Adverse Benefit Determinations subsection.

14. If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.floridablue.com or by calling the number on your ID card.

15. If you are not satisfied with our decision, you have the right to an independent external review through an external review organization for certain appeals, as described in the How to Request External Review of Our Appeal Decision subsection below.

Appeals must be sent to the address below:

Blue Cross and Blue Shield of Florida
Attention: Member Appeals
P.O. Box 44197
Jacksonville, Florida 32231-4197

Timing of Our Appeal Review on Adverse Benefit Determinations

We will use our best efforts to review your appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

1. Pre-Service Claims: within 30 days of the receipt of your appeal;

2. Post-Service Claims: within 60 days of the receipt of your appeal; or

3. Claims Involving Urgent Care (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services): within 72 hours of receipt of your request. If additional information is necessary we will notify you within 24 hours and we must receive the requested additional information within 48 hours of the request. After we receive the additional information, we will have an additional 48 hours to make a final determination.

Note: The nature of a claim for Services (i.e. whether it is “urgent care” or not) is judged as of the time of the benefit determination on review, not as of the time the Service was initially reviewed or provided.

The following **new** provision is added:

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted our appeal requirements (“Deemed Exhaustion”) and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-

prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueScript 2019 Pharmacy Program Amendment

This amendment is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto.

Your BlueScript Pharmacy Program Endorsement is amended as described below. If you have any questions or complaints concerning this amendment, please call us toll free at 800-FLA-BLUE.

This amendment is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2019** or first Anniversary Date occurring on or after **January 01, 2019** whichever occurs first.

COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Covered Over-the-Counter (OTC) Drugs** category is deleted in its entirety and replaced with the following:

Covered Over-the-Counter (OTC) Drugs

Certain OTC Drugs, listed in the Medication Guide, may be covered when you get a Prescription for the OTC Drug from your Physician. Only OTC Drugs that are listed in the Medication Guide are covered.

Covered OTC Drugs are listed in the most current Medication Guide which can be viewed at www.floridablue.com or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.

The **Oral Chemotherapy Drugs** category is deleted in its entirety and replaced with the following:

Oral Chemotherapy Drugs

Your Cost Share for oral Prescription Drugs used to kill or slow the growth of cancerous cells (chemotherapy), as consistent with nationally accepted standards, shall not exceed the Cost Share for Intravenous (IV) Chemotherapy Infusions when provided from an In-Network Provider.

LIMITATIONS AND EXCLUSIONS

Exclusion number 7.n. is deleted in its entirety.

This amendment 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 the provisions contained in this amendment. In the event of any inconsistencies between the provisions contained in this amendment and the provisions contained in the Benefit Booklet, the provisions contained in this amendment shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2020 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2020** or first Anniversary Date occurring on or after January **01, 2020** whichever occurs first.

WHAT IS COVERED?

The **Physician Services** category is deleted in its entirety and replaced with the following:

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility.

Exclusion

Expenses for failure to keep a scheduled appointment and for telephone consultations (except as indicated as covered under the Preventive Health Services category of this section).

The following **new** category is added in alphabetical order:

Virtual Visits

Covered Services may be provided via a Virtual Visit. Virtual Visits are limited to:

- Virtual Visits between you and a Virtual Care Provider that is designated by us and has a contract with us to provide Virtual Visits at the time the Services are rendered. Virtual Visits must be provided consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered.

  Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion

Expenses for failure to keep a scheduled appointment or scheduled Virtual Visit.

WHAT IS NOT COVERED?

The **Telemedicine** exclusion is deleted in its entirety.

The following **new** exclusions are added:

Virtual Visits, except as described in the WHAT IS COVERED? section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits and does not have a contract with us to provide Virtual Visits under this Booklet.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
    a. a licensed outdoor youth program, and/or
    b. a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

GENERAL PROVISIONS

The **Customer Rewards Program** provision is deleted in its entirety and replaced with the following:

Customer Rewards Program

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

DEFINITIONS

The **Certified Nurse Midwife, Certified Registered Nurse Anesthetist** and **Convenient Care Center** definitions are deleted in their entirety and replaced with the following:

Certified Nurse Midwife means a person who is properly licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced practice registered nurse and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is a certified advanced practice registered nurse within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or similar applicable laws of another state.

Convenient Care Center means a properly licensed ambulatory center that: (1) treats a limited number of common, low-intensity illnesses when ready-access to the patient's primary Physician is not possible; (2) shares clinical information about the treatment with the patient's primary Physician; (3) is usually housed in a retail business; and (4) is staffed by at least one master's level advanced practice registered nurse (APRN) who operates under a set of clinical protocols that strictly limit the Conditions the APRN can treat. Although no Physician is present at the convenient care center, medical oversight is based on a written collaborative agreement between a supervising Physician and the APRN.

The **E-Visit** and **Telemedicine** definitions are deleted in their entirety.

The following **new** definitions are added in alphabetical order:

Virtual Care Provider is a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered. A Provider that is designated to offer Virtual Care will be indicated as such in the provider directory.

Virtual Visit, for purposes of this Benefit Booklet, means the lawful practice of medicine by a Virtual Care Provider where patient care, treatment or Services are rendered, in place of a face-to-face visit, through the use of medical information exchanged via electronic communications.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2021 Changes Endorsement

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Endorsement, please call us toll free at 800-FLA-BLUE.

This Endorsement is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2021** or first Anniversary Date occurring on or after January **01, 2021** whichever occurs first.

WHAT IS COVERED?

The **Transplant Services** category is deleted in its entirety and replaced with the following:

Transplant Services

Transplant Services, limited to the procedures listed below, are covered when performed at a facility acceptable to us. Coverage is subject to the conditions and limitations described below. Transplant includes pre-transplant, transplant and post-discharge Services, and treatment of complications after transplantation.

1. Bone Marrow Transplant, as defined herein and specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. We will cover the expenses incurred for the donation of bone marrow by a donor to o the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant;
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. whole single or whole bilateral lung transplant.

You may call the customer service phone number on your ID Card in order to determine which Bone Marrow Transplants are covered under this Booklet.

Lodging and Transportation

Expenses for lodging (hotel, motel, apartment or house rentals) and transportation (air, rail, bus, and/or taxi) for a transplant recipient and companion may be covered when:

1. the transplant recipient is a Covered Person at the time Services are rendered;
2. Covered Services are performed at a Designated Transplant Facility;
3. lodging and transportation to and from the Designated Transplant Facility are booked through a travel agency designated by us;
4. the transplant has been approved by us in advance; and
5. the facility where the transplant will be performed is 50 miles or more away from the recipient's home.

The lodging and transportation benefit is limited to $10,000 per transplant.

Exclusion

1. Transplant procedures not included in the list above, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** we are contacted for authorization.
3. Transplant procedures which are not authorized by us **before** they are provided.
4. Transplant procedures involving the transplantation or implantation of any non-human animal organ or tissue.
5. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.
6. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.
7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any Service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
10. Any non-medical costs, including, but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility, except as indicated under the Lodging and Transportation heading above.
11. Expenses related to evaluation for registration at more than one transplant center (dual listing).
12. Travel expenses that are not authorized by us in advance and those associated with:
    a) transplants that are not covered under this Booklet;

b) dual listing; or

c) costs not allowed under IRS regulations.

WHAT IS NOT COVERED?

The following **Transplant Services** exclusion is added.

Transplant Services except as indicated in the WHAT IS COVERED? section, including:

1. Transplant procedures not included in the Transplant Services category of the WHAT IS COVERED? section, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** we are contacted for authorization.
3. Transplant procedures which are not authorized by us **before** they are provided.
4. Transplant procedures involving the transplantation of any non-human animal organ or tissue.
5. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.
6. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.
7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
10. Any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility, except as indicated under the Lodging and Transportation heading of the Transplant Services category in the WHAT IS COVERED? section.
11. Expenses related to evaluation for registration at more than one transplant center (dual listing).
12. Travel expenses that are not authorized by us in advance and those associated with:
    a. transplants that are not covered under this Booklet;
    b. dual listing; or
    c. costs not allowed under IRS regulations.

PHYSICIANS, HOSPITALS AND OTHER HEALTH CARE PROVIDER OPTIONS

The **Value Choice Providers** subsection is deleted in its entirety and replaced with the following:

Value Choice Providers

Some Providers, designated by us, may provide Services other than advanced imaging, maternity and Medical Pharmacy at a lower Cost Share. The Deductible will be waived for these Services and your Cost Share is lower when they are rendered in the Value Choice Provider's office. The chart below lists the Services included and the Cost Share amounts:

Value Choice Provider Type	Services Included	Cost Share
Primary Care Physician	• Office Visits* • Diagnostic Testing (such as lab work and x-rays done in the office) • Allergy Testing and Injections	$0
Specialist Physician	• Office Visits* • Diagnostic Testing (such as lab work and x-rays done in the office)	$20**
Dietician / Nutritionist	Covered Services such as Diabetic Education	$0
Urgent Care Center	Covered urgent care Services for the first 2 visits per Covered Person, per Benefit Period	$0 for first 2 visits***

* Advanced imaging, maternity and Medical Pharmacy Services will remain at the Cost Share listed on your Schedule of Benefits.

** Or the Specialist Physician office Cost Share listed on your Schedule of Benefits; whichever is lower.

*** After the first 2 visits, the urgent care Cost Share listed on your Schedule of Benefits will apply.

To find a Value Choice Provider, access the most recent provider directory at www.floridablue.com and look for Providers with "Value Choice Providers" under "Programs".

BLUEPRINT FOR HEALTH PROGRAMS

The **Prior Coverage Authorization/ Pre-Service Notification Programs** subsection is deleted in its entirety and replaced with the following:

Prior Coverage Authorization/ Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these requirements and ultimately how much you will have to pay under this Booklet.

You or your Physician will be required to obtain prior coverage authorization from us for Covered Services listed below. You are solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider.

For details on how to obtain prior coverage authorization for these Services, please call the customer service phone number on your ID Card.

Services that Require Prior Authorization

Advanced Diagnostic Imaging Services

You must obtain an authorization for advanced diagnostic imaging Services such as CT scans, MRIs, MRA and nuclear imaging, when rendered or referred by a Provider **before** the advanced diagnostic imaging Services are provided. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Applied Behavioral Analysis

You must obtain an authorization for Applied Behavioral Analysis for Autism Spectrum Disorder or Down Syndrome, **before** the Services are provided. **If you do not obtain prior coverage authorization this plan will not make any payment for such Services**.

Approved Clinical Trials

You must obtain an authorization for Services rendered in connection with Approved Clinical Trials, when rendered or referred by a Provider **before** you obtain routine patient care provided in connection with an Approved Clinical Trial. **If you do not obtain prior coverage authorization this plan will not make any payment for such Services**.

Prescription Drugs

In the case of Prescription Drugs, it is your sole responsibility to obtain prior coverage authorization **before** the drug is purchased or administered. **If you do not obtain prior coverage authorization, this plan will deny coverage for the Prescription Drug and not make any payment for the drug or any Service related to the drug or its administration.**

All Prescription Drugs covered under the Medical Pharmacy category in the WHAT IS COVERED? section, require prior authorization. For a list of other medications that require prior coverage authorization and details on how to get an authorization, please refer to the Medication Guide.

Transplant Services

You must obtain an authorization for all Transplant Services, including the pre-transplant evaluation **before** the transplant evaluation is scheduled. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Other Health Care Services

In the case of other Health Care Services under a prior coverage authorization or pre-service notification program, you must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

We will inform you of any Health Care Service that is or will become subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to you upon enrollment, or at least 30 days prior to such Services becoming subject to a prior coverage authorization or pre-service notification program. Such information may be provided to you electronically, if you have elected the delivery of notifications from us in that manner. Changes to the list of other Health Care Services that require prior authorization shall occur no more frequently than twice in a Calendar Year.

Additional Information

Once the necessary medical documentation has been received from you and/or the Provider, Florida Blue or a designated vendor, will review the information and make a prior coverage authorization decision, based on our established criteria then in effect. You will be notified of the prior coverage authorization decision.

If you do not obtain authorization or provide pre-service notification, we may:

1. deny payment of the claim; or
2. apply a benefit penalty when the claim is presented to us for payment consisting of one of the following:
    a. $500
    b. 20% of the total Allowed Amount of the claim; or
    c. The lesser of $500 or 20% of the total Amount of the claim.

The decision to apply a penalty or deny the claim will be made uniformly and the applicable denial/penalty will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

Note:

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior coverage authorizations expire on the earlier of, but not to exceed 12 months:
    a. the termination date of your policy, or
    b. the period authorized by us, as indicated in the letter you receive from us.

Subject to our review and approval, we may authorize continued coverage of a previously approved Service. To request a continuation we must receive appropriate documentation from your Provider. The fact that we may have previously authorized coverage does not guarantee a continued authorization.

See the CLAIMS PROCESSING section for information on what you can do if prior coverage authorization is denied.

GENERAL PROVISIONS

The **Customer Rewards Program** provision is deleted in its entirety and replaced with the following:

Customer Rewards and Incentive Programs

From time to time we may offer you rewards or incentives for participating in certain activities and programs. These may be one-time rewards, available periodically or related to completing activities under a particular program. This includes but is not limited to shared savings incentive programs as defined under Florida law.

Types of Rewards or Incentives

The rewards and incentives available to you may exceed $100 per year and may include things like Premium credits, reduced Copayments, Coinsurance or Deductibles, cash equivalents or other incentives such as gift cards, debit cards, free or low cost transportation for medical Services, discounts, contributions to a health savings account and memberships to gyms or other programs.

Types of Programs

Rewards and incentives may be earned by taking part in programs or activities that focus on (for example):

- managing specific Conditions;
- preventive or wellness Services;
- certain behaviors, such as completing an annual physical; or
- optimizing your health plan, such as filling out a health assessment upon enrollment.

These are only examples of the types of programs that may be available to you. By logging into your rewards portal, you will be able to track rewards you have earned and access other programs that may be available to you.

Transportation Program

We understand that access to transportation can sometimes be a barrier to getting the health care you need. To assist you, we may offer programs to help you access health and wellness facilities and services.

Note: We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. You may not have access to every reward, incentive, health or transportation program. You are not obligated to take part in any of these programs and they will not affect the coverage available to you under this Booklet. We reserve the right to stop or change the features of any rewards or incentive programs at any time. The rewards, incentives or transportation provided may be taxable income and you should consult a tax advisor for further guidance.

DEFINITIONS

The following **new** definition is added in alphabetical order:

Designated Transplant Facility is a licensed facility that is designated by us and has a contract with us to provide covered transplant Services at the time the Services are rendered. Designated transplant facilities may or may not be located in the Service Area. The fact that a Hospital is an In-Network Hospital does not mean that it is a designated facility.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2021 Pharmacy Program Changes Amendment

This Amendment is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet and any Endorsements attached thereto.

If you have any questions or complaints concerning this Amendment, please call us toll free at 800-FLA-BLUE.

This Amendment is effective at your Group plan's initial Effective Date occurring on or after **January 01, 2021** or first Anniversary Date occurring on or after **January 01, 2021** whichever occurs first.

COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES AND COVERED OTC DRUGS

The **Contraceptive Coverage** category is amended by deleting the **Exclusion** in its entirety and replacing it with the following:

Exclusion

Contraceptive injectable Prescription Drugs (unless indicated as covered in the Medication Guide) and implants, such as Norplant and IUD inserted for any purpose are excluded from coverage under this Endorsement.

LIMITATIONS AND EXCLUSIONS

Exclusion Number 24 is deleted in its entirety and replaced with the following:

24. We may not apply manufacturer or provider cost share assistance program payments (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket maximums.

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Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2022 Changes Endorsement

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WHAT IS COVERED?

The **Autism Spectrum Disorder** and **Down Syndrome** categories are deleted in their entirety and replaced with the following:

Autism Spectrum Disorder and Down Syndrome

Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with a Developmental Disability prior to his or her 9th birthday consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by a person certified per Florida Statutes Section 393.17 or licensed under Chapters 490 or 491; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder and Down Syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Rules for Autism Spectrum Disorder and Down Syndrome

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition**.**

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

The **Surgical Procedures** category is amended as follows:

List item 6 is deleted in its entirety and replaced with the following:

6. gender reassignment surgery and Services, including breast augmentation and reduction mammoplasty related to gender dysphoria or gender transition are covered.

Exclusions h and i are deleted in their entirety and replaced with the following:

h) hair removal/hairplasty; and

i) breast augmentation and reduction mammoplasty, except as specifically indicated as a Covered Service elsewhere in this Booklet.

The **Transplant Services** category is amended as follows:

The **Lodging and Transportation** subsection is deleted in its entirety and replaced with the following:

Lodging and Transportation

Expenses for lodging (hotel, motel, apartment or house rentals) and transportation (air, rail, bus, and/or taxi) for a transplant recipient and companion may be covered when:

1. the transplant recipient is a Covered Person at the time Services are rendered;
2. the transplant is a Covered Service at the time Services are rendered and is designated by us as eligible for lodging and transportation assistance. Please note that only certain types of transplants are eligible for lodging and transportation assistance; the fact that a transplant is a Covered Service under this Booklet, does not mean such transplant is eligible for lodging and transportation assistance;
3. Covered Services are performed at a Designated Transplant Facility;
4. lodging and transportation arrangements to and from the Designated Transplant Facility are coordinated through us;
5. the transplant, including pre-transplant evaluation has been approved by us in advance; and
6. the facility where the transplant will be performed is 50 miles or more away from the recipient's home, unless a shorter distance is Medically Necessary, as determined by us.

The lodging and transportation benefit is limited to $10,000 per Transplant Travel Benefit Period.

Exclusions 2 and 12 are deleted in their entirety and replaced with the following:

2. Transplant evaluations, for transplants designated by us as eligible for lodging and transportation assistance, rendered **before** we are contacted for authorization.

12. Travel expenses that are not authorized by us in advance and those associated with:

a) transplants that are not covered under this Booklet;

b) evaluation for registration at more than one transplant center (dual listing); or

c) costs considered taxable income under IRS regulations.

The **Virtual Visits** category is deleted in its entirety and replaced with the following:

Virtual Visits

Your plan covers Virtual Visits between you and a Virtual Care Provider when rendered consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered. Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Exclusion

1. Expenses for failure to keep a scheduled Virtual Visit.
2. Virtual Visits rendered by any Provider other than a Virtual Care Provider, as defined in the DEFINITIONS section.

WHAT IS NOT COVERED?

The **Cosmetic Services** exclusion is deleted in its entirety and replaced with the following:

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants, or services used to improve the gender specific appearance of an individual including, but not limited to breast augmentation and reduction mammoplasty except as specifically indicated as a Covered Service elsewhere in this Booklet, reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, and hair removal/hairplasty.

The **Transplant Services** category is amended by deleting **Exclusions 2 and 12** in their entirety and replacing with the following:

2. Transplant evaluations, for transplants designated by us as eligible for lodging and transportation assistance, rendered **before** we are contacted for authorization.

12. Travel expenses that are not authorized by us in advance and those associated with:

    d) transplants that are not covered under this Booklet;

    e) evaluation for registration at more than one transplant center (dual listing); or

    f) costs considered taxable income under IRS regulations.

The **Virtual Visits** exclusion is deleted in its entirety and replaced with the following:

Virtual Visits, except as described in the WHAT IS COVERED? section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits under this Booklet.

UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Copayment Requirements** subsection is amended by deleting the **Copayment for Emergency Room Facility Services** paragraph in its entirety and replacing it with the following:

The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Coinsurance amount, and applies to emergency room facility Services in or outside the state of Florida. The Copayment for emergency room facility Services, if applicable to your plan, must be satisfied by you for each visit. If you are admitted to the Hospital as an inpatient at the time of the emergency room visit, you will pay the Cost Share that applies to inpatient facility Services, as listed in your Schedule of Benefits.

The **Special Payment Rules** subsection is amended as follows:

The first paragraph under **Emergency Services in an Emergency Room** is deleted in its entirety and replaced with the following:

Unless modified by the federal No Surprises Act (H.R. 133, P.L. 116-260), payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered.

The first paragraph under **Non-Emergency Services** is deleted in its entirety and replaced with the following:

Unless modified by the federal No Surprises Act (H.R. 133, P.L. 116-260), payment for Services rendered by an Out-of-Network Provider will comply with section 627.64194(4) of the Florida Statutes when:

PHYSICIANS, HOSPITALS AND OTHER PROVIDER OPTIONS

The **Value Choice Providers** subsection is deleted in its entirety and replaced with the following:

Value Choice Providers

Some Providers, designated by us, may provide Services other than maternity and Medical Pharmacy at a lower Cost Share. The Deductible will be waived for these Services and your Cost Share is lower when they are rendered in the Value Choice Provider's office or Independent Diagnostic Testing Centers designated as Value Choice Providers. The chart below lists the Services included and the Cost Share amounts:

Value Choice Provider Type	Services Included	Cost Share
Primary Care Physician	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Allergy Testing and Injections • Diagnostic Testing (such as lab work and x-rays done in the office) • Occupational Therapy and Physical Therapy	$0
Specialist Physician	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Diagnostic Testing (such as lab work and x-rays done in the office) • Occupational Therapy and Physical Therapy	$20**
Dietician / Nutritionist	Covered Services such as Diabetic Education	$0
Independent Diagnostic Testing Center	Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$20**
Urgent Care Center	Covered urgent care Services for the first 2 visits per Covered Person, per Benefit Period	$0 for first 2 visits***

* Maternity and Medical Pharmacy Services will remain at the Cost Share listed on your Schedule of Benefits.

** Or the Specialist Physician office Cost Share listed on your Schedule of Benefits; whichever is lower.

*** After the first 2 visits, the urgent care Cost Share listed on your Schedule of Benefits will apply.

To find a Value Choice Provider, access the most recent provider directory at www.floridablue.com and look for Providers with “Value Choice Providers” under “Programs”.

BLUEPRINT FOR HEALTH PROGRAMS

The **Prior Coverage Authorization/ Pre-Service Notification Programs** subsection is amended by deleting the **Transplant Services** provision under Services that Require Prior Authorization, in its entirety and replacing it with the following:

Transplant Services

1. In the case of **Transplant Services**, you must obtain an authorization for the transplant **before** the transplant is scheduled.
2. In the case of **Transplant Services designated by us as eligible for lodging and transportation assistance**, you must obtain an authorization for all Services, including the pre-transplant evaluation **before** the transplant evaluation is scheduled.

If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services.

For details on how to obtain prior coverage authorization for transplant evaluation and procedures, please call the customer service phone number on your ID Card.

EXTENSION OF BENEFITS

The heading is changed to **Extension of Benefits and Continuity of Care**; and the following is added at the end:

Continuity of Care

We will provide benefits for continuing care patients as required by the federal No Surprises Act (H.R. 133, P.L. 116-260).

DEFINITIONS

The following **new** definitions are added in alphabetical order:

Developmental Disability means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

Transplant Travel Benefit Period begins with pre-evaluation testing and ends when post-transplant Services are complete, but not to exceed 12 months after organ transplantation.

The **Virtual Care Provider** definition is deleted in its entirety and replaced with the following:

Virtual Care Provider means (1) an In-Network Provider that is designated by us and that offers Virtual Visits at the time Services are rendered; or (2) a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered unless otherwise designated by us or the Group as ineligible to provide Virtual Visits.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2022 Pharmacy Program Changes Amendment

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PHARMACY UTILIZATION REVIEW PROGRAMS

The following is added after the first paragraph:

Prescription Drugs covered by this plan are subject to misuse, waste and/or abuse utilization review by us, your Provider and/or your Participating Pharmacy. The outcome of this review may include:

- Limiting coverage of the applicable Drug(s) to one prescribing Provider and/or one In-Network Pharmacy.
- Limiting the quantity, dosage or Day Supply.
- Allowing only a partial fill or denial of coverage for such Drug(s).

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WHAT IS COVERED?

The **Mammograms** category is deleted in its entirety and replaced with the following:

Mammograms

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate regulatory agencies for diagnostic purposes or breast cancer screening may be Covered Services.

In accordance with the Florida Statute 627.6613, coverage is available under the following circumstances:

1. A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
2. A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's Physician's recommendation.
3. A mammogram every year for any woman who is 50 years of age or older.
4. One or more mammograms a year, based upon a Physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.

The **Virtual Visits** category is amended by adding the following paragraph after the first paragraph:

Coverage includes Virtual Visits between you and an In-Network Provider who offers Virtual Visits at the time the Services are rendered. The Cost Shares for Virtual Care Provider Services are listed in your Schedule of Benefits.

WHAT IS NOT COVERED?

The **Complementary or Alternative Medicine** exclusion is deleted in its entirety and replaced with the following:

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification

therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; prayer and mental healing; Massage except as listed in the WHAT IS COVERED? section; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, Swedish massage, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Special Payment Rules** provision is deleted in its entirety and replaced with the following.

Special Payment Rules

Emergency Services in an Emergency Room

Unless modified by the federal No Surprises Act (H.R. 133, P.L. 116-260), payment for Emergency Services rendered by an Out-of-Network Provider that has not entered into an agreement with us to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered. If the No Surprises Act applies but section 627.64194(4) of the Florida Statute does not apply, then payment under this section will comply with the qualifying payment amount (QPA) rules of the federal No Surprises Act (H.R. 133, P.L. 116-260).

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

Non-Emergency Services

If you receive Services from an Out-of-Network Provider in an In-Network Health Care Facility (as defined below) and you did not have the ability and opportunity to choose an In-Network Provider that is available to treat you, then payment will be determined in accordance with either: (1) 627.64194(4) of the Florida Statutes or (2) the qualifying payment amount (QPA) rules of the federal No Surprises Act (H.R. 133, P.L. 116-260), as applicable. The Out-of-Network Provider in such case, should only bill you for the applicable In-Network Cost Share.

For purposes of this subsection, an In-Network Health Care Facility means an In-Network Ambulatory Surgical Center, Hospital, Hospital outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act) or Urgent Care Center.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

Air Ambulance

If an Out-of-Network air Ambulance Provider renders Covered Services under this Booklet, the In-Network Cost Share will apply and the payment will be determined in accordance with the provisions of the federal No Surprises Act (H.R. 133, P.L. 116-260) applicable to air Ambulance Providers.

In no event, subject to this Special Payment Rules subsection, will Out-of-Network Providers be paid more than their charges for the Services rendered.

BLUEPRINT FOR HEALTH

The following **new** subsection is added at the end of the section:

Coverage Protocol Exemption Request

In some cases, Services under this Booklet require you to complete use of another Prescription Drug, medical procedure, or course of treatment other than the one requested by your treating Physician, before coverage will be authorized/granted. Florida Statute 627.42393 permits you to request a protocol exemption in order to receive coverage without completing our coverage protocol for the Prescription Drug, medical procedure, or course of treatment. If we deny the coverage protocol exemption request, we will provide you with a written explanation of the reason for the denial, the clinical rationale that supports the denial, and the procedure for appealing the denial. In some instances, the process for appealing a denied coverage protocol exemption request will be your formal appeal of an Adverse Benefit Determination process as outlined in the CLAIMS PROCESSING section of this Booklet.

Information on how to request a coverage protocol exemption or to appeal a denial of a request for exemption can be found on our website at https://www.floridablue.com/docview/coverage-protocol-exemption-request/.

CLAIMS PROCESSING

The **How to Request External Review of Our Appeal Decision** subsection is amended as follows:

The **heading** is hereby changed to **External Review**.

The **first paragraph** is deleted in its entirety and replaced with the following:

You have a right to independent external review if we have denied your request for payment of a claim (in whole or in part) in the following circumstances:

1. Our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational;
2. Whether or not a Covered Service is subject to the federal No Surprises Act (H.R. 133, P.L. 116-260); and/or

3. The calculation of your Cost Sharing associated with a Covered Service that is subject to the federal No Surprises Act (H.R. 133, P.L. 116-260).

Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with us. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the External Review Request form within four months after receipt of your denial to the below address:

DEFINITIONS

The **Allowed Amount** definition is amended by adding number 6 below:

6. In the case of Covered Services rendered by an Out-of-Network Provider where the Services are subject to either the federal No Surprises Act (H.R. 133, P.L. 116-260) or 627.64194(4) F.S., then the allowed amount will be calculated in accordance with the applicable statute. For clarity, if the Provider is located in Florida and 627.64194(4) F.S. applies, then the allowed amount calculated under 5. above is presumed to meet the requirements 627.64194(4) F.S.

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Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2023 Pharmacy Program Changes Amendment

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PHARMACY UTILIZATION REVIEW PROGRAMS

The **Responsible Steps** provision is deleted in its entirety and replaced with the following:

Responsible Steps Program

Many medical Conditions have several Drug treatment options that have been approved by the FDA, which means there may be a lower cost Drug that will effectively treat your Condition. Under the responsible steps program, certain Prescription Drugs and OTC Drugs may not be covered unless you have first tried one or more designated Drugs identified in the Medication Guide.

Your Physician must contact us to request coverage for a Prescription Drug that is part of the responsible steps program prior to prescribing the Drug. In order to be covered, we must receive written documentation from your Physician that the designated Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Coverage Protocol Exemption

Information on how to request a coverage protocol exemption or to appeal a denial of a request for exemption can be found on our website at https://www.floridablue.com/docview/coverage-protocol-exemption-request/.

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Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

BlueOptions 2024 Changes Endorsement

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HOW TO USE YOUR BENEFIT BOOKLET

The following is added to the **Where do you find information on…** subsection:

- **what happens if I receive a surprise bill?**

  Read the Surprise Billing subsection in the "Understanding Your Share of Health Care Expenses" section.

WHAT IS COVERED?

The **Autism Spectrum Disorder and Down Syndrome** category is deleted in its entirety and replaced with the following:

Autism Spectrum Disorder and Down Syndrome

Services provided to a Covered Dependent consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by a person certified per Florida Statutes Section 393.17 or licensed under Chapters 490 or 491; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder and Down Syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Rules for Autism Spectrum Disorder and Down Syndrome

Applied Behavior Analysis Services for Autism Spectrum Disorder must be authorized in accordance with criteria established by us, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition**.**

The **Behavioral Health Services** category is amended by deleting the **Exclusion** under the **Mental Health Services** subsection in its entirety and replacing it with the following:

Exclusion

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability, except for Services that meet the definition of Medical Necessity for the Condition;
4. Services for educational purposes, except for Services that meet the definition of Medical Necessity for the Condition;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation, except for Services that meet the definition of Medical Necessity for the Condition;
8. Services to test aptitude, ability, intelligence or interest, except as covered under the Autism Spectrum Disorder and Down Syndrome category;
9. Services required to maintain employment;
10. Services for cognitive remediation; and
11. inpatient stays for Custodial Care, convalescent care, change of environment or any other Service primarily for your convenience or that of your family members or the Provider

The **Home Health Care** category is amended by deleting the first numbered list in its entirety and replacing it with the following:

1. you are unable to leave your home without considerable effort and the assistance of another person because you are: bedridden or chairbound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition; and
2. the Home Health Care Services rendered have been prescribed by a Physician.
3. the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals as documented in the clinical progress notes.

The **Inpatient Rehabilitation** category is amended by deleting **item number 4** in its entirety and replacing it with the following:

4. the individual must be able to actively participate in at least two Rehabilitative Therapies and be able to tolerate at least three hours per day of skilled Rehabilitation Services for at least five days a week; and

The following **new** category is added in alphabetical order:

Nutrition Counseling

Nutrition counseling by a licensed Dietitian as described in the Diabetes Outpatient Self-Management category or as part of the treatment of a Mental and Nervous Disorder or Substance Dependency Condition or Services that meet the definition of Medical Necessity for treatment of a Condition.

UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

The **Special Payment Rules** subsection is deleted in its entirety and replaced with the following:

Surprise Billing

Sometimes you may receive Covered Services from Out-of-Network Providers who will not accept our payment as payment in full. Out-of-Network Providers in the specific situations described below are prohibited from balance billing you for amounts over what we pay. Should you receive a bill for more than your Cost Share (as described below) from the Out-of-Network Provider in these situations, please send that information to us at the address on your ID card and we will attempt to work with the Out-of-Network Provider to appropriately honor their obligation to not balance bill you, if applicable.

Out-of-Network Services where I should not be balance billed

Please note, in the following specific circumstances federal and/or Florida state law prohibits Out-of-Network Providers from balance billing you for receipt of Covered Services.

- **Emergency Services for an Emergency Medical Condition** provided at an Out-of-Network facility to Stabilize you (which may include part or all of an inpatient admission from the Emergency Room of an Out-of-Network Hospital); and
- **Certain non-Emergency Services or ancillary Services** provided by an Out-of-Network Provider at an In-Network facility including but not limited to:
  - Surgery
  - Pathology
  - Hospital Services
  - Anesthesiology
  - Radiology
  - Laboratory Services

  Note: If the Out-of-Network Provider rendering the non-Emergency Services referenced above has given you the following, in advance: (a) the estimated charges for the Covered Services to be rendered; (b) notice that the Provider is an Out-of-Network Provider; and (c) notice for your approval in writing to the treatment to be rendered by the Out-of-Network Provider, then the Provider **may** be able to balance bill you and this Surprise Billing subsection will not apply.

- **Air Ambulance Services** if the Services are Covered Services under this Benefit Booklet regardless of whether or not the Services are due to an Emergency Medical Condition.

Please note that an authorization is never required for Covered Services for the treatment of an Emergency Medical Condition. Not all Air Ambulance Services are Covered Services under this Benefit Booklet. Please refer to the Ambulance Services category in the WHAT IS COVERED? section of this Benefit Booklet.

Facility, as used above means:

- hospital (as defined in section 1861 of the Social Security Act)
- hospital outpatient department
- critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act)
- an ambulatory surgical center (as defined in section 1833(i)(1)(A) of the Social Security Act)
- and for an Emergency Medical Condition only, an independent freestanding emergency medical department

How Much we will Pay Out-of-Network Providers

Generally, Florida state law prohibits Out-of-Network Providers rendering Covered Services subject to this Surprise Billing section from balance billing you. If section 627.64194(4), Florida Statutes applies, then the Allowed Amount (i.e., the amount we base payment on) will generally be calculated in accordance with the definition within this Benefit Booklet. In certain circumstances, the Allowed Amount will be calculated for Out-of-Network Providers, including all Covered Services rendered by Out-of-Network Air Ambulance Providers, based upon the Median Contracted Rate. The term "Median Contracted Rate" as used here means, generally:

1. The rate that is the median contracted rate for all In-Network Providers for the same or similar item(s) or Service(s) for all plans offered by us:
   a) in the same insurance market (i.e., individual, small group or large group); and,
   b) provided in the same geographic region as the Covered Service provided to you.

Important Note: The above definition of "Median Contracted Rate" has been simplified here to make it easier to understand. The term "Median Contracted Rate", as defined by federal law, is complicated. We will calculate the "Median Contracted Rate" more specifically in accordance with the federal law (and regulations then in effect) known as the federal No Surprises Act (H.R. 133, P.L. 116-260).

Calculating Your Share of the Cost

If you receive Covered Services subject to this Surprise Billing subsection, your Cost Share (e.g., Deductibles and/or Coinsurance) will be calculated based upon the Allowed Amount we initially paid the Out-of-Network Provider as described above. Should we decide to pay more, or if the federal Independent Dispute Resolution Process results in us paying the Out-of-Network Provider more, your Cost Share will not change.

Any Cost Share you paid with respect to Covered Services identified in this subsection will be applied toward your In-Network Deductible and out-of-pocket maximum, if applicable. We will provide notice of payment or denial no later than 30 calendar days after receipt of the bill from the Provider.

Important Note: It is not a surprise bill when you knowingly choose to go to an Out-of-Network Provider for a planned Service or have signed a consent as noted above, in advance for the Covered Services. In such a case, you are responsible for all charges.

PHYSICIANS, HOSPITALS AND OTHER PROVIDER OPTIONS

The **Family Physician Program** is deleted in its entirety and replaced with the following:

Primary Care Provider Program

We encourage you to select and develop a relationship with an In-Network Primary Care Provider ("PCP"). There are several advantages to selecting a PCP (Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians)

- PCPs are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs.
- Developing and continuing a relationship with a PCP allows the Provider to become knowledgeable about you and your family's health history.
- A PCP can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific health care needs.
- Care rendered by PCPs usually results in lower out-of-pocket expenses for you.

We will check our records periodically to see if you have visited a PCP. If not, we may provide your name and contact information to an In-Network PCP who will call you and offer to schedule a wellness visit. This program is completely voluntary and although we encourage you to schedule this visit, you are not obligated to do so. The applicable PCP Cost Share will apply to this visit.

You are responsible for checking to see if a Provider is In-Network for your plan prior to receiving Services. To find out if a Provider is In-Network, refer to the current Provider directory at www.floridablue.com or call the customer service phone number on your ID Card.

The **Value Choice Providers** subsection is deleted in its entirety and replaced with the following:

Value Choice Providers

Some Providers, designated by us, may provide Services other than maternity and Medical Pharmacy at a lower Cost Share. The Deductible will be waived for these Services and your Cost Share is lower when they are rendered in the Value Choice Provider's office or Independent Diagnostic Testing Centers designated as Value Choice Providers. The chart below lists the Services included and the Cost Share amounts:

Value Choice Provider Type	Services Included	Cost Share
Primary Care Provider	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Allergy Testing and Injections • Diagnostic Testing (such as lab work and x-rays done in the office) • Occupational Therapy and Physical Therapy	$0
Specialist Physician	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Allergy Testing and Injections • Diagnostic Testing (such as lab work and x-rays done in the office) • Occupational Therapy and Physical Therapy	$20**
Dietitian / Nutritionist	Covered Services such as Diabetic Education	$0
Independent Diagnostic Testing Center	Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$20**
Urgent Care Center	Covered urgent care Services for the first 2 visits per Covered Person, per Benefit Period	$0 for first 2 visits***

* Maternity and Medical Pharmacy Services will remain at the Cost Share listed on your Schedule of Benefits.

** Or the Specialist Physician office Cost Share listed on your Schedule of Benefits; whichever is lower.

*** After the first 2 visits, the urgent care Cost Share listed on your Schedule of Benefits will apply.

To find a Value Choice Provider, access the most recent provider directory at www.floridablue.com and look for Providers with “Value Choice Providers” under “Programs”.

The following **new** subsection is added before the **Assignment of Benefits to Providers** subsection:

Continuity of Coverage and Care Upon Termination of a Provider Contract Under Federal Law

Federal law (42 U.S. Code § 300gg –113) provides for continuity of Services for enrollees of health plans when there is a change in the plans’ Provider network resulting in a Provider no longer being In-Network for the enrollee’s benefit plan. These protections extend to individuals defined as a “Continuing Care Patient” and include patients who are undergoing a course of treatment for:

1. a serious or complex Condition,
    a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
    b) in the case of a chronic illness or Condition, a Condition that:
        i. is life-threatening, degenerative, potentially disabling, or congenital; and
        ii. requires specialized medical care over a prolonged period of time.
2. institutional or inpatient care,
3. a scheduled non-elective surgery including postoperative care.
4. pregnancy; or
5. a terminal illness.

Such patients will have up to 90 days of continued coverage at the In-Network Cost Share to allow for a transition of care to an In-Network Provider.

EXTENSION OF BENEFITS

The **Extension of Benefits and Continuity of Care** subsection is deleted in its entirety and replaced with the following:

Extension of Benefits and Continuity of Care

Continuity of Coverage and Care Upon Termination of a Group Policy Under Federal Law

Plans are required to ensure continuing care patients receive timely notification of changes in the network status of Providers and facilities.

Federal law (42 U.S. Code § 300gg–113) provides for continuity of Services for enrollees of health plans when there is a termination of a contract between a group and the group's insurer. These protections extend to individuals defined as a "Continuing Care Patient" and include patients who are undergoing a course of treatment for:

1. a serious or complex Condition,
    a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
    b) in the case of a chronic illness or Condition, a Condition that:
        i. is life-threatening, degenerative, potentially disabling, or congenital; and
        ii. requires specialized medical care over a prolonged period of time.
2. institutional or inpatient care;
3. a scheduled non-elective surgery including postoperative care;
4. pregnancy; or
5. a terminal illness.

Such patients will have up to 90 days of continued coverage at the In-Network Cost Share to allow for a transition of care to an In-Network Provider.

Continuity of Coverage and Care Upon Termination of a Group Policy Under State Law

If the Group Plan is terminated, coverage will end on the termination date. We will not provide coverage or benefits for any Service rendered on or after the termination date, except as listed below. The extension of benefits described below only applies when the Group Plan is terminated, and the benefits provided under an extension of benefits are subject to all other terms included in this Booklet.

Note: You must provide proof that you are entitled to an extension of benefits.

Extension of Benefits

1. If you are pregnant on the termination date of the Group Plan, we will provide a limited extension of the maternity benefits, as long as the pregnancy started while you were covered by us. This extension of benefits is only for Covered Services necessary to treat the pregnancy and will automatically terminate on the date the child is born.

2. If you are totally disabled on the termination date of the Group Plan because of a specific Accident or illness that happened while you were covered under the Group Plan we will provide a limited extension of benefits for you only. This extension of benefits is only for Covered Services necessary to treat the disabling Condition. This extension of benefits will only continue as long as the disability is continuous and uninterrupted, however, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Plan.

   Note: For purposes of this subsection, you will be considered totally disabled only if, in our opinion, you are unable to work at a job for which you have the education, training, or experience, and you continue to require regular care from a Physician for the disability. This applies, even if you are not working (e.g., a student, non-working spouse, or children), if you are unable to perform those normal day-to-day activities which you would otherwise perform the normal day-to-day activities which you would otherwise be able to perform.

3. If you are receiving covered dental treatment on the termination date of the Group Plan, we will provide a limited extension of such covered dental treatment as long as the course of dental treatment or dental procedures were recommended in writing and started while you were covered by us. Additionally, the dental procedures must be for Services other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic Services and performed within 90 days after the Group Plan terminated.

   Note: This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of the Group Plan or on the date you become covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or Services for similar dental procedures. You are not required to be totally disabled in order to be eligible for this extension of benefits.

   Please refer to the Dental Services category of the WHAT IS COVERED? section for a description of the dental Services covered under this Booklet.

CLAIMS PROCESSING

The **Post-Service Claims** subsection is amended by deleting the **Payment for Post-Service Claims** provision in its entirety and replacing it with the following:

Payment for Post-Service Claims

When payment is due under the terms of this Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt, however all claims subject to the No Surprises Act will be paid or denied within 30 days as stated in the Surprise Billing subsection of the UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES section of this Booklet. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more information, we may contest or deny the claim within the timeframes set forth below.

GENERAL PROVISIONS

The following **new** subsection is added at the end of the section:

Your Rights and Responsibilities

We are committed to providing quality health care coverage at a reasonable cost while maintaining your dignity and integrity. Consistent with our commitment and recognizing that In-Network Providers are independent contractors and not our agents, the following statement of your Rights and Responsibilities has been adopted.

Rights

1. To be provided with information about our services, coverage and benefits, the In-Network Providers delivering care and members' rights and responsibilities.
2. To receive medical care and treatment from In-Network Providers who have met our credentialing standards.
3. To expect In-Network Providers to:
    a) discuss appropriate or Medically Necessary treatment options for your Condition, regardless of cost or benefit coverage;
    b) permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.
    c) advise whether your medical care or treatment is part of a research experiment, and to give you the opportunity to refuse any experimental treatments; and
    d) inform you about any medications you are told to take, how to take them, and their possible side effects

4. To expect courteous service from us and considerate care from our In-Network Providers with respect and concern for your dignity and privacy.
5. To voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal procedures found in this Booklet.
6. To inform In-Network Providers that you refuse treatment, and to expect them to honor your decision, if you choose to accept the responsibility and the consequences of your decision. In the event, members are encouraged (but not required) to:
    a) complete an advance directive, such as a living will and provide it to In-Network Providers; and
    b) have someone help make decisions, or to give another person the legal responsibility to make decisions about medical care on a member's behalf.
7. To have access to your medical records and to be assured that the confidentiality of your medical records is maintained in accordance with applicable law.
8. To call or write to us any time with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. You also may make recommendations regarding our rights and responsibilities policies. Please call the phone number on your ID Card or write to us at the address on your ID Card.

Responsibilities

1. To cooperate with anyone providing your care and treatment.
2. To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.
3. To take responsibility for understanding your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions about your care and to ask questions if you do not understand or need an explanation.
4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
5. To pay your Cost Share amounts and be financially responsible for non-covered Services and to provide current information concerning your coverage status to any In-Network Provider.
6. To follow the process for filing an appeal about medical or administrative decisions that you feel were made in error.
7. To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
8. To review information regarding Covered Services, policies and procedures as stated in this Booklet.

DEFINITIONS

The following **new** definition is added:

Continuing Care Patient means a patient who is undergoing a course of treatment for:

1. a serious or complex Condition:
    a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
    b) in the case of a chronic illness or Condition, a Condition that:
        i. is life-threatening, degenerative, potentially disabling, or congenital; and
        ii. requires specialized medical care over a prolonged period of time.
2. institutional or inpatient care;
3. a scheduled non-elective surgery including postoperative care;
4. pregnancy; or
5. a terminal illness.

The **Developmental Disability** definition is deleted in its entirety.

The **Dietitian** definition is deleted in its entirety and replaced with the following:

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management Services and appropriate behavioral health Conditions covered under this plan.

The following **new** definition is added:

Primary Care Provider or **Family Physician (PCP)** means a Provider who, at the time Covered Services are rendered, was under a primary care Provider contract with us. A primary care Provider may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist, or APRN may elect to contract with us as a primary care Provider.

The definition of **Skilled Nursing Facility** is deleted in its entirety and replaced with the following:

Skilled Nursing Facility means a facility or part thereof which is properly licensed under Florida law, or a similar applicable law of another state, to provide care and treatment of medical Conditions and meets all of the following requirements:

1. is accredited as a Skilled Nursing Facility by The Joint Commission or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by us;
2. has nursing staff on-site 24 hours per day and 7 days per week;
3. provides access to necessary medical Services 24 hours per day and 7 days per week;
4. provides appropriate access to any Physician-ordered Services required for treatment of your Condition on at least a daily basis (and likely multiple times per day). These Services may consist of

skilled nursing Services, (e.g., intravenous fluids and medication administration, wound care, etc.) and therapy Services (i.e., physical, occupational and speech);

5. has individualized active treatment plan (e.g., skilled nursing and therapy Services) directed toward the management and improvement of the Condition that caused the admission; and
6. provides a level of skilled care consistent with your Condition and care needs.

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 the provisions contained 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

Patrick J. Geraghty
Chief Executive Officer

As the incumbent carrier, our Administrative Services Agreement will remain in place.

.

Florida Blue

City of Gainesville	
Effective Date:	1/1/2025
Members:	3,425
Employees:	1,951

CUSTOM PASSTHROUGH PRICING	
Contract Period	**BlueBasic Rx**
BRAND DISCOUNTS	
Retail Network	
1/1/2025 to 12/31/2025	21.50%
1/1/2026 to 12/31/2026	21.55%
1/1/2027 to 12/31/2027	21.60%
Extended Supply Network (ESN) - 90 Day Channel	
1/1/2025 to 12/31/2025	24.50%
1/1/2026 to 12/31/2026	24.55%
1/1/2027 to 12/31/2027	24.60%
Exclusive Mail	
1/1/2025 to 12/31/2025	24.50%
1/1/2026 to 12/31/2026	24.50%
1/1/2027 to 12/31/2027	24.50%
GENERIC DISCOUNTS	
Retail Network	
1/1/2025 to 12/31/2025	86.25%
1/1/2026 to 12/31/2026	86.35%
1/1/2027 to 12/31/2027	86.45%
Extended Supply Network (ESN) - 90 Day Channel	
1/1/2025 to 12/31/2025	89.00%
1/1/2026 to 12/31/2026	89.10%
1/1/2027 to 12/31/2027	89.20%
Exclusive Mail	
1/1/2025 to 12/31/2025	89.00%
1/1/2026 to 12/31/2026	89.10%
1/1/2027 to 12/31/2027	89.20%
BRAND DISPENSING FEES	
Retail Network	
1/1/2025 to 12/31/2025	$0.20
1/1/2026 to 12/31/2026	$0.20
1/1/2027 to 12/31/2027	$0.20
Extended Supply Network (ESN) - 90 Day Channel	
1/1/2025 to 12/31/2025	$0.00
1/1/2026 to 12/31/2026	$0.00
1/1/2027 to 12/31/2027	$0.00
Exclusive Mail	
1/1/2025 to 12/31/2025	$0.00
1/1/2026 to 12/31/2026	$0.00
1/1/2027 to 12/31/2027	$0.00
GENERIC DISPENSING FEES	
Retail Network	
1/1/2025 to 12/31/2025	$0.20
1/1/2026 to 12/31/2026	$0.20
1/1/2027 to 12/31/2027	$0.20
Extended Supply Network (ESN) - 90 Day Channel	
1/1/2025 to 12/31/2025	$0.00
1/1/2026 to 12/31/2026	$0.00
1/1/2027 to 12/31/2027	$0.00
Exclusive Mail	
1/1/2025 to 12/31/2025	$0.00
1/1/2026 to 12/31/2026	$0.00
1/1/2027 to 12/31/2027	$0.00
AGGREGATE SPECIALTY	
Discount	
1/1/2025 to 12/31/2025	22.00%
1/1/2026 to 12/31/2026	22.00%
1/1/2027 to 12/31/2027	22.00%
Specialty Pharmacy Dispensing Fee	
1/1/2025 to 12/31/2025	$0.00
1/1/2026 to 12/31/2026	$0.00
1/1/2027 to 12/31/2027	$0.00

Notes: UR-14150

- Discounts are based on the actual NDC-11 dispensed on the fill date.
- Guarantees are based upon the above selected Florida Blue Network.
- Guarantees are based upon an implemented Florida Blue Extended Supply Network (90-day retail). If not implemented, Retail rates apply.
- Discount and dispensing fee rates exclude compound, long term care (LTC) pharmacy, home infusion (HI) pharmacy, veterans affairs (VA) pharmacy, Indian/tribal/urban (I/T/U) pharmacy, U.S. territory (TER) pharmacy, 340B, Medicare/Medicaid, out-of-network, member-submitted (e.g. direct member reimbursement), coordination of benefits (COB), subrogation, invalid, usual and customary (U&C) claims and non-specialty discount and dispensing fees also exclude specialty (as defined by the Florida Blue specialty drug management list) claims.
- For discount purposes, Specialty is defined by the Florida Blue specialty drug management list.
- Guarantees are based upon a exclusive specialty network arrangement.
- Aggregate Specialty discount guarantees do not include limited distribution drugs (LDDs) nor any new specialty drugs brought to market and added to the specialty list during the term of each contract year.
- For discount and dispensing fees, Brand drugs are defined as drugs that have a Medi-Span multisource code field equal to “M", “N", or “O".
- For discount and dispensing fees, Generic drugs are defined as drugs that have a Medi-Span multisource code field equal to “Y”.
- Unexpected generic launches and products launched at risk or under patent litigation are excluded from generic guarantees.
- Guarantees are based upon MedsYourWay Home Delivery being the exclusive mail provider.

Florida Blue

City of Gainesville	
Effective Date:	1/1/2025
Members:	3,425
Employees:	1,951

CUSTOM PASSTHROUGH PRICING	
Contract Period	**FL 3 Tier**
REBATE PER BRAND	
Retail Network	
1/1/2025 to 12/31/2025	$414.90
1/1/2026 to 12/31/2026	$449.70
1/1/2027 to 12/31/2027	$484.75
Extended Supply Network (ESN) - 90 Day Channel	
1/1/2025 to 12/31/2025	$944.35
1/1/2026 to 12/31/2026	$1,000.10
1/1/2027 to 12/31/2027	$1,072.65
Exclusive Mail	
1/1/2025 to 12/31/2025	$897.85
1/1/2026 to 12/31/2026	$934.20
1/1/2027 to 12/31/2027	$969.85
Specialty	
1/1/2025 to 12/31/2025	$4,775.25
1/1/2026 to 12/31/2026	$5,174.95
1/1/2027 to 12/31/2027	$5,569.55

Notes: UR-14150

- For rebate purposes, Specialty is defined by the Florida Blue specialty drug management list.
- Compound, long term care (LTC) pharmacy, home infusion (HI) pharmacy, veterans affairs (VA) pharmacy, Indian/tribal/urban (I/T/U) pharmacy, U.S. territory (TER) pharmacy, 340b, Medicare/Medicaid, out of network, member-submitted (e.g. direct member reimbursement), coordination of benefits (COB), subrogation, invalid, vaccine, over-the-counter (OTC), zero balance due (100% member paid), biosimilar, and limited distribution drug (LDD) claims are excluded from rebate guarantees.
- Rebate guarantees do not reflect adjustments for CMS negotiated drug prices as outlined in the Inflation Reduction Act. In the event CMS drug price negotiations impact Florida Blue ability to meet rebate guarantees, Florida Blue reserves the right to apply a rebate credit to rebate guarantee reconciliation.
- For rebate purposes, Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to “M”, “N”, or “O”.
- Rebate guarantees assume WAC reduction for the following products due to AMP CAP: all versions of HUMALOG, HUMULIN, LANTUS, LEVEMIR, NOVOLIN, NOVOLOG, VICTOZA. Florida Blue reserves the right to adjust the reconciliation of guarantees for any other products with a WAC decrease.

City of Gainesville	
Effective Date:	1/1/2025
Members:	3,425
Employees:	1,951

CUSTOM PASSTHROUGH PRICING	
ADMINISTRATIVE FEE	
Contract Period	**Per Employee Per Month**
1/1/2025 to 12/31/2025	$8.00
1/1/2026 to 12/31/2026	$8.00
1/1/2027 to 12/31/2027	$8.00

Notes: UR-14150

- Administrative Fees will be charged at the above rate on a per employee per month basis.

Additional Caveats:

- For the purpose of reconciliation at contract year end, all guarantees are reconciled in aggregate, as long as the contract remains in effect.
- Guarantees are based on adoption and adherence of an above Florida Blue formulary, including associated utilization management, recommended formulary strategies, and clinical programs. Florida Blue reserves the right to make an equitable modification to the pricing terms of the agreement for the following: changes in any law or regulation, changes in interpretation of a law or regulation, changes within PBM marketplace which lead to a significant deviation from the current economic environment, unexpected market events, unexpected generic launches, authorized generic launches, biosimilar products, products launched at risk, products under patent litigation, new lower cost NDCs priced net of rebates from the innovator, products with WAC decreases, biosimilar utilization or mix being materially different from underwriting assumptions, changes in drug indications, implementation of new clinical programs, removal of existing clinical programs, changes in pharmacy benefit plan design, specialty drug management list, limited distribution list, or formulary changes.
- Members will pay the lower of the contracted rate, U&C, or their applicable copayment.
- Assumes client does not have 340B pricing.
- Guarantees provided does not include savings from DUR or other clinical programs.
- Specialty drugs dispensed through the medical benefit will not be included in reconciliation of guarantees.
- Guarantees assumes 34% ESN penetration, if that differs significantly, Florida Blue reserves the right to revise guarantees terms and financials.
- Guarantees assumes 2% Mail penetration, if that differs significantly, Florida Blue reserves the right to revise guarantees terms and financials.
- Florida Blue reserves the right to equitably adjust the guarantees in the event the number of covered members or pharmacy claims volume changes by greater than 10% over the course of the contract.
- Products with government mandated reimbursement, emergency use protocols, or related to Covid-19 (e.g testing, vaccines, and treatments) are excluded from guarantee reconciliation.
- Florida Blue reserves the right to remove financial guarantees if the implementation of a drug importation program materially impacts the drug utilization of the group.
- Mail guarantees only include claims from a mail vendor with 84 days of supply or greater. Claims from 1 to 83 days of supply from a mail vendor are included in the retail guarantees.

Flex Access Estimated Savings

ENTER CLIENT NAME HERE

Date Range: 4/1/2023 to 3/31/2024

Claim Impact

# of Claims	Savings per Claim	% of Claims
564	$540	2.4%

Incremental Plan Savings * Minus Fee

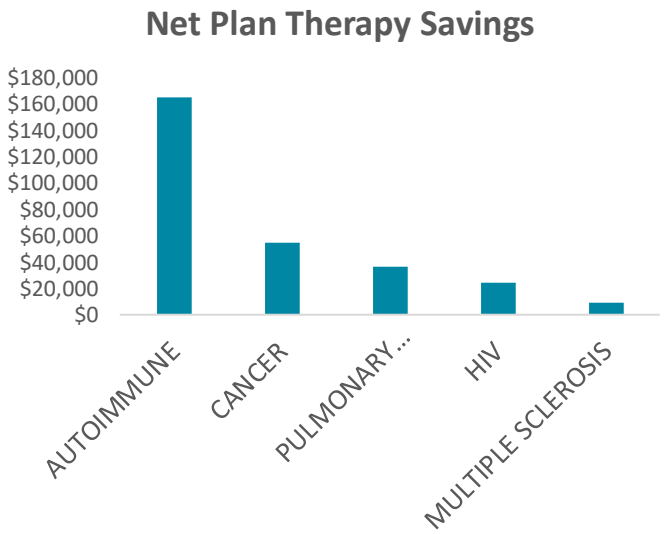
Savings $	Savings %
$304,296	4.9%

Utilizer Impact

# of Utilizers	Savings per Utilizer
127	$2,396

Top 10 Drugs

Drug Name	Plan Savings	Rx Count
STELARA	$31,747	14
DUPIXENT	$31,289	69
ADEMPAS	$26,398	12
JAKAFI	$19,249	16
COSENTYX	$16,855	26
OTEZLA	$14,699	31
LYNPARZA	$14,304	11
VERZENIO	$13,763	9
HUMIRA	$13,130	116
TREMFYA	$12,236	9



Program Fee

Program Fee	Program Fee %
$53,699	15%

*Savings calculations exclude claims processing via SCS programs like Copay Max and SaveOn

Savings values are based on full drug list

FlexAccess Savings Methodology

- Net Plan Savings are the estimated manufacturer funds that are applied to the cost of the drug minus members' estimated cost share that would have been paid if they were not enrolled in Flex Access.
- Net Plan Savings are reduced by all program fees
- Net Plan Savings remove any claims adjudicated by Specialty Copay Solutions (Copay Max/Save On), including associated fees and savings

- Savings % are based on Net Flex Access Savings divided by all paid claims (including specialty and retail)
- Includes all Groups and plan codes requested by client (potentially including HDHP if not explicitly excluded and assuming 100% of eligible members use a coupon)

- Program Fee will be based on the manufacturer copay assistance dollars allocated to the cost of the drug minus the members' estimated cost share that would have been paid if they were not enrolled in the program. This number is already excluded from Net Plan Savings
- Specialty Copay Solutions (e.g. Copay Max, Save On) claims are removed from the prospective model to ensure savings are not overstated. This may understate the program fee for groups using a copay program.

- All Savings are estimates based on prior utilization and future results may vary
- Utilizer Count is based on number of members-products prospectively in Flex Access Program
- The Flex Access drug list is subject to change based on the availability of manufacture assistance programs
- Data includes paid claims through date range displayed

Florida Blue
Your Health Solutions Partner

Open Medication Guide

July 2024

Please consider talking to your doctor about prescribing one of the formulary medications that are indicated as covered under your plan; which may help reduce your out-of-pocket costs. This list may help guide you and your doctor in selecting an appropriate medication for you.

The drug formulary is regularly updated. Please visit www.floridablue.com for the most up-to-date information.

Contents

Preferred Medication List

To search for a drug name within this PDF document, use the **Control** and **F** keys on your keyboard, or go to **Edit** in the drop-down menu and select **Find/Search**. Type in the word or phrase you are looking for and click on **Search**.

Introduction

Florida Blue and Florida Blue HMO are pleased to present the Open Formulary Medication Guide. This is a general guide that includes an abbreviated listing of Brand and Generic medications that are covered under your plan. Since coverage for medication varies by the plan purchased by you or your employer, it's important that you refer to your plan documents for complete coverage details. When we refer to "plan documents" we are referring to one or more of the following: Benefit Booklet, Certificate of Coverage, Contract, Member Handbook or prescription drug endorsement.

The Open Formulary Medication Guide provides helpful tips on how to make the most of your pharmacy benefits and details about the various coverage programs that are designed to provide safe and appropriate medication when you need it. Changes in the formulary can occur over time and the most up-to-date listing can always be found by viewing the Medication Guide online at www.floridablue.com or by calling the customer service number listed on your member ID card. For the hearing impaired, call Florida TTY Relay Service 711.

Si de se a hablar sobre esta guía en español con uno de nuestros representantes, por favor llame al número de atención al cliente indicado en su tarjeta de asegurado y pida ser transferido a un representante bilingüe.

NOTE: The decision concerning whether a prescription medication should be prescribed must be made by you and your physician. Any and all decisions that require or pertain to independent professional medical judgments or training, or the need for, and dosage of, a prescription medication, must be made solely by you and your treating physician in accordance with the patient/physician relationship.

Key Tips and Coverage Guidelines

By following these simple guidelines, you will be assured that you are getting the maximum benefit from your plan.

- When you have your prescriptions filled, ask your pharmacist if a generic equivalent is available. Generic medications are usually less expensive, and most generics are covered unless specifically excluded under your plan documents.
- Select Brand Name medications are included in the formulary and are therefore available to you through your plan. The List includes all covered brand name medications unless specifically excluded under your plan documents.
- Take this Guide with you when you visit your doctor or health care provider so that he or she is aware of the drugs listed and cost impacts when you discuss medication options.

Medication List

The Medication Guide includes the Preferred Medication List and some commonly prescribed Non-Preferred prescription medications. The Preferred Medication List reflects the current recommendations of Florida Blue and is developed in conjunction with Prime Therapeutics' National Pharmacy & Therapeutics Committee.

NOTE: This is not a complete listing of all covered prescriptions medications. Florida Blue reserves the right to modify (add, remove or change) the tier or apply limits of coverage to any prescription medication in this Medication Guide at any time.

For your out-of-pocket expenses to be as low as possible, please consider asking your doctor to prescribe generic medications, or if necessary, brand name medications that are included on the List. This will help ensure that your covered medications are allowed and reimbursed under your plan. In addition, consider using a participating pharmacy to obtain your covered medications because your out-of-pocket expenses should be lower than if you used a non-participating pharmacy.

To save the most money on medications, share this Medication Guide with your doctor or health care provider at each visit so he or she is aware of the drugs listed and cost impacts when you discuss medication options.

Changes to the formulary

This guide includes the medication list which reflects the current recommendations of Florida Blue and is developed in conjunction with Prime Therapeutics' National Pharmacy & Therapeutics Committee. Florida Blue reserves the right to add or remove or change the tier of any medication in this Medication Guide at any time.

The medication list is reviewed quarterly to examine new medications and new information about medications that are already on the market concerning safety, effectiveness and current use in therapy.

There are varying reasons changes are made to the medications listed in the Medication Guide:

- The tier level of a medication included on the medication list may increase (change to a higher tier or non-covered) when an FDA-approved bioequivalent generic medication becomes available.
- Newly marketed prescription medications may not be covered until the Pharmacy & Therapeutics Committee has had an opportunity to review the medication, to determine whether the medication will be covered and if so, which tier will apply based on safety, efficacy, and the availability of other products within that class of medications. Go to New To Market Drug List forthe most up-to-date information.

The most up to date information about modifications to the medications listed in this Medication Guide can be found by:

Going to www.floridablue.com

- Click on the **Members** tab.
- Click on the **Login Now** button and either **Login** or **Register**.
- Once Logged in, click on **My Plan**, then select **Pharmacy** under Additional Items.
- Under Pharmacy Resources, click on **Medication Guide & Specialty Pharmacy**
- Under **Medication Guide/Approved Drug Lists**, click Open Medication Guide or Open Medication Guide Updates
- Medication Guides and Medication Guide updates are posted every January, April July, and October.

Your Share of Expenses

Your cost share will depend on which cost share tier the medication is assigned. You can determine your out-of- pocket amount for medication by reviewing your Schedule of Benefits. If your plan includes a Deductible, you may have to satisfy that amount before the costs of your medications are covered.

If you or your provider requests a covered brand name medication when there is a generic medication available; you will be responsible for:
the difference in cost between the generic medication and the brand name medication; and the cost share applicable to brand name medication, as indicated on your Schedule of Benefits.

Example: If your drug copay is $10 for generic and $40 for brand, and you choose a brand name drug when a generic is available, here is what you might pay.

Difference in Drug Cost is $70 (Brand Drug Cost $120- Generic Drug Cost $50) + Brand Co-Pay $40=
$110 is Your Total Cost

Pharmacy Benefits

The pharmacy benefit has three parts/components, called Tiers. This means that covered medications must be included in one of the following Tiers, unless specifically excluded by your plan:

Tier 1: Covered Generic Prescription Medications

Tier 2: Covered Preferred Brand Prescription Medications

Tier 3: Covered Non-Preferred Brand Prescription Medications or Medications not listed on the Preferred Medication List

Specialty Medications: Covered Specialty Medications as indicated in the Medication List. Your plan may include a separate cost share for Specialty Medications. Since coverage for medication varies by the plan purchases by you or your employer, it's important that you refer to your plan documents for complete coverage details.

Specialty Drugs are only covered when they're dispensed from a Specialty Pharmacy, up to a one-month supply. Certain Specialty Pharmacy products may vary from the one-month supply. These Specialty Drugs may be dispensed in lesser or greater quantities due to manufacturer package size or FDA-approved dosage requirements for a course of therapy. A list of medications covered under this benefit may be found at: Specialty Drugs with Extended Day Supply.

Condition Care Rx* Value/HSA Preventive Prescription Medications: Refer to the Condition Care Rx Program section of this Medication Guide for a description of the program

Medications that are not covered

Your pharmacy benefit may not cover select medications. Some of the reasons a medication may not be covered are:

- The medication has been shown to have excessive adverse effects and/or safer alternatives.
- The medication has a preferred formulary alternative or over-the-counter (OTC)alternative.
- The medication is no longer marketed.
- The medication has a widely available/distributed AB rated generic equivalent formulation.
- The medication has not been approved by the FDA.
- The medication has been repackaged — a pharmaceutical product that is removed from the

original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

- The medication is not covered because of safety or effectiveness concerns.
- The medication is not covered for weight loss indication. See your Schedule of Benefit for additional details on coverage.

In addition to any drug not listed in the medication guide, a list of certain medication that are not covered may be found at Medications Not Covered List.

NOTE: To determine the medication exclusions that apply to your plan, check your plan documents. Coverage details are also available to you by logging into the member section of www.floridablue.com.

Condition Care Rx Program

The Condition Care Rx Program is designed to help manage the cost of medications used to treat certain chronic conditions and encourage medication adherence. If members have the Condition Care Rx Program as part of their benefits, they can purchase medications from the Condition Care Rx Program Value/Health Savings Account Preventive List at a reduced cost.

A list of medications that are part of the Condition Care Rx Value Program may be found at: Condition Care Rx Program Value List.

A list of medications that are part of the Condition Care Rx Program for Health Savings Account (HSA) compatible plans may be found at: Condition Care Rx Program HSA Preventive List.

Note: Check your plan documents to determine if the Condition Care Rx Program applies to your plan and the applicable cost share. Coverage details may also be available to you by logging into the member section of www.floridablue.com or by calling the customer service number listed on your member ID card.

Generic drugs

Florida Blue encourages the use of generic medications as a way to provide high-quality medications at a reduced cost. Generic medications are as safe and effective as their brand name counterparts and are usually considerably less expensive.

A Food and Drug Administration (FDA) approved generic medication may be substituted for its brand name counterpart because it:

- Contains the same active ingredient(s) as the brand name medication.
- Is identical in strength, dosage form, and route of administration.
- Is therapeutically equivalent and can be expected to have the same clinical effect and safety profile.

Check with your doctor or health care provider to determine if switching to a generic medication is appropriate for you.

Oral Chemotherapy Drugs

Oral chemotherapy drugs are drugs prescribed by a physician to kill or slow the growth of cancerous cells in a manner consistent with the national accepted standards of practice. A list of these drugs can be found at: Oral Chemotherapy Drug List.

Over-the-Counter (OTC) medications

An over-the-counter medication can be an appropriate treatment for some conditions and may offer a lower cost alternative to some commonly prescribed medications. Your pharmacy benefit may provide coverage for select OTC medications. Some groups may customize their pharmacy plan to exclude coverage for OTC medications, so it is important to check your plan documents to determine if OTC medications are covered under your plan. Only those OTC medications prescribed by your physician and designated on the formulary with "OTC" in parenthesis following the medication name are eligible for coverage.

NOTE: Check your plan documents to determine if this benefit applies to your plan. Coverage details are also available to you logging into the member section of www.floridablue.com

Patient Protection Affordable Care Act (PPACA) Preventive Services

- Preventive medications - Certain preventive care services, medications, and immunizations are covered at no cost share when purchased at a participating pharmacy.

A list of medications covered under this benefit may be found at: Preventive Medications List.

- Immunizations - Certain vaccines which are covered under your preventive benefit can be administered by pharmacists that are certified. Not all pharmacies provide services for vaccine administration. It is important to contact the pharmacy prior to your visit to ensure availability and administration of the vaccine.

A list of vaccines that are covered under your pharmacy benefits may be found at: Pharmacy Benefit Vaccines List.

- Women's preventive services - Certain contraceptive medications or devices (e.g., oral contraceptives, emergency contraceptive, and diaphragms) are covered at no cost share when purchased at a participating pharmacy.

A list of medications and devices covered under this benefit may be found at: Women's Preventive Services List.

Tier Exception Requests for Contraceptives & HIV Pre-Exposure Prophylaxis (PrEP)

If, for medical reasons, you need a contraceptive or HIV PrEP medication that is not included on these Preventive Service list(s), you may request an exception to waive the otherwise applicable cost sharing for your medication. To request an exception, your doctor must complete and submit request online at covermymeds.com or by fax using the Exception Request Forms in links below.

Contraceptives Tier Exception Request Form

HIV PrEP Tier Exception Request Form

Specialty Pharmacy medications

Specialty Pharmacy medications are high-cost injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of the patient's therapy.

NOTE: Check your plan documents for information on how Specialty Pharmacy medications are covered on your plan. Coverage details are also available by calling the customer service number listed on your member ID card.

Specialty Medications are divided into two categories:

- Self-Administered Specialty Medication – Patients administer these Specialty Pharmacy medications themselves. Because these medications are intended to be self-administered, these medications may not be covered if administered in a physician's office. If these medications are not obtained from a participating Specialty Pharmacy, out-of-network cost shares will apply (where out-of-network coverage is available). A current listing of Self-Administered Specialty Medications can be found here.
    - Self-administered injectable medications are designated in the Medication List with "inj" following the medication name (e.g., enoxaparin inj). No other Self-administered injectables will be covered unless such injectable is identified as a Specialty Drug in this Medication Guide. Self-administered injectables will be subject to the Brand or Generic cost share, as described in your Schedule of Benefits. Florida Blue reserves the right to change the Self-administered injectables covered through your plan at any time and for any reason.

- Provider-Administered Specialty Medications – These medications require the administration to be performed by a physician. The Specialty Pharmacy medications are ordered by a provider and administered in an office or outpatient setting. Provider- administered Specialty Pharmacy medications are covered under your *medical* benefit. A current listing of Provider- Administered Specialty Medications can be found here.

NOTE: We have noted medications that may be covered as either Self-Administered and/or Provider-Administered. Specialty Pharmacy products can be obtained as a pharmacy or medication benefit. Please check your handbook for details.

Pharmacy Options

There are two different types of pharmacies for you to be aware of as you decide where to get your prescriptions filled – retail pharmacies and specialty pharmacies. To save the most money, before you get a prescription filled, you should confirm which pharmacy is considered 'in-network' for that particular medication.

Participating Pharmacy

- Retail Pharmacy Network – Non-Specialty 'Generic' medications and 'Brand Name' medications listed in the Medication Guide can be filled at these pharmacies at a lower cost to you than other pharmacies in your area. If you go to a non- participating pharmacy, your prescription will cost you more.
- Specialty Pharmacy Network – We have identified certain drugs as specialty drugs due to requirements such as special handling, storage, training, distribution, and management of the therapy. These drugs are listed as a 'Specialty Drug' in this Medication Guide. To be covered under your pharmacy program at the in-network cost share, they must be purchased at a preferred Specialty Pharmacy. These pharmacies are **different** than the retail pharmacies and are identified in both the Provider Directory and this Medication Guide. Using an in-network Specialty Pharmacy to provide these Specialty Drugs lowers the amount you pay for these medications.
    - Limited Distribution (LD) Pharmacy – Drug manufacturers will choose one or a limited number of specialty pharmacies to handle and dispense certain specialty drugs. Typically, these drugs are costly and require special monitoring and prior authorization (pre-approval). The pharmacy that dispenses your limited distribution drug can be found here: Limited Distribution Drugs

Non-Participating Pharmacy

- If your plan offers out-of-network pharmacy coverage, choosing a non-participating pharmacy will cost you more money. You may have to pay the full cost of the medication and then file a claim for benefit determination. Our payment will be based on our Non-Participating Pharmacy Allowance minus your cost share. You will be responsible for your cost share and the difference between our Allowance and the cost of the medication.
- If your plan doesn't offer out-of-network pharmacy coverage, choosing a non-participating pharmacy may risk your ability to be reimbursed. You may have to pay the full cost of the medication.

Participating Specialty Pharmacy Provider

If you are currently taking a Specialty Pharmacy medication, then your network for Specialty Pharmacies is limited to the following participating Specialty Pharmacy providers. Unless indicated below, any other pharmacy is considered a non- participating Specialty Pharmacy even if it participates in Florida Blue's networks for non-Specialty Pharmacy medications. You may pay more out of pocket if you use a different specialty pharmacy.

CVS/Caremark Specialty Pharmacy Services
Provider-Administered and Self- Administered Products; excludes hemophilia
Phone: (866) 278-5108
Fax: (800) 323-2445
CVS/Caremark Specialty Pharmacy

Accredo
Self-Administered Products (excluding Hemophilia)
Phone: (888) 425-5970
Fax: (888) 302-1028
Accredo

CVS/Caremark Hemophilia Services
Hemophilia Products
Phone: (866) 792-2731
Fax: (866) 811-7450
(Mon-Fri., 9:00 a.m. to 7:30 p.m. EST)
CVS/Caremark Hemophilia Specialty Pharmacy

AllianceRx Walgreens Prime
****Baptist Employer Group B0496 ONLY****
Self-Administered Products (excluding Hemophilia)
Phone: (877) 627-6337
Fax: (877) 828-3939
AllianceRx Walgreens Prime

Note: Specialty Pharmacy medications are not covered when purchased through the Mail Order Pharmacy.

Self-administered specialty medications as classified by Florida Blue outside of the state of Florida may be obtained by a member with a written prescription through the preferred specialty pharmacy providers Accredo or CVS/Caremark Specialty.

If a member resides or is traveling outsides the state of Florida and needs to receive a provider-administered specialty medication, the prescribing physician should coordinate with the participating specialty pharmacy provider for their area or contact the local BlueCross and BlueShield Plan. This coordination can help ensure members receive their medications at the in-network cost share.

Members that receive a written prescription directly from their provider for a provider-administered specialty medication should contact customer service for further assistance.

Mail Order Pharmacy (also known as home delivery)

Most plans home delivery pharmacy is serviced by Amazon Pharmacy. To confirm your home delivery pharmacy provider, log into floridablue.com and view the home delivery section in your member account for additional details.

NOTE: If the original prescription was filled at a pharmacy other than the home delivery pharmacy, a new, original three- month supply prescription with a quantity of up to a three-month supply and not less than a two-month supply will be required. Prescriptions may not be transferred from a retail pharmacy to the home delivery pharmacy.

Three-month supply at Retail Pharmacy

In addition to being able to obtain up to a three-month supply of medication through our home delivery pharmacy, you may be able to receive up to a three-month supply of your medication through a participating retail pharmacy. Please refer to your Benefit Booklet, Certificate of Coverage, Contract, Member Handbook or prescription drug endorsement for complete coverage details.

Utilization Management Programs

Prior Authorization Program

The Prior Authorization Program encourages the appropriate, safe and cost-effective use of medication. If you are currently taking or are prescribed a medication that is included in the Prior Authorization Program, your physician will need to submit a request form in order for your prescription to be considered for coverage. If you do not request and/or receive prior approval, the medication will not be covered. A current listing of drugs requiring prior authorization are indicated in the prior authorization column following the product name in the medication list.

Florida Blue reserves the right to change the medications that require Prior Authorization at any time and for any reason.

NOTE: Some groups may customize their pharmacy plan to exclude prior authorization requirements, so it is important to check your plan documents to determine if prior authorization requirements apply to your plan. Coverage details are also available to you by logging into the member section of www.floridablue.com.

NOTE: Prior Authorizations expire on the earlier of, but not to exceed 12 months for most medications:

- The termination date of your policy or
- The period authorized by us, as indicated in the letter you received from us.

Obtaining Prior Authorization

Information about **Prior Authorization** and forms for how to obtain a prior authorization approval can be found here: Prior Authorization Program Information and Forms

NOTE: Your provider is required to complete and submit the Prior Authorization form in order for a coverage determination to be made.

1. Once a decision is made, you and/or your doctor will be informed of the decision.
2. If the decision is made to authorize coverage, the medication(s) and/or supplies may be obtained from a participating pharmacy or at the appropriate location if the medication(s) will be administered by a health professional. Prior authorization approval does not waive your cost share.
3. If a decision is made to deny authorization, you are free to purchase the prescription medication, supplies or over-the- counter (OTC) medication, but you will have to pay the full cost of the medication and will not be entitled to reimbursement under your plan.

NOTE: You have the right to request an appeal if coverage authorization is denied. Please refer to the "How to Appeal an Adverse Benefit Determination" subsection of the Claims Processing or Appeal and Grievance Process section in your current plan documents for information on how to file an appeal.

Responsible Quantity Program

The Responsible Quantity Program encourages the appropriate, safe and cost-effective use of medication by setting a maximum quantity per month for a medication or supply. The quantity limitations are based on the Food and Drug Administration guidelines and the manufacturer's dosing recommendations. Medications that are subject to this program are indicated in the quantity limits column following the product name in the medication list.

Florida Blue reserves the right to change the Drugs and the quantity limits subject to the Responsible Quantity Program at any time and for any reason. In cases where a larger quantity of a Responsible Quantity Drug is medically required, your doctor or health care provider can request an override.

Information about the Responsible Quantity Program and steps for how to obtain an exception can be found here:

Responsible Quantity Program Information

Responsible Quantity Authorization Form

Responsible Steps Program

The Responsible Steps Program promotes the appropriate, safe, and effective use of medications and helps you save on prescriptions. Responsible Steps is based on nationally recognized therapeutic guidelines, clinical evidence, and research. Prescription medications included in the Responsible Steps Program are not covered unless you have tried one or more covered alternative medications first.

A list of current drugs included in the Responsible Steps Program may be found here: Responsible Steps Program Information and Authorization Forms

Responsible Steps Program for Medical Pharmacy

Certain physician-administered prescription drugs which are rendered in a physician's office may be included in the Responsible Steps for Medical Pharmacy Program**.** If you are taking a medication in the Responsible Steps Program, please contact your physician/provider to discuss what medication options are best for you.

If, due to medical reasons, you cannot use the prerequisite drug and require the Responsible Steps Medication, your doctor or health care provider may request prior authorization for an override. If the override request is approved, coverage will be provided for the Responsible Steps Medication. Florida Blue reserves the right to change the drugs subject to the Responsible Steps Program at any time and for any reason.

A list of current drugs included in the Responsible Steps Program for Medical Pharmacy may be found here: Responsible Steps Program for Medical Pharmacy Information and Authorization Forms

NOTE: Check your plan documents to determine if Responsible Steps requirements apply to your plan. Coverage details are also available to you by logging into the member section of www.floridablue.com or by calling the customer service number listed on your ID card.

Coverage Protocol Exemption

Your doctor may want to prescribe a medication for a condition that is different from the step-therapy protocol developed by Florida Blue. If this is the case, either you or your doctor can request an exemption by submitting a Coverage Protocol Exemption Request.

Notice

This Medication Guide shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in your plan documents. In the event of any inconsistencies between the Medication Guide and the provisions contained in your plan documents, the provisions contained in your plan documents shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida and Health Options, Inc.

How to use this Drug list

Column 1: Drug Name
The drug list is organized into broad categories (e.g., HORMONES, DIABETES AND RELATED DRUGS). Please use the drug search function (Ctrl+F) to find current information for drugs on the drug list. Generic drugs are shown in lower-case **boldface** type. Most generic drugs are followed by a reference brand drug in (parentheses). Some generic products have no reference brand. Brand prescription drugs are shown in capital letters followed by the generic name. The Requirements/Limits column displays information about whether that drug requires prior authorization, responsible step, limited distribution, or quantity limits. Below are the meanings of the indicators used in the Drug Tier and Requirements/Limits columns.

Column 2: Drug Tier
Indicates the formulary tier level for each drug.

Column 3: Specialty (SP)
Indicates this is a self-administered specialty drug.

Note: Additional information about specialty drugs can be found in this document under Specialty Pharmacy medications, Self-Administered.

Column 4: Requirements/Limits

- Prior Authorization (PA)- Some drugs require prior authorization to ensure appropriate use and prescribing before a drug will be covered. Coverage may be approved after certain criteria are met. Approval is required for claims to process at network pharmacies. If the PA indicator is present, then the PA program noted is possibly applied to your benefit.
- Responsible Steps (ST)- Requires members to try another drug that may be more safe, clinically effective and, in some cases, less expensive, before a more expensive drug will be approved. If the ST indicator is present, then the ST program noted is possibly applied to your benefit.
- Limited Distribution (LD)- Drug manufacturers will choose one or limited number of specialty pharmacies to dispense drugs. Additional information about limited distribution drugs can be found in this document under Participating Pharmacy.
- Quantity Limits (QL)- Certain drugs have quantity limits to encourage safe and appropriate use. The quantity limit is the maximum quantity that can be dispensed over a given period of time. If the QL indicator is present, then the QL program noted is possibly applied to your benefit.

Some plans may have Utilization Management (UM) programs (e.g., PA, QL, and ST) on additional drugs beyond those noted in this document.

Abbreviation key

aer.....aerosol
cap..... capsules
chew ..... chewable
conc.....concentrate
cr.....controlled release
dr.....delayed release
ec .....enteric coated
equiv.....equivalent
er.....extended release
gm..... gram
inhal.....inhaler
inj ..... injection
liqd..... liquid
mg.....milligram
ml..... milliliter
nebu..... nebulizer
odt..... orally disintegrating tabs
oint..... ointment
ophth .....ophthalmic
osm .....osmotic release
pack .....packets
powd ..... powder
pttw .....twice-weekly patch
sl .....sublingual
soln .....solution
suppos.....suppositories
susp .....suspension
tab ..... tablets
td ..... transdermal
w/.....with

To determine if your drug is covered and/or find drug pricing, please login to Your Account on the Florida Blue website at **www.floridablue.com**. In Your Account choose Tools, and then Compare Drug Prices.

Drug Name	Drug Tier	Specialty	Requirements/Limits
ANTI-INFECTIVE AGENTS			
PENICILLINS			
AMOXICILLIN - amoxicillin (trihydrate) for susp 400 mg/5ml	3		
AMOXICILLIN - amoxicillin (trihydrate) chew tab 125 mg	3		
AMOXICILLIN - amoxicillin (trihydrate) chew tab 250 mg	2		
amoxicillin (trihydrate) cap 250 mg, 500 mg	1		
amoxicillin (trihydrate) for susp 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1		
amoxicillin (trihydrate) tab 500 mg, 875 mg	1		
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml	1		
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml (Augmentin es-600)	1		
amoxicillin & k clavulanate tab 250-125 mg, 875-125 mg	1		
amoxicillin & k clavulanate tab 500-125 mg (Augmentin)	1		
AMOXICILLIN/CLAVULANATE P - amoxicillin & k clavulanate chew tab 200-28.5 mg, 400-57 mg	3		
AMOXICILLIN/CLAVULANATE P - amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	3		
ampicillin cap 500 mg	1		
AUGMENTIN - amoxicillin & k clavulanate tab 500-125 mg	3		
AUGMENTIN - amoxicillin & k clavulanate for susp 125-31.25 mg/5ml	2		
AUGMENTIN ES-600 - amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	3		
dicloxacillin sodium cap 250 mg, 500 mg	1		
PENICILLIN V POTASSIUM - penicillin v potassium for soln 125 mg/5ml, 250 mg/5ml	2		
penicillin v potassium tab 250 mg, 500 mg	1		
CEPHALOSPORINS			
CEFACLOR - cefaclor cap 250 mg, 500 mg	3		
CEFACLOR - cefaclor for susp 250 mg/5ml	3		
CEFADROXIL - cefadroxil tab 1 gm	3		
cefadroxil cap 500 mg	1		
cefadroxil for susp 250 mg/5ml, 500 mg/5ml	1		
cefdinir cap 300 mg	1		
cefdinir for susp 125 mg/5ml, 250 mg/5ml	1		

KEY | **PA** = Prior Authorization | **ST** = Responsible Steps
LD = Limited Distribution | **QL** = Quantity Limit (Max Quantity/Time)
SP = Specialty; different Specialty Tier & cost-share may apply - see endorsement

Drug Name	Drug Tier	Specialty	Requirements/Limits
cefixime cap 400 mg (Suprax)	1		
cefixime for susp 100 mg/5ml	1		
cefixime for susp 200 mg/5ml (Suprax)	1		
cefpodoxime proxetil for susp 50 mg/5ml, 100 mg/5ml	1		
cefpodoxime proxetil tab 100 mg, 200 mg	1		
cefprozil for susp 125 mg/5ml, 250 mg/5ml	1		
cefprozil tab 250 mg, 500 mg	1		
cefuroxime axetil tab 250 mg, 500 mg	1		
cephalexin cap 250 mg, 500 mg	1		
cephalexin for susp 125 mg/5ml, 250 mg/5ml	1		
MACROLIDES			
AZITHROMYCIN - azithromycin powd pack for susp 1 gm	3		
azithromycin for susp 100 mg/5ml, 200 mg/5ml (Zithromax)	1		
azithromycin tab 250 mg, 500 mg (Zithromax)	1		
azithromycin tab 600 mg	1		
CLARITHROMYCIN - clarithromycin for susp 125 mg/5ml, 250 mg/5ml	3		
clarithromycin tab er 24hr 500 mg	1		
clarithromycin tab 250 mg, 500 mg	1		
DIFICID - fidaxomicin tab 200 mg	2		QL (40 tablets/180 days)
DIFICID - fidaxomicin for susp 40 mg/ml	2		QL (272 mls/180 days)
E.E.S. GRANULES - erythromycin ethylsuccinate for susp 200 mg/5ml	3		
E.E.S. 400 - erythromycin ethylsuccinate tab 400 mg	3		
ERYPED 200 - erythromycin ethylsuccinate for susp 200 mg/5ml	3		
ERYPED 400 - erythromycin ethylsuccinate for susp 400 mg/5ml	3		
ERYTHROCIN STEARATE - erythromycin stearate tab 250 mg	3		
ERYTHROMYCIN - erythromycin w/ delayed release particles cap 250 mg	3		
ERYTHROMYCIN ETHYLSUCCINA - erythromycin ethylsuccinate tab 400 mg	3		
erythromycin ethylsuccinate for susp 200 mg/5ml (E.e.s. granules)	1		
erythromycin ethylsuccinate for susp 400 mg/5ml (Eryped 400)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
erythromycin tab delayed release 250 mg, 333 mg, 500 mg	1		
erythromycin tab 250 mg, 500 mg	1		
ZITHROMAX - azithromycin powd pack for susp 1 gm	2		
TETRACYCLINES			
demeclocycline hcl tab 150 mg, 300 mg	1		
doxycycline hyclate cap 50 mg	1		
doxycycline hyclate cap 100 mg (Vibramycin)	1		
doxycycline hyclate tab 20 mg, 50 mg, 100 mg	1		
doxycycline monohydrate cap 50 mg, 100 mg	1		
doxycycline monohydrate for susp 25 mg/5ml (Vibramycin)	1		
doxycycline monohydrate tab 50 mg, 75 mg, 100 mg	1		
minocycline hcl cap 50 mg, 75 mg, 100 mg	1		
NUZYRA - omadacycline tosylate tab 150 mg (base equivalent)	3	SP	PA, LD, QL (30 tablets/180 days)
tetracycline hcl cap 250 mg, 500 mg	1		
FLUOROQUINOLONES			
BAXDELA - delafloxacin meglumine tab 450 mg (base equiv)	3		PA, QL (28 tablets/14 days)
CIPRO - ciprofloxacin for oral susp 250 mg/5ml (5%) (5 gm/100ml)	3		
CIPRO - ciprofloxacin for oral susp 500 mg/5ml (10%) (10 gm/100ml)	2		
ciprofloxacin hcl tab 250 mg (base equiv), 500 mg (base equiv) (Cipro)	1		
ciprofloxacin hcl tab 750 mg (base equiv)	1		
levofloxacin oral soln 25 mg/ml	1		
levofloxacin tab 250 mg, 500 mg, 750 mg	1		
moxifloxacin hcl tab 400 mg (base equiv)	1		
OFLOXACIN - ofloxacin tab 300 mg	3		
ofloxacin tab 400 mg	1		
AMINOGLYCOSIDES			
ARIKAYCE - amikacin sulfate liposome inhal susp 590 mg/8.4ml (base eq)	3	SP	LD
BETHKIS - tobramycin nebu soln 300 mg/4ml	3	SP	LD
HUMATIN - paromomycin sulfate cap 250 mg	2		LD
KITABIS PAK - tobramycin nebu soln 300 mg/5ml	3	SP	LD
neomycin sulfate tab 500 mg	1		
TOBI PODHALER - tobramycin inhal cap 28 mg	2	SP	LD
TOBRAMYCIN - tobramycin nebu soln 300 mg/5ml	3	SP	

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tobramycin nebu soln 300 mg/5ml (Tobi)	1	SP	
tobramycin nebu soln 300 mg/4ml (Bethkis)	1	SP	
SULFONAMIDES			
SULFADIAZINE - sulfadiazine tab 500 mg	2		
ANTIMYCOBACTERIAL AGENTS			
cycloserine cap 250 mg	1		
ethambutol hcl tab 100 mg	1		
ethambutol hcl tab 400 mg (Myambutol)	1		
ISONIAZID - isoniazid tab 100 mg	3		
isoniazid syrup 50 mg/5ml	1		
isoniazid tab 300 mg	1		
MYAMBUTOL - ethambutol hcl tab 400 mg	3		
MYCOBUTIN - rifabutin cap 150 mg	3		
PRETOMANID - pretomanid tab 200 mg	3		LD, QL (182 tablets/365 days)
PRIFTIN - rifapentine tab 150 mg	2		
pyrazinamide tab 500 mg	1		
rifabutin cap 150 mg (Mycobutin)	1		
rifampin cap 150 mg, 300 mg	1		
SIRTURO - bedaquiline fumarate tab 20 mg (base equiv)	3	SP	LD, QL (940 tablets/365 days)
SIRTURO - bedaquiline fumarate tab 100 mg (base equiv)	3	SP	LD, QL (188 tablets/365 days)
TRECATOR - ethionamide tab 250 mg	3		
ANTIFUNGALS			
ANCOBON - flucytosine cap 250 mg, 500 mg	3		
CRESEMBA - isavuconazonium sulfate cap 74.5 mg (isavuconazole 40 mg), 186 mg (isavuconazole 100 mg)	3		PA
DIFLUCAN - fluconazole for susp 10 mg/ml, 40 mg/ml	3		
fluconazole for susp 10 mg/ml, 40 mg/ml (Diflucan)	1		
fluconazole tab 50 mg, 100 mg, 150 mg, 200 mg (Diflucan)	1		
flucytosine cap 250 mg, 500 mg (Ancobon)	1		
griseofulvin microsize susp 125 mg/5ml	1		
griseofulvin microsize tab 500 mg	1		
griseofulvin ultramicrosize tab 125 mg, 250 mg	1		
itraconazole cap 100 mg (Sporanox)	1		PA, QL (120 capsules/30 days)
itraconazole oral soln 10 mg/ml (Sporanox)	1		PA, QL (1200 mls/30 days)
ketoconazole tab 200 mg	1		
NOXAFIL - posaconazole tab delayed release 100 mg	3		PA
NOXAFIL - posaconazole susp 40 mg/ml	3		PA

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Drug Name	Drug Tier	Specialty	Requirements/Limits
NOXAFIL - posaconazole for delayed release susp packet 300 mg	2		PA
nystatin tab 500000 unit	1		
posaconazole susp 40 mg/ml (Noxafil)	1		PA
posaconazole tab delayed release 100 mg (Noxafil)	1		PA
SPORANOX - itraconazole cap 100 mg	3		PA, QL (120 capsules/30 days)
SPORANOX - itraconazole oral soln 10 mg/ml	3		PA, QL (1200 mls/30 days)
terbinafine hcl tab 250 mg	1		QL (30 tablets/30 days)
VFEND - voriconazole tab 50 mg, 200 mg	3		PA
VFEND - voriconazole for susp 40 mg/ml	3		PA
VIVJOA - oteseconazole cap therapy pack 150 mg (12 weeks)	3		PA, QL (18 capsules/180 days)
voriconazole for susp 40 mg/ml (Vfend)	1		PA
voriconazole tab 50 mg, 200 mg (Vfend)	1		PA
ANTIVIRALS			
abacavir sulfate soln 20 mg/ml (base equiv) (Ziagen)	1		QL (960 mls/30 days)
abacavir sulfate tab 300 mg (base equiv) (Ziagen)	1		QL (60 tablets/30 days)
abacavir sulfate-lamivudine tab 600-300 mg (Epzicom)	1		QL (30 tablets/30 days)
acyclovir cap 200 mg	1		
acyclovir susp 200 mg/5ml (Zovirax)	1		
acyclovir tab 400 mg, 800 mg	1		
adefovir dipivoxil tab 10 mg (Hepsera)	1		QL (30 tablets/30 days)
APTIVUS - tipranavir cap 250 mg	2		QL (120 capsules/30 days)
atazanavir sulfate cap 150 mg (base equiv)	1		QL (30 capsules/30 days)
atazanavir sulfate cap 200 mg (base equiv) (Reyataz)	1		QL (60 capsules/30 days)
atazanavir sulfate cap 300 mg (base equiv) (Reyataz)	1		QL (30 capsules/30 days)
BARACLUDE - entecavir oral soln 0.05 mg/ml	2		QL (630 mls/30 days)
BIKTARVY - bictegravir-emtricitabine-tenofovir af tab 30-120-15 mg, 50-200-25 mg	2		QL (30 tablets/30 days)
CIMDUO - lamivudine-tenofovir disoproxil fumarate tab 300-300 mg	2		QL (30 tablets/30 days)
COMPLERA - emtricitabine-rilpivirine-tenofovir df tab 200-25-300 mg	2		QL (30 tablets/30 days)
darunavir tab 600 mg (Prezista)	1		QL (60 tablets/30 days)
darunavir tab 800 mg (Prezista)	1		QL (30 tablets/30 days)
DELSTRIGO - doravirine-lamivudine-tenofovir df tab 100-300-300 mg	2		QL (30 tablets/30 days)
DESCOVY - emtricitabine-tenofovir alafenamide fumarate tab 120-15 mg, 200-25 mg	2		QL (30 tablets/30 days)

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DOVATO - dolutegravir sodium-lamivudine tab 50-300 mg (base eq)	2		QL (30 tablets/30 days)
EDURANT - rilpivirine hcl tab 25 mg (base equivalent)	2		QL (30 tablets/30 days)
EFAVIRENZ - efavirenz cap 50 mg	2		QL (90 capsules/30 days)
EFAVIRENZ - efavirenz cap 200 mg	2		QL (60 capsules/30 days)
efavirenz tab 600 mg (Sustiva)	1		QL (30 tablets/30 days)
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	1		QL (30 tablets/30 days)
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg (Symfi lo)	1		QL (30 tablets/30 days)
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg (Symfi)	1		QL (30 tablets/30 days)
emtricitabine caps 200 mg (Emtriva)	1		QL (30 capsules/30 days)
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg (Truvada)	1		QL (30 tablets/30 days)
EMTRIVA - emtricitabine caps 200 mg	3		QL (30 capsules/30 days)
EMTRIVA - emtricitabine soln 10 mg/ml	2		QL (680 mls/28 days)
entecavir tab 0.5 mg, 1 mg (Baraclude)	1		QL (30 tablets/30 days)
EPCLUSA - sofosbuvir-velpatasvir tab 200-50 mg	2	SP	PA, QL (30 tablets/30 days)
EPCLUSA - sofosbuvir-velpatasvir tab 400-100 mg	2	SP	PA, QL (28 tablets/28 days)
EPCLUSA - sofosbuvir-velpatasvir pellet pack 150-37.5 mg	2	SP	PA, QL (30 packets/30 days)
EPCLUSA - sofosbuvir-velpatasvir pellet pack 200-50 mg	2	SP	PA, QL (60 packets/30 days)
EPIVIR - lamivudine oral soln 10 mg/ml	3		QL (960 mls/30 days)
EPIVIR - lamivudine tab 150 mg	3		QL (60 tablets/30 days)
EPIVIR - lamivudine tab 300 mg	3		QL (30 tablets/30 days)
etravirine tab 100 mg, 200 mg (Intelence)	1		QL (60 tablets/30 days)
EVOTAZ - atazanavir sulfate-cobicistat tab 300-150 mg (base equiv)	2		QL (30 tablets/30 days)
famciclovir tab 125 mg, 250 mg, 500 mg	1		
fosamprenavir calcium tab 700 mg (base equiv) (Lexiva)	1		QL (120 tablets/30 days)
FUZEON - enfuvirtide for inj 90 mg	2	SP	QL (60 vials/30 days)
GENVOYA - elvitegrav-cobic-emtricitab-tenofov af tab 150-150-200-10 mg	2		QL (30 tablets/30 days)
HARVONI - ledipasvir-sofosbuvir pellet pack 33.75-150 mg, 45-200 mg	2	SP	PA, QL (30 packets/30 days)
HARVONI - ledipasvir-sofosbuvir tab 45-200 mg, 90-400 mg	2	SP	PA, QL (30 tablets/30 days)
INTELENCE - etravirine tab 25 mg	2		QL (120 tablets/30 days)

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INTELENCE - etravirine tab 100 mg, 200 mg	3		QL (60 tablets/30 days)
ISENTRESS - raltegravir potassium chew tab 25 mg (base equiv), 100 mg (base equiv)	2		QL (180 tablets/30 days)
ISENTRESS - raltegravir potassium packet for susp 100 mg (base equiv)	2		QL (60 packets/30 days)
ISENTRESS - raltegravir potassium tab 400 mg (base equiv)	2		QL (60 tablets/30 days)
ISENTRESS HD - raltegravir potassium tab 600 mg (base equiv)	2		QL (60 tablets/30 days)
JULUCA - dolutegravir sodium-rilpivirine hcl tab 50-25 mg (base eq)	2		QL (30 tablets/30 days)
KALETRA - lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	3		QL (480 mls/30 days)
KALETRA - lopinavir-ritonavir tab 100-25 mg	3		QL (180 tablets/30 days)
KALETRA - lopinavir-ritonavir tab 200-50 mg	3		QL (120 tablets/30 days)
LAGEVRIO - molnupiravir cap 200 mg	3		QL (40 capsules/30 days)
lamivudine oral soln 10 mg/ml (Epivir)	1		QL (960 mls/30 days)
lamivudine tab 100 mg (hbv) (Epivir hbv)	1		QL (30 tablets/30 days)
lamivudine tab 150 mg (Epivir)	1		QL (60 tablets/30 days)
lamivudine tab 300 mg (Epivir)	1		QL (30 tablets/30 days)
lamivudine-zidovudine tab 150-300 mg (Combivir)	1		QL (60 tablets/30 days)
LEDIPASVIR/SOFOSBUVIR - ledipasvir-sofosbuvir tab 90-400 mg	2	SP	PA, QL (30 tablets/30 days)
LIVTENCITY - maribavir tab 200 mg	3	SP	PA, LD, QL (120 tablets/30 days)
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml) (Kaletra)	1		QL (480 mls/30 days)
lopinavir-ritonavir tab 100-25 mg (Kaletra)	1		QL (180 tablets/30 days)
lopinavir-ritonavir tab 200-50 mg (Kaletra)	1		QL (120 tablets/30 days)
maraviroc tab 150 mg (Selzentry)	1		QL (60 tablets/30 days)
maraviroc tab 300 mg (Selzentry)	1		QL (120 tablets/30 days)
MAVYRET - glecaprevir-pibrentasvir tab 100-40 mg	2	SP	PA, QL (90 tablets/30 days)
MAVYRET - glecaprevir-pibrentasvir pellet pack 50-20 mg	2	SP	PA, QL (150 packets/30 days)
NEVIRAPINE - nevirapine susp 50 mg/5ml	2		QL (1200 mls/30 days)
nevirapine tab er 24hr 400 mg	1		QL (30 tablets/30 days)
nevirapine tab 200 mg	1		QL (60 tablets/30 days)
NORVIR - ritonavir tab 100 mg	3		QL (360 tablets/30 days)
NORVIR - ritonavir powder packet 100 mg	2		QL (360 packets/30 days)
ODEFSEY - emtricitabine-rilpivirine-tenofovir af tab 200-25-25 mg	2		QL (30 tablets/30 days)

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oseltamivir phosphate cap 30 mg (base equiv) (Tamiflu)	1		QL (40 capsules/120 days)
oseltamivir phosphate cap 45 mg (base equiv), 75 mg (base equiv) (Tamiflu)	1		QL (20 capsules/120 days)
oseltamivir phosphate for susp 6 mg/ml (base equiv) (Tamiflu)	1		QL (300 mls/120 days)
PAXLOVID - nirmatrelvir tab 10 x 150 mg & ritonavir tab 10 x 100 mg pak	2		QL (20 tablets/30 days)
PAXLOVID - nirmatrelvir tab 20 x 150 mg & ritonavir tab 10 x 100 mg pak	2		QL (30 tablets/30 days)
PEGASYS - peginterferon alfa-2a soln prefilled syr 180 mcg/0.5ml	3	SP	PA
PEGASYS - peginterferon alfa-2a inj 180 mcg/ml	3	SP	PA
PIFELTRO - doravirine tab 100 mg	2		QL (30 tablets/30 days)
PREVYMIS - letermovir tab 240 mg, 480 mg	3		
PREZCOBIX - darunavir-cobicistat tab 800-150 mg	2		QL (30 tablets/30 days)
PREZISTA - darunavir oral susp 100 mg/ml	2		QL (400 mls/30 days)
PREZISTA - darunavir tab 75 mg	2		QL (300 tablets/30 days)
PREZISTA - darunavir tab 150 mg	2		QL (180 tablets/30 days)
PREZISTA - darunavir tab 600 mg	3		QL (60 tablets/30 days)
PREZISTA - darunavir tab 800 mg	3		QL (30 tablets/30 days)
RELENZA DISKHALER - zanamivir aerosol powder breath activated 5 mg/act	3		QL (40 blisters/120 days)
RETROVIR - zidovudine cap 100 mg	3		QL (180 capsules/30 days)
RETROVIR - zidovudine syrup 10 mg/ml	3		QL (1920 mls/30 days)
REYATAZ - atazanavir sulfate oral powder packet 50 mg (base equiv)	2		QL (240 packets/30 days)
REYATAZ - atazanavir sulfate cap 200 mg (base equiv)	3		QL (60 capsules/30 days)
REYATAZ - atazanavir sulfate cap 300 mg (base equiv)	3		QL (30 capsules/30 days)
RIBAVIRIN - ribavirin cap 200 mg	2		
RIBAVIRIN - ribavirin tab 200 mg	2		
RIMANTADINE HYDROCHLORIDE - rimantadine hydrochloride tab 100 mg	3		
ritonavir tab 100 mg (Norvir)	1		QL (360 tablets/30 days)
RUKOBIA - fostemsavir tromethamine tab er 12hr 600 mg	2		QL (60 tablets/30 days)
SELZENTRY - maraviroc oral soln 20 mg/ml	2		QL (1840 mls/30 days)
SELZENTRY - maraviroc tab 150 mg	3		QL (60 tablets/30 days)
SELZENTRY - maraviroc tab 300 mg	3		QL (120 tablets/30 days)
SOFOSBUVIR/VELPATASVIR - sofosbuvir-velpatasvir tab 400-100 mg	2	SP	PA, QL (28 tablets/28 days)

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SOVALDI - sofosbuvir tab 200 mg, 400 mg	2	SP	PA, QL (30 tablets/30 days)
SOVALDI - sofosbuvir pellet pack 150 mg, 200 mg	2	SP	PA, QL (30 packets/30 days)
STRIBILD - elvitegrav-cobic-emtricitab-tenofovdf tab 150-150-200-300 mg	2		QL (30 tablets/30 days)
SUNLENCA - lenacapavir sodium tab therapy pack 4 x 300 mg	2		LD, QL (4 tablets/365 days)
SUNLENCA - lenacapavir sodium tab therapy pack 5 x 300 mg	2		LD, QL (5 tablets/365 days)
SYMFI - efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	3		QL (30 tablets/30 days)
SYMFI LO - efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	3		QL (30 tablets/30 days)
SYMTUZA - darunavir-cobic-emtricitab-tenofov af tab 800-150-200-10 mg	2		QL (30 tablets/30 days)
TAMIFLU - oseltamivir phosphate for susp 6 mg/ml (base equiv)	3		QL (300 mls/120 days)
TAMIFLU - oseltamivir phosphate cap 30 mg (base equiv)	3		QL (40 capsules/120 days)
TAMIFLU - oseltamivir phosphate cap 45 mg (base equiv), 75 mg (base equiv)	3		QL (20 capsules/120 days)
tenofovir disoproxil fumarate tab 300 mg (Viread)	1		QL (30 tablets/30 days)
TIVICAY - dolutegravir sodium tab 50 mg (base equiv)	2		QL (60 tablets/30 days)
TIVICAY PD - dolutegravir sodium tab for oral susp 5 mg (base equiv)	2		QL (360 tablets/30 days)
TRIUMEQ - abacavir-dolutegravir-lamivudine tab 600-50-300 mg	2		QL (30 tablets/30 days)
TRIUMEQ PD - abacavir-dolutegravir-lamivudine tab for oral sus 60-5-30 mg	2		QL (180 tablets/30 days)
TRUVADA - emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg	3		QL (30 tablets/30 days)
TYBOST - cobicistat tab 150 mg	2		QL (30 tablets/30 days)
valacyclovir hcl tab 500 mg, 1 gm (Valtrex)	1		
valganciclovir hcl for soln 50 mg/ml (base equiv) (Valcyte)	1		
valganciclovir hcl tab 450 mg (base equivalent) (Valcyte)	1		
VEMLIDY - tenofovir alafenamide fumarate tab 25 mg	2		QL (30 tablets/30 days)
VIRACEPT - nelfinavir mesylate tab 250 mg	2		QL (270 tablets/30 days)
VIRACEPT - nelfinavir mesylate tab 625 mg	2		QL (120 tablets/30 days)
VIREAD - tenofovir disoproxil fumarate oral powder 40 mg/gm	2		QL (240 grams/30 days)

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VIREAD - tenofovir disoproxil fumarate tab 150 mg, 200 mg, 250 mg	2		QL (30 tablets/30 days)
VIREAD - tenofovir disoproxil fumarate tab 300 mg	3		QL (30 tablets/30 days)
VOSEVI - sofosbuvir-velpatasvir-voxilaprevir tab 400-100-100 mg	2	SP	PA, QL (30 tablets/30 days)
XOFLUZA - baloxavir marboxil tab therapy pack 1 x 40 mg (40 mg dose), 1 x 80 mg (80 mg dose)	3		QL (2 tablets/120 days)
ZIAGEN - abacavir sulfate soln 20 mg/ml (base equiv)	3		QL (960 mls/30 days)
zidovudine cap 100 mg (Retrovir)	1		QL (180 capsules/30 days)
zidovudine syrup 10 mg/ml (Retrovir)	1		QL (1920 mls/30 days)
zidovudine tab 300 mg	1		QL (60 tablets/30 days)
ANTIMALARIALS			
ARAKODA - tafenoquine succinate tab 100 mg (base equivalent)	3		
atovaquone-proguanil hcl tab 62.5-25 mg, 250-100 mg (Malarone)	1		
chloroquine phosphate tab 250 mg, 500 mg	1		
COARTEM - artemether-lumefantrine tab 20-120 mg	2		
DARAPRIM - pyrimethamine tab 25 mg	3	SP	PA, LD, QL (90 tablets/30 days)
hydroxychloroquine sulfate tab 100 mg, 300 mg, 400 mg	1		
hydroxychloroquine sulfate tab 200 mg (Plaquenil)	1		
KRINTAFEL - tafenoquine succinate tab 150 mg (base equivalent)	3		
mefloquine hcl tab 250 mg	1		
PLAQUENIL - hydroxychloroquine sulfate tab 200 mg	3		
PRIMAQUINE PHOSPHATE - primaquine phosphate tab 26.3 mg (15 mg base)	3		
primaquine phosphate tab 26.3 mg (15 mg base) (Primaquine phosphate)	1		
pyrimethamine tab 25 mg (Daraprim)	1	SP	PA, QL (90 tablets/30 days)
QUALAQUIN - quinine sulfate cap 324 mg	3		QL (42 capsules/90 days)
quinine sulfate cap 324 mg (Qualaquin)	1		QL (42 capsules/90 days)
ANTHELMINTICS			
albendazole tab 200 mg	1		PA, QL (120 tablets/30 days)
BENZNIDAZOLE - benznidazole tab 12.5 mg, 100 mg	2		LD
BILTRICIDE - praziquantel tab 600 mg	3		
EGATEN - triclabendazole tab 250 mg	2	SP	PA
EMVERM - mebendazole chew tab 100 mg	3		PA, QL (180 tablets/30 days)
ivermectin tab 3 mg (Stromectol)	1		
praziquantel tab 600 mg (Biltricide)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
STROMECTOL - ivermectin tab 3 mg	3		
ANTI-INFECTIVE AGENTS - MISC.			
AEMCOLO - rifamycin sodium tab delayed release 194 mg (base equiv)	3		QL (12 tablets/180 days)
ALINIA - nitazoxanide tab 500 mg	3		QL (12 tablets/90 days)
ALINIA - nitazoxanide for susp 100 mg/5ml	2		QL (300 mls/90 days)
atovaquone susp 750 mg/5ml (Mepron)	1		
BACTRIM - sulfamethoxazole-trimethoprim tab 400-80 mg	3		
BACTRIM DS - sulfamethoxazole-trimethoprim tab 800-160 mg	3		
CAYSTON - aztreonam lysine for inhal soln 75 mg (base equivalent)	2	SP	LD
CLEOCIN - clindamycin hcl cap 75 mg, 150 mg, 300 mg	3		
CLEOCIN PEDIATRIC GRANULE - clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)	3		
clindamycin hcl cap 75 mg, 150 mg, 300 mg (Cleocin)	1		
clindamycin palmitate hcl for soln 75 mg/5ml (base equiv) (Cleocin pediatric gr)	1		
colistimethate sod for inj 150 mg (colistin base activity) (Coly-mycin m)	1		
COLY-MYCIN M - colistimethate sod for inj 150 mg (colistin base activity)	3		
dapsone tab 25 mg, 100 mg	1		
FIRVANQ - vancomycin hcl for oral soln 25 mg/ml (base equivalent)	3		
FIRVANQ - vancomycin hcl for oral soln 50 mg/ml (base equivalent)	3		QL (1200 mls/30 days)
FLAGYL - metronidazole cap 375 mg	3		
fosfomycin tromethamine powd pack 3 gm (base equivalent) (Monurol)	1		
HIPREX - methenamine hippurate tab 1 gm	3		
IMPAVIDO - miltefosine cap 50 mg	2	SP	PA
LAMPIT - nifurtimox tab 30 mg	3		LD, QL (540 tablets/180 days)
LAMPIT - nifurtimox tab 120 mg	3		LD, QL (450 tablets/180 days)
linezolid for susp 100 mg/5ml (Zyvox)	1		
linezolid tab 600 mg (Zyvox)	1		
MACROBID - nitrofurantoin monohydrate macrocrystalline cap 100 mg	3		
MACRODANTIN - nitrofurantoin macrocrystalline cap 25 mg, 50 mg, 100 mg	3		
MEPRON - atovaquone susp 750 mg/5ml	3		

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methenamine hippurate tab 1 gm (Hiprex)	1		
metronidazole cap 375 mg (Flagyl)	1		
metronidazole tab 250 mg, 500 mg	1		
NEBUPENT - pentamidine isethionate for nebulization soln 300 mg	3		
nitazoxanide tab 500 mg (Alinia)	1		QL (12 tablets/90 days)
nitrofurantoin macrocrystalline cap 25 mg, 50 mg, 100 mg (Macrodantin)	1		
nitrofurantoin monohydrate macrocrystalline cap 100 mg (Macrobid)	1		
nitrofurantoin susp 25 mg/5ml	1		
pentamidine isethionate for nebulization soln 300 mg (Nebupent)	1		
SIVEXTRO - tedizolid phosphate tab 200 mg	2		PA, QL (6 tablets/30 days)
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	1		
sulfamethoxazole-trimethoprim tab 400-80 mg (Bactrim)	1		
sulfamethoxazole-trimethoprim tab 800-160 mg (Bactrim ds)	1		
tinidazole tab 250 mg, 500 mg	1		
TRIMETHOPRIM - trimethoprim tab 100 mg	3		
trimethoprim tab 100 mg (Trimethoprim)	1		
VANCOCIN - vancomycin hcl cap 125 mg (base equivalent)	3		QL (480 capsules/30 days)
VANCOCIN - vancomycin hcl cap 250 mg (base equivalent)	3		QL (240 capsules/30 days)
vancomycin hcl cap 125 mg (base equivalent) (Vancocin)	1		QL (480 capsules/30 days)
vancomycin hcl cap 250 mg (base equivalent) (Vancocin)	1		QL (240 capsules/30 days)
vancomycin hcl for oral soln 25 mg/ml (base equivalent) (Firvanq)	1		
vancomycin hcl for oral soln 50 mg/ml (base equivalent) (Firvanq)	1		QL (1200 mls/30 days)
XIFAXAN - rifaximin tab 200 mg	3		PA, QL (9 tablets/180 days)
XIFAXAN - rifaximin tab 550 mg	2		PA, QL (90 tablets/30 days)
BIOLOGICALS			
VACCINES			
ABRYSVO - rsv pre-fusion f a&b vac recomb for im soln 120 mcg/0.5ml	3		
ACTHIB - haemophilus b polysaccharide conjugate vaccine for inj	3		

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AFLURIA QUADRIVALENT 2023 - influenza virus vac split quadrivalent susp pref syr 0.5ml	3		QL (1 vaccine/90 days)
AFLURIA QUADRIVALENT 2023 - influenza virus vaccine split quadrivalent im inj	3		QL (1 vaccine/90 days)
AREXVY - rsvpref3 vaccine recomb adjuvanted for im susp 120 mcg/0.5ml	3		
BEXSERO - meningococcal vac b (recomb omv adjuv) inj prefilled syringe	3		
COMIRNATY 2023-24 - covid-19 mrna vac tris-pfizer im susp pref syr 30 mcg/0.3ml	3		
COMIRNATY 2023-24 - covid-19 mrna vac tris-sucrose-pfizer im susp 30 mcg/0.3ml	3		
ENGERIX-B - hepatitis b vaccine (recombinant) susp pref syr 10 mcg/0.5ml, 20 mcg/ml	3		
ENGERIX-B - hepatitis b vaccine (recombinant) susp 20 mcg/ml	3		
FLUAD QUADRIVALENT 2023-2 - influenza vac type a&b surface ant adj quad pref syr 0.5 ml	3		QL (1 vaccine/90 days)
FLUARIX QUADRIVALENT 2023 - influenza virus vac split quadrivalent susp pref syr 0.5ml	3		QL (1 vaccine/90 days)
FLUBLOK QUADRIVALENT 2023 - influenza vac recomb ha quad pf soln pref syr 0.5 ml	3		QL (1 vaccine/90 days)
FLUCELVAX QUADRIVALENT 20 - influenza vac tiss-cult subunt quad susp pref syr 0.5 ml	3		QL (1 vaccine/90 days)
FLUCELVAX QUADRIVALENT 20 - influenza vac tissue-cultured subunit quadrivalent im susp	3		QL (1 vaccine/90 days)
FLULAVAL QUADRIVALENT 202 - influenza virus vac split quadrivalent susp pref syr 0.5ml	3		QL (1 vaccine/90 days)
FLUMIST QUADRIVALENT - influenza virus vaccine live quadrivalent intranasal susp	3		QL (1 vaccine/90 days)
FLUZONE HIGH-DOSE PF 2023 - influenza vac split high-dose quad pf susp pref syr 0.7 ml	3		QL (1 vaccine/90 days)
FLUZONE QUADRIVALENT 2023 - influenza virus vac split quadrivalent susp pref syr 0.5ml	3		QL (1 vaccine/90 days)
FLUZONE QUADRIVALENT 2023 - influenza virus vaccine split quadrivalent im inj	3		QL (1 vaccine/90 days)
GARDASIL 9 - human papillomavirus (hpv) 9-valent recomb vac susp pref syr	3		
GARDASIL 9 - human papillomavirus (hpv) 9-valent recomb vac im susp	3		
HAVRIX - hepatitis a vaccine inj susp 720 el unit/0.5ml, 1440 el unit/ml	3		
HEPLISAV-B - hepatitis b vaccine recomb adjuvanted pref syr 20 mcg/0.5ml	3		

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HIBERIX - haemophilus b polysaccharide conjugate vac for inj 10 mcg	3		
IPOL INACTIVATED IPV - poliovirus vaccine, ipv injection	3		
JYNNEOS - smallpox & monkeypox vac, live, non-replicating inj 0.5 ml	3		
M-M-R II - measles-mumps-rubella virus vaccines for inj soln	3		
MENQUADFI - meningococcal (a, c, y, and w-135) tetanus conjugate vaccine	3		
MENVEO - meningococcal (a, c, y, and w-135) oligo conj vac im soln	3		
MENVEO - meningococcal (a, c, y, and w-135) oligo conj vac for inj	3		
MODERNA COVID-19 VACCINE - covid-19 mrna vaccine 6mo-11yr-moderna im susp 25 mcg/0.25ml	3		
NOVAVAX COVID-19 VACCINE/ - covid-19 subunit prot recom adjuv vac-novavax im 5 mcg/0.5ml	3		
PEDVAX HIB - haemophilus b polysaccharide conj vac im susp 7.5 mcg/0.5 ml	3		
PENBRAYA - meningococcal acyw (tet conj)-mening b (rcmb) vacc for inj	3		
PFIZER-BIONTECH COVID-19 - covid-19 mrna vac tris-s 5-11y-pfizer im susp 10 mcg/0.3ml	3		
PFIZER-BIONTECH COVID-19 - covid-19 mrna vac tris-s 6mo-4y-pfizer im susp 3 mcg/0.3ml	3		
PNEUMOVAX 23 - pneumococcal vaccine polyvalent inj 25 mcg/0.5ml	3		QL (1 vaccine/90 days)
PNEUMOVAX 23/1 DOSE - pneumococcal vaccine polyvalent inj 25 mcg/0.5ml	3		QL (1 vaccine/90 days)
PREHEVBRIO - hepatitis b vaccine 3-antigen (recombinant) susp 10 mcg/ml	3		
PREVNAR 20 - pneumococcal 20-valent conjugate vaccine sus pref syr 0.5 ml	3		QL (1 vaccine/90 days)
PRIORIX - measles-mumps-rubella virus vaccines for subcutaneous susp	3		
PROQUAD - measles-mumps-rubella-varicella virus vaccines for susp	3		
RECOMBIVAX HB - hepatitis b vaccine (recombinant) susp pref syr 5 mcg/0.5ml, 10 mcg/ml	3		
RECOMBIVAX HB - hepatitis b vaccine (recombinant) susp 5 mcg/0.5ml, 10 mcg/ml, 40 mcg/ml	3		
ROTARIX - rotavirus vaccine, live oral susp	3		

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ROTATEQ - rotavirus vaccine, live oral pentavalent soln	3		
SHINGRIX - zoster vac recombinant adjuvanted for im inj 50 mcg/0.5ml	2		QL (2 vaccines/1 lifetime)
SPIKEVAX COVID-19 VACCINE - covid-19 mrna vaccine-moderna im susp pref syr 50 mcg/0.5ml	3		
SPIKEVAX COVID-19 VACCINE - covid-19 (sars-cov-2)mrna vacc-moderna im susp 50 mcg/0.5ml	3		
TRUMENBA - meningococcal group b vac (recomb) im susp prefilled syr	3		
TWINRIX - hep a-hep b vaccine susp pref syr 720-20 elu-mcg/ml	3		
VAQTA - hepatitis a vaccine inj susp 25 unit/0.5ml, 50 unit/ml	3		
VARIVAX - varicella virus vac live for subcutaneous inj 1350 pfu/0.5ml	3		
VAXCHORA - cholera vaccine live attenuated for oral susp	3		
VAXNEUVANCE - pneumococcal 15-valent conjugate vaccine sus pref syr 0.5 ml	3		QL (1 vaccine/90 days)
VIVOTIF - typhoid vaccine cap delayed release	3		
TOXOIDS			
ADACEL - tet tox-diph-acell pertuss ad inj 5-2-15.5 lf-lf-mcg/0.5ml	3		
BOOSTRIX - tet-diph-acell pertuss ad pref syr 5-2.5-18.5 lf-mcg/0.5ml	3		
BOOSTRIX - tet tox-diph-acell pertuss ad inj 5-2.5-18.5 lf-lf-mcg/0.5ml	3		
DAPTACEL - diph, acellular pert & tet tox inj 15 lf-23 mcg-5 lf/0.5ml	3		
INFANRIX - diph, acellular pert & tet tox inj 25 lf-58 mcg-10 lf/0.5ml	3		
KINRIX - diph-tetanus-acell pert-polio, ipv vacc susp pref syr 0.5 ml	3		
PEDIARIX - diph-tet tox-acell pert-hep b-polio ipv vac susp pref syr	3		
PENTACEL - diph-ac per-tet tox ad-poliov-haemoph b poly vac for im susp	3		
QUADRACEL - diph-tetanus tox ad-acell pert & polio virus, ipv vac inj	3		
QUADRACEL - diph-tetanus-acell pert-polio, ipv vacc susp pref syr 0.5 ml	3		
TDVAX - tetanus-diphtheria toxoids (td) inj 2-2 lf/0.5ml	3		
TENIVAC - tetanus-diphtheria toxoids (td) inj 5-2 lfu	3		

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VAXELIS - diph-tet tox-ac pert ad-polio ipv-hib-hep b rec susp pre syr	3		
VAXELIS - diph-tet tox-ac pert ad-polio ipv-hib-hepatitis b recmb susp	3		
PASSIVE IMMUNIZING AGENTS			
GAMMAGARD LIQUID - immune globulin (human) iv or subcutaneous soln 1 gm/10ml, 2.5 gm/25ml, 5 gm/50ml, 10 gm/100ml, 20 gm/200ml, 30 gm/300ml	2	SP	PA
GAMMAKED - immune globulin (human) iv or subcutaneous soln 1 gm/10ml	3	SP	PA
GAMMAKED - immune globulin (human) iv or subcutaneous soln 5 gm/50ml, 10 gm/100ml, 20 gm/200ml	2	SP	PA
GAMUNEX-C - immune globulin (human) iv or subcutaneous soln 1 gm/10ml, 2.5 gm/25ml, 5 gm/50ml, 10 gm/100ml, 20 gm/200ml, 40 gm/400ml	2	SP	PA
HIZENTRA - immune globulin (human) subcutaneous soln pref syr 1 gm/5ml, 2 gm/10ml, 4 gm/20ml	3	SP	PA, LD
HIZENTRA - immune globulin (human) subcutaneous inj 1 gm/5ml, 2 gm/10ml, 4 gm/20ml, 10 gm/50ml	3	SP	PA, LD
HYQVIA - immun glob inj 2.5 gm/25ml-hyaluron inj 200 unt/1.25 ml kit	3	SP	PA, LD
HYQVIA - immun glob inj 5 gm/50ml-hyaluron inj 400 unt/2.5 ml kit	3	SP	PA, LD
HYQVIA - immun glob inj 10 gm/100ml-hyaluron inj 800 unt/5 ml kit	3	SP	PA, LD
HYQVIA - immun glob inj 20 gm/200ml-hyaluron inj 1600 unt/10 ml kit	3	SP	PA, LD
HYQVIA - immun glob inj 30 gm/300ml-hyaluron inj 2400 unt/15 ml kit	3	SP	PA, LD
BIOLOGICALS MISC			
GRASTEK - timothy grass pollen allergen ext sl tab 2800 bau	3		PA, QL (30 tablets/30 days)
ODACTRA - dust mite mixed ext sl tab 12 sq-hdm	3		PA, QL (30 tablets/30 days)
PALFORZIA INITIAL DOSE ES - peanut powder-dnfp starter pack 0.5 & 1 & 1.5 & 3 & 6 mg	3	SP	PA, LD, QL (1 pack/180 days)
PALFORZIA LEVEL 1 - peanut powder-dnfp cap sprinkle pack 3 x 1 mg (3 mg dose)	3	SP	PA, LD, QL (90 capsules/30 days)
PALFORZIA LEVEL 10 - peanut powder-dnfp pack 2 x 20 mg & 2 x 100 mg (240 mg dose)	3	SP	PA, LD, QL (120 capsules/30 days)
PALFORZIA LEVEL 11 (MAINT - peanut allergen powder-dnfp maintenance packet 300 mg	3	SP	PA, LD, QL (30 packets/30 days)

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PALFORZIA LEVEL 11 (TITRA - peanut allergen powder-dnfp titration packet 300 mg	3	SP	PA, LD, QL (30 packets/30 days)
PALFORZIA LEVEL 2 - peanut powder-dnfp cap sprinkle pack 6 x 1 mg (6 mg dose)	3	SP	PA, LD, QL (180 capsules/30 days)
PALFORZIA LEVEL 3 - peanut powder-dnfp pack 2 x 1 mg & 10 mg (12 mg dose)	3	SP	PA, LD, QL (90 capsules/30 days)
PALFORZIA LEVEL 4 - peanut powder-dnfp cap sprinkle pack 20 mg (20 mg dose)	3	SP	PA, LD, QL (30 capsules/30 days)
PALFORZIA LEVEL 5 - peanut powder-dnfp cap sprinkle pack 2 x 20 mg (40 mg dose)	3	SP	PA, LD, QL (60 capsules/30 days)
PALFORZIA LEVEL 6 - peanut powder-dnfp cap sprinkle pack 4 x 20 mg (80 mg dose)	3	SP	PA, LD, QL (120 capsules/30 days)
PALFORZIA LEVEL 7 - peanut powder-dnfp pack 20 mg & 100 mg (120 mg dose)	3	SP	PA, LD, QL (60 capsules/30 days)
PALFORZIA LEVEL 8 - peanut powder-dnfp pack 3 x 20 mg & 100 mg (160 mg dose)	3	SP	PA, LD, QL (120 capsules/30 days)
PALFORZIA LEVEL 9 - peanut powder-dnfp pack 2 x 100 mg (200 mg dose)	3	SP	PA, LD, QL (60 capsules/30 days)
RAGWITEK - short ragweed pollen allergen extract sl tab 12 amb a 1-u	3		PA, QL (30 tablets/30 days)
ANTINEOPLASTIC AGENTS			
ANTINEOPLASTICS			
abiraterone acetate tab 250 mg (Zytiga)	1	SP	PA, QL (120 tablets/30 days)
abiraterone acetate tab 500 mg (Zytiga)	1	SP	PA, QL (60 tablets/30 days)
ACTIMMUNE - interferon gamma-1b inj 100 mcg/0.5ml (2000000 unit/0.5ml)	2	SP	PA, LD
AFINITOR - everolimus tab 2.5 mg, 5 mg, 7.5 mg, 10 mg	3	SP	PA, LD, QL (30 tablets/30 days)
AFINITOR DISPERZ - everolimus tab for oral susp 2 mg, 5 mg	3	SP	PA, LD, QL (60 tablets/30 days)
AFINITOR DISPERZ - everolimus tab for oral susp 3 mg	3	SP	PA, LD, QL (90 tablets/30 days)
AKEEGA - niraparib tosylate-abiraterone acetate tab 50-500 mg, 100-500 mg	2	SP	PA, LD, QL (60 tablets/30 days)
ALECENSA - alectinib hcl cap 150 mg (base equivalent)	2	SP	PA, LD, QL (240 capsules/30 days)
ALUNBRIG - brigatinib tab initiation therapy pack 90 mg & 180 mg	2	SP	PA, LD, QL (30 tablets/180 days)
ALUNBRIG - brigatinib tab 30 mg	2	SP	PA, LD, QL (180 tablets/30 days)
ALUNBRIG - brigatinib tab 90 mg, 180 mg	2	SP	PA, LD, QL (30 tablets/30 days)
anastrozole tab 1 mg (Arimidex)	1		
AUGTYRO - repotrectinib cap 40 mg	2	SP	PA, QL (240 capsules/30 days)
AYVAKIT - avapritinib tab 25 mg, 50 mg, 100 mg, 200 mg, 300 mg	2	SP	PA, LD, QL (30 tablets/30 days)
BALVERSA - erdafitinib tab 3 mg	2	SP	PA, LD, QL (90 tablets/30 days)

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BALVERSA - erdafitinib tab 4 mg	2	SP	PA, LD, QL (60 tablets/30 days)
BALVERSA - erdafitinib tab 5 mg	2	SP	PA, LD, QL (30 tablets/30 days)
BESREMI - ropeginterferon alfa-2b-njft soln prefilled syr 500 mcg/ml	2	SP	PA, LD, QL (2 syringes/28 days)
bexarotene cap 75 mg (Targretin)	1	SP	PA
bicalutamide tab 50 mg (Casodex)	1		
BOSULIF - bosutinib cap 50 mg	2	SP	PA, LD, QL (30 capsules/30 days)
BOSULIF - bosutinib cap 100 mg	2	SP	PA, LD, QL (150 capsules/30 days)
BOSULIF - bosutinib tab 100 mg	2	SP	PA, LD, QL (120 tablets/30 days)
BOSULIF - bosutinib tab 400 mg, 500 mg	2	SP	PA, LD, QL (30 tablets/30 days)
BRAFTOVI - encorafenib cap 75 mg	2	SP	PA, LD, QL (180 capsules/30 days)
BRUKINSA - zanubrutinib cap 80 mg	2	SP	PA, LD, QL (120 capsules/30 days)
CABOMETYX - cabozantinib s-malate tab 20 mg (base equivalent), 40 mg (base equivalent), 60 mg (base equivalent)	2	SP	PA, LD, QL (30 tablets/30 days)
CALQUENCE - acalabrutinib maleate tab 100 mg	2	SP	PA, LD, QL (60 tablets/30 days)
capecitabine tab 150 mg, 500 mg (Xeloda)	1	SP	
CAPRELSA - vandetanib tab 100 mg	2	SP	PA, LD, QL (60 tablets/30 days)
CAPRELSA - vandetanib tab 300 mg	2	SP	PA, LD, QL (30 tablets/30 days)
COMETRIQ - cabozantinib s-malate cap 3 x 20 mg (60 mg dose) kit	2	SP	PA, LD, QL (1 kit/28 days)
COMETRIQ - cabozantinib s-mal cap 1 x 80 mg & 1 x 20 mg (100 dose) kit	2	SP	PA, LD, QL (1 kit/28 days)
COMETRIQ - cabozantinib s-mal cap 1 x 80 mg & 3 x 20 mg (140 dose) kit	2	SP	PA, LD, QL (1 kit/28 days)
COPIKTRA - duvelisib cap 15 mg, 25 mg	2	SP	PA, LD, QL (60 capsules/30 days)
COTELLIC - cobimetinib fumarate tab 20 mg (base equivalent)	2	SP	PA, LD, QL (63 tablets/28 days)
CYCLOPHOSPHAMIDE - cyclophosphamide cap 25 mg, 50 mg	3		
CYCLOPHOSPHAMIDE - cyclophosphamide tab 25 mg, 50 mg	2		
cyclophosphamide cap 25 mg, 50 mg (Cyclophosphamide)	1		
DAURISMO - glasdegib maleate tab 25 mg (base equivalent)	2	SP	PA, LD, QL (60 tablets/30 days)
DAURISMO - glasdegib maleate tab 100 mg (base equivalent)	2	SP	PA, LD, QL (30 tablets/30 days)
EMCYT - estramustine phosphate sodium cap 140 mg	2		
ERIVEDGE - vismodegib cap 150 mg	2	SP	PA, LD, QL (30 capsules/30 days)
ERLEADA - apalutamide tab 60 mg	2	SP	PA, LD, QL (120 tablets/30 days)
ERLEADA - apalutamide tab 240 mg	2	SP	PA, LD, QL (30 tablets/30 days)

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erlotinib hcl tab 25 mg (base equivalent) (Tarceva)	1	SP	PA, QL (60 tablets/30 days)
erlotinib hcl tab 100 mg (base equivalent), 150 mg (base equivalent) (Tarceva)	1	SP	PA, QL (30 tablets/30 days)
ETOPOSIDE - etoposide cap 50 mg	2		
EULEXIN - flutamide cap 125 mg	3		LD
everolimus tab for oral susp 2 mg, 5 mg (Afinitor disperz)	1	SP	PA, QL (60 tablets/30 days)
everolimus tab for oral susp 3 mg (Afinitor disperz)	1	SP	PA, QL (90 tablets/30 days)
everolimus tab 2.5 mg, 5 mg, 7.5 mg, 10 mg (Afinitor)	1	SP	PA, QL (30 tablets/30 days)
exemestane tab 25 mg (Aromasin)	1		
EXKIVITY - mobocertinib succinate cap 40 mg	2	SP	PA, LD, QL (120 capsules/30 days)
FARESTON - toremifene citrate tab 60 mg (base equivalent)	3		
FOTIVDA - tivozanib hcl cap 0.89 mg (base equivalent), 1.34 mg (base equivalent)	2	SP	PA, LD, QL (21 capsules/28 days)
FRUZAQLA - fruquintinib cap 1 mg	2	SP	PA, QL (84 capsules/28 days)
FRUZAQLA - fruquintinib cap 5 mg	2	SP	PA, QL (21 capsules/28 days)
GAVRETO - pralsetinib cap 100 mg	2	SP	PA, LD, QL (120 capsules/30 days)
gefitinib tab 250 mg (Iressa)	1	SP	PA, QL (30 tablets/30 days)
GILOTRIF - afatinib dimaleate tab 20 mg (base equivalent), 30 mg (base equivalent), 40 mg (base equivalent)	2	SP	PA, LD, QL (30 tablets/30 days)
GLEOSTINE - lomustine cap 10 mg, 40 mg, 100 mg	2	SP	
HYCAMTIN - topotecan hcl cap 0.25 mg (base equiv), 1 mg (base equiv)	2	SP	PA
HYDREA - hydroxyurea cap 500 mg	3		
hydroxyurea cap 500 mg (Hydrea)	1		
IBRANCE - palbociclib cap 75 mg, 100 mg, 125 mg	2	SP	PA, LD, QL (21 capsules/28 days)
IBRANCE - palbociclib tab 75 mg, 100 mg, 125 mg	2	SP	PA, LD, QL (21 tablets/28 days)
ICLUSIG - ponatinib hcl tab 10 mg (base equiv), 15 mg (base equiv), 30 mg (base equiv), 45 mg (base equiv)	2	SP	PA, LD, QL (30 tablets/30 days)
IDHIFA - enasidenib mesylate tab 50 mg (base equivalent), 100 mg (base equivalent)	2	SP	PA, LD, QL (30 tablets/30 days)
imatinib mesylate tab 100 mg (base equivalent) (Gleevec)	1	SP	PA, QL (90 tablets/30 days)
imatinib mesylate tab 400 mg (base equivalent) (Gleevec)	1	SP	PA, QL (60 tablets/30 days)
IMBRUVICA - ibrutinib tab 140 mg, 280 mg, 420 mg	2	SP	PA, LD, QL (30 tablets/30 days)
IMBRUVICA - ibrutinib oral susp 70 mg/ml	2	SP	PA, LD, QL (216 mls/30 days)
IMBRUVICA - ibrutinib cap 70 mg	2	SP	PA, LD, QL (30 capsules/30 days)
IMBRUVICA - ibrutinib cap 140 mg	2	SP	PA, LD, QL (120 capsules/30 days)

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INLYTA - axitinib tab 1 mg	2	SP	PA, LD, QL (180 tablets/30 days)
INLYTA - axitinib tab 5 mg	2	SP	PA, LD, QL (120 tablets/30 days)
INQOVI - decitabine-cedazuridine tab 35-100 mg	2	SP	PA, LD, QL (5 tablets/28 days)
INREBIC - fedratinib hcl cap 100 mg	2	SP	PA, LD, QL (120 capsules/30 days)
IRESSA - gefitinib tab 250 mg	3	SP	PA, LD, QL (30 tablets/30 days)
IWILFIN - eflornithine hcl tab 192 mg	2	SP	PA, QL (240 tablets/30 days)
JAKAFI - ruxolitinib phosphate tab 5 mg (base equivalent), 10 mg (base equivalent), 15 mg (base equivalent), 20 mg (base equivalent), 25 mg (base equivalent)	2	SP	PA, LD, QL (60 tablets/30 days)
JAYPIRCA - pirtobrutinib tab 50 mg	2	SP	PA, LD, QL (30 tablets/30 days)
JAYPIRCA - pirtobrutinib tab 100 mg	2	SP	PA, LD, QL (60 tablets/30 days)
KISQALI - ribociclib succinate tab pack 200 mg daily dose, 400 mg daily dose (200 mg tab), 600 mg daily dose (200 mg tab)	2	SP	PA, QL (63 tablets/28 days)
KISQALI FEMARA 200 DOSE - ribociclib 200 mg dose (200 mg tab) & letrozole 2.5 mg tbpk	2	SP	PA, QL (91 tablets/28 days)
KISQALI FEMARA 400 DOSE - ribociclib 400 mg dose (200 mg tab) & letrozole 2.5 mg tbpk	2	SP	PA, QL (91 tablets/28 days)
KISQALI FEMARA 600 DOSE - ribociclib 600 mg dose (200 mg tab) & letrozole 2.5 mg tbpk	2	SP	PA, QL (91 tablets/28 days)
KOSELUGO - selumetinib sulfate cap 10 mg	2	SP	PA, LD, QL (240 capsules/30 days)
KOSELUGO - selumetinib sulfate cap 25 mg	2	SP	PA, LD, QL (120 capsules/30 days)
KRAZATI - adagrasib tab 200 mg	2	SP	PA, LD, QL (180 tablets/30 days)
lapatinib ditosylate tab 250 mg (base equiv) (Tykerb)	1	SP	PA, QL (180 tablets/30 days)
LENVIMA 10 MG DAILY DOSE - lenvatinib cap therapy pack 10 mg (10 mg daily dose)	2	SP	PA, LD, QL (30 capsules/30 days)
LENVIMA 12MG DAILY DOSE - lenvatinib cap therapy pack 3 x 4 mg (12 mg daily dose)	2	SP	PA, LD, QL (90 capsules/30 days)
LENVIMA 14 MG DAILY DOSE - lenvatinib cap therapy pack 10 & 4 mg (14 mg daily dose)	2	SP	PA, LD, QL (60 capsules/30 days)
LENVIMA 18 MG DAILY DOSE - lenvatinib cap ther pack 10 mg & 2 x 4 mg (18 mg daily dose)	2	SP	PA, LD, QL (90 capsules/30 days)
LENVIMA 20 MG DAILY DOSE - lenvatinib cap therapy pack 2 x 10 mg (20 mg daily dose)	2	SP	PA, LD, QL (60 capsules/30 days)
LENVIMA 24 MG DAILY DOSE - lenvatinib cap ther pack 2 x 10 mg & 4 mg (24 mg daily dose)	2	SP	PA, LD, QL (90 capsules/30 days)
LENVIMA 4 MG DAILY DOSE - lenvatinib cap therapy pack 4 mg (4 mg daily dose)	2	SP	PA, LD, QL (30 capsules/30 days)
LENVIMA 8 MG DAILY DOSE - lenvatinib cap therapy pack 2 x 4 mg (8 mg daily dose)	2	SP	PA, LD, QL (60 capsules/30 days)
letrozole tab 2.5 mg (Femara)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
leucovorin calcium tab 5 mg, 10 mg, 15 mg, 25 mg	1		
LEUKERAN - chlorambucil tab 2 mg	2		
leuprolide acetate inj kit 1 mg/0.2ml (5 mg/ml)	1	SP	PA, QL (6 vials/30 days)
LONSURF - trifluridine-tipiracil tab 15-6.14 mg	2	SP	PA, LD, QL (100 tablets/28 days)
LONSURF - trifluridine-tipiracil tab 20-8.19 mg	2	SP	PA, LD, QL (80 tablets/28 days)
LORBRENA - lorlatinib tab 25 mg	2	SP	PA, LD, QL (90 tablets/30 days)
LORBRENA - lorlatinib tab 100 mg	2	SP	PA, LD, QL (30 tablets/30 days)
LUMAKRAS - sotorasib tab 120 mg	2	SP	PA, LD, QL (240 tablets/30 days)
LUMAKRAS - sotorasib tab 320 mg	2	SP	PA, LD, QL (90 tablets/30 days)
LYNPARZA - olaparib tab 100 mg, 150 mg	2	SP	PA, LD, QL (120 tablets/30 days)
LYSODREN - mitotane tab 500 mg	2	SP	LD
LYTGOBI - futibatinib tab therapy pack 4 mg (12 mg daily dose)	2	SP	PA, LD, QL (84 tablets/28 days)
LYTGOBI - futibatinib tab therapy pack 4 mg (16 mg daily dose)	2	SP	PA, LD, QL (112 tablets/28 days)
LYTGOBI - futibatinib tab therapy pack 4 mg (20 mg daily dose)	2	SP	PA, LD, QL (140 tablets/28 days)
MATULANE - procarbazine hcl cap 50 mg	2	SP	LD
megestrol acetate susp 40 mg/ml	1		
megestrol acetate tab 20 mg, 40 mg	1		
MEKINIST - trametinib dimethyl sulfoxide for soln 0.05 mg/ml (base eq)	2	SP	PA, QL (1170 mls/28 day)
MEKINIST - trametinib dimethyl sulfoxide tab 0.5 mg (base equivalent)	2	SP	PA, QL (90 tablets/30 days)
MEKINIST - trametinib dimethyl sulfoxide tab 2 mg (base equivalent)	2	SP	PA, QL (30 tablets/30 days)
MEKTOVI - binimetinib tab 15 mg	2	SP	PA, LD, QL (180 tablets/30 days)
mercaptopurine tab 50 mg	1		
MESNEX - mesna tab 400 mg	2		
METHOTREXATE SODIUM - methotrexate sodium inj 250 mg/10ml (25 mg/ml)	3		
methotrexate sodium for inj 1 gm	1		
methotrexate sodium inj pf 50 mg/2ml (25 mg/ml), 250 mg/10ml (25 mg/ml), 1000 mg/40ml (25 mg/ml)	1		
methotrexate sodium inj 50 mg/2ml (25 mg/ml)	1		
methotrexate sodium tab 2.5 mg (base equiv)	1		
MYLERAN - busulfan tab 2 mg	2		
NERLYNX - neratinib maleate tab 40 mg (base equivalent)	2	SP	PA, LD, QL (180 tablets/30 days)
NEXAVAR - sorafenib tosylate tab 200 mg (base equivalent)	3	SP	PA, LD, QL (120 tablets/30 days)

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NILANDRON - nilutamide tab 150 mg	3		
nilutamide tab 150 mg (Nilandron)	1		
NINLARO - ixazomib citrate cap 2.3 mg (base equivalent), 3 mg (base equivalent), 4 mg (base equivalent)	2	SP	PA, LD, QL (3 capsules/28 days)
NUBEQA - darolutamide tab 300 mg	2	SP	PA, QL (120 tablets/30 days)
ODOMZO - sonidegib phosphate cap 200 mg (base equivalent)	2	SP	PA, LD, QL (30 capsules/30 days)
OGSIVEO - nirogacestat hydrobromide tab 50 mg	2	SP	PA, LD, QL (180 tablets/30 days)
OGSIVEO - nirogacestat hydrobromide tab 100 mg, 150 mg	2	SP	PA, LD, QL (56 tablets/28 days)
OJEMDA - tovorafenib tab 100 mg	2	SP	PA, QL (24 tablets/28 days)
OJEMDA - tovorafenib for oral susp 25 mg/ml	2	SP	PA, QL (96 mls/28 days)
OJJAARA - momelotinib dihydrochloride tab 100 mg, 150 mg, 200 mg	2	SP	PA, LD, QL (30 tablets/30 days)
ONUREG - azacitidine tab 200 mg, 300 mg	2	SP	PA, QL (14 tablets/28 days)
ORGOVYX - relugolix tab 120 mg	2	SP	PA, LD, QL (30 tablets/30 days)
ORSERDU - elacestrant hydrochloride tab 86 mg	2	SP	PA, LD, QL (90 tablets/30 days)
ORSERDU - elacestrant hydrochloride tab 345 mg	2	SP	PA, LD, QL (30 tablets/30 days)
pazopanib hcl tab 200 mg (base equiv) (Votrient)	1	SP	PA, QL (120 tablets/30 days)
PEMAZYRE - pemigatinib tab 4.5 mg, 9 mg, 13.5 mg	2	SP	PA, LD, QL (14 tablets/21 days)
PIQRAY 200MG DAILY DOSE - alpelisib tab therapy pack 200 mg daily dose	2	SP	PA, QL (1 pack/28 days)
PIQRAY 250MG DAILY DOSE - alpelisib tab pack 250 mg daily dose (200 mg & 50 mg tabs)	2	SP	PA, QL (1 pack/28 days)
PIQRAY 300MG DAILY DOSE - alpelisib tab pack 300 mg daily dose (2x150 mg tab)	2	SP	PA, QL (1 pack/28 days)
POMALYST - pomalidomide cap 1 mg, 2 mg, 3 mg, 4 mg	2	SP	PA, LD, QL (21 capsules/28 days)
PURIXAN - mercaptopurine susp 2000 mg/100ml (20 mg/ml)	2	SP	LD
QINLOCK - ripretinib tab 50 mg	2	SP	PA, LD, QL (90 tablets/30 days)
RETEVMO - selpercatinib cap 40 mg	2	SP	PA, LD, QL (240 capsules/30 days)
RETEVMO - selpercatinib cap 80 mg	2	SP	PA, LD, QL (120 capsules/30 days)
REZLIDHIA - olutasidenib cap 150 mg	2	SP	PA, LD, QL (60 capsules/30 days)
ROZLYTREK - entrectinib pellet pack 50 mg	2	SP	PA, LD, QL (336 packets/28 days)
ROZLYTREK - entrectinib cap 100 mg	2	SP	PA, LD, QL (30 capsules/30 days)
ROZLYTREK - entrectinib cap 200 mg	2	SP	PA, LD, QL (90 capsules/30 days)
RUBRACA - rucaparib camsylate tab 200 mg (base equivalent), 250 mg (base equivalent), 300 mg (base equivalent)	2	SP	PA, LD, QL (120 tablets/30 days)
RYDAPT - midostaurin cap 25 mg	2	SP	PA, QL (240 capsules/30 days)

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SCEMBLIX - asciminib hcl tab 20 mg	2	SP	PA, LD, QL (60 tablets/30 days)
SCEMBLIX - asciminib hcl tab 40 mg	2	SP	PA, LD, QL (300 tablets/30 days)
SOLTAMOX - tamoxifen citrate oral soln 10 mg/5ml (base equivalent)	3		
sorafenib tosylate tab 200 mg (base equivalent) (Nexavar)	1	SP	PA, QL (120 tablets/30 days)
SPRYCEL - dasatinib tab 20 mg	2	SP	PA, QL (90 tablets/30 days)
SPRYCEL - dasatinib tab 50 mg, 70 mg, 80 mg, 100 mg, 140 mg	2	SP	PA, QL (30 tablets/30 days)
STIVARGA - regorafenib tab 40 mg	2	SP	PA, LD, QL (84 tablets/28 days)
sunitinib malate cap 12.5 mg (base equivalent) (Sutent)	1	SP	PA, QL (90 capsules/30 days)
sunitinib malate cap 25 mg (base equivalent), 37.5 mg (base equivalent), 50 mg (base equivalent) (Sutent)	1	SP	PA, QL (30 capsules/30 days)
SUTENT - sunitinib malate cap 12.5 mg (base equivalent)	3	SP	PA, LD, QL (90 capsules/30 days)
SUTENT - sunitinib malate cap 25 mg (base equivalent), 37.5 mg (base equivalent), 50 mg (base equivalent)	3	SP	PA, LD, QL (30 capsules/30 days)
TABLOID - thioguanine tab 40 mg	2		
TABRECTA - capmatinib hcl tab 150 mg, 200 mg	2	SP	PA, QL (120 tablets/30 days)
TAFINLAR - dabrafenib mesylate cap 50 mg (base equivalent), 75 mg (base equivalent)	2	SP	PA, QL (120 capsules/30 days)
TAFINLAR - dabrafenib mesylate tab for oral susp 10 mg (base equiv)	2	SP	PA, QL (840 tablets/28 days)
TAGRISSO - osimertinib mesylate tab 40 mg (base equivalent), 80 mg (base equivalent)	2	SP	PA, LD, QL (30 tablets/30 days)
TALZENNA - talazoparib tosylate cap 0.1 mg (base equivalent), 0.35 mg (base equivalent), 0.75 mg (base equivalent), 1 mg (base equivalent)	2	SP	PA, LD, QL (30 capsules/30 days)
TALZENNA - talazoparib tosylate cap 0.25 mg (base equivalent)	2	SP	PA, LD, QL (90 capsules/30 days)
tamoxifen citrate tab 10 mg (base equivalent), 20 mg (base equivalent)	1		
TARCEVA - erlotinib hcl tab 25 mg (base equivalent)	3	SP	PA, LD, QL (60 tablets/30 days)
TARCEVA - erlotinib hcl tab 100 mg (base equivalent), 150 mg (base equivalent)	3	SP	PA, LD, QL (30 tablets/30 days)
TARGRETIN - bexarotene cap 75 mg	3	SP	PA
TASIGNA - nilotinib hcl cap 50 mg (base equivalent), 150 mg (base equivalent), 200 mg (base equivalent)	2	SP	PA, QL (120 capsules/30 days)
TAZVERIK - tazemetostat hbr tab 200 mg	2	SP	PA, LD, QL (240 tablets/30 days)
temozolomide cap 5 mg, 20 mg, 100 mg, 140 mg, 180 mg	1	SP	PA

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temozolomide cap 250 mg (Temodar)	1	SP	PA
TEPMETKO - tepotinib hcl tab 225 mg	2	SP	PA, LD, QL (60 tablets/30 days)
TIBSOVO - ivosidenib tab 250 mg	2	SP	PA, LD, QL (60 tablets/30 days)
toremifene citrate tab 60 mg (base equivalent) (Fareston)	1		
tretinoin cap 10 mg	1	SP	PA
TRUQAP - capivasertib tab 160 mg, 200 mg	2	SP	PA, LD, QL (64 tablets/28 days)
TUKYSA - tucatinib tab 50 mg	2	SP	PA, LD, QL (300 tablets/30 days)
TUKYSA - tucatinib tab 150 mg	2	SP	PA, LD, QL (120 tablets/30 days)
TURALIO - pexidartinib hcl cap 125 mg (base equivalent)	2	SP	PA, LD, QL (120 capsules/30 days)
TYKERB - lapatinib ditosylate tab 250 mg (base equiv)	3	SP	PA, QL (180 tablets/30 days)
VANFLYTA - quizartinib dihydrochloride tab 17.7 mg	2	SP	PA, LD, QL (28 tablets/28 days)
VANFLYTA - quizartinib dihydrochloride tab 26.5 mg	2	SP	PA, LD, QL (56 tablets/28 days)
VENCLEXTA - venetoclax tab 10 mg	2	SP	PA, LD, QL (60 tablets/30 days)
VENCLEXTA - venetoclax tab 50 mg	2	SP	PA, LD, QL (30 tablets/30 days)
VENCLEXTA - venetoclax tab 100 mg	2	SP	PA, LD, QL (120 tablets/30 days)
VENCLEXTA STARTING PACK - venetoclax tab therapy starter pack 10 & 50 & 100 mg	2	SP	PA, LD, QL (1 pack/180 days)
VERZENIO - abemaciclib tab 50 mg, 100 mg, 150 mg, 200 mg	2	SP	PA, LD, QL (60 tablets/30 days)
VITRAKVI - larotrectinib sulfate oral soln 20 mg/ml (base equivalent)	2	SP	PA, LD, QL (300 mls/30 days)
VITRAKVI - larotrectinib sulfate cap 25 mg (base equivalent)	2	SP	PA, LD, QL (180 capsules/30 days)
VITRAKVI - larotrectinib sulfate cap 100 mg (base equivalent)	2	SP	PA, LD, QL (60 capsules/30 days)
VIZIMPRO - dacomitinib tab 15 mg, 30 mg, 45 mg	2	SP	PA, LD, QL (30 tablets/30 days)
VONJO - pacritinib citrate cap 100 mg	2	SP	PA, LD, QL (120 capsules/30 days)
VOTRIENT - pazopanib hcl tab 200 mg (base equiv)	3	SP	PA, QL (120 tablets/30 days)
WELIREG - belzutifan tab 40 mg	2	SP	PA, LD, QL (90 tablets/30 days)
XALKORI - crizotinib cap 200 mg, 250 mg	2	SP	PA, LD, QL (60 capsules/30 days)
XALKORI - crizotinib cap sprinkle 20 mg	2	SP	PA, LD, QL (120 capsules/30 day)
XALKORI - crizotinib cap sprinkle 50 mg	2	SP	PA, LD, QL (120 capsules/30 days)
XALKORI - crizotinib cap sprinkle 150 mg	2	SP	PA, LD, QL (180 capsules/30 days)
XOSPATA - gilteritinib fumarate tablet 40 mg (base equivalent)	2	SP	PA, LD, QL (90 tablets/30 days)
XPOVIO - selinexor tab therapy pack 40 mg (40 mg once weekly), 60 mg (60 mg once weekly)	2	SP	PA, LD, QL (4 tablets/28 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
XPOVIO - selinexor tab therapy pack 40 mg (40 mg twice weekly), 40 mg (80 mg once weekly), 50 mg (100 mg once weekly)	2	SP	PA, LD, QL (8 tablets/28 days)
XPOVIO 60 MG TWICE WEEKLY - selinexor tab therapy pack 20 mg (60 mg twice weekly)	2	SP	PA, LD, QL (24 tablets/28 days)
XPOVIO 80 MG TWICE WEEKLY - selinexor tab therapy pack 20 mg (80 mg twice weekly)	2	SP	PA, LD, QL (32 tablets/28 days)
XTANDI - enzalutamide cap 40 mg	2	SP	PA, LD, QL (120 capsules/30 days)
XTANDI - enzalutamide tab 40 mg	2	SP	PA, LD, QL (120 tablets/30 days)
XTANDI - enzalutamide tab 80 mg	2	SP	PA, LD, QL (60 tablets/30 days)
YONSA - abiraterone acetate micronized tab 125 mg	2	SP	PA, LD, QL (120 tablets/30 days)
ZEJULA - niraparib tosylate tab 100 mg (base equivalent), 200 mg (base equivalent), 300 mg (base equivalent)	2	SP	PA, LD, QL (30 tablets/30 days)
ZELBORAF - vemurafenib tab 240 mg	2	SP	PA, LD, QL (240 tablets/30 days)
ZOLINZA - vorinostat cap 100 mg	2	SP	PA, LD, QL (120 capsules/30 days)
ZYDELIG - idelalisib tab 100 mg, 150 mg	2	SP	PA, LD, QL (60 tablets/30 days)
ZYKADIA - ceritinib tab 150 mg	2	SP	PA, LD, QL (90 tablets/30 days)
ENDOCRINE AND METABOLIC DRUGS			
CORTICOSTEROIDS			
budesonide delayed release particles cap 3 mg	1		
budesonide tab er 24hr 9 mg (Uceris)	1		
CORTISONE ACETATE - cortisone acetate tab 25 mg	3		
deflazacort tab 6 mg (Emflaza)	1	SP	PA, QL (60 tablets/30 days)
deflazacort tab 18 mg (Emflaza)	1	SP	PA, QL (30 tablets/30 days)
deflazacort tab 30 mg, 36 mg (Emflaza)	1	SP	PA
DEXAMETHASONE - dexamethasone soln 0.5 mg/5ml	2		
dexamethasone elixir 0.5 mg/5ml	1		
DEXAMETHASONE INTENSOL - dexamethasone conc 1 mg/ml	3		
dexamethasone tab 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1		
EMFLAZA - deflazacort susp 22.75 mg/ml	3	SP	PA, LD
EMFLAZA - deflazacort tab 6 mg	3	SP	PA, LD, QL (60 tablets/30 days)
EMFLAZA - deflazacort tab 18 mg	3	SP	PA, LD, QL (30 tablets/30 days)
EMFLAZA - deflazacort tab 30 mg, 36 mg	3	SP	PA, LD
fludrocortisone acetate tab 0.1 mg	1		
hydrocortisone tab 5 mg, 10 mg, 20 mg (Cortef)	1		
MEDROL - methylprednisolone tab 2 mg, 4 mg, 8 mg, 16 mg	3		

Drug Name	Drug Tier	Specialty	Requirements/Limits
MEDROL DOSEPAK - methylprednisolone tab therapy pack 4 mg (21)	3		
methylprednisolone tab therapy pack 4 mg (21) (Medrol dosepak)	1		
methylprednisolone tab 4 mg, 8 mg, 16 mg, 32 mg (Medrol)	1		
PEDIAPRED - prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)	3		
prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base) (Pediapred)	1		
prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)	1		
PREDNISOLONE SODIUM PHOSP - prednisolone sod phos orally disintegr tab 10 mg (base eq), 15 mg (base eq), 30 mg (base eq)	3		
prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)	1		
prednisolone soln 15 mg/5ml	1		
prednisolone tab 5 mg	1		
PREDNISONE - prednisone oral soln 5 mg/5ml	2		
PREDNISONE INTENSOL - prednisone conc 5 mg/ml	3		
prednisone tab therapy pack 5 mg (21), 5 mg (48), 10 mg (21), 10 mg (48)	1		
prednisone tab 1 mg, 2.5 mg, 5 mg, 10 mg, 20 mg, 50 mg	1		
TARPEYO - budesonide delayed release cap 4 mg	3	SP	PA, LD, QL (120 capsules/30 days)
ANDROGEN-ANABOLIC			
danazol cap 50 mg, 100 mg, 200 mg	1		PA
METHITEST - methyltestosterone oral tab 10 mg	3		PA, QL (600 tablets/30 days)
methyltestosterone cap 10 mg	1		PA, QL (600 capsules/30 days)
TESTOSTERONE - testosterone td gel 10mg/act (2%)	3		PA, QL (2 pumps/30 days)
testosterone cypionate im inj in oil 100 mg/ml (Depo-testosterone)	1		QL (1 vial/28 days)
testosterone cypionate im inj in oil 200 mg/ml (Depo-testosterone)	1		QL (10 mls/28 days)
TESTOSTERONE ENANTHATE - testosterone enanthate im inj in oil 200 mg/ml	3		QL (1 vial/28 days)
testosterone td gel 25 mg/2.5gm (1%), 50 mg/5gm (1%) (Androgel)	1		PA, QL (60 packets/30 days)
testosterone td gel 12.5 mg/act (1%)	1		PA, QL (4 pumps/30 days)
testosterone td gel 20.25 mg/act (1.62%) (Androgel pump)	1		PA, QL (2 pumps/30 days)

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testosterone td soln 30 mg/act	1		PA, QL (2 pumps/30 days)
ESTROGENS			
ALORA - estradiol td patch twice weekly 0.025 mg/24hr, 0.075 mg/24hr	3		QL (8 patches/28 days)
ANGELIQ - drospirenone-estradiol tab 0.25-0.5 mg, 0.5-1 mg	3		
BIJUVA - estradiol-progesterone cap 0.5-100 mg, 1-100 mg	3		
CLIMARA PRO - estradiol-levonorgestrel td patch weekly 0.045-0.015 mg/day	2		QL (4 patches/28 days)
COMBIPATCH - estradiol-norethindrone ace td pttw 0.05-0.14 mg/day, 0.05-0.25 mg/day	3		
DIVIGEL - estradiol td gel 0.25 mg/0.25gm (0.1%), 0.5 mg/0.5gm (0.1%), 0.75 mg/0.75gm (0.1%), 1 mg/gm (0.1%), 1.25 mg/1.25gm (0.1%)	3		QL (30 packets/30 days)
DUAVEE - conjugated estrogens-bazedoxifene tab 0.45-20 mg	2		
ELESTRIN - estradiol gel 0.06% (0.52 mg/0.87 gm metered-dose pump)	3		QL (1 pump/30 days)
ESTRACE - estradiol tab 0.5 mg, 1 mg, 2 mg	3		
estradiol & norethindrone acetate tab 0.5-0.1 mg	1		
estradiol & norethindrone acetate tab 1-0.5 mg (Activella)	1		
estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump) (Estrogel)	1		QL (1 pump/30 days)
estradiol tab 0.5 mg, 1 mg, 2 mg (Estrace)	1		
estradiol td gel 0.25 mg/0.25gm (0.1%), 0.5 mg/0.5gm (0.1%), 0.75 mg/0.75gm (0.1%), 1 mg/gm (0.1%), 1.25 mg/1.25gm (0.1%) (Divigel)	1		QL (30 packets/30 days)
estradiol td patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr (Vivelle-dot)	1		QL (8 patches/28 days)
estradiol td patch weekly 0.025 mg/24hr, 0.0375 mg/24hr (37.5 mcg/24hr), 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr (Climara)	1		QL (4 patches/28 days)
ESTROGEL - estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump)	2		QL (1 pump/30 days)
EVAMIST - estradiol transdermal spray 1.53 mg/spray	3		QL (5 bottles/93 days)
MENEST - esterified estrogens tab 0.3 mg, 0.625 mg, 1.25 mg, 2.5 mg	2		
MENOSTAR - estradiol td patch weekly 14 mcg/24hr	3		QL (4 patches/28 days)
MYFEMBREE - relugolix-estradiol-norethindrone acetate tab 40-1-0.5 mg	2		PA, QL (30 tablets/30 days)

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norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg, 1 mg-5 mcg	1		
ORIAHNN - elagolix-estrad-noreth 300-1-0.5mg & elagolix 300mg cap pack	2		PA, QL (56 capsules/28 days)
PREMARIN - estrogens, conjugated tab 0.3 mg, 0.45 mg, 0.625 mg, 0.9 mg, 1.25 mg	2		
PREMPHASE - conj est 0.625(14)/conj est-medroxypro ac tab 0.625-5mg(14)	2		
PREMPRO - conjugated estrogen-medroxyprogest acetate tab 0.3-1.5 mg, 0.45-1.5 mg, 0.625-2.5 mg, 0.625-5 mg	2		
CONTRACEPTIVES			
BEYAZ - drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	3		
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5) (Mircette)	1		
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	1		
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg (Beyaz)	1		
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg (Safyral)	1		
drospirenone-ethinyl estradiol tab 3-0.02 mg (Yaz)	1		
drospirenone-ethinyl estradiol tab 3-0.03 mg (Yasmin 28)	1		
ELLA - ulipristal acetate tab 30 mg	2		
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg, 1 mg-50 mcg	1		
etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr (Nuvaring)	1		PA
levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg (Quartette)	1		
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7) (Loseasonique)	1		
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7) (Seasonique)	1		
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	1		
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg, 0.15 mg-30 mcg	1		
levonorgestrel tab 1.5 mg	1		
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	1		
LO LOESTRIN FE - norethin-eth estradiol-fe tab 1 mg-10 mcg (24)/10 mcg (2)	2		
medroxyprogesterone acetate im susp prefilled syr 150 mg/ml (Depo-provera contrac)	1		
medroxyprogesterone acetate im susp 150 mg/ml (Depo-provera contrac)	1		
NATAZIA - estradiol valerate-dienogest tab 3 mg /2-2 mg/2-3 mg/1 mg	3		
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	1		
norethindrone & ethinyl estradiol tab 0.4 mg-35 mcg, 0.5 mg-35 mcg, 1 mg-35 mcg	1		
norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg (Generess fe)	1		
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	1		
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg, 1.5 mg-30 mcg	1		
norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg, 1.5 mg-30 mcg	1		
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24) (Taytulla)	1		
norethindrone tab 0.35 mg	1		
norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg, 0.5-35/1-35/0.5-35 mg-mcg	1		
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	1		
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg, 0.18-35/0.215-35/0.25-35 mg-mcg	1		
norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg	1		
NUVARING - etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr	2		
OPILL - norgestrel tab 0.075 mg	2		QL (28 tablets/28 days)
PLAN B ONE-STEP - levonorgestrel tab 1.5 mg	3		
SAFYRAL - drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	3		
SLYND - drospirenone tab 4 mg	3		
TYBLUME - levonorgestrel & ethinyl estradiol chew tab 0.1 mg-20 mcg	3		

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VELIVET - desogest-ethin est tab 0.1-0.025/0.125-0.025/0.15-0.025mg-mg	2		
YASMIN 28 - drospirenone-ethinyl estradiol tab 3-0.03 mg	3		
YAZ - drospirenone-ethinyl estradiol tab 3-0.02 mg	3		
PROGESTINS			
medroxyprogesterone acetate tab 2.5 mg, 5 mg, 10 mg (Provera)	1		
norethindrone acetate tab 5 mg (Aygestin)	1		
progesterone cap 100 mg, 200 mg (Prometrium)	1		
PROVERA - medroxyprogesterone acetate tab 2.5 mg, 5 mg, 10 mg	3		
ANTIDIABETICS			
Antidiabetics			
acarbose tab 25 mg, 50 mg, 100 mg (Precose)	1		
BAQSIMI ONE PACK - glucagon nasal powder 3 mg/ dose	2		
BAQSIMI TWO PACK - glucagon nasal powder 3 mg/ dose	2		
BYDUREON BCISE - exenatide extended release susp auto-injector 2 mg/0.85ml	3		PA, QL (4 pens/28 days)
CYCLOSET - bromocriptine mesylate tab 0.8 mg (base equivalent)	3		
diazoxide susp 50 mg/ml (Proglycem)	1		
FARXIGA - dapagliflozin propanediol tab 5 mg (base equivalent), 10 mg (base equivalent)	2		ST, QL (30 tablets/30 days)
glimepiride tab 1 mg, 2 mg, 4 mg (Amaryl)	1		
GLIPIZIDE - glipizide tab 2.5 mg	3		
glipizide tab er 24hr 2.5 mg, 5 mg, 10 mg (Glucotrol xl)	1		
glipizide tab 5 mg, 10 mg	1		
glipizide-metformin hcl tab 2.5-250 mg, 2.5-500 mg, 5-500 mg	1		
GLUCAGEN HYPOKIT - glucagon hcl (rdna) for inj 1 mg (base equiv)	3		
GLUCAGON EMERGENCY KIT FO - glucagon (rdna) for inj kit 1 mg	2		
GLUCAGON EMERGENCY KIT FO - glucagon hcl for inj 1 mg	2		
GLYBURIDE MICRONIZED - glyburide micronized tab 1.5 mg, 3 mg, 6 mg	2		
glyburide tab 1.25 mg, 2.5 mg, 5 mg	1		

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glyburide-metformin tab 1.25-250 mg, 2.5-500 mg, 5-500 mg	1		
GLYXAMBI - empagliflozin-linagliptin tab 10-5 mg, 25-5 mg	2		ST, QL (30 tablets/30 days)
GVOKE HYPOPEN 1-PACK - glucagon subcutaneous solution auto-injector 0.5 mg/0.1ml, 1 mg/0.2ml	2		
GVOKE HYPOPEN 2-PACK - glucagon subcutaneous solution auto-injector 0.5 mg/0.1ml, 1 mg/0.2ml	2		
GVOKE KIT - glucagon subcutaneous soln 1 mg/0.2ml	2		
GVOKE PFS - glucagon subcutaneous soln pref syringe 1 mg/0.2ml	2		
JANUMET - sitagliptin-metformin hcl tab 50-500 mg, 50-1000 mg	2		ST, QL (60 tablets/30 days)
JANUMET XR - sitagliptin-metformin hcl tab er 24hr 50-500 mg, 100-1000 mg	2		ST, QL (30 tablets/30 days)
JANUMET XR - sitagliptin-metformin hcl tab er 24hr 50-1000 mg	2		ST, QL (60 tablets/30 days)
JANUVIA - sitagliptin phosphate tab 25 mg (base equiv), 50 mg (base equiv), 100 mg (base equiv)	2		ST, QL (30 tablets/30 days)
JARDIANCE - empagliflozin tab 10 mg, 25 mg	2		ST, QL (30 tablets/30 days)
KORLYM - mifepristone tab 300 mg	3	SP	PA, LD, QL (120 tablets/30 days)
metformin hcl tab er 24hr 500 mg, 750 mg	1		
metformin hcl tab 500 mg, 850 mg, 1000 mg	1		
mifepristone tab 300 mg (Korlym)	1	SP	PA, QL (120 tablets/30 days)
MIGLITOL - miglitol tab 25 mg, 50 mg, 100 mg	2		
MOUNJARO - tirzepatide soln pen-injector 2.5 mg/0.5ml, 5 mg/0.5ml, 7.5 mg/0.5ml, 10 mg/0.5ml, 12.5 mg/0.5ml, 15 mg/0.5ml	2		PA, QL (4 pens/28 days)
nateglinide tab 60 mg, 120 mg	1		
OZEMPIC - semaglutide soln pen-inj 0.25 or 0.5 mg/dose (2 mg/3ml), 1 mg/dose (4 mg/3ml), 2 mg/dose (8 mg/3ml)	2		PA, QL (1 pen/28 days)
pioglitazone hcl tab 15 mg (base equiv), 30 mg (base equiv), 45 mg (base equiv) (Actos)	1		
pioglitazone hcl-metformin hcl tab 15-500 mg, 15-850 mg (Actoplus met)	1		
PROGLYCEM - diazoxide susp 50 mg/ml	3		
repaglinide tab 0.5 mg, 1 mg, 2 mg	1		
RYBELSUS - semaglutide tab 3 mg	2		PA, QL (30 tablets/180 days)
RYBELSUS - semaglutide tab 7 mg, 14 mg	2		PA, QL (30 tablets/30 days)
saxagliptin hcl tab 2.5 mg (base equiv), 5 mg (base equiv) (Onglyza)	1		QL (30 tablets/30 days)

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saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg (Kombiglyze xr)	1		QL (60 tablets/30 days)
saxagliptin-metformin hcl tab er 24hr 5-500 mg, 5-1000 mg (Kombiglyze xr)	1		QL (30 tablets/30 days)
SOLIQUA 100/33 - insulin glargine-lixisenatide sol pen-inj 100-33 unit-mcg/ml	2		ST, QL (6 pens/30 days)
SYMLINPEN 120 - pramlintide acetate pen-inj 2700 mcg/2.7ml (1000 mcg/ml)	2		
SYMLINPEN 60 - pramlintide acetate pen-inj 1500 mcg/1.5ml (1000 mcg/ml)	2		
SYNJARDY - empagliflozin-metformin hcl tab 5-500 mg, 5-1000 mg, 12.5-500 mg, 12.5-1000 mg	2		ST, QL (60 tablets/30 days)
SYNJARDY XR - empagliflozin-metformin hcl tab er 24hr 5-1000 mg, 10-1000 mg, 12.5-1000 mg	2		ST, QL (60 tablets/30 days)
SYNJARDY XR - empagliflozin-metformin hcl tab er 24hr 25-1000 mg	2		ST, QL (30 tablets/30 days)
TRIJARDY XR - empagliflozin-linagliptin-metformin tab er 24hr 5-2.5-1000mg	2		ST, QL (60 tablets/30 days)
TRIJARDY XR - empagliflozin-linagliptin-metformin tab er 24hr 10-5-1000 mg, 25-5-1000 mg	2		ST, QL (30 tablets/30 days)
TRIJARDY XR - empagliflozin-linaglip-metformin tab er 24hr 12.5-2.5-1000mg	2		ST, QL (60 tablets/30 days)
TRULICITY - dulaglutide soln pen-injector 0.75 mg/0.5ml, 1.5 mg/0.5ml, 3 mg/0.5ml, 4.5 mg/0.5ml	2		PA, QL (4 pens/28 days)
XIGDUO XR - dapagliflozin prop-metformin hcl tab er 24hr 2.5-1000 mg, 5-1000 mg	2		ST, QL (60 tablets/30 days)
XIGDUO XR - dapagliflozin prop-metformin hcl tab er 24hr 5-500 mg, 10-500 mg, 10-1000 mg	2		ST, QL (30 tablets/30 days)
XULTOPHY 100/3.6 - insulin degludec-liraglutide sol pen-inj 100-3.6 unit-mg/ml	2		ST, QL (5 pens/30 days)
ZEGALOGUE - dasiglucagon hcl subcutaneous soln auto-inj 0.6 mg/0.6ml	2		
ZEGALOGUE - dasiglucagon hcl subcutaneous soln pref syringe 0.6 mg/0.6ml	2		
Rapid-Acting Insulins			
FIASP - insulin aspart (with niacinamide) inj 100 unit/ml	2		
FIASP FLEXTOUCH - insulin aspart (with niacinamide) sol pen-inj 100 unit/ml	2		
FIASP PENFILL - insulin aspart (with niacinamide) soln cartridge 100 unit/ml	2		
NOVOLOG - insulin aspart inj soln 100 unit/ml	2		

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NOVOLOG FLEXPEN - insulin aspart soln pen-injector 100 unit/ml	2		
NOVOLOG FLEXPEN RELION - insulin aspart soln pen-injector 100 unit/ml	2		
NOVOLOG PENFILL - insulin aspart soln cartridge 100 unit/ml	2		
NOVOLOG RELION - insulin aspart inj soln 100 unit/ml	2		
Short-Acting Insulins			
AFREZZA - insulin regular (human) inhalation powder 4 unit/cartridge	3		PA, QL (2520 cartridges/30 days)
AFREZZA - insulin regular (human) inhalation powder 8 unit/cartridge	3		PA, QL (1260 cartridges/30 days)
AFREZZA - insulin regular (human) inhalation powder 12 unit/cartridge	3		PA, QL (900 cartridges/30 days)
AFREZZA - insulin regular (human) inhal powd 90 x 4 unit & 90 x 8 unit	3		PA, QL (1800 cartridges/30 days)
AFREZZA - insulin regular (human) inh powd 90 x 8 unit & 90 x 12 unit	3		PA, QL (1080 cartridges/30 days)
AFREZZA - insulin regular (human) inh powd 60x4 & 60x8 & 60x12 ut/cart	3		PA, QL (1260 cartridges/30 days)
HUMULIN R U-500 (CONCENTR - insulin regular (human) inj 500 unit/ml	2		
HUMULIN R U-500 KWIKPEN - insulin regular (human) soln pen-injector 500 unit/ml	2		
NOVOLIN R - insulin regular (human) inj 100 unit/ml	2		
NOVOLIN R FLEXPEN - insulin regular (human) soln pen-injector 100 unit/ml	2		
NOVOLIN R FLEXPEN RELION - insulin regular (human) soln pen-injector 100 unit/ml	2		
NOVOLIN R RELION - insulin regular (human) inj 100 unit/ml	2		
RELION R - insulin regular (human) inj 100 unit/ml	2		
Intermediate-Acting Insulins			
NOVOLIN N - insulin nph (human) (isophane) inj 100 unit/ml	2		
NOVOLIN N FLEXPEN - insulin nph (human) (isophane) susp pen-injector 100 unit/ml	2		
NOVOLIN N FLEXPEN RELION - insulin nph (human) (isophane) susp pen-injector 100 unit/ml	2		
NOVOLIN N RELION - insulin nph (human) (isophane) inj 100 unit/ml	2		
NOVOLIN 70/30 - insulin nph isophane & regular human inj 100 unit/ml (70-30)	2		

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NOVOLIN 70/30 FLEXPEN - insulin nph & regular susp pen-inj 100 unit/ml (70-30)	2		
NOVOLIN 70/30 FLEXPEN REL - insulin nph & regular susp pen-inj 100 unit/ml (70-30)	2		
NOVOLIN 70/30 RELION - insulin nph isophane & regular human inj 100 unit/ml (70-30)	2		
NOVOLOG MIX 70/30 - insulin aspart prot & aspart (human) inj 100 unit/ml (70-30)	2		
NOVOLOG MIX 70/30 PREFILL - insulin aspart prot & aspart sus pen-inj 100 unit/ml (70-30)	2		
NOVOLOG MIX 70/30 RELION - insulin aspart prot & aspart (human) inj 100 unit/ml (70-30)	2		
Basal Insulins			
BASAGLAR KWIKPEN - insulin glargine soln pen-injector 100 unit/ml	3		
BASAGLAR TEMPO PEN - insulin glargine pen-inj with transmitter port 100 unit/ml	3		
INSULIN DEGLUDEC - insulin degludec inj 100 unit/ml	2		
INSULIN DEGLUDEC FLEXTOUC - insulin degludec soln pen-injector 100 unit/ml, 200 unit/ml	2		
LANTUS - insulin glargine inj 100 unit/ml	2		
LANTUS SOLOSTAR - insulin glargine soln pen-injector 100 unit/ml	2		
LEVEMIR - insulin detemir inj 100 unit/ml	2		
LEVEMIR FLEXPEN - insulin detemir soln pen-injector 100 unit/ml	2		
TOUJEO MAX SOLOSTAR - insulin glargine soln pen-injector 300 unit/ml (2 unit dial)	2		
TOUJEO SOLOSTAR - insulin glargine soln pen-injector 300 unit/ml (1 unit dial)	2		
TRESIBA - insulin degludec inj 100 unit/ml	2		
TRESIBA FLEXTOUCH - insulin degludec soln pen-injector 100 unit/ml, 200 unit/ml	2		
THYROID AGENTS			
ADTHYZA - thyroid tab 15 mg (1/4 grain), 16.25 mg, 30 mg (1/2 grain), 32.5 mg, 60 mg (1 grain), 65 mg, 90 mg (1 1/2 grain), 97.5 mg, 120 mg (2 grain), 130 mg	3		
ARMOUR THYROID - thyroid tab 15 mg (1/4 grain), 30 mg (1/2 grain), 60 mg (1 grain), 90 mg (1 1/2 grain), 120 mg (2 grain), 180 mg (3 grain), 240 mg (4 grain), 300 mg (5 grain)	3		
ERMEZA - levothyroxine sodium oral solution 150 mcg/5ml	3		

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levothyroxine sodium tab 25 mcg, 50 mcg, 75 mcg, 88 mcg, 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 300 mcg (Synthroid)	1		
liothyronine sodium tab 5 mcg, 25 mcg, 50 mcg (Cytomel)	1		
methimazole tab 5 mg, 10 mg	1		
NIVA THYROID - thyroid tab 15 mg (1/4 grain), 30 mg (1/2 grain), 60 mg (1 grain), 90 mg (1 1/2 grain), 120 mg (2 grain)	3		
NP THYROID 120 - thyroid tab 120 mg (2 grain)	3		
NP THYROID 15 - thyroid tab 15 mg (1/4 grain)	3		
NP THYROID 30 - thyroid tab 30 mg (1/2 grain)	3		
NP THYROID 60 - thyroid tab 60 mg (1 grain)	3		
NP THYROID 90 - thyroid tab 90 mg (1 1/2 grain)	3		
propylthiouracil tab 50 mg	1		
SYNTHROID - levothyroxine sodium tab 25 mcg, 50 mcg, 75 mcg, 88 mcg, 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 300 mcg	2		
THYQUIDITY - levothyroxine sodium oral solution 100 mcg/5ml	3		
THYROID - thyroid tab 15 mg (1/4 grain), 30 mg (1/2 grain), 60 mg (1 grain), 90 mg (1 1/2 grain), 120 mg (2 grain)	3		
OXYTOCICS			
methylergonovine maleate tab 0.2 mg	1		QL (28 tablets/270 days)
ENDOCRINE and METABOLIC AGENTS - MISC.			
ACTHAR - corticotropin inj gel 80 unit/ml	3	SP	PA, LD, QL (7 vials/21 days)
ALENDRONATE SODIUM - alendronate sodium tab 5 mg	3		
alendronate sodium oral soln 70 mg/75ml	1		
alendronate sodium tab 10 mg, 35 mg	1		
alendronate sodium tab 70 mg (Fosamax)	1		
betaine powder for oral solution (Cystadane)	1	SP	PA
BINOSTO - alendronate sodium effervescent tab 70 mg	3		
BUPHENYL - sodium phenylbutyrate tab 500 mg	3	SP	PA, LD, QL (1200 tablets/30 days)
cabergoline tab 0.5 mg	1		
calcitonin (salmon) inj 200 unit/ml (Miacalcin)	1		
calcitonin (salmon) nasal soln 200 unit/act	1		
calcitriol cap 0.25 mcg, 0.5 mcg (Rocaltrol)	1		
calcitriol oral soln 1 mcg/ml (Rocaltrol)	1		
CARBAGLU - carglumic acid soluble tab 200 mg	3	SP	LD

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carglumic acid soluble tab 200 mg (Carbaglu)	1	SP	
CARNITOR - levocarnitine tab 330 mg	3		
CARNITOR - levocarnitine oral soln 1 gm/10ml (10%)	3		
CARNITOR SF - levocarnitine oral soln 1 gm/10ml (10%)	3		
cinacalcet hcl tab 30 mg (base equiv), 60 mg (base equiv), 90 mg (base equiv) (Sensipar)	1		PA
CYSTADANE - betaine powder for oral solution	3	SP	PA, LD
DDAVP - desmopressin acetate inj 4 mcg/ml	3		
DDAVP - desmopressin acetate preservative free (pf) inj 4 mcg/ml	3		
DESMOPRESSIN ACETATE - desmopressin acetate nasal soln 1.5 mg/ml	2		
desmopressin acetate inj 4 mcg/ml (Ddavp)	1		
desmopressin acetate nasal spray soln 0.01% (refrigerated), 0.01%	1		
desmopressin acetate preservative free (pf) inj 4 mcg/ml (Ddavp)	1		
desmopressin acetate tab 0.1 mg, 0.2 mg (Ddavp)	1		
doxercalciferol cap 0.5 mcg, 1 mcg, 2.5 mcg	1		
EGRIFTA SV - tesamorelin acetate for inj 2 mg (base equiv)	3	SP	PA
FOSAMAX - alendronate sodium tab 70 mg	3		
GALAFOLD - migalastat hcl cap 123 mg (base equivalent)	3	SP	PA, LD, QL (14 capsules/28 days)
GENOTROPIN - somatropin for subcutaneous inj cartridge 5 mg, 12 mg (36 unit)	2	SP	PA
GENOTROPIN MINIQUICK - somatropin for subcutaneous inj prefilled syr 0.2 mg, 0.4 mg, 0.6 mg, 0.8 mg, 1 mg, 1.2 mg, 1.4 mg, 1.6 mg, 1.8 mg, 2 mg	2	SP	PA
ibandronate sodium tab 150 mg (base equivalent)	1		
INCRELEX - mecasermin inj 40 mg/4ml (10 mg/ml)	2	SP	PA, LD
ISTURISA - osilodrostat phosphate tab 1 mg	3	SP	PA, LD, QL (240 tablets/30 days)
ISTURISA - osilodrostat phosphate tab 5 mg	3	SP	PA, LD, QL (300 tablets/30 days)
JYNARQUE - tolvaptan tab therapy pack 15 mg, 30 & 15 mg	3	SP	PA, LD, QL (56 tablets/28 days)
JYNARQUE - tolvaptan tab therapy pack 45 & 15 mg, 60 & 30 mg, 90 & 30 mg	3	SP	PA, LD, QL (4 blisters/28 days)
JYNARQUE - tolvaptan tab 15 mg	3	SP	PA, LD, QL (60 tablets/30 days)
JYNARQUE - tolvaptan tab 30 mg	3	SP	PA, LD, QL (30 tablets/30 days)
KERENDIA - finerenone tab 10 mg, 20 mg	3		PA, QL (30 tablets/30 days)
KUVAN - sapropterin dihydrochloride tab 100 mg	3	SP	PA, LD

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KUVAN - sapropterin dihydrochloride powder packet 100 mg, 500 mg	3	SP	PA, LD
levocarnitine oral soln 1 gm/10ml (10%) (Carnitor)	1		
levocarnitine tab 330 mg (Carnitor)	1		
MIACALCIN - calcitonin (salmon) inj 200 unit/ml	3		
MIFEPREX - mifepristone tab 200 mg	2		QL (1 tablet/30 days)
mifepristone tab 200 mg (Mifeprex)	1		QL (1 tablet/30 days)
MYALEPT - metreleptin for subcutaneous inj 11.3 mg	3	SP	PA, LD, QL (30 vials/30 days)
MYCAPSSA - octreotide acetate cap delayed release 20 mg	3	SP	PA, LD, QL (120 capsules/30 days)
nitisinone cap 2 mg, 5 mg, 10 mg, 20 mg (Orfadin)	1	SP	PA, LD
NITYR - nitisinone tab 2 mg, 5 mg, 10 mg	2	SP	PA, LD
NORDITROPIN FLEXPRO - somatropin solution pen-injector 5 mg/1.5ml, 10 mg/1.5ml, 15 mg/1.5ml, 30 mg/3ml	2	SP	PA
NULIBRY - fosdenopterin hydrobromide for iv soln 9.5 mg	3	SP	PA, LD
OCTREOTIDE ACETATE - octreotide acetate subcutaneous soln pref syr 50 mcg/ml, 100 mcg/ml, 500 mcg/ml	3	SP	
octreotide acetate inj 50 mcg/ml (0.05 mg/ml), 100 mcg/ml (0.1 mg/ml), 500 mcg/ml (0.5 mg/ml) (Sandostatin)	1	SP	
octreotide acetate inj 200 mcg/ml (0.2 mg/ml), 1000 mcg/ml (1 mg/ml)	1	SP	
OMNITROPE - somatropin solution cartridge 5 mg/1.5ml, 10 mg/1.5ml	2	SP	PA, LD
OMNITROPE - somatropin for inj 5.8 mg	2	SP	PA, LD
OPFOLDA - miglustat (gaa deficiency) cap 65 mg	3	SP	PA, LD, QL (8 capsules/28 days)
ORFADIN - nitisinone cap 2 mg, 5 mg, 10 mg, 20 mg	3	SP	PA, LD
ORFADIN - nitisinone susp 4 mg/ml	2	SP	PA, LD
ORILISSA - elagolix sodium tab 150 mg (base equiv)	2		PA, QL (30 tablets/30 days)
ORILISSA - elagolix sodium tab 200 mg (base equiv)	2		PA, QL (60 tablets/30 days)
OSPHENA - ospemifene tab 60 mg	3		
OVIDREL - choriogonadotropin alfa inj 250 mcg/0.5ml	2		
PALYNZIQ - pegvaliase-pqpz subcutaneous soln pref syringe 2.5 mg/0.5ml, 10 mg/0.5ml	3	SP	PA, LD, QL (30 syringes/30 days)
PALYNZIQ - pegvaliase-pqpz subcutaneous soln pref syringe 20 mg/ml	3	SP	PA, LD, QL (60 syringes/30 days)
paricalcitol cap 1 mcg, 2 mcg (Zemplar)	1		
paricalcitol cap 4 mcg	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
PHEBURANE - sodium phenylbutyrate oral pellets 483 mg/gm	3	SP	PA, LD, QL (7 bottles/29 days)
raloxifene hcl tab 60 mg (Evista)	1		
RAVICTI - glycerol phenylbutyrate liquid 1.1 gm/ml	3	SP	PA, LD, QL (525 mls/30 days)
risedronate sodium tab delayed release 35 mg (Atelvia)	1		
risedronate sodium tab 5 mg, 30 mg	1		
risedronate sodium tab 35 mg, 150 mg (Actonel)	1		
ROCALTROL - calcitriol cap 0.25 mcg, 0.5 mcg	3		
ROCALTROL - calcitriol oral soln 1 mcg/ml	3		
SAMSCA - tolvaptan tab 15 mg	3	SP	LD, QL (30 tablets/365 days)
SANDOSTATIN - octreotide acetate inj 50 mcg/ml (0.05 mg/ml), 100 mcg/ml (0.1 mg/ml), 500 mcg/ml (0.5 mg/ml)	3	SP	
sapropterin dihydrochloride powder packet 100 mg, 500 mg (Kuvan)	1	SP	PA, LD
sapropterin dihydrochloride tab 100 mg (Kuvan)	1	SP	PA, LD
SENSIPAR - cinacalcet hcl tab 30 mg (base equiv), 60 mg (base equiv), 90 mg (base equiv)	3		PA
SEROSTIM - somatropin (non-refrigerated) for subcutaneous inj 4 mg, 5 mg, 6 mg	3	SP	PA, LD
SIGNIFOR - pasireotide diaspartate inj 0.3 mg/ml (base equiv), 0.6 mg/ml (base equiv), 0.9 mg/ml (base equiv)	3	SP	PA, LD, QL (60 vials/30 days)
SIGNIFOR LAR - pasireotide pamoate for im er susp 10 mg (base equiv), 20 mg (base equiv), 30 mg (base equiv), 40 mg (base equiv), 60 mg (base equiv)	3	SP	PA, LD, QL (1 vial/28 days)
sodium phenylbutyrate oral powder 3 gm/ teaspoonful (Buphenyl)	1	SP	PA, QL (600 grams/30 days)
sodium phenylbutyrate tab 500 mg (Buphenyl)	1	SP	PA, QL (1200 tablets/30 days)
SOMAVERT - pegvisomant for inj 10 mg (as protein), 15 mg (as protein), 20 mg (as protein), 25 mg (as protein), 30 mg (as protein)	2	SP	LD
STRENSIQ - asfotase alfa subcutaneous inj 18 mg/0.45ml, 28 mg/0.7ml, 40 mg/ml, 80 mg/0.8ml	2	SP	PA, LD
SYNAREL - nafarelin acetate nasal soln 2 mg/ml (200 mcg/act) (base eq)	2	SP	
TERIPARATIDE - teriparatide (recombinant) soln pen-inj 620 mcg/2.48ml	3	SP	PA
teriparatide (recombinant) soln pen-inj 600 mcg/2.4ml (Forteo)	1	SP	PA
tolvaptan tab 15 mg (Samsca)	1	SP	QL (30 tablets/365 days)
tolvaptan tab 30 mg (Samsca)	1	SP	QL (60 tablets/365 days)

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TYMLOS - abaloparatide subcutaneous soln pen-injector 3120 mcg/1.56ml	2	SP	PA, LD
VOXZOGO - vosoritide for subcutaneous inj 0.4 mg, 0.56 mg, 1.2 mg	3	SP	PA, LD, QL (30 vials/30 days)
XURIDEN - uridine triacetate oral granules packet 2 gm	3	SP	PA, LD
ZEMPLAR - paricalcitol cap 1 mcg, 2 mcg	3		
CARDIOVASCULAR AGENTS			
CARDIOTONICS			
DIGOXIN - digoxin oral soln 0.05 mg/ml	3		
digoxin oral soln 0.05 mg/ml (Digoxin)	1		
digoxin tab 62.5 mcg (0.0625 mg), 125 mcg (0.125 mg), 250 mcg (0.25 mg) (Lanoxin)	1		
LANOXIN - digoxin tab 62.5 mcg (0.0625 mg), 125 mcg (0.125 mg), 250 mcg (0.25 mg)	3		
ANTIANGINAL AGENTS			
isosorbide dinitrate tab 5 mg, 40 mg (Isordil titradose)	1		
isosorbide dinitrate tab 10 mg, 20 mg, 30 mg	1		
ISOSORBIDE MONONITRATE - isosorbide mononitrate tab 10 mg, 20 mg	2		
isosorbide mononitrate tab er 24hr 30 mg, 60 mg, 120 mg	1		
NITRO-BID - nitroglycerin oint 2%	2		
NITRO-DUR - nitroglycerin td patch 24hr 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	3		
NITRO-DUR - nitroglycerin td patch 24hr 0.3 mg/hr, 0.8 mg/hr	2		
NITRO-TIME - nitroglycerin cap er 2.5 mg, 6.5 mg, 9 mg	3		
nitroglycerin sl tab 0.3 mg, 0.4 mg, 0.6 mg (Nitrostat)	1		
nitroglycerin td patch 24hr 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr (Nitro-dur)	1		
nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray) (Nitrolingual pumpspr)	1		
NITROLINGUAL - nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)	3		
NITROSTAT - nitroglycerin sl tab 0.3 mg, 0.4 mg, 0.6 mg	3		
ranolazine tab er 12hr 500 mg, 1000 mg (Ranexa)	1		
BETA BLOCKERS			
acebutolol hcl cap 200 mg, 400 mg	1		
atenolol tab 25 mg, 50 mg, 100 mg (Tenormin)	1		
betaxolol hcl tab 10 mg, 20 mg	1		

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bisoprolol fumarate tab 5 mg, 10 mg	1		
carvedilol tab 3.125 mg, 6.25 mg, 12.5 mg, 25 mg (Coreg)	1		
CORGARD - nadolol tab 20 mg, 40 mg	3		
INNOPRAN XL - propranolol hcl sustained-release beads cap er 24hr 80 mg, 120 mg	2		
labetalol hcl tab 100 mg, 200 mg, 300 mg	1		
LOPRESSOR - metoprolol tartrate tab 50 mg, 100 mg	3		
metoprolol succinate tab er 24hr 25 mg (tartrate equiv), 50 mg (tartrate equiv), 100 mg (tartrate equiv), 200 mg (tartrate equiv) (Toprol xl)	1		
metoprolol tartrate tab 25 mg, 37.5 mg, 75 mg	1		
metoprolol tartrate tab 50 mg, 100 mg (Lopressor)	1		
nadolol tab 20 mg, 40 mg, 80 mg (Corgard)	1		
nebivolol hcl tab 2.5 mg (base equivalent), 5 mg (base equivalent), 10 mg (base equivalent), 20 mg (base equivalent) (Bystolic)	1		
pindolol tab 5 mg, 10 mg	1		
PROPRANOLOL HCL - propranolol hcl oral soln 40 mg/5ml	2		
propranolol hcl cap er 24hr 60 mg, 80 mg, 120 mg, 160 mg (Inderal la)	1		
propranolol hcl oral soln 20 mg/5ml	1		
propranolol hcl tab 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1		
sotalol hcl (afib/afl) tab 80 mg, 120 mg, 160 mg (Betapace af)	1		
sotalol hcl tab 80 mg, 120 mg, 160 mg (Betapace)	1		
sotalol hcl tab 240 mg	1		
timolol maleate tab 5 mg, 10 mg, 20 mg	1		
TOPROL XL - metoprolol succinate tab er 24hr 25 mg (tartrate equiv), 50 mg (tartrate equiv), 100 mg (tartrate equiv), 200 mg (tartrate equiv)	3		
CALCIUM CHANNEL BLOCKERS			
amlodipine besylate tab 2.5 mg (base equivalent), 5 mg (base equivalent), 10 mg (base equivalent) (Norvasc)	1		
diltiazem hcl cap er 12hr 60 mg, 90 mg, 120 mg	1		
diltiazem hcl cap er 24hr 120 mg, 180 mg, 240 mg	1		
diltiazem hcl coated beads cap er 24hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg (Cardizem cd)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
diltiazem hcl extended release beads cap er 24hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg (Tiazac)	1		
diltiazem hcl tab er 24hr 420 mg (Cardizem la)	1		
diltiazem hcl tab 30 mg, 60 mg, 120 mg (Cardizem)	1		
diltiazem hcl tab 90 mg	1		
felodipine tab er 24hr 2.5 mg, 5 mg, 10 mg	1		
isradipine cap 2.5 mg, 5 mg	1		
nicardipine hcl cap 20 mg, 30 mg	1		
nifedipine cap 10 mg, 20 mg	1		
nifedipine tab er 24hr 30 mg, 60 mg, 90 mg	1		
nifedipine tab er 24hr osmotic release 30 mg, 60 mg, 90 mg (Procardia xl)	1		
nimodipine cap 30 mg	1		
NISOLDIPINE ER - nisoldipine tab er 24hr 20 mg, 25.5 mg, 30 mg, 40 mg	2		
nisoldipine tab er 24hr 8.5 mg, 17 mg, 34 mg (Sular)	1		
NYMALIZE - nimodipine oral soln 6 mg/ml	3		
SULAR - nisoldipine tab er 24hr 8.5 mg, 17 mg, 34 mg	3		
verapamil hcl cap er 24hr 120 mg, 180 mg, 240 mg (Verelan)	1		
VERAPAMIL HCL ER - verapamil hcl cap er 24hr 100 mg, 300 mg	3		
VERAPAMIL HCL SR - verapamil hcl cap er 24hr 360 mg	3		
verapamil hcl tab er 120 mg, 180 mg, 240 mg (Calan sr)	1		
verapamil hcl tab 40 mg, 80 mg, 120 mg	1		
VERAPAMIL HYDROCHLORIDE E - verapamil hcl cap er 24hr 100 mg, 200 mg	3		
VERELAN - verapamil hcl cap er 24hr 120 mg, 180 mg, 240 mg, 360 mg	3		
ANTIARRHYTHMICS			
amiodarone hcl tab 100 mg, 200 mg, 400 mg	1		
disopyramide phosphate cap 100 mg, 150 mg (Norpace)	1		
dofetilide cap 125 mcg (0.125 mg), 250 mcg (0.25 mg), 500 mcg (0.5 mg) (Tikosyn)	1		
flecainide acetate tab 50 mg, 100 mg, 150 mg	1		
mexiletine hcl cap 150 mg, 200 mg, 250 mg	1		
MULTAQ - dronedarone hcl tab 400 mg (base equivalent)	2		

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NORPACE - disopyramide phosphate cap 100 mg, 150 mg	3		
NORPACE CR - disopyramide phosphate cap er 12hr 100 mg, 150 mg	3		
propafenone hcl cap er 12hr 225 mg, 325 mg, 425 mg (Rythmol sr)	1		
propafenone hcl tab 150 mg, 225 mg, 300 mg	1		
quinidine gluconate tab er 324 mg	1		
QUINIDINE SULFATE - quinidine sulfate tab 200 mg, 300 mg	3		
ANTIHYPERTENSIVES			
ACCURETIC - quinapril-hydrochlorothiazide tab 10-12.5 mg, 20-12.5 mg	3		
aliskiren fumarate tab 150 mg (base equivalent), 300 mg (base equivalent) (Tekturna)	1		QL (30 tablets/30 days)
amlodipine besylate-benazepril hcl cap 2.5-10 mg, 5-40 mg	1		
amlodipine besylate-benazepril hcl cap 5-10 mg, 5-20 mg, 10-20 mg, 10-40 mg (Lotrel)	1		
amlodipine besylate-olmesartan medoxomil tab 5-20 mg, 5-40 mg, 10-20 mg, 10-40 mg (Azor)	1		QL (30 tablets/30 days)
amlodipine besylate-valsartan tab 5-160 mg, 5-320 mg, 10-160 mg, 10-320 mg (Exforge)	1		QL (30 tablets/30 days)
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg, 5-160-25 mg, 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg (Exforge hct)	1		QL (30 tablets/30 days)
atenolol & chlorthalidone tab 50-25 mg (Tenoretic 50)	1		
atenolol & chlorthalidone tab 100-25 mg (Tenoretic 100)	1		
benazepril & hydrochlorothiazide tab 5-6.25 mg	1		
benazepril & hydrochlorothiazide tab 10-12.5 mg, 20-12.5 mg, 20-25 mg (Lotensin hct)	1		
benazepril hcl tab 5 mg	1		
benazepril hcl tab 10 mg, 20 mg, 40 mg (Lotensin)	1		
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg, 5-6.25 mg, 10-6.25 mg (Ziac)	1		
candesartan cilexetil tab 4 mg, 8 mg, 16 mg (Atacand)	1		QL (60 tablets/30 days)
candesartan cilexetil tab 32 mg (Atacand)	1		QL (30 tablets/30 days)
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg, 32-12.5 mg, 32-25 mg (Atacand hct)	1		QL (30 tablets/30 days)
captopril tab 12.5 mg, 25 mg, 50 mg, 100 mg	1		

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clonidine hcl tab 0.1 mg, 0.2 mg, 0.3 mg	1		
clonidine td patch weekly 0.1 mg/24hr (Catapres-tts-1)	1		
clonidine td patch weekly 0.2 mg/24hr (Catapres-tts-2)	1		
clonidine td patch weekly 0.3 mg/24hr (Catapres-tts-3)	1		
DIBENZYLINE - phenoxybenzamine hcl cap 10 mg	3		
doxazosin mesylate tab 1 mg, 2 mg, 4 mg, 8 mg (Cardura)	1		
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1		
enalapril maleate & hydrochlorothiazide tab 10-25 mg (Vaseretic)	1		
enalapril maleate oral soln 1 mg/ml (Epaned)	1		
enalapril maleate tab 2.5 mg, 5 mg, 10 mg, 20 mg (Vasotec)	1		
EPANED - enalapril maleate oral soln 1 mg/ml	3		
eplerenone tab 25 mg, 50 mg (Inspra)	1		
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg, 20-12.5 mg	1		
fosinopril sodium tab 10 mg, 20 mg, 40 mg	1		
guanfacine hcl tab 1 mg, 2 mg	1		
hydralazine hcl tab 10 mg, 25 mg, 50 mg, 100 mg	1		
irbesartan tab 75 mg, 150 mg, 300 mg (Avapro)	1		QL (30 tablets/30 days)
irbesartan-hydrochlorothiazide tab 150-12.5 mg, 300-12.5 mg (Avalide)	1		QL (30 tablets/30 days)
lisinopril & hydrochlorothiazide tab 10-12.5 mg, 20-12.5 mg, 20-25 mg (Zestoretic)	1		
lisinopril tab 2.5 mg, 5 mg, 10 mg, 20 mg, 30 mg, 40 mg (Zestril)	1		
losartan potassium & hydrochlorothiazide tab 50-12.5 mg, 100-12.5 mg, 100-25 mg (Hyzaar)	1		QL (30 tablets/30 days)
losartan potassium tab 25 mg, 50 mg (Cozaar)	1		QL (60 tablets/30 days)
losartan potassium tab 100 mg (Cozaar)	1		QL (30 tablets/30 days)
LOTENSIN - benazepril hcl tab 10 mg, 20 mg, 40 mg	3		
LOTENSIN HCT - benazepril & hydrochlorothiazide tab 10-12.5 mg, 20-12.5 mg, 20-25 mg	3		
METHYLDOPA - methyldopa tab 250 mg, 500 mg	2		
metoprolol & hydrochlorothiazide tab 50-25 mg, 100-25 mg, 100-50 mg	1		
MINIPRESS - prazosin hcl cap 2 mg, 5 mg	3		

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minoxidil tab 2.5 mg, 10 mg	1		
moexipril hcl tab 7.5 mg, 15 mg	1		
olmesartan medoxomil tab 5 mg (Benicar)	1		QL (60 tablets/30 days)
olmesartan medoxomil tab 20 mg, 40 mg (Benicar)	1		QL (30 tablets/30 days)
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg, 40-12.5 mg, 40-25 mg (Benicar hct)	1		QL (30 tablets/30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg, 40-5-12.5 mg, 40-5-25 mg, 40-10-12.5 mg, 40-10-25 mg (Tribenzor)	1		QL (30 tablets/30 days)
PERINDOPRIL ERBUMINE - perindopril erbumine tab 2 mg, 8 mg	2		
perindopril erbumine tab 4 mg	1		
phenoxybenzamine hcl cap 10 mg (Dibenzyline)	1		
prazosin hcl cap 1 mg, 2 mg, 5 mg (Minipress)	1		
quinapril hcl tab 5 mg, 10 mg, 20 mg, 40 mg (Accupril)	1		
quinapril-hydrochlorothiazide tab 10-12.5 mg, 20-12.5 mg (Accuretic)	1		
QUINAPRIL/HYDROCHLOROTHIA - quinapril-hydrochlorothiazide tab 20-25 mg	3		
ramipril cap 1.25 mg, 2.5 mg, 5 mg, 10 mg (Altace)	1		
TEKTURNA - aliskiren fumarate tab 150 mg (base equivalent), 300 mg (base equivalent)	3		ST, QL (30 tablets/30 days)
telmisartan tab 20 mg, 40 mg, 80 mg (Micardis)	1		QL (30 tablets/30 days)
telmisartan-hydrochlorothiazide tab 40-12.5 mg, 80-25 mg (Micardis hct)	1		QL (30 tablets/30 days)
telmisartan-hydrochlorothiazide tab 80-12.5 mg (Micardis hct)	1		QL (60 tablets/30 days)
TELMISARTAN/AMLODIPINE - telmisartan-amlodipine tab 40-5 mg, 40-10 mg, 80-5 mg, 80-10 mg	2		ST, QL (30 tablets/30 days)
TENORETIC 100 - atenolol & chlorthalidone tab 100-25 mg	3		
TENORETIC 50 - atenolol & chlorthalidone tab 50-25 mg	3		
terazosin hcl cap 1 mg (base equivalent), 2 mg (base equivalent), 5 mg (base equivalent), 10 mg (base equivalent)	1		
trandolapril tab 1 mg, 2 mg, 4 mg	1		
TRANDOLAPRIL/VERAPAMIL HC - trandolapril-verapamil hcl tab er 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	3		
valsartan tab 40 mg, 80 mg, 160 mg (Diovan)	1		QL (60 tablets/30 days)
valsartan tab 320 mg (Diovan)	1		QL (30 tablets/30 days)

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valsartan-hydrochlorothiazide tab 80-12.5 mg, 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg (Diovan hct)	1		QL (30 tablets/30 days)
VECAMYL - mecamylamine hcl tab 2.5 mg	3		LD
DIURETICS			
acetazolamide cap er 12hr 500 mg	1		
acetazolamide tab 125 mg, 250 mg	1		
amiloride hcl tab 5 mg	1		
AMILORIDE/HYDROCHLOROTHIA - amiloride & hydrochlorothiazide tab 5-50 mg	2		
bumetanide tab 0.5 mg (Bumex)	1		
bumetanide tab 1 mg, 2 mg	1		
BUMEX - bumetanide tab 0.5 mg	3		
chlorthalidone tab 25 mg, 50 mg	1		
dichlorphenamide tab 50 mg (Keveyis)	1	SP	PA, QL (120 tablets/30 days)
DIURIL - chlorothiazide susp 250 mg/5ml	3		
DYRENIUM - triamterene cap 50 mg, 100 mg	3		
EDECRIN - ethacrynic acid tab 25 mg	3		
ethacrynic acid tab 25 mg (Edecrin)	1		
FUROSCIX - furosemide subcutaneous cartridge kit 80 mg/10ml	3	SP	PA, LD, QL (8 kits/30 days)
FUROSEMIDE - furosemide oral soln 8 mg/ml	3		
furosemide oral soln 10 mg/ml	1		
furosemide tab 20 mg, 40 mg, 80 mg (Lasix)	1		
hydrochlorothiazide cap 12.5 mg	1		
hydrochlorothiazide tab 12.5 mg, 25 mg, 50 mg	1		
indapamide tab 1.25 mg, 2.5 mg	1		
KEVEYIS - dichlorphenamide tab 50 mg	3	SP	PA, LD, QL (120 tablets/30 days)
LASIX - furosemide tab 20 mg, 40 mg, 80 mg	3		
methazolamide tab 25 mg, 50 mg	1		
metolazone tab 2.5 mg, 5 mg, 10 mg	1		
spironolactone & hydrochlorothiazide tab 25-25 mg (Aldactazide)	1		
spironolactone tab 25 mg, 50 mg, 100 mg (Aldactone)	1		
torsemide tab 5 mg, 10 mg, 20 mg, 100 mg	1		
triamterene & hydrochlorothiazide cap 37.5-25 mg	1		
triamterene & hydrochlorothiazide tab 37.5-25 mg (Maxzide-25)	1		
triamterene & hydrochlorothiazide tab 75-50 mg (Maxzide)	1		

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triamterene cap 50 mg, 100 mg (Dyrenium)	1		
VASOPRESSORS			
AUVI-Q - epinephrine solution auto-injector 0.1 mg/0.1ml, 0.15 mg/0.15ml (1:1000), 0.3 mg/0.3ml (1:1000)	2		
EPINEPHRINE - epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000), 0.3 mg/0.3ml (1:1000)	3		
epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000) (Epipen-jr 2-pak)	1		
epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000) (Epipen 2-pak)	1		
midodrine hcl tab 2.5 mg, 5 mg, 10 mg	1		
ANTIHYPERLIPIDEMICS			
atorvastatin calcium tab 10 mg (base equivalent), 20 mg (base equivalent), 40 mg (base equivalent) (Lipitor)	1		QL (45 tablets/30 days)
atorvastatin calcium tab 80 mg (base equivalent) (Lipitor)	1		QL (30 tablets/30 days)
cholestyramine light powder packets 4 gm	1		
cholestyramine light powder 4 gm/dose (Questran light)	1		
cholestyramine powder packets 4 gm (Questran)	1		
cholestyramine powder 4 gm/dose (Questran)	1		
choline fenofibrate cap dr 45 mg (fenofibric acid equiv), 135 mg (fenofibric acid equiv) (Trilipix)	1		
colesevelam hcl packet for susp 3.75 gm (Welchol)	1		
colesevelam hcl tab 625 mg (Welchol)	1		
COLESTID - colestipol hcl tab 1 gm	3		
COLESTID - colestipol hcl granules 5 gm	3		
colestipol hcl granule packets 5 gm (Colestid flavored)	1		
colestipol hcl granules 5 gm (Colestid flavored)	1		
colestipol hcl tab 1 gm (Colestid)	1		
ezetimibe tab 10 mg (Zetia)	1		
ezetimibe-simvastatin tab 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg (Vytorin)	1		QL (30 tablets/30 days)
fenofibrate micronized cap 43 mg, 67 mg, 130 mg, 134 mg, 200 mg	1		
fenofibrate tab 48 mg, 145 mg (Tricor)	1		
fenofibrate tab 54 mg, 160 mg	1		
fluvastatin sodium cap 20 mg (base equivalent), 40 mg (base equivalent)	1		QL (60 capsules/30 days)

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fluvastatin sodium tab er 24 hr 80 mg (base equivalent) (Lescol xl)	1		QL (30 tablets/30 days)
gemfibrozil tab 600 mg (Lopid)	1		
JUXTAPID - lomitapide mesylate cap 5 mg (base equiv), 10 mg (base equiv), 20 mg (base equiv), 30 mg (base equiv)	3	SP	PA, LD, QL (30 capsules/30 days)
LOPID - gemfibrozil tab 600 mg	3		
lovastatin tab 10 mg, 20 mg, 40 mg	1		QL (60 tablets/30 days)
NEXLETOL - bempedoic acid tab 180 mg	2		PA, QL (30 tablets/30 days)
NEXLIZET - bempedoic acid-ezetimibe tab 180-10 mg	2		PA, QL (30 tablets/30 days)
niacin tab er 500 mg (antihyperlipidemic), 750 mg (antihyperlipidemic)	1		
niacin tab er 1000 mg (antihyperlipidemic) (Niaspan)	1		
omega-3-acid ethyl esters cap 1 gm (Lovaza)	1		
pitavastatin calcium tab 1 mg, 2 mg (Livalo)	1		QL (45 tablets/30 days)
pitavastatin calcium tab 4 mg (Livalo)	1		QL (30 tablets/30 days)
pravastatin sodium tab 10 mg, 20 mg, 40 mg	1		QL (45 tablets/30 days)
pravastatin sodium tab 80 mg	1		QL (30 tablets/30 days)
QUESTRAN - cholestyramine powder 4 gm/dose	3		
QUESTRAN - cholestyramine powder packets 4 gm	3		
QUESTRAN LIGHT - cholestyramine light powder 4 gm/dose	3		
REPATHA - evolocumab subcutaneous soln prefilled syringe 140 mg/ml	2		PA, QL (2 syringes/28 days)
REPATHA PUSHTRONEX SYSTEM - evolocumab subcutaneous soln cartridge/infusor 420 mg/3.5ml	2		PA, QL (2 cartridges/28 days)
REPATHA SURECLICK - evolocumab subcutaneous soln auto-injector 140 mg/ml	2		PA, QL (2 pens/28 days)
rosuvastatin calcium tab 5 mg, 10 mg, 20 mg (Crestor)	1		QL (45 tablets/30 days)
rosuvastatin calcium tab 40 mg (Crestor)	1		QL (30 tablets/30 days)
simvastatin tab 5 mg	1		QL (45 tablets/30 days)
simvastatin tab 10 mg, 40 mg (Zocor)	1		QL (45 tablets/30 days)
simvastatin tab 20 mg (Zocor)	1		QL (60 tablets/30 days)
simvastatin tab 80 mg	1		QL (30 tablets/30 days)
TRICOR - fenofibrate tab 48 mg, 145 mg	3		
VASCEPA - icosapent ethyl cap 0.5 gm	2		PA, QL (240 capsules/30 days)
VASCEPA - icosapent ethyl cap 1 gm	2		PA, QL (120 capsules/30 days)
CARDIOVASCULAR AGENTS - MISC.			
ADEMPAS - riociguat tab 0.5 mg, 1 mg, 1.5 mg, 2 mg, 2.5 mg	3	SP	PA, LD, QL (90 tablets/30 days)

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ambrisentan tab 5 mg, 10 mg (Letairis)	1	SP	PA, LD, QL (30 tablets/30 days)
BIDIL - isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg	3		
bosentan tab 62.5 mg, 125 mg (Tracleer)	1	SP	PA, QL (60 tablets/30 days)
CAMZYOS - mavacamten cap 2.5 mg, 5 mg, 10 mg, 15 mg	3	SP	PA, LD, QL (30 capsules/30 days)
CORLANOR - ivabradine hcl tab 5 mg (base equiv), 7.5 mg (base equiv)	2		LD
CORLANOR - ivabradine hcl oral soln 5 mg/5ml (base equiv)	2		LD
ENTRESTO - sacubitril-valsartan tab 24-26 mg, 49-51 mg, 97-103 mg	2		QL (60 tablets/30 days)
isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg (Bidil)	1		
LETAIRIS - ambrisentan tab 5 mg, 10 mg	3	SP	PA, LD, QL (30 tablets/30 days)
OPSUMIT - macitentan tab 10 mg	2	SP	PA, LD, QL (30 tablets/30 days)
ORENITRAM - treprostinil diolamine tab er 0.125 mg (base equiv), 0.25 mg (base equiv), 1 mg (base equiv), 2.5 mg (base equiv), 5 mg (base equiv)	3	SP	PA, LD
ORENITRAM TITRATION KIT M - treprostinil tab er titr pk (mo1) 126 x0.125mg & 42 x0.25mg, titr pk (mo2) 126 x0.125mg & 210 x0.25mg, titr pk(mo3)126x0.125mg&42x0.25mg&84x1mg	3	SP	PA, LD, QL (1 kit/180 days)
REMODULIN - treprostinil inj soln 20 mg/20ml (1 mg/ml), 50 mg/20ml (2.5 mg/ml), 100 mg/20ml (5 mg/ml), 200 mg/20ml (10 mg/ml)	3	SP	PA, LD
sildenafil citrate for suspension 10 mg/ml (Revatio)	1		PA, QL (224 mls/30 days)
sildenafil citrate tab 20 mg (Revatio)	1		PA, QL (90 tablets/30 days)
tadalafil tab 20 mg (pah) (Adcirca)	1	SP	PA, QL (60 tablets/30 days)
TRACLEER - bosentan tab 62.5 mg, 125 mg	3	SP	PA, LD, QL (60 tablets/30 days)
TRACLEER - bosentan tab for oral susp 32 mg	2	SP	PA, LD, QL (120 tablets/30 days)
treprostinil inj soln 20 mg/20ml (1 mg/ml), 50 mg/20ml (2.5 mg/ml), 100 mg/20ml (5 mg/ml), 200 mg/20ml (10 mg/ml) (Remodulin)	1	SP	PA
TYVASO - treprostinil inhalation solution 0.6 mg/ml	3	SP	PA, LD, QL (28 ampules/28 days)
TYVASO DPI MAINTENANCE KI - treprostinil inh powder 16 mcg/cartridge, 32 mcg/cartridge, 48 mcg/cartridge, 64 mcg/cartridge	3	SP	PA, LD, QL (112 cartridges/28 days)
TYVASO DPI TITRATION KIT - treprostinil inh powd 112 x 16mcg & 112 x 32mcg & 28 x 48mcg	3	SP	PA, LD, QL (252 cartridges/180 days)
TYVASO REFILL - treprostinil inhalation solution 0.6 mg/ml	3	SP	PA, LD, QL (28 ampules/28 days)

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TYVASO STARTER - treprostinil inhalation solution 0.6 mg/ml	3	SP	PA, LD, QL (1 kit/180 days)
UPTRAVI - selexipag tab 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1000 mcg, 1200 mcg, 1400 mcg, 1600 mcg	2	SP	PA, LD, QL (60 tablets/30 days)
UPTRAVI TITRATION PACK - selexipag tab therapy pack 200 mcg (140) & 800 mcg (60)	2	SP	PA, LD, QL (1 pack/180 days)
VENTAVIS - iloprost inhalation solution 10 mcg/ml, 20 mcg/ml	2	SP	PA, LD, QL (68 ampules/30 days)
VERQUVO - vericiguat tab 2.5 mg, 5 mg, 10 mg	2		PA, QL (30 tablets/30 days)
VYNDAMAX - tafamidis cap 61 mg	2	SP	PA, QL (30 capsules/30 days)
VYNDAQEL - tafamidis meglumine (cardiac) cap 20 mg	2	SP	PA, QL (120 capsules/30 days)
ERECTILE DYSFUNCTION			
CIALIS - tadalafil tab 5 mg	3		QL (30 tablets/30 days)
tadalafil tab 2.5 mg, 5 mg (Cialis)	1		QL (30 tablets/30 days)
RESPIRATORY AGENTS			
ANTIHISTAMINES			
CARBINOXAMINE MALEATE - carbinoxamine maleate soln 4 mg/5ml	3		
carbinoxamine maleate tab 4 mg	1		
CLEMASTINE FUMARATE - clemastine fumarate tab 2.68 mg	3		
clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)	1		
cyproheptadine hcl syrup 2 mg/5ml	1		
cyproheptadine hcl tab 4 mg	1		
desloratadine tab 5 mg (Clarinex)	1		
levocetirizine dihydrochloride tab 5 mg	1		
loratadine oral soln 5 mg/5ml	1		
loratadine rapidly-disintegrating tab 10 mg (Claritin)	1		
loratadine tab 10 mg	1		
promethazine hcl oral soln 6.25 mg/5ml	1		
promethazine hcl suppos 12.5 mg, 25 mg	1		
promethazine hcl tab 12.5 mg, 25 mg, 50 mg	1		
PROMETHEGAN - promethazine hcl suppos 50 mg	3		
NASAL AGENTS - SYSTEMIC and TOPICAL			
azelastine hcl nasal spray 0.1% (137 mcg/spray)	1		QL (2 bottles/30 days)
flunisolide nasal soln 25 mcg/act (0.025%)	1		QL (3 bottles/30 days)
fluticasone propionate nasal susp 50 mcg/act	1		QL (1 bottle/30 days)
ipratropium bromide nasal soln 0.03% (21 mcg/spray)	1		QL (2 bottles/30 days)

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ipratropium bromide nasal soln 0.06% (42 mcg/ spray)	1		QL (3 bottles/30 days)
olopatadine hcl nasal soln 0.6% (Patanase)	1		QL (1 bottle/30 days)
XHANCE - fluticasone propionate nasal exhaler susp 93 mcg/act	3		PA, QL (2 bottles/30 days)
COUGH/COLD/ALLERGY			
acetylcysteine inhal soln 10%, 20%	1		
benzonatate cap 100 mg, 200 mg	1		
HYCODAN - hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg	3		
HYCODAN - hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml	3		
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml (Hycodan)	1		
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg (Hycodan)	1		
HYDROCODONE POLISTIREX/CH - hydrocod polst-chlorphen polst er susp 10-8 mg/5ml	2		
HYPERSAL - sodium chloride soln nebu 7%	3		
loratadine & pseudoephedrine tab er 12hr 5-120 mg	1		
loratadine & pseudoephedrine tab er 24hr 10-240 mg	1		
PROMETHAZINE VC - promethazine & phenylephrine syrup 6.25-5 mg/5ml	2		
promethazine w/ codeine syrup 6.25-10 mg/5ml	1		
promethazine-dm syrup 6.25-15 mg/5ml	1		
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	1		
sodium chloride soln nebu 3%, 10%	1		
sodium chloride soln nebu 7% (Hypersal)	1		
ANTIASTHMATIC and BRONCHODILATOR AGENTS			
ACCOLATE - zafirlukast tab 10 mg, 20 mg	3		
ADVAIR HFA - fluticasone-salmeterol inhal aerosol 45-21 mcg/act, 115-21 mcg/act, 230-21 mcg/act	2		QL (1 canister/30 days)
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv) (Proventil hfa)	1		QL (2 inhalers/30 days)
albuterol sulfate soln nebu 0.083% (2.5 mg/3ml), 0.5% (5 mg/ml), 0.63 mg/3ml (base equiv), 1.25 mg/3ml (base equiv)	1		
albuterol sulfate syrup 2 mg/5ml	1		
albuterol sulfate tab 2 mg, 4 mg	1		
ANORO ELLIPTA - umeclidinium-vilanterol aero powd ba 62.5-25 mcg/act	2		QL (1 inhaler/30 days)

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arformoterol tartrate soln nebu 15 mcg/2ml (base equiv) (Brovana)	1		
ARNUITY ELLIPTA - fluticasone furoate aerosol powder breath activ 50 mcg/act, 100 mcg/act, 200 mcg/act	2		QL (30 blisters/30 days)
ASMANEX HFA - mometasone furoate inhal aerosol suspension 50 mcg/act, 100 mcg/act, 200 mcg/act	2		QL (1 canister/30 days)
ASMANEX TWISTHALER 120 ME - mometasone furoate inhal powd 220 mcg/act (breath activated)	2		QL (1 canister/30 days)
ASMANEX TWISTHALER 30 MET - mometasone furoate inhal powd 110 mcg/act (breath activated), 220 mcg/act (breath activated)	2		QL (1 canister/30 days)
ASMANEX TWISTHALER 60 MET - mometasone furoate inhal powd 220 mcg/act (breath activated)	2		QL (1 canister/30 days)
ATROVENT HFA - ipratropium bromide hfa inhal aerosol 17 mcg/act	2		QL (2 canisters/30 days)
BEVESPI AEROSPHERE - glycopyrrolate-formoterol fumarate aerosol 9-4.8 mcg/act	3		QL (1 canister/30 days)
BREO ELLIPTA - fluticasone furoate-vilanterol aero powd ba 50-25 mcg/act, 100-25 mcg/act, 200-25 mcg/act	2		QL (1 inhaler/30 days)
BREZTRI AEROSPHERE - budesonide-glycopyrrolate-formoterol aers 160-9-4.8 mcg/act	2		QL (1 inhaler/30 days)
BROVANA - arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)	3		
budesonide inhalation susp 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml (Pulmicort)	1		
budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act, 160-4.5 mcg/act (Symbicort)	1		PA, QL (3 inhalers/30 days)
COMBIVENT RESPIMAT - ipratropium-albuterol inhal aerosol soln 20-100 mcg/act	2		QL (2 canisters/30 days)
cromolyn sodium soln nebu 20 mg/2ml	1		
DULERA - mometasone furoate-formoterol fumarate aerosol 50-5 mcg/act, 100-5 mcg/act, 200-5 mcg/act	2		QL (3 canisters/30 days)
FASENRA PEN - benralizumab subcutaneous soln auto-injector 30 mg/ml	2	SP	PA, LD, QL (1 pen/56 days)
FLUTICASONE PROPIONATE DI - fluticasone propionate aer pow ba 50 mcg/act, 100 mcg/act	2		QL (60 blisters/30 days)
FLUTICASONE PROPIONATE DI - fluticasone propionate aer pow ba 250 mcg/act	2		QL (240 blisters/30 days)
FLUTICASONE PROPIONATE HF - fluticasone propionate hfa inhal aero 44 mcg/act	2		QL (1 canister/30 days)
FLUTICASONE PROPIONATE HF - fluticasone propionate hfa inhal aer 110 mcg/act	2		QL (1 canister/30 days)

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FLUTICASONE PROPIONATE HF - fluticasone propionate hfa inhal aer 220 mcg/act	2		QL (2 canisters/30 days)
FLUTICASONE PROPIONATE/SA - fluticasone-salmeterol aer powder ba 55-14 mcg/act, 113-14 mcg/act, 232-14 mcg/act	2		QL (1 inhaler/30 days)
fluticasone-salmeterol aer powder ba 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act (Advair diskus)	1		QL (60 blisters/30 days)
INCRUSE ELLIPTA - umeclidinium br aero powd breath act 62.5 mcg/act (base eq)	2		QL (30 blisters/30 days)
ipratropium bromide inhal soln 0.02%	1		
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1		
levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv) (Xopenex concentrate)	1		
levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv), 0.63 mg/3ml (base equiv), 1.25 mg/3ml (base equiv) (Xopenex)	1		
montelukast sodium chew tab 4 mg (base equiv), 5 mg (base equiv) (Singulair)	1		
montelukast sodium tab 10 mg (base equiv) (Singulair)	1		
NUCALA - mepolizumab subcutaneous solution auto-injector 100 mg/ml	2	SP	PA, LD, QL (3 pens/28 days)
NUCALA - mepolizumab subcutaneous solution pref syringe 40 mg/0.4ml	2	SP	PA, LD, QL (1 syringe/28 days)
NUCALA - mepolizumab subcutaneous solution pref syringe 100 mg/ml	2	SP	PA, LD, QL (3 syringes/28 days)
QVAR REDIHALER - beclomethasone diprop hfa breath act inh aer 40 mcg/act	2		QL (1 canister/30 days)
QVAR REDIHALER - beclomethasone diprop hfa breath act inh aer 80 mcg/act	2		QL (2 canisters/30 days)
roflumilast tab 250 mcg, 500 mcg (Daliresp)	1		
SEREVENT DISKUS - salmeterol xinafoate aer pow ba 50 mcg/act (base equiv)	2		QL (60 blisters/30 days)
SPIRIVA HANDIHALER - tiotropium bromide monohydrate inhal cap 18 mcg (base equiv)	2		QL (30 capsules/30 days)
SPIRIVA RESPIMAT - tiotropium bromide monohydrate inhal aerosol 1.25 mcg/act, 2.5 mcg/act	2		QL (1 cartridge/30 days)
STIOLTO RESPIMAT - tiotropium br-olodaterol inhal aero soln 2.5-2.5 mcg/act	2		QL (1 cartridge/30 days)
STRIVERDI RESPIMAT - olodaterol hcl inhal aerosol soln 2.5 mcg/act (base equiv)	2		QL (1 cartridge/30 days)
SYMBICORT - budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act, 160-4.5 mcg/act	2		QL (3 inhalers/30 days)

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terbutaline sulfate tab 2.5 mg, 5 mg	1		
TEZSPIRE - tezepelumab-ekko subcutaneous soln auto-inj 210 mg/1.91ml	2	SP	PA, LD, QL (1 pen/28 days)
THEO-24 - theophylline cap er 24hr 100 mg, 200 mg, 300 mg, 400 mg	3		
theophylline elixir 80 mg/15ml	1		
THEOPHYLLINE ER - theophylline tab er 12hr 100 mg, 200 mg	3		
theophylline soln 80 mg/15ml	1		
theophylline tab er 12hr 300 mg, 450 mg	1		
theophylline tab er 24hr 400 mg, 600 mg	1		
tiotropium bromide monohydrate inhal cap 18 mcg (base equiv) (Spiriva handihaler)	1		PA, QL (30 capsules/30 days)
TRELEGY ELLIPTA - fluticasone-umeclidinium-vilanterol aepb 100-62.5-25 mcg/act, 200-62.5-25 mcg/act	2		QL (1 inhaler/30 days)
VENTOLIN HFA - albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)	2		QL (2 inhalers/30 days)
XOLAIR - omalizumab subcutaneous soln auto-injector 75 mg/0.5ml, 150 mg/ml, 300 mg/2ml	2	SP	PA, LD
XOLAIR - omalizumab subcutaneous soln prefilled syringe 75 mg/0.5ml, 150 mg/ml, 300 mg/2ml	2	SP	PA, LD
zafirlukast tab 10 mg, 20 mg (Accolate)	1		
zileuton tab er 12hr 600 mg	1		PA, QL (120 tablets/30 days)
RESPIRATORY AGENTS - MISC.			
BRONCHITOL - mannitol inhal cap 40 mg	3	SP	
BRONCHITOL TOLERANCE TEST - mannitol inhal cap 40 mg	3	SP	
ESBRIET - pirfenidone cap 267 mg	3	SP	PA, LD, QL (180 capsules/30 days)
ESBRIET - pirfenidone tab 267 mg	3	SP	PA, LD, QL (180 tablets/30 days)
ESBRIET - pirfenidone tab 801 mg	3	SP	PA, LD, QL (90 tablets/30 days)
KALYDECO - ivacaftor tab 150 mg	2	SP	PA, LD, QL (60 tablets/30 days)
KALYDECO - ivacaftor packet 5.8 mg, 13.4 mg, 25 mg, 50 mg, 75 mg	2	SP	PA, LD, QL (56 packets/28 days)
OFEV - nintedanib esylate cap 100 mg (base equivalent), 150 mg (base equivalent)	3	SP	PA, LD, QL (60 capsules/30 days)
ORKAMBI - lumacaftor-ivacaftor tab 100-125 mg, 200-125 mg	3	SP	PA, LD, QL (120 tablets/30 days)
ORKAMBI - lumacaftor-ivacaftor granules packet 75-94 mg, 100-125 mg, 150-188 mg	3	SP	PA, LD, QL (60 packets/30 days)
PIRFENIDONE - pirfenidone tab 534 mg	3	SP	PA, QL (21 tablets/180 days)
pirfenidone cap 267 mg (Esbriet)	1	SP	PA, QL (180 capsules/30 days)
pirfenidone tab 267 mg (Esbriet)	1	SP	PA, QL (180 tablets/30 days)

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pirfenidone tab 801 mg (Esbriet)	1	SP	PA, QL (90 tablets/30 days)
PULMOZYME - dornase alfa inhal soln 2.5 mg/2.5ml	2	SP	
SYMDEKO - tezacaftor-ivacaftor 50-75 mg & ivacaftor 75 mg tab tbpk	2	SP	PA, LD, QL (56 tablets/28 days)
SYMDEKO - tezacaftor-ivacaftor 100-150 mg & ivacaftor 150 mg tab tbpk	2	SP	PA, LD, QL (60 tablets/30 days)
TRIKAFTA - elexacaf-tezacaf-ivacaf 80-40-60 mg& ivacaf 59.5mg thpk gran	2	SP	PA, LD, QL (56 packets/28 days)
TRIKAFTA - elexacaf-tezacaf-ivacaf 100-50-75 mg& ivacaf 75mg thpk gran	2	SP	PA, LD, QL (56 packets/28 days)
TRIKAFTA - elexacaf-tezacaf-ivacaf 50-25-37.5 mg & ivacaftor 75 mg tbpk	2	SP	PA, LD, QL (90 tablets/30 day)
TRIKAFTA - elexacaf-tezacaf-ivacaf 100-50-75 mg &ivacaftor 150 mg tbpk	2	SP	PA, LD, QL (90 tablets/30 days)
GASTROINTESTINAL AGENTS			
LAXATIVES			
GAVILYTE-C - peg 3350-kcl-na bicarb-nacl-na sulfate for soln 240 gm	3		
GOLYTELY - peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	3		
lactulose solution 10 gm/15ml	1		
MOVIPREP - peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm	3		
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm (Golytely)	1		
peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm (Moviprep)	1		
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1		
PEG-PREP - bisacodyl tab & peg 3350-kcl-sod bicarb-nacl for soln kit	3		
PLENVU - peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 140 gm	3		
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml (Suprep bowel prep ki)	1		
SUFLAVE - peg 3350-kcl-nacl-na sulfate-mag sulfate for soln 178.7 gm	3		
SUPREP BOWEL PREP KIT - sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	3		
SUTAB - sod sulfate-mg sulfate-pot chloride tab 1479-225-188 mg	3		
ANTIDIARRHEALS			
diphenoxylate w/ atropine tab 2.5-0.025 mg (Lomotil)	1		

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LOMOTIL - diphenoxylate w/ atropine tab 2.5-0.025 mg	3		
MYTESI - crofelemer tab delayed release 125 mg	3		LD
ULCER DRUGS			
CIMETIDINE HYDROCHLORIDE - cimetidine hcl soln 300 mg/5ml	2		
CUVPOSA - glycopyrrolate oral soln 1 mg/5ml	3		
CYTOTEC - misoprostol tab 100 mcg, 200 mcg	3		
dicyclomine hcl cap 10 mg	1		
dicyclomine hcl oral soln 10 mg/5ml	1		
dicyclomine hcl tab 20 mg	1		
esomeprazole magnesium cap delayed release 40 mg (base eq) (Nexium)	1		QL (30 capsules/30 days)
esomeprazole magnesium for delayed release susp packet 10 mg, 20 mg, 40 mg (Nexium)	1		QL (30 packets/30 days)
famotidine for susp 40 mg/5ml	1		
famotidine tab 20 mg, 40 mg (Pepcid)	1		
glycopyrrolate oral soln 1 mg/5ml (Cuvposa)	1		
glycopyrrolate tab 1 mg (Robinul)	1		
glycopyrrolate tab 2 mg (Robinul forte)	1		
HELIDAC THERAPY - metronidaz tab-tetracyc cap-bis subsal chew tab therapy pack	3		
lansoprazole cap delayed release 30 mg (Prevacid)	1		QL (60 capsules/30 days)
methscopolamine bromide tab 2.5 mg, 5 mg	1		
misoprostol tab 100 mcg, 200 mcg (Cytotec)	1		
NEXIUM - esomeprazole magnesium for delayed release susp pack 2.5 mg	2		QL (30 packets/30 days)
NEXIUM - esomeprazole magnesium for delayed release susp packet 5 mg	2		QL (30 packets/30 days)
NIZATIDINE - nizatidine cap 150 mg, 300 mg	3		
omeprazole cap delayed release 10 mg, 40 mg	1		QL (60 capsules/30 days)
omeprazole cap delayed release 20 mg	1		QL (120 capsules/30 days)
pantoprazole sodium ec tab 20 mg (base equiv), 40 mg (base equiv) (Protonix)	1		QL (60 tablets/30 days)
pantoprazole sodium for delayed release susp packet 40 mg (Protonix)	1		QL (60 packets/30 days)
rabeprazole sodium ec tab 20 mg (Aciphex)	1		QL (60 tablets/30 days)
sucralfate tab 1 gm (Carafate)	1		
ANTIEMETICS			
AKYNZEO - netupitant-palonosetron cap 300-0.5 mg	3		QL (2 capsules/30 days)
ANZEMET - dolasetron mesylate tab 50 mg	3		QL (7 tablets/30 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
aprepitant capsule therapy pack 80 & 125 mg (Emend tripack)	1		QL (2 packs/30 days)
aprepitant capsule 40 mg	1		
aprepitant capsule 80 mg (Emend)	1		QL (4 capsules/30 days)
aprepitant capsule 125 mg	1		QL (2 capsules/30 days)
BONJESTA - doxylamine-pyridoxine tab er 20-20 mg	3		PA, QL (60 tablets/30 days)
DICLEGIS - doxylamine-pyridoxine tab delayed release 10-10 mg	3		PA, QL (120 tablets/30 days)
doxylamine-pyridoxine tab delayed release 10-10 mg (Diclegis)	1		PA, QL (120 tablets/30 days)
dronabinol cap 2.5 mg (Marinol)	1		
dronabinol cap 5 mg, 10 mg	1		
EMEND - aprepitant capsule 80 mg	3		QL (4 capsules/30 days)
EMEND - aprepitant for oral susp 125 mg (125 mg/5ml)	2		QL (6 packages/30 days)
EMEND TRIPACK - aprepitant capsule therapy pack 80 & 125 mg	3		QL (2 packs/30 days)
granisetron hcl tab 1 mg	1		QL (14 tablets/30 days)
meclizine hcl tab 12.5 mg, 25 mg	1		
ONDANSETRON HCL - ondansetron hcl tab 24 mg	3		QL (1 tablet/30 days)
ondansetron hcl oral soln 4 mg/5ml	1		
ondansetron hcl tab 4 mg, 8 mg	1		
ondansetron orally disintegrating tab 4 mg, 8 mg	1		
SANCUSO - granisetron td patch 3.1 mg/24hr (contains 34.3 mg)	3		ST, QL (2 patches/30 days)
scopolamine td patch 72hr 1 mg/3days (Transderm-scop)	1		
TRANSDERM-SCOP - scopolamine td patch 72hr 1 mg/3days	3		
trimethobenzamide hcl cap 300 mg	1		
VARUBI - rolapitant hcl tab therapy pack 2 x 90 mg (base equiv)	2	SP	LD, QL (4 tablets/30 days)
DIGESTIVE AIDS			
CREON - pancrelipase (lip-prot-amyl) dr cap 3000-9500-15000 unit, 6000-19000-30000 unit, 12000-38000-60000 unit, 24000-76000-120000 unit, 36000-114000-180000 unit	2		
SUCRAID - sacrosidase soln 8500 unit/ml	3	SP	PA, LD, QL (236 mls/29 days)
ZENPEP - pancrelipase (lip-prot-amyl) dr cap 3000-10000-14000 unit, 5000-17000-24000 unit, 10000-32000-42000 unit, 15000-47000-63000 unit, 20000-63000-84000 unit, 25000-79000-105000 unit,	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
40000-126000-168000 unit, 60000-189600-252600 unit			
GASTROINTESTINAL AGENTS- MISC.			
alosetron hcl tab 0.5 mg (base equiv), 1 mg (base equiv) (Lotronex)	1		PA, QL (60 tablets/30 days)
AZULFIDINE - sulfasalazine tab 500 mg	3		
AZULFIDINE EN-TABS - sulfasalazine tab delayed release 500 mg	3		
balsalazide disodium cap 750 mg (Colazal)	1		
BYLVAY - odevixibat cap 400 mcg	3	SP	PA, LD, QL (450 capsules/30 days)
BYLVAY - odevixibat cap 1200 mcg	3	SP	PA, LD, QL (150 capsules/30 days)
BYLVAY (PELLETS) - odevixibat pellets cap sprinkle 200 mcg	3	SP	PA, LD, QL (900 capsules/30 days)
BYLVAY (PELLETS) - odevixibat pellets cap sprinkle 600 mcg	3	SP	PA, LD, QL (300 capsules/30 days)
calcium acetate (phosphate binder) cap 667 mg (169 mg ca)	1		
calcium acetate (phosphate binder) tab 667 mg	1		
CHENODAL - chenodiol tab 250 mg	2	SP	LD
CHOLBAM - cholic acid cap 50 mg, 250 mg	3	SP	PA, LD
CIMZIA - certolizumab pegol for inj kit 2 x 200 mg	3	SP	PA, QL (2 kits/28 days)
CIMZIA - certolizumab pegol prefilled syringe kit 200 mg/ml	3	SP	PA, QL (2 kits/28 days)
CIMZIA STARTER KIT - certolizumab pegol prefilled syringe kit 6 x 200 mg/ml	3	SP	PA, QL (1 kit/180 days)
cromolyn sodium oral conc 100 mg/5ml (Gastrocrom)	1		
DELZICOL - mesalamine cap dr 400 mg	3		
FOSRENOL - lanthanum carbonate chew tab 500 mg (elemental), 750 mg (elemental), 1000 mg (elemental)	3		ST
FOSRENOL - lanthanum carbonate oral powder pack 750 mg (elemental), 1000 mg (elemental)	3		ST
GATTEX - teduglutide (rdna) for inj kit 5 mg	3	SP	PA, LD, QL (30 vials/30 days)
lactulose (encephalopathy) solution 10 gm/15ml	1		
lanthanum carbonate chew tab 500 mg (elemental), 750 mg (elemental), 1000 mg (elemental) (Fosrenol)	1		ST
LIVMARLI - maralixibat chloride oral soln 9.5 mg/ml	3	SP	PA, LD, QL (90 mls/30 days)
lubiprostone cap 8 mcg (Amitiza)	1		PA, QL (120 capsules/30 days)
lubiprostone cap 24 mcg (Amitiza)	1		PA, QL (60 capsules/30 days)
mesalamine cap dr 400 mg (Delzicol)	1		
mesalamine cap er 24hr 0.375 gm (Apriso)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
MESALAMINE DR - mesalamine tab delayed release 800 mg	2		
mesalamine enema 4 gm	1		
mesalamine suppos 1000 mg (Canasa)	1		
mesalamine tab delayed release 1.2 gm (Lialda)	1		
metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)	1		
metoclopramide hcl tab 5 mg (base equivalent), 10 mg (base equivalent) (Reglan)	1		
MOVANTIK - naloxegol oxalate tab 12.5 mg (base equivalent), 25 mg (base equivalent)	2		PA, QL (30 tablets/30 days)
OCALIVA - obeticholic acid tab 5 mg, 10 mg	3	SP	PA, LD, QL (30 tablets/30 days)
REGLAN - metoclopramide hcl tab 5 mg (base equivalent), 10 mg (base equivalent)	3		
sevelamer carbonate packet 0.8 gm, 2.4 gm (Renvela)	1		
sevelamer carbonate tab 800 mg (Renvela)	1		
sevelamer hcl tab 400 mg	1		
sevelamer hcl tab 800 mg (Renagel)	1		
SFROWASA - mesalamine sulfite-free (sf) enema 4 gm/60ml	3		
SKYRIZI - risankizumab-rzaa subcutaneous soln cartridge 180 mg/1.2ml, 360 mg/2.4ml	2	SP	PA, QL (1 cartridge/56 days)
sulfasalazine tab delayed release 500 mg (Azulfidine en-tabs)	1		
sulfasalazine tab 500 mg (Azulfidine)	1		
SYMPROIC - naldemedine tosylate tab 0.2 mg (base equivalent)	2		PA, QL (30 tablets/30 days)
TRULANCE - plecanatide tab 3 mg	2		PA, QL (30 tablets/30 days)
ursodiol cap 300 mg	1		
ursodiol tab 250 mg (Urso 250)	1		
ursodiol tab 500 mg (Urso forte)	1		
VELPHORO - sucroferric oxyhydroxide chew tab 500 mg	2		ST
VIBERZI - eluxadoline tab 75 mg, 100 mg	2		PA, QL (60 tablets/30 days)
VOWST - fecal microbiota spores, live-brpk caps	3	SP	PA, LD
XERMELO - telotristat ethyl tab 250 mg (as telotristat etiprate)	3	SP	PA, LD
GENITOURINARY AGENTS			
URINARY ANTISPASMODICS			
bethanechol chloride tab 5 mg, 10 mg, 25 mg, 50 mg	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv), 15 mg (base equiv)	1		QL (30 tablets/30 days)
fesoterodine fumarate tab er 24hr 4 mg, 8 mg (Toviaz)	1		QL (30 tablets/30 days)
flavoxate hcl tab 100 mg	1		
MYRBETRIQ - mirabegron granules for oral extended release susp 8 mg/ml	2		QL (300 mls/28 days)
MYRBETRIQ - mirabegron tab er 24 hr 25 mg, 50 mg	2		QL (30 tablets/30 days)
oxybutynin chloride solution 5 mg/5ml	1		QL (600 mls/30 days)
oxybutynin chloride tab er 24hr 5 mg (Ditropan xl)	1		QL (30 tablets/30 days)
oxybutynin chloride tab er 24hr 10 mg (Ditropan xl)	1		QL (60 tablets/30 days)
oxybutynin chloride tab er 24hr 15 mg	1		QL (60 tablets/30 days)
oxybutynin chloride tab 5 mg	1		QL (120 tablets/30 days)
solifenacin succinate tab 5 mg, 10 mg (Vesicare)	1		QL (30 tablets/30 days)
tolterodine tartrate cap er 24hr 2 mg, 4 mg (Detrol la)	1		QL (30 capsules/30 days)
tolterodine tartrate tab 1 mg, 2 mg (Detrol)	1		QL (60 tablets/30 days)
trospium chloride cap er 24hr 60 mg	1		QL (30 capsules/30 days)
trospium chloride tab 20 mg	1		QL (60 tablets/30 days)
VESICARE - solifenacin succinate tab 5 mg, 10 mg	3		QL (30 tablets/30 days)
VAGINAL PRODUCTS			
CLEOCIN - clindamycin phosphate vaginal cream 2%	3		
CLEOCIN - clindamycin phosphate vaginal suppos 100 mg	2		
clindamycin phosphate vaginal cream 2% (Cleocin)	1		
CLINDESSE - clindamycin phosphate (one dose) vaginal cream 2%	3		
CRINONE - progesterone vaginal gel 4%	3		
ENCARE - nonoxynol-9 vaginal suppos 100 mg	3		
ESTRACE - estradiol vaginal cream 0.1 mg/gm	3		QL (255 grams/365 days)
estradiol vaginal cream 0.1 mg/gm (Estrace)	1		QL (255 grams/365 days)
estradiol vaginal tab 10 mcg (Vagifem)	1		
ESTRING - estradiol vaginal ring 2 mg (7.5 mcg/24hrs)	2		QL (1 ring/90 days)
GYNAZOLE-1 - butoconazole nitrate (one dose) vaginal cream 2%	3		
IMVEXXY MAINTENANCE PACK - estradiol vaginal insert 4 mcg, 10 mcg	3		QL (8 suppositories/28 days)
IMVEXXY STARTER PACK - estradiol vaginal insert starter pack 4 mcg, 10 mcg	3		QL (18 suppositories/180 days)
INTRAROSA - prasterone vaginal insert 6.5 mg	3		
metronidazole vaginal gel 0.75%	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
MICONAZOLE 3 - miconazole nitrate vaginal suppos 200 mg	3		
OPTIONS GYNOL II VAGINAL - nonoxynol-9 gel 3%	3		
PHEXXI - lactic acid-citric acid-potassium bitartrate gel 1.8-1-0.4%	2		
PREMARIN - estrogens, conjugated vaginal cream 0.625 mg/gm	2		
terconazole vaginal cream 0.4%, 0.8%	1		
terconazole vaginal suppos 80 mg	1		
TODAY SPONGE - nonoxynol-9 vaginal sponge 1000 mg	3		
VANDAZOLE - metronidazole vaginal gel 0.75%	3		
VCF VAGINAL CONTRACEPTIVE - nonoxynol-9 foam 12.5%	3		
VCF VAGINAL CONTRACEPTIVE - nonoxynol-9 film 28%	3		
VCF VAGINAL CONTRACEPTIVE - nonoxynol-9 gel 4%	3		
GENITOURINARY AGENTS - MISC.			
acetic acid irrigation soln 0.25%	1		
alfuzosin hcl tab er 24hr 10 mg (Uroxatral)	1		
CYSTAGON - cysteamine bitartrate cap 50 mg, 150 mg	2		LD
dutasteride cap 0.5 mg (Avodart)	1		
dutasteride-tamsulosin hcl cap 0.5-0.4 mg (Jalyn)	1		
ELMIRON - pentosan polysulfate sodium caps 100 mg	3		PA
FILSPARI - sparsentan tab 200 mg, 400 mg	3	SP	PA, LD, QL (30 tablets/30 days)
finasteride tab 5 mg (Proscar)	1		
K-PHOS NO 2 - potassium & sodium acid phosphates tab 305-700 mg	2		
LITHOSTAT - acetohydroxamic acid tab 250 mg	3		
potassium citrate tab er 5 meq (540 mg) (Urocit-k 5)	1		
potassium citrate tab er 10 meq (1080 mg) (Urocit-k 10)	1		
potassium citrate tab er 15 meq (1620 mg) (Urocit-k 15)	1		
PROCYSBI - cysteamine bitartrate delayed release granules packet 75 mg, 300 mg	3	SP	PA, LD
PROCYSBI - cysteamine bitartrate cap delayed release 25 mg (base equiv), 75 mg (base equiv)	3	SP	PA, LD
PROSCAR - finasteride tab 5 mg	3		
RAPAFLO - silodosin cap 4 mg, 8 mg	3		
silodosin cap 4 mg, 8 mg (Rapaflo)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
sodium chloride irrigation soln 0.9%	1		
sodium citrate & citric acid soln 500-334 mg/5ml	1		
tamsulosin hcl cap 0.4 mg (Flomax)	1		
THIOLA - tiopronin tab 100 mg	3	SP	PA, LD, QL (600 tablets/30 days)
THIOLA EC - tiopronin tab delayed release 100 mg	3	SP	PA, LD, QL (600 tablets/30 days)
THIOLA EC - tiopronin tab delayed release 300 mg	3	SP	PA, LD, QL (180 tablets/30 days)
tiopronin tab delayed release 100 mg (Thiola ec)	1	SP	PA, LD, QL (600 tablets/30 days)
tiopronin tab delayed release 300 mg (Thiola ec)	1	SP	PA, LD, QL (180 tablets/30 days)
tiopronin tab 100 mg (Thiola)	1	SP	PA, LD, QL (600 tablets/30 days)
UROCIT-K 10 - potassium citrate tab er 10 meq (1080 mg)	3		
UROCIT-K 15 - potassium citrate tab er 15 meq (1620 mg)	3		
UROCIT-K 5 - potassium citrate tab er 5 meq (540 mg)	3		
CENTRAL NERVOUS SYSTEM DRUGS			
ANTIANXIETY AGENTS			
ALPRAZOLAM INTENSOL - alprazolam conc 1 mg/ml	3		
alprazolam orally disintegrating tab 0.25 mg, 0.5 mg, 1 mg, 2 mg	1		
alprazolam tab er 24hr 0.5 mg, 1 mg, 2 mg, 3 mg (Xanax xr)	1		
alprazolam tab 0.25 mg, 0.5 mg, 1 mg, 2 mg (Xanax)	1		
buspirone hcl tab 5 mg, 7.5 mg, 10 mg, 15 mg, 30 mg	1		
chlordiazepoxide hcl cap 5 mg, 10 mg, 25 mg	1		
clorazepate dipotassium tab 3.75 mg, 15 mg	1		
clorazepate dipotassium tab 7.5 mg (Tranxene t)	1		
diazepam conc 5 mg/ml	1		
diazepam oral soln 1 mg/ml	1		
diazepam tab 2 mg, 5 mg, 10 mg (Valium)	1		
hydroxyzine hcl syrup 10 mg/5ml	1		
hydroxyzine hcl tab 10 mg, 25 mg, 50 mg	1		
HYDROXYZINE PAMOATE - hydroxyzine pamoate cap 100 mg	3		
hydroxyzine pamoate cap 25 mg, 50 mg (Vistaril)	1		
lorazepam conc 2 mg/ml	1		
lorazepam tab 0.5 mg, 1 mg, 2 mg (Ativan)	1		
meprobamate tab 200 mg	1		QL (120 tablets/30 days)
meprobamate tab 400 mg	1		QL (180 tablets/30 days)
oxazepam cap 10 mg, 15 mg, 30 mg	1		
VISTARIL - hydroxyzine pamoate cap 25 mg	3		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
ANTIDEPRESSANTS			
amitriptyline hcl tab 10 mg, 25 mg, 50 mg, 75 mg, 100 mg, 150 mg	1		
amoxapine tab 25 mg, 50 mg, 100 mg, 150 mg	1		
bupropion hcl tab er 12hr 100 mg, 150 mg, 200 mg (Wellbutrin sr)	1		
bupropion hcl tab er 24hr 150 mg, 300 mg (Wellbutrin xl)	1		
bupropion hcl tab 75 mg, 100 mg	1		
citalopram hydrobromide oral soln 10 mg/5ml	1		
citalopram hydrobromide tab 10 mg (base equiv), 20 mg (base equiv), 40 mg (base equiv) (Celexa)	1		
clomipramine hcl cap 25 mg, 50 mg, 75 mg (Anafranil)	1		
desipramine hcl tab 10 mg, 25 mg (Norpramin)	1		
desipramine hcl tab 50 mg, 75 mg, 100 mg, 150 mg	1		
DESVENLAFAXINE ER - desvenlafaxine tab er 24hr 50 mg, 100 mg	3		ST, QL (30 tablets/30 days)
desvenlafaxine succinate tab er 24hr 25 mg (base equiv), 50 mg (base equiv), 100 mg (base equiv) (Pristiq)	1		QL (30 tablets/30 days)
doxepin hcl cap 10 mg, 25 mg, 50 mg, 75 mg, 100 mg, 150 mg	1		
doxepin hcl conc 10 mg/ml	1		
duloxetine hcl enteric coated pellets cap 20 mg (base eq), 30 mg (base eq), 60 mg (base eq) (Cymbalta)	1		
EMSAM - selegiline td patch 24hr 6 mg/24hr, 9 mg/24hr, 12 mg/24hr	3		
escitalopram oxalate soln 5 mg/5ml (base equiv)	1		
escitalopram oxalate tab 5 mg (base equiv), 10 mg (base equiv), 20 mg (base equiv) (Lexapro)	1		
FETZIMA - levomilnacipran hcl cap er 24hr 20 mg (base equivalent), 40 mg (base equivalent), 80 mg (base equivalent), 120 mg (base equivalent)	3		ST, QL (30 capsules/30 days)
FETZIMA TITRATION PACK - levomilnacipran hcl cap er 24hr 20 & 40 mg therapy pack	3		ST, QL (1 pack/180 days)
FLUOXETINE DR - fluoxetine hcl cap delayed release 90 mg	3		ST
fluoxetine hcl cap 10 mg, 20 mg, 40 mg (Prozac)	1		
fluoxetine hcl solution 20 mg/5ml	1		
fluoxetine hcl tab 60 mg (Fluoxetine hydrochlo)	1		

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fluvoxamine maleate tab 25 mg, 50 mg	1		QL (30 tablets/30 days)
fluvoxamine maleate tab 100 mg	1		QL (90 tablets/30 days)
imipramine hcl tab 10 mg, 25 mg, 50 mg	1		
MARPLAN - isocarboxazid tab 10 mg	3		
mirtazapine orally disintegrating tab 15 mg, 30 mg, 45 mg (Remeron soltab)	1		QL (30 tablets/30 days)
mirtazapine tab 7.5 mg, 45 mg	1		QL (30 tablets/30 days)
mirtazapine tab 15 mg, 30 mg (Remeron)	1		QL (30 tablets/30 days)
NARDIL - phenelzine sulfate tab 15 mg	3		
NEFAZODONE HYDROCHLORIDE - nefazodone hcl tab 50 mg, 100 mg, 150 mg, 200 mg, 250 mg	3		
NORPRAMIN - desipramine hcl tab 10 mg, 25 mg	3		
nortriptyline hcl cap 10 mg, 25 mg, 50 mg, 75 mg (Pamelor)	1		
nortriptyline hcl soln 10 mg/5ml	1		
PAMELOR - nortriptyline hcl cap 10 mg, 25 mg, 50 mg, 75 mg	3		
PARNATE - tranylcypromine sulfate tab 10 mg	3		
paroxetine hcl oral susp 10 mg/5ml (base equiv) (Paxil)	1		
paroxetine hcl tab 10 mg, 20 mg, 30 mg, 40 mg (Paxil)	1		
PHENELZINE SULFATE - phenelzine sulfate tab 15 mg	2		
protriptyline hcl tab 5 mg, 10 mg	1		
sertraline hcl oral concentrate for solution 20 mg/ml (Zoloft)	1		
sertraline hcl tab 25 mg, 50 mg, 100 mg (Zoloft)	1		
SPRAVATO 56MG DOSE - esketamine hcl nasal soln 28 mg/device x 2 (56 mg dose pack)	3	SP	PA, QL (4 packs/28 days)
SPRAVATO 84MG DOSE - esketamine hcl nasal soln 28 mg/device x 3 (84 mg dose pack)	3	SP	PA, QL (4 packs/28 days)
tranylcypromine sulfate tab 10 mg (Parnate)	1		
trazodone hcl tab 50 mg, 100 mg, 150 mg	1		
trimipramine maleate cap 25 mg, 50 mg, 100 mg	1		
TRINTELLIX - vortioxetine hbr tab 5 mg (base equiv), 10 mg (base equiv), 20 mg (base equiv)	3		ST, QL (30 tablets/30 days)
venlafaxine hcl cap er 24hr 37.5 mg (base equivalent), 75 mg (base equivalent), 150 mg (base equivalent) (Effexor xr)	1		
venlafaxine hcl tab 25 mg (base equivalent), 37.5 mg (base equivalent), 50 mg (base equivalent), 75 mg (base equivalent), 100 mg (base equivalent)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
vilazodone hcl tab 10 mg, 20 mg, 40 mg (Viibryd)	1		QL (30 tablets/30 days)
ZOLOFT - sertraline hcl oral concentrate for solution 20 mg/ml	3		ST
ZURZUVAE - zuranolone cap 20 mg, 25 mg	3	SP	PA, QL (28 capsules/30 days)
ZURZUVAE - zuranolone cap 30 mg	3	SP	PA, QL (14 capsules/30 days)
ANTIPSYCHOTICS			
ABILIFY ASIMTUFII - aripiprazole im er susp prefilled syringe 720 mg/2.4ml, 960 mg/3.2ml	3	SP	
ABILIFY MAINTENA - aripiprazole im for extended release susp 300 mg, 400 mg	3	SP	
ABILIFY MAINTENA - aripiprazole im for er susp prefilled syringe 300 mg, 400 mg	3	SP	
aripiprazole oral solution 1 mg/ml	1		QL (750 mls/30 days)
aripiprazole orally disintegrating tab 10 mg, 15 mg	1		QL (60 tablets/30 days)
aripiprazole tab 2 mg, 5 mg, 10 mg, 15 mg, 20 mg, 30 mg (Abilify)	1		QL (30 tablets/30 days)
ARISTADA - aripiprazole lauroxil im er susp prefilled syr 441 mg/1.6ml, 662 mg/2.4ml, 882 mg/3.2ml, 1064 mg/3.9ml	3	SP	
ARISTADA INITIO - aripiprazole lauroxil im er susp prefilled syr 675 mg/2.4ml	3	SP	
asenapine maleate sl tab 2.5 mg (base equiv), 5 mg (base equiv), 10 mg (base equiv) (Saphris)	1		QL (60 tablets/30 days)
CAPLYTA - lumateperone tosylate cap 10.5 mg, 21 mg, 42 mg	3		ST, QL (30 capsules/30 days)
chlorpromazine hcl tab 10 mg, 25 mg, 50 mg, 100 mg, 200 mg	1		
CHLORPROMAZINE HYDROCHLOR - chlorpromazine hcl conc 30 mg/ml, 100 mg/ml	3		
CLOZAPINE ODT - clozapine orally disintegrating tab 12.5 mg	3		
clozapine orally disintegrating tab 25 mg, 100 mg, 150 mg, 200 mg	1		
clozapine tab 25 mg, 50 mg, 100 mg, 200 mg (Clozaril)	1		
EQUETRO - carbamazepine (mood) cap er 12hr 100 mg, 200 mg, 300 mg	3		
FANAPT - iloperidone tab 1 mg, 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, 12 mg	3		ST, QL (60 tablets/30 days)
FANAPT TITRATION PACK - iloperidone tab 1 mg & 2 mg & 4 mg & 6 mg titration pak	3		ST, QL (1 pack/180 days)
fluphenazine decanoate inj 25 mg/ml	1	SP	

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FLUPHENAZINE HCL - fluphenazine hcl oral conc 5 mg/ml	2		
FLUPHENAZINE HCL - fluphenazine hcl inj 2.5 mg/ml	3	SP	
fluphenazine hcl tab 1 mg, 2.5 mg, 5 mg, 10 mg	1		
FLUPHENAZINE HYDROCHLORID - fluphenazine hcl elixir 2.5 mg/5ml	2		
GEODON - ziprasidone mesylate for inj 20 mg (base equivalent)	3	SP	
HALDOL DECANOATE 100 - haloperidol decanoate im soln 100 mg/ml	3	SP	
HALDOL DECANOATE 50 - haloperidol decanoate im soln 50 mg/ml	3	SP	
haloperidol decanoate im soln 50 mg/ml (Haldol decanoate 50)	1	SP	
haloperidol decanoate im soln 100 mg/ml (Haldol decanoate 100)	1	SP	
haloperidol lactate oral conc 2 mg/ml	1		
haloperidol tab 0.5 mg, 1 mg, 2 mg, 5 mg, 10 mg, 20 mg	1		
INVEGA - paliperidone tab er 24hr 3 mg, 9 mg	3		ST, QL (30 tablets/30 days)
INVEGA - paliperidone tab er 24hr 6 mg	3		ST, QL (60 tablets/30 days)
INVEGA HAFYERA - paliperidone palmitate er susp pref syr 1,092 mg/3.5ml, 1,560 mg/5ml	3	SP	
INVEGA SUSTENNA - paliperidone palmitate er susp pref syr 39 mg/0.25ml, 78 mg/0.5ml, 117 mg/0.75ml, 156 mg/ml, 234 mg/1.5ml	3	SP	
INVEGA TRINZA - paliperidone palmitate er susp pref syr 273 mg/0.88ml, 410 mg/1.32ml, 546 mg/1.75ml, 819 mg/2.63ml	3	SP	
LITHIUM CARBONATE - lithium carbonate cap 150 mg, 300 mg, 600 mg	3		
lithium carbonate cap 150 mg, 300 mg, 600 mg (Lithium carbonate)	1		
lithium carbonate tab er 300 mg (Lithobid)	1		
lithium carbonate tab er 450 mg	1		
lithium carbonate tab 300 mg	1		
lithium oral solution 8 meq/5ml	1		
LITHOBID - lithium carbonate tab er 300 mg	3		
loxapine succinate cap 5 mg, 10 mg, 25 mg, 50 mg	1		
lurasidone hcl tab 20 mg, 40 mg, 60 mg, 120 mg (Latuda)	1		QL (30 tablets/30 days)
lurasidone hcl tab 80 mg (Latuda)	1		QL (60 tablets/30 days)

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MOLINDONE HYDROCHLORIDE - molindone hcl tab 5 mg, 10 mg, 25 mg	3		
NUPLAZID - pimavanserin tartrate cap 34 mg (base equivalent)	3	SP	PA, LD, QL (30 capsules/30 days)
NUPLAZID - pimavanserin tartrate tab 10 mg (base equivalent)	3	SP	PA, LD, QL (30 tablets/30 days)
olanzapine for im inj 10 mg (Zyprexa)	1	SP	
olanzapine orally disintegrating tab 5 mg, 10 mg, 15 mg, 20 mg (Zyprexa zydis)	1		QL (30 tablets/30 days)
olanzapine tab 2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg (Zyprexa)	1		QL (30 tablets/30 days)
paliperidone tab er 24hr 1.5 mg, 3 mg, 9 mg (Invega)	1		QL (30 tablets/30 days)
paliperidone tab er 24hr 6 mg (Invega)	1		QL (60 tablets/30 days)
perphenazine tab 2 mg, 4 mg, 8 mg, 16 mg	1		
PERSERIS - risperidone subcutaneous for er susp prefilled syr 90 mg, 120 mg	3	SP	
prochlorperazine maleate tab 5 mg (base equivalent), 10 mg (base equivalent)	1		
prochlorperazine suppos 25 mg	1		
QUETIAPINE FUMARATE - quetiapine fumarate tab 150 mg	3		ST, QL (30 tablets/30 days)
quetiapine fumarate tab er 24hr 50 mg, 300 mg, 400 mg (Seroquel xr)	1		QL (60 tablets/30 days)
quetiapine fumarate tab er 24hr 150 mg, 200 mg (Seroquel xr)	1		QL (30 tablets/30 days)
quetiapine fumarate tab 25 mg, 50 mg, 100 mg, 200 mg (Seroquel)	1		QL (90 tablets/30 days)
quetiapine fumarate tab 300 mg, 400 mg (Seroquel)	1		QL (60 tablets/30 days)
REXULTI - brexpiprazole tab 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	2		QL (30 tablets/30 days)
RISPERDAL CONSTA - risperidone microspheres for im extended rel susp 12.5 mg, 25 mg, 37.5 mg, 50 mg	3	SP	
risperidone microspheres for im extended rel susp 12.5 mg, 25 mg, 37.5 mg, 50 mg (Risperdal consta)	1	SP	
RISPERIDONE ODT - risperidone orally disintegrating tab 0.25 mg	3		ST, QL (60 tablets/30 days)
risperidone orally disintegrating tab 0.5 mg, 1 mg, 2 mg, 3 mg	1		QL (60 tablets/30 days)
risperidone orally disintegrating tab 4 mg	1		QL (120 tablets/30 days)
risperidone soln 1 mg/ml (Risperdal)	1		QL (480 mls/30 days)
risperidone tab 0.25 mg	1		QL (60 tablets/30 days)
risperidone tab 0.5 mg, 1 mg, 2 mg, 3 mg (Risperdal)	1		QL (60 tablets/30 days)

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risperidone tab 4 mg (Risperdal)	1		QL (120 tablets/30 days)
RYKINDO - risperidone for im extended release suspension 25 mg, 37.5 mg, 50 mg	3	SP	
SAPHRIS - asenapine maleate sl tab 2.5 mg (base equiv), 5 mg (base equiv), 10 mg (base equiv)	3		ST, QL (60 tablets/30 days)
SECUADO - asenapine td patch 24 hr 3.8 mg/24hr, 5.7 mg/24hr, 7.6 mg/24hr	3		ST, QL (30 patches/30 days)
thioridazine hcl tab 10 mg, 25 mg, 50 mg, 100 mg	1		
thiothixene cap 1 mg, 2 mg, 5 mg, 10 mg	1		
trifluoperazine hcl tab 1 mg (base equivalent), 2 mg (base equivalent), 5 mg (base equivalent), 10 mg (base equivalent)	1		
UZEDY - risperidone subcutaneous er susp pref syr 50 mg/0.14ml, 75 mg/0.21ml, 100 mg/0.28ml, 125 mg/0.35ml, 150 mg/0.42ml, 200 mg/0.56ml, 250 mg/0.7ml	3	SP	
VERSACLOZ - clozapine susp 50 mg/ml	3		ST, QL (540 mls/30 days)
VRAYLAR - cariprazine hcl cap 1.5 mg (base equivalent), 3 mg (base equivalent), 4.5 mg (base equivalent), 6 mg (base equivalent)	3		QL (30 capsules/30 days)
ziprasidone hcl cap 20 mg, 40 mg, 60 mg, 80 mg (Geodon)	1		QL (60 capsules/30 days)
ziprasidone mesylate for inj 20 mg (base equivalent) (Geodon)	1	SP	
ZYPREXA - olanzapine for im inj 10 mg	3	SP	
ZYPREXA RELPREVV - olanzapine pamoate for extended rel im susp 210 mg (base eq), 300 mg (base eq), 405 mg (base eq)	3	SP	
HYPNOTICS			
BELSOMRA - suvorexant tab 5 mg, 10 mg, 15 mg, 20 mg	3		ST, QL (30 tablets/30 days)
doxepin hcl (sleep) tab 3 mg (base equiv), 6 mg (base equiv) (Silenor)	1		QL (30 tablets/30 days)
estazolam tab 1 mg, 2 mg	1		
eszopiclone tab 1 mg, 2 mg, 3 mg (Lunesta)	1		QL (30 tablets/30 days)
FLURAZEPAM HYDROCHLORIDE - flurazepam hcl cap 15 mg, 30 mg	3		
HETLIOZ LQ - tasimelteon oral susp 4 mg/ml	3	SP	PA, LD, QL (158 mls/30 days)
phenobarbital elixir 20 mg/5ml	1		
phenobarbital tab 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg, 100 mg	1		
QUVIVIQ - daridorexant hcl tab 25 mg, 50 mg	2		ST, QL (30 tablets/30 days)
ramelteon tab 8 mg (Rozerem)	1		QL (30 tablets/30 days)

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ROZEREM - ramelteon tab 8 mg	3		ST, QL (30 tablets/30 days)
SILENOR - doxepin hcl (sleep) tab 3 mg (base equiv), 6 mg (base equiv)	3		ST, QL (30 tablets/30 days)
tasimelteon capsule 20 mg (Hetlioz)	1	SP	PA, QL (30 capsules/30 days)
temazepam cap 7.5 mg, 15 mg, 22.5 mg, 30 mg (Restoril)	1		
zaleplon cap 5 mg, 10 mg	1		QL (30 capsules/30 days)
zolpidem tartrate tab er 6.25 mg, 12.5 mg (Ambien cr)	1		QL (30 tablets/30 days)
zolpidem tartrate tab 5 mg, 10 mg (Ambien)	1		QL (30 tablets/30 days)
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS			
ADDERALL - amphetamine-dextroamphetamine tab 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg, 30 mg	3		QL (60 tablets/30 days)
ADDERALL - amphetamine-dextroamphetamine tab 20 mg	3		QL (90 tablets/30 days)
ADDERALL XR - amphetamine-dextroamphetamine cap er 24hr 5 mg, 10 mg, 15 mg	3		QL (30 capsules/30 days)
ADDERALL XR - amphetamine-dextroamphetamine cap er 24hr 20 mg, 25 mg, 30 mg	3		QL (60 capsules/30 days)
amphetamine-dextroamphetamine cap er 24hr 5 mg, 10 mg, 15 mg (Adderall xr)	1		QL (30 capsules/30 days)
amphetamine-dextroamphetamine cap er 24hr 20 mg, 25 mg, 30 mg (Adderall xr)	1		QL (60 capsules/30 days)
amphetamine-dextroamphetamine tab 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg, 30 mg (Adderall)	1		QL (60 tablets/30 days)
amphetamine-dextroamphetamine tab 20 mg (Adderall)	1		QL (90 tablets/30 days)
armodafinil tab 50 mg, 150 mg, 200 mg, 250 mg (Nuvigil)	1		QL (30 tablets/30 days)
atomoxetine hcl cap 10 mg (base equiv), 18 mg (base equiv), 25 mg (base equiv), 40 mg (base equiv) (Strattera)	1		QL (60 capsules/30 days)
atomoxetine hcl cap 60 mg (base equiv), 80 mg (base equiv), 100 mg (base equiv) (Strattera)	1		QL (30 capsules/30 days)
AZSTARYS - serdexmethylphenidate-dexmethylphenidate cap 26.1-5.2 mg, 39.2-7.8 mg, 52.3-10.4 mg	2		QL (30 capsules/30 days)
caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)	1		
clonidine hcl tab er 12hr 0.1 mg (Kapvay)	1		QL (120 tablets/30 days)
CONCERTA - methylphenidate hcl tab er osmotic release (osm) 18 mg, 27 mg, 54 mg	3		QL (30 tablets/30 days)
CONCERTA - methylphenidate hcl tab er osmotic release (osm) 36 mg	3		QL (60 tablets/30 days)

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DESOXYN - methamphetamine hcl tab 5 mg	3		QL (150 tablets/30 days)
dexmethylphenidate hcl cap er 24 hr 5 mg, 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg (Focalin xr)	1		QL (30 capsules/30 days)
dexmethylphenidate hcl tab 2.5 mg, 5 mg, 10 mg (Focalin)	1		QL (60 tablets/30 days)
dextroamphetamine sulfate cap er 24hr 5 mg	1		QL (90 capsules/30 days)
dextroamphetamine sulfate cap er 24hr 10 mg, 15 mg (Dexedrine)	1		QL (120 capsules/30 days)
dextroamphetamine sulfate oral solution 5 mg/5ml	1		QL (1800 mls/30 days)
dextroamphetamine sulfate tab 5 mg	1		QL (90 tablets/30 days)
dextroamphetamine sulfate tab 10 mg	1		QL (180 tablets/30 days)
FOCALIN - dexmethylphenidate hcl tab 2.5 mg, 5 mg, 10 mg	3		QL (60 tablets/30 days)
guanfacine hcl tab er 24hr 1 mg (base equiv), 2 mg (base equiv), 3 mg (base equiv), 4 mg (base equiv) (Intuniv)	1		QL (30 tablets/30 days)
IMCIVREE - setmelanotide acetate subcutaneous soln 10 mg/ml	3	SP	PA, LD, QL (10 vials/30 days)
lisdexamfetamine dimesylate cap 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg (Vyvanse)	1		QL (30 capsules/30 days)
lisdexamfetamine dimesylate chew tab 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg (Vyvanse)	1		QL (30 tablets/30 days)
METADATE CD - methylphenidate hcl cap er 10 mg (cd), 20 mg (cd), 30 mg (cd), 40 mg (cd), 50 mg (cd), 60 mg (cd)	3		QL (30 capsules/30 days)
methamphetamine hcl tab 5 mg (Desoxyn)	1		QL (150 tablets/30 days)
METHYLIN - methylphenidate hcl soln 5 mg/5ml	3		QL (450 mls/30 days)
METHYLIN - methylphenidate hcl soln 10 mg/5ml	3		QL (900 mls/30 days)
methylphenidate hcl cap er 10 mg (cd), 20 mg (cd), 30 mg (cd), 40 mg (cd), 50 mg (cd), 60 mg (cd)	1		QL (30 capsules/30 days)
methylphenidate hcl cap er 24hr 10 mg (la), 20 mg (la), 30 mg (la), 40 mg (la) (Ritalin la)	1		QL (30 capsules/30 days)
methylphenidate hcl chew tab 2.5 mg, 5 mg	1		QL (90 tablets/30 days)
methylphenidate hcl chew tab 10 mg	1		QL (180 tablets/30 days)
methylphenidate hcl soln 5 mg/5ml (Methylin)	1		QL (450 mls/30 days)
methylphenidate hcl soln 10 mg/5ml (Methylin)	1		QL (900 mls/30 days)
methylphenidate hcl tab er osmotic release (osm) 18 mg, 27 mg, 54 mg (Concerta)	1		QL (30 tablets/30 days)
methylphenidate hcl tab er osmotic release (osm) 36 mg (Concerta)	1		QL (60 tablets/30 days)
methylphenidate hcl tab er 10 mg, 20 mg	1		QL (90 tablets/30 days)

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methylphenidate hcl tab 5 mg, 10 mg, 20 mg (Ritalin)	1		QL (90 tablets/30 days)
METHYLPHENIDATE HYDROCHLO - methylphenidate hcl tab er 24hr 18 mg	3		QL (30 tablets/30 days)
METHYLPHENIDATE HYDROCHLO - methylphenidate hcl tab er 24hr 27 mg, 54 mg	2		QL (30 tablets/30 days)
METHYLPHENIDATE HYDROCHLO - methylphenidate hcl tab er 24hr 36 mg	2		QL (60 tablets/30 days)
modafinil tab 100 mg, 200 mg (Provigil)	1		QL (30 tablets/30 days)
QUILLICHEW ER - methylphenidate hcl chew tab extended release 20 mg, 40 mg	3		QL (30 tablets/30 days)
QUILLICHEW ER - methylphenidate hcl chew tab extended release 30 mg	3		QL (60 tablets/30 days)
QUILLIVANT XR - methylphenidate hcl for er susp 25 mg/5ml (5 mg/ml)	3		QL (360 mls/30 days)
RITALIN - methylphenidate hcl tab 5 mg, 10 mg, 20 mg	3		QL (90 tablets/30 days)
SUNOSI - solriamfetol hcl tab 75 mg (base equiv), 150 mg (base equiv)	2		PA, QL (30 tablets/30 days)
VYVANSE - lisdexamfetamine dimesylate cap 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg	3		QL (30 capsules/30 days)
VYVANSE - lisdexamfetamine dimesylate chew tab 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	3		QL (30 tablets/30 days)
WAKIX - pitolisant hcl tab 4.45 mg (base equivalent), 17.8 mg (base equivalent)	3	SP	PA, LD, QL (60 tablets/30 days)
PSYCHOTHERAPEUTIC and NEUROLOGICAL AGENTS - MISC.			
acamprosate calcium tab delayed release 333 mg	1		
AUBAGIO - teriflunomide tab 7 mg, 14 mg	3	SP	PA, LD, QL (30 tablets/30 days)
AUSTEDO - deutetrabenazine tab 6 mg	3	SP	PA, QL (60 tablets/30 days)
AUSTEDO - deutetrabenazine tab 9 mg, 12 mg	3	SP	PA, QL (120 tablets/30 days)
AUSTEDO XR - deutetrabenazine tab er 24hr 6 mg, 12 mg	3	SP	PA, QL (30 tablets/30 days)
AUSTEDO XR - deutetrabenazine tab er 24hr 24 mg	3	SP	PA, QL (60 tablets/30 days)
AUSTEDO XR PATIENT TITRAT - deutetrabenazine tab er titration pack 6 mg & 12 mg & 24 mg	3	SP	PA, QL (1 kit/180 days)
AVONEX - interferon beta-1a im prefilled syringe kit 30 mcg/0.5ml	2	SP	PA, QL (1 kit/28 days)
AVONEX PEN - interferon beta-1a im auto-injector kit 30 mcg/0.5ml	2	SP	PA, QL (1 kit/28 days)
BETASERON - interferon beta-1b for inj kit 0.3 mg	2	SP	PA, QL (1 kit/28 days)
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	1		
CHLORDIAZEPOXIDE/AMITRIPT - chlordiazepoxide-amitriptyline tab 5-12.5 mg, 10-25 mg	3		

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dalfampridine tab er 12hr 10 mg (Ampyra)	1		PA, QL (60 tablets/30 days)
dimethyl fumarate capsule delayed release 120 mg (Tecfidera)	1	SP	QL (14 capsules/180 days)
dimethyl fumarate capsule delayed release 240 mg (Tecfidera)	1	SP	QL (60 capsules/30 days)
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg (Tecfidera starter pa)	1	SP	QL (1 pack/180 days)
DISULFIRAM - disulfiram tab 500 mg	3		
disulfiram tab 250 mg	1		
donepezil hydrochloride orally disintegrating tab 5 mg, 10 mg	1		
donepezil hydrochloride tab 5 mg, 10 mg, 23 mg (Aricept)	1		
ERGOLOID MESYLATES - ergoloid mesylates tab 1 mg	3		
EXELON - rivastigmine td patch 24hr 4.6 mg/24hr, 9.5 mg/24hr, 13.3 mg/24hr	3		
fingolimod hcl cap 0.5 mg (base equiv) (Gilenya)	1	SP	QL (30 capsules/30 days)
GALANTAMINE HYDROBROMIDE - galantamine hydrobromide oral soln 4 mg/ml	3		
galantamine hydrobromide cap er 24hr 8 mg, 16 mg, 24 mg (Razadyne er)	1		
galantamine hydrobromide tab 4 mg, 8 mg, 12 mg	1		
glatiramer acetate soln prefilled syringe 20 mg/ml (Copaxone)	1	SP	QL (30 syringes/30 days)
glatiramer acetate soln prefilled syringe 40 mg/ml (Copaxone)	1	SP	QL (12 syringes/28 days)
INGREZZA - valbenazine tosylate cap therapy pack 40 mg (7) & 80 mg (21)	3	SP	PA, LD, QL (28 capsules/180 days)
INGREZZA - valbenazine tosylate cap 40 mg (base equiv), 60 mg (base equiv), 80 mg (base equiv)	3	SP	PA, LD, QL (30 capsules/30 days)
INGREZZA - valbenazine tosylate capsule sprinkle 40 mg (base equiv), 60 mg (base equiv), 80 mg (base equiv)	3	SP	PA, LD, QL (30 capsules/30 days)
KESIMPTA - ofatumumab soln auto-injector 20 mg/0.4ml	2	SP	PA, QL (1 pen/28 days)
LUCEMYRA - lofexidine hcl tab 0.18 mg (base equivalent)	2		PA, QL (228 tablets/180 days)
LUMRYZ - sodium oxybate pack for oral er susp 4.5 gm, 6 gm, 7.5 gm, 9 gm	3	SP	PA, LD, QL (30 packets/30 days)
LYBALVI - olanzapine-samidorphan l-malate tab 5-10 mg, 10-10 mg, 15-10 mg, 20-10 mg	3		ST, QL (30 tablets/30 days)
MAVENCLAD - cladribine tab therapy pack 10 mg (4 tabs), 10 mg (8 tabs)	2	SP	PA, LD, QL (8 tablets/301 days)

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MAVENCLAD - cladribine tab therapy pack 10 mg (5 tabs)	2	SP	PA, LD, QL (10 tablets/301 days)
MAVENCLAD - cladribine tab therapy pack 10 mg (6 tabs)	2	SP	PA, LD, QL (12 tablets/301 days)
MAVENCLAD - cladribine tab therapy pack 10 mg (7 tabs)	2	SP	PA, LD, QL (14 tablets/301 days)
MAVENCLAD - cladribine tab therapy pack 10 mg (9 tabs)	2	SP	PA, LD, QL (9 tablets/301 days)
MAVENCLAD - cladribine tab therapy pack 10 mg (10 tabs)	2	SP	PA, LD, QL (20 tablets/301 days)
MAYZENT - siponimod fumarate tab 0.25 mg (base equiv)	2	SP	PA, LD, QL (120 tablets/30 days)
MAYZENT - siponimod fumarate tab 1 mg (base equiv), 2 mg (base equiv)	2	SP	PA, LD, QL (30 tablets/30 days)
MAYZENT STARTER PACK - siponimod fumarate tab 0.25 mg (7) starter pack	2	SP	PA, LD, QL (7 tablets/180 days)
MAYZENT STARTER PACK - siponimod fumarate tab 0.25 mg (12) starter pack	2	SP	PA, LD, QL (12 tablets/180 days)
memantine hcl oral solution 2 mg/ml	1		
memantine hcl tab 5 mg, 10 mg (Namenda)	1		
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack (Namenda titration pa)	1		
nicotine polacrilex gum 2 mg, 4 mg	1		
nicotine polacrilex lozenge 2 mg, 4 mg	1		
nicotine td patch 24hr 7 mg/24hr, 14 mg/24hr, 21 mg/24hr	1		
NICOTROL INHALER - nicotine inhaler system 10 mg (4 mg delivered)	2		
NICOTROL NS - nicotine nasal spray 10 mg/ml (0.5 mg/ spray)	2		
NUEDEXTA - dextromethorphan hbr-quinidine sulfate cap 20-10 mg	3		PA, QL (60 capsules/30 days)
paroxetine mesylate cap 7.5 mg (base equiv)	1		
PERPHENAZINE/AMITRIPTYLIN - perphenazine-amitriptyline tab 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	3		
PIMOZIDE - pimozide tab 1 mg, 2 mg	3		
PLEGRIDY - peginterferon beta-1a soln pen-injector 125 mcg/0.5ml	2	SP	PA, LD, QL (2 pens/28 days)
PLEGRIDY - peginterferon beta-1a soln prefilled syringe 125 mcg/0.5ml	2	SP	PA, LD, QL (2 syringes/28 days)
PLEGRIDY - peginterferon beta-1a im soln prefilled syr 125 mcg/0.5ml	2	SP	PA, LD, QL (2 syringes/28 days)

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PLEGRIDY STARTER PACK - peginterferon beta-1a soln pen-inj 63 & 94 mcg/0.5ml pack	2	SP	PA, LD, QL (1 kit/180 days)
PLEGRIDY STARTER PACK - peginterferon beta-1a soln pref syr 63 & 94 mcg/0.5ml pack	2	SP	PA, LD, QL (1 kit/180 days)
PONVORY - ponesimod tab 20 mg	3	SP	PA, LD, QL (30 tablets/30 days)
PONVORY 14-DAY STARTER PA - ponesimod tab starter pack 2,3,4,5,6,7,8,9 &10 mg	3	SP	PA, QL (14 tablets/180 days)
REBIF - interferon beta-1a soln pref syr 22 mcg/0.5ml, 44 mcg/0.5ml	2	SP	PA, QL (12 syringes/28 days)
REBIF REBIDOSE - interferon beta-1a soln auto-inj 22 mcg/0.5ml, 44 mcg/0.5ml	2	SP	PA, QL (12 syringes/28 days)
REBIF REBIDOSE TITRATION - interferon beta-1a auto-inj 6x8.8 mcg/0.2ml & 6x22 mcg/0.5ml	2	SP	PA, QL (1 kit/28 days)
REBIF TITRATION PACK - interferon beta-1a pref syr 6x8.8 mcg/0.2ml & 6x22 mcg/0.5ml	2	SP	PA, QL (1 kit/28 days)
rivastigmine tartrate cap 1.5 mg (base equivalent), 3 mg (base equivalent), 4.5 mg (base equivalent), 6 mg (base equivalent)	1		
rivastigmine td patch 24hr 4.6 mg/24hr, 9.5 mg/24hr, 13.3 mg/24hr (Exelon)	1		
SAVELLA - milnacipran hcl tab 12.5 mg, 25 mg, 50 mg, 100 mg	3		ST, QL (60 tablets/30 days)
SAVELLA TITRATION PACK - milnacipran hcl tab 12.5 mg (5) & 25 mg (8) & 50 mg (42) pak	3		ST, QL (1 pack/180 days)
SODIUM OXYBATE - sodium oxybate oral solution 500 mg/ml	3	SP	PA, LD, QL (540 ml/30 days)
TASCENSO ODT - fingolimod lauryl sulfate tablet disintegrating 0.25 mg	2	SP	PA, LD, QL (30 tablets/30 days)
TEGSEDI - inotersen sod subcutaneous pref syr 284 mg/1.5ml (base eq)	3	SP	PA, LD, QL (4 syringes/28 days)
teriflunomide tab 7 mg, 14 mg (Aubagio)	1	SP	QL (30 tablets/30 days)
tetrabenazine tab 12.5 mg (Xenazine)	1	SP	PA, QL (240 tablets/30 days)
tetrabenazine tab 25 mg (Xenazine)	1	SP	PA, QL (120 tablets/30 days)
varenicline tartrate tab 0.5 mg (base equiv), 1 mg (base equiv)	1		
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	1		
XYWAV - calcium, mag, potassium, & sod oxybates oral soln 500 mg/ml	3	SP	PA, LD, QL (540 mls/30 days)
ZEPOSIA - ozanimod hcl cap 0.92 mg	2	SP	PA, QL (30 capsules/30 days)
ZEPOSIA STARTER KIT - ozanimod cap pack 4 x 0.23 mg & 3 x 0.46 mg & 21 x 0.92 mg	2	SP	PA, QL (28 capsules/180 days)

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ZEPOSIA 7-DAY STARTER PAC - ozanimod cap pack 4 x 0.23 mg & 3 x 0.46 mg	2	SP	PA, QL (7 capsules/180 days)
ANALGESICS AND ANESTHETICS			
ANALGESICS - NON-NARCOTIC			
aspirin chew tab 81 mg	1		
aspirin tab delayed release 81 mg	1		
butalbital-acetaminophen cap 50-300 mg (Butalbital/ acetamino)	1		QL (180 capsules/30 days)
butalbital-acetaminophen tab 50-325 mg	1		QL (180 tablets/30 days)
butalbital-acetaminophen-caffeine tab 50-325-40 mg (Esgic)	1		QL (180 tablets/30 days)
butalbital-aspirin-caffeine cap 50-325-40 mg	1		QL (180 capsules/30 days)
diflunisal tab 500 mg	1		
TENCON - butalbital-acetaminophen tab 50-325 mg	3		QL (180 tablets/30 days)
ANALGESICS - NARCOTIC			
acetaminophen w/ codeine tab 300-15 mg (Tylenol/ codeine)	1		PA, QL (360 tablets/30 days)
acetaminophen w/ codeine tab 300-30 mg	1		PA, QL (360 tablets/30 days)
acetaminophen w/ codeine tab 300-60 mg	1		PA, QL (180 tablets/30 days)
ACETAMINOPHEN/CODEINE - acetaminophen w/ codeine soln 120-12 mg/5ml	2		PA, QL (2700 mls/30 days)
APADAZ - benzhydrocodone hcl-acetaminophen tab 4.08-325 mg	3		PA, QL (360 tablets/30 days)
BELBUCA - buprenorphine hcl buccal film 75 mcg (base equivalent), 150 mcg (base equivalent), 300 mcg (base equivalent), 450 mcg (base equivalent), 600 mcg (base equivalent), 750 mcg (base equivalent), 900 mcg (base equivalent)	2		PA, QL (60 films/30 days)
BENZHYDROCODONE/ACETAMINO - benzhydrocodone hcl-acetaminophen tab 4.08-325 mg	3		PA, QL (360 tablets/30 days)
BRIXADI - buprenorphine extended release soln pref syr 64 mg/0.18ml, 96 mg/0.27ml, 128 mg/0.36ml	3	SP	PA, LD, QL (1 syringe/28 days)
BRIXADI - buprenorphine ext rel soln pref syr (weekly) 8 mg/0.16ml, (weekly) 24 mg/0.48ml, (weekly) 32 mg/0.64ml	3	SP	PA, LD, QL (4 syringes/28 days)
BRIXADI - buprenorphine ext rel soln pref syr (weekly) 16 mg/0.32ml	3	SP	PA, LD, QL (4 syringes/28 day)
buprenorphine hcl sl tab 2 mg (base equiv), 8 mg (base equiv)	1		QL (90 tablets/30 days)
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) (Suboxone)	1		QL (120 films/30 days)

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buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv), 12-3 mg (base equiv) (Suboxone)	1		QL (60 films/30 days)
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) (Suboxone)	1		QL (90 films/30 days)
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	1		QL (120 tablets/30 days)
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	1		QL (90 tablets/30 days)
buprenorphine td patch weekly 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr, 15 mcg/hr, 20 mcg/hr (Butrans)	1		PA, QL (4 patches/28 days)
butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg	1		PA, QL (180 capsules/30 days)
butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg	1		PA, QL (180 capsules/30 days)
butorphanol tartrate nasal soln 10 mg/ml	1		PA, QL (2 bottles/30 days)
CODEINE SULFATE - codeine sulfate tab 15 mg, 30 mg, 60 mg	3		PA, QL (180 tablets/30 days)
codeine sulfate tab 30 mg (Codeine sulfate)	1		PA, QL (180 tablets/30 days)
DILAUDID - hydromorphone hcl liqd 1 mg/ml	3		PA, QL (1440 mls/30 days)
fentanyl citrate lozenge on a handle 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg (Actiq)	1		PA, QL (120 lozenges/30 days)
fentanyl td patch 72hr 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr	1		PA, QL (15 patches/30 days)
HYDROCODONE BITARTRATE ER - hydrocodone bitartrate cap er 12hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg	3		PA, QL (60 capsules/30 days)
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1		PA, QL (3600 mls/30 days)
hydrocodone-acetaminophen tab 10-325 mg, 7.5-325 mg	1		PA, QL (180 tablets/30 days)
hydrocodone-acetaminophen tab 5-325 mg	1		PA, QL (360 tablets/30 days)
hydrocodone-ibuprofen tab 7.5-200 mg	1		PA, QL (150 tablets/30 days)
HYDROCODONE/IBUPROFEN - hydrocodone-ibuprofen tab 5-200 mg	3		PA, QL (150 tablets/30 days)
hydromorphone hcl liqd 1 mg/ml (Dilaudid)	1		PA, QL (1440 mls/30 days)
hydromorphone hcl tab er 24hr 8 mg, 12 mg, 16 mg, 32 mg	1		PA, QL (30 tablets/30 days)
hydromorphone hcl tab 2 mg, 4 mg, 8 mg (Dilaudid)	1		PA, QL (180 tablets/30 days)
levorphanol tartrate tab 2 mg	1		PA, QL (120 tablets/30 days)
MEPERIDINE HCL - meperidine hcl oral soln 50 mg/5ml	3		PA, QL (2400 mls/30 days)
METHADONE HCL - methadone hcl soln 5 mg/5ml	3		PA, QL (900 mls/30 days)
METHADONE HCL - methadone hcl soln 10 mg/5ml	3		PA, QL (450 mls/30 days)

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methadone hcl conc 10 mg/ml (Methadose)	1		PA, QL (90 mls/30 days)
methadone hcl soln 5 mg/5ml (Methadone hcl)	1		PA, QL (900 mls/30 days)
methadone hcl soln 10 mg/5ml (Methadone hcl)	1		PA, QL (450 mls/30 days)
methadone hcl tab for oral susp 40 mg	1		PA, QL (90 tablets/30 days)
methadone hcl tab 5 mg, 10 mg	1		PA, QL (90 tablets/30 days)
METHADOSE - methadone hcl conc 10 mg/ml	3		PA, QL (90 mls/30 days)
METHADOSE SUGAR-FREE - methadone hcl conc 10 mg/ml	3		PA, QL (90 mls/30 days)
MORPHINE SULFATE - morphine sulfate tab 15 mg	3		PA, QL (240 tablets/30 days)
MORPHINE SULFATE - morphine sulfate tab 30 mg	3		PA, QL (180 tablets/30 days)
MORPHINE SULFATE - morphine sulfate oral soln 10 mg/5ml	2		PA, QL (2700 mls/30 day)
MORPHINE SULFATE - morphine sulfate oral soln 20 mg/5ml	2		PA, QL (1350 mls/30 days)
MORPHINE SULFATE - morphine sulfate oral soln 100 mg/5ml (20 mg/ml)	3		PA, QL (270 mls/30 days)
MORPHINE SULFATE ER - morphine sulfate beads cap er 24hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg, 120 mg	3		PA, QL (30 capsules/30 days)
morphine sulfate oral soln 10 mg/5ml (Morphine sulfate)	1		PA, QL (2700 mls/30 days)
morphine sulfate oral soln 100 mg/5ml (20 mg/ml)	1		PA, QL (270 mls/30 days)
morphine sulfate tab er 15 mg, 30 mg, 60 mg (Ms contin)	1		PA, QL (120 tablets/30 days)
morphine sulfate tab er 100 mg, 200 mg (Ms contin)	1		PA, QL (180 tablets/30 days)
morphine sulfate tab 15 mg (Morphine sulfate)	1		PA, QL (240 tablets/30 days)
morphine sulfate tab 30 mg (Morphine sulfate)	1		PA, QL (180 tablets/30 days)
NUCYNTA ER - tapentadol hcl tab er 12hr 50 mg, 100 mg, 150 mg, 200 mg, 250 mg	3		PA, QL (60 tablets/30 days)
oxycodone hcl cap 5 mg	1		PA, QL (360 capsules/30 days)
oxycodone hcl conc 100 mg/5ml (20 mg/ml)	1		PA, QL (270 mls/30 days)
oxycodone hcl soln 5 mg/5ml	1		PA, QL (5400 mls/30 days)
oxycodone hcl tab 5 mg (Roxicodone)	1		PA, QL (360 tablets/30 days)
oxycodone hcl tab 10 mg	1		PA, QL (180 tablets/30 days)
oxycodone hcl tab 15 mg, 30 mg (Roxicodone)	1		PA, QL (120 tablets/30 days)
oxycodone hcl tab 20 mg	1		PA, QL (120 tablets/30 days)
OXYCODONE HYDROCHLORIDE/A - oxycodone w/ acetaminophen soln 5-325 mg/5ml	3		PA, QL (1800 mls/30 days)
oxycodone w/ acetaminophen tab 2.5-325 mg, 5-325 mg (Percocet)	1		PA, QL (360 tablets/30 days)
oxycodone w/ acetaminophen tab 7.5-325 mg (Percocet)	1		PA, QL (240 tablets/30 days)

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oxycodone w/ acetaminophen tab 10-325 mg (Percocet)	1		PA, QL (180 tablets/30 days)
OXYCODONE/ACETAMINOPHEN - oxycodone w/ acetaminophen tab 2.5-300 mg	3		PA, QL (360 tablets/30 days)
pentazocine w/ naloxone hcl tab 50-0.5 mg	1		PA, QL (360 tablets/30 days)
SUBLOCADE - buprenorphine extended release soln pref syr 100 mg/0.5ml	3	SP	PA, LD, QL (1 syringe/28 days)
SUBLOCADE - buprenorphine extended release soln pref syr 300 mg/1.5ml	3	SP	PA, LD, QL (2 syringe/180 days)
tramadol hcl tab er 24hr 100 mg, 200 mg, 300 mg	1		PA, QL (30 tablets/30 days)
tramadol hcl tab 50 mg (Ultram)	1		PA, QL (240 tablets/30 days)
tramadol-acetaminophen tab 37.5-325 mg (Ultracet)	1		PA, QL (240 tablets/30 days)
XTAMPZA ER - oxycodone cap er 12hr abuse-deterrent 9 mg, 13.5 mg, 18 mg, 27 mg, 36 mg	2		PA, QL (180 capsules/30 days)
ZUBSOLV - buprenorphine hcl-naloxone hcl sl tab 0.7-0.18 mg (base eq), 2.9-0.71 mg (base eq), 5.7-1.4 mg (base eq), 11.4-2.9 mg (base eq)	3		QL (30 tablets/30 days)
ZUBSOLV - buprenorphine hcl-naloxone hcl sl tab 1.4-0.36 mg (base eq)	3		QL (90 tablets/30 days)
ZUBSOLV - buprenorphine hcl-naloxone hcl sl tab 8.6-2.1 mg (base eq)	3		QL (60 tablets/30 days)
ANALGESICS - ANTI-INFLAMMATORY			
ACTEMRA - tocilizumab subcutaneous soln prefilled syringe 162 mg/0.9ml	2	SP	PA, LD, QL (4 syringes/28 days)
ACTEMRA ACTPEN - tocilizumab subcutaneous soln auto-injector 162 mg/0.9ml	2	SP	PA, QL (4 pens/28 days)
ANAPROX DS - naproxen sodium tab 550 mg	3		
ARCALYST - rilonacept for inj 220 mg	2	SP	PA, LD, QL (4 vials/28 days)
celecoxib cap 50 mg, 100 mg, 200 mg, 400 mg (Celebrex)	1		
DAYPRO - oxaprozin tab 600 mg	3		
diclofenac potassium tab 50 mg	1		
diclofenac sodium tab delayed release 25 mg, 50 mg, 75 mg	1		
diclofenac w/ misoprostol tab delayed release 50-0.2 mg (Arthrotec 50)	1		
diclofenac w/ misoprostol tab delayed release 75-0.2 mg (Arthrotec 75)	1		
ENBREL - etanercept subcutaneous inj 25 mg/0.5ml	2	SP	PA, QL (8 vials/28 days)
ENBREL - etanercept subcutaneous soln prefilled syringe 25 mg/0.5ml	2	SP	PA, QL (8 syringes/28 days)

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ENBREL - etanercept subcutaneous soln prefilled syringe 50 mg/ml	2	SP	PA, QL (4 syringes/28 days)
ENBREL MINI - etanercept subcutaneous solution cartridge 50 mg/ml	2	SP	PA, QL (4 cartridges/28 days)
ENBREL SURECLICK - etanercept subcutaneous solution auto-injector 50 mg/ml	2	SP	PA, QL (4 pens/28 days)
etodolac cap 200 mg, 300 mg	1		
etodolac tab er 24hr 400 mg, 500 mg, 600 mg	1		
etodolac tab 400 mg (Lodine)	1		
etodolac tab 500 mg	1		
fenoprofen calcium tab 600 mg (Nalfon)	1		
FLURBIPROFEN - flurbiprofen tab 50 mg	3		
flurbiprofen tab 100 mg	1		
HADLIMA - adalimumab-bwwd soln prefilled syringe 40 mg/0.4ml, 40 mg/0.8ml	2	SP	PA, QL (2 syringes/28 days)
HADLIMA PUSHTOUCH - adalimumab-bwwd soln auto-injector 40 mg/0.4ml, 40 mg/0.8ml	2	SP	PA, QL (2 pens/28 days)
HUMIRA - adalimumab prefilled syringe kit 10 mg/0.1ml, 20 mg/0.2ml, 40 mg/0.8ml, 40 mg/0.4ml	2	SP	PA, QL (2 syringes/28 days)
HUMIRA PEDIATRIC CROHNS D - adalimumab prefilled syringe kit 80 mg/0.8ml, 80 mg/0.8ml & 40 mg/0.4ml	2	SP	PA, QL (1 kit/180 days)
HUMIRA PEN - adalimumab pen-injector kit 40 mg/0.8ml, 40 mg/0.4ml, 80 mg/0.8ml	2	SP	PA, QL (2 pens/28 days)
HUMIRA PEN-CD/UC/HS START - adalimumab pen-injector kit 80 mg/0.8ml	2	SP	PA, QL (1 kit/180 days)
HUMIRA PEN-PEDIATRIC UC S - adalimumab pen-injector kit 80 mg/0.8ml	2	SP	PA, QL (1 kit/180 days)
HUMIRA PEN-PS/UV STARTER - adalimumab pen-injector kit 80 mg/0.8ml & 40 mg/0.4ml	2	SP	PA, QL (1 kit/180 days)
ibuprofen tab 400 mg, 600 mg, 800 mg	1		
indomethacin cap er 75 mg	1		
indomethacin cap 25 mg, 50 mg	1		
ketorolac tromethamine tab 10 mg	1		QL (20 tablets/5 days)
KEVZARA - sarilumab subcutaneous solution auto-injector 150 mg/1.14ml, 200 mg/1.14ml	3	SP	PA, QL (2 pens/28 days)
KEVZARA - sarilumab subcutaneous soln prefilled syringe 150 mg/1.14ml, 200 mg/1.14ml	3	SP	PA, QL (2 syringes/28 days)
KINERET - anakinra subcutaneous soln prefilled syringe 100 mg/0.67ml	3	SP	PA, LD, QL (30 syringes/30 days)
leflunomide tab 10 mg, 20 mg (Arava)	1		
LODINE - etodolac tab 400 mg	3		

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MECLOFENAMATE SODIUM - meclofenamate sodium cap 50 mg, 100 mg	3		
MELOXICAM - meloxicam susp 7.5 mg/5ml	3		
meloxicam tab 7.5 mg, 15 mg	1		
nabumetone tab 500 mg, 750 mg	1		
NAPROSYN - naproxen tab 500 mg	3		
naproxen sodium tab 275 mg	1		
naproxen sodium tab 550 mg (Anaprox ds)	1		
naproxen tab 250 mg, 375 mg	1		
naproxen tab 500 mg (Naprosyn)	1		
OLUMIANT - baricitinib tab 1 mg, 2 mg, 4 mg	3	SP	PA, LD, QL (30 tablets/30 days)
ORENCIA - abatacept subcutaneous soln prefilled syringe 50 mg/0.4ml, 87.5 mg/0.7ml, 125 mg/ml	3	SP	PA, QL (4 syringes/28 days)
ORENCIA CLICKJECT - abatacept subcutaneous soln auto-injector 125 mg/ml	3	SP	PA, QL (4 pens/28 days)
OTEZLA - apremilast tab starter therapy pack 10 mg & 20 mg & 30 mg	2	SP	PA, QL (55 tablets/180 days)
OTEZLA - apremilast tab 30 mg	2	SP	PA, QL (60 tablets/30 days)
OTREXUP - methotrexate soln pf auto-injector 10 mg/0.4ml, 12.5 mg/0.4ml, 15 mg/0.4ml, 17.5 mg/0.4ml, 20 mg/0.4ml, 22.5 mg/0.4ml, 25 mg/0.4ml	2		ST
oxaprozin tab 600 mg (Daypro)	1		
piroxicam cap 10 mg, 20 mg (Feldene)	1		
RIDAURA - auranofin cap 3 mg	2		
RINVOQ - upadacitinib tab er 24hr 15 mg, 30 mg	2	SP	PA, LD, QL (30 tablets/30 days)
RINVOQ - upadacitinib tab er 24hr 45 mg	2	SP	PA, LD, QL (84 tablets/365 days)
SIMPONI - golimumab subcutaneous soln auto-injector 50 mg/0.5ml	3	SP	PA, QL (1 pen/28 days)
SIMPONI - golimumab subcutaneous soln auto-injector 100 mg/ml	2	SP	PA, QL (1 pen/28 days)
SIMPONI - golimumab subcutaneous soln prefilled syringe 50 mg/0.5ml	3	SP	PA, QL (1 syringe/28 days)
SIMPONI - golimumab subcutaneous soln prefilled syringe 100 mg/ml	2	SP	PA, QL (1 syringe/28 days)
sulindac tab 150 mg, 200 mg	1		
TOLECTIN 600 - tolmetin sodium tab 600 mg	3		
TOLMETIN SODIUM - tolmetin sodium cap 400 mg	3		
XELJANZ - tofacitinib citrate oral soln 1 mg/ml (base equivalent)	2	SP	PA, QL (240 mls/30 days)
XELJANZ - tofacitinib citrate tab 5 mg (base equivalent)	2	SP	PA, QL (60 tablets/30 days)
XELJANZ - tofacitinib citrate tab 10 mg (base equivalent)	2	SP	PA, QL (240 tablets/365 days)

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XELJANZ XR - tofacitinib citrate tab er 24hr 11 mg (base equivalent)	2	SP	PA, QL (30 tablets/30 days)
XELJANZ XR - tofacitinib citrate tab er 24hr 22 mg (base equivalent)	2	SP	PA, QL (120 tablets/365 days)
MIGRAINE PRODUCTS			
AIMOVIG - erenumab-aooe subcutaneous soln auto-injector 70 mg/ml, 140 mg/ml	2		PA, QL (1 pen/28 days)
AJOVY - fremanezumab-vfrm subcutaneous soln auto-inj 225 mg/1.5ml	2		PA, QL (3 pens/84 days)
AJOVY - fremanezumab-vfrm subcutaneous soln pref syr 225 mg/1.5ml	2		PA, QL (3 syringes/84 days)
almotriptan malate tab 6.25 mg, 12.5 mg	1		ST, QL (12 tablets/30 days)
dihydroergotamine mesylate inj 1 mg/ml	1		PA, QL (24 ampules/28 days)
dihydroergotamine mesylate nasal spray 4 mg/ml (Migranal)	1		PA, QL (8 vials/28 days)
eletriptan hydrobromide tab 20 mg (base equivalent), 40 mg (base equivalent) (Relpax)	1		QL (12 tablets/30 days)
EMGALITY - galcanezumab-gnlm subcutaneous soln auto-injector 120 mg/ml	2		PA, QL (1 pen/28 days)
EMGALITY - galcanezumab-gnlm subcutaneous soln prefilled syr 100 mg/ml	2		PA, QL (9 syringes/180 days)
EMGALITY - galcanezumab-gnlm subcutaneous soln prefilled syr 120 mg/ml	2		PA, QL (1 syringe/28 days)
ERGOTAMINE TARTRATE/CAFFE - ergotamine w/ caffeine tab 1-100 mg	3		PA, QL (40 tablets/28 days)
frovatriptan succinate tab 2.5 mg (base equivalent) (Frova)	1		ST, QL (18 tablets/30 days)
MIGERGOT - ergotamine w/ caffeine suppos 2-100 mg	3		PA, QL (20 suppositories/28 days)
naratriptan hcl tab 1 mg (base equiv), 2.5 mg (base equiv)	1		QL (18 tablets/30 days)
NURTEC - rimegepant sulfate tab disint 75 mg	2		PA, QL (16 tablets/30 days)
QULIPTA - atogepant tab 10 mg, 30 mg, 60 mg	2		PA, QL (30 tablets/30 days)
REYVOW - lasmiditan succinate tab 50 mg, 100 mg	2		PA, QL (8 tablets/30 days)
rizatriptan benzoate oral disintegrating tab 5 mg (base eq)	1		QL (24 tablets/30 days)
rizatriptan benzoate oral disintegrating tab 10 mg (base eq) (Maxalt-mlt)	1		QL (18 tablets/30 days)
rizatriptan benzoate tab 5 mg (base equivalent)	1		QL (24 tablets/30 days)
rizatriptan benzoate tab 10 mg (base equivalent) (Maxalt)	1		QL (18 tablets/30 days)
sumatriptan nasal spray 5 mg/act (Imitrex)	1		QL (6 packs/30 days)
sumatriptan nasal spray 20 mg/act (Imitrex)	1		QL (2 packs/30 days)

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sumatriptan succinate inj 6 mg/0.5ml	1		QL (10 vials/30 days)
SUMATRIPTAN SUCCINATE REF - sumatriptan succinate solution cartridge 4 mg/0.5ml, 6 mg/0.5ml	2		ST, QL (12 doses/30 days)
sumatriptan succinate solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml (Imitrex statdose sys)	1		QL (12 doses/30 days)
sumatriptan succinate tab 25 mg (Imitrex)	1		QL (36 tablets/30 days)
sumatriptan succinate tab 50 mg, 100 mg (Imitrex)	1		QL (18 tablets/30 days)
UBRELVY - ubrogepant tab 50 mg, 100 mg	2		PA, QL (16 tablets/30 days)
zolmitriptan nasal spray 5 mg/spray unit (Zomig)	1		ST, QL (12 units/30 days)
zolmitriptan orally disintegrating tab 2.5 mg, 5 mg	1		QL (12 tablets/30 days)
zolmitriptan tab 2.5 mg, 5 mg (Zomig)	1		QL (12 tablets/30 days)
ZOMIG - zolmitriptan nasal spray 5 mg/spray unit	3		ST, QL (12 units/30 days)
GOUT AGENTS			
allopurinol tab 100 mg, 300 mg (Zyloprim)	1		
colchicine tab 0.6 mg (Colcrys)	1		
colchicine w/ probenecid tab 0.5-500 mg	1		
febuxostat tab 40 mg, 80 mg (Uloric)	1		QL (30 tablets/30 days)
probenecid tab 500 mg	1		
NEUROMUSCULAR DRUGS			
ANTICONVULSANTS			
APTIOM - eslicarbazepine acetate tab 200 mg, 400 mg, 600 mg, 800 mg	2		
BANZEL - rufinamide tab 200 mg, 400 mg	3		
BANZEL - rufinamide susp 40 mg/ml	3		
BRIVIACT - brivaracetam tab 10 mg, 25 mg, 50 mg, 75 mg, 100 mg	3		
BRIVIACT - brivaracetam oral soln 10 mg/ml	3		
BRIVIACT - brivaracetam iv soln 50 mg/5ml	3		
carbamazepine cap er 12hr 100 mg, 200 mg, 300 mg (Carbatrol)	1		
carbamazepine chew tab 100 mg	1		
carbamazepine susp 100 mg/5ml (Tegretol)	1		
carbamazepine tab er 12hr 100 mg, 200 mg, 400 mg (Tegretol-xr)	1		
carbamazepine tab 200 mg (Tegretol)	1		
CARBATROL - carbamazepine cap er 12hr 100 mg, 200 mg, 300 mg	3		
CELONTIN - methsuximide cap 300 mg	3		
clobazam suspension 2.5 mg/ml (Onfi)	1		
clobazam tab 10 mg, 20 mg (Onfi)	1		

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clonazepam orally disintegrating tab 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	1		
clonazepam tab 0.5 mg, 1 mg, 2 mg (Klonopin)	1		
DEPAKOTE - divalproex sodium tab delayed release 125 mg, 250 mg, 500 mg	3		
DEPAKOTE ER - divalproex sodium tab er 24 hr 250 mg, 500 mg	3		
DEPAKOTE SPRINKLES - divalproex sodium cap delayed release sprinkle 125 mg	3		
DIACOMIT - stiripentol cap 250 mg, 500 mg	3	SP	
DIACOMIT - stiripentol packet 250 mg, 500 mg	3	SP	
DIAZEPAM RECTAL GEL - diazepam rectal gel delivery system 2.5 mg	3		
diazepam rectal gel delivery system 10 mg, 20 mg (Diastat acudial)	1		
DILANTIN - phenytoin sodium extended cap 30 mg	2		
DILANTIN - phenytoin sodium extended cap 100 mg	3		
DILANTIN INFATABS - phenytoin chew tab 50 mg	3		
DILANTIN-125 - phenytoin susp 125 mg/5ml	3		
divalproex sodium cap delayed release sprinkle 125 mg (Depakote sprinkles)	1		
divalproex sodium tab delayed release 125 mg, 250 mg, 500 mg (Depakote)	1		
divalproex sodium tab er 24 hr 250 mg, 500 mg (Depakote er)	1		
EPIDIOLEX - cannabidiol soln 100 mg/ml	2	SP	PA, LD
EPRONTIA - topiramate oral soln 25 mg/ml	3		
ethosuximide cap 250 mg (Zarontin)	1		
ethosuximide soln 250 mg/5ml (Zarontin)	1		
felbamate susp 600 mg/5ml (Felbatol)	1		
felbamate tab 400 mg, 600 mg (Felbatol)	1		
FELBATOL - felbamate tab 400 mg, 600 mg	3		
FINTEPLA - fenfluramine hcl oral soln 2.2 mg/ml	3	SP	PA, LD
FYCOMPA - perampanel tab 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, 12 mg	3		
FYCOMPA - perampanel susp 0.5 mg/ml	3		
gabapentin cap 100 mg, 300 mg, 400 mg (Neurontin)	1		
gabapentin oral soln 250 mg/5ml (Neurontin)	1		
gabapentin tab 600 mg, 800 mg (Neurontin)	1		
KEPPRA - levetiracetam tab 250 mg, 500 mg, 750 mg, 1000 mg	3		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
KEPPRA - levetiracetam oral soln 100 mg/ml	3		
KEPPRA XR - levetiracetam tab er 24hr 500 mg, 750 mg	3		
lacosamide oral solution 10 mg/ml (Vimpat)	1		
lacosamide tab 50 mg, 100 mg, 150 mg, 200 mg (Vimpat)	1		
LAMICTAL - lamotrigine tab 25 mg, 100 mg, 150 mg, 200 mg	3		
LAMICTAL CHEWABLE DISPERS - lamotrigine tab chewable dispersible 5 mg, 25 mg	3		
LAMICTAL ODT - lamotrigine orally disintegrating tab 25 mg, 50 mg, 100 mg, 200 mg	3		
LAMICTAL ODT - lamotrigine tab disint 21 x 25 mg & 7 x 50 mg titration kit	3		
LAMICTAL ODT - lamotrigine tab disint 42 x 50mg & 14 x 100mg titration kit	3		
LAMICTAL ODT - lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit	3		
LAMICTAL STARTER/NOT TAKI - lamotrigine tab 25 mg (42) & 100 mg (7) starter kit	3		
LAMICTAL STARTER/TAKING C - lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit	3		
LAMICTAL STARTER/TAKING V - lamotrigine tab 35 x 25 mg starter kit	3		
LAMICTAL XR - lamotrigine tab er 24hr 25 mg, 50 mg, 100 mg, 200 mg, 250 mg, 300 mg	3		
LAMICTAL XR - lamotrigine tab er 24hr 21 x 25 mg & 7 x 50 mg titration kit	3		
LAMICTAL XR - lamotrigine tab er 24hr 25 (14) & 50 mg (14) & 100 mg(7) kit	3		
LAMICTAL XR - lamotrigine tab er 24hr 50 (14) & 100 mg(14) & 200 mg(7) kit	3		
lamotrigine orally disintegrating tab 25 mg, 50 mg, 100 mg, 200 mg (Lamictal odt)	1		
lamotrigine tab chewable dispersible 5 mg, 25 mg (Lamictal chewable di)	1		
lamotrigine tab disint 21 x 25 mg & 7 x 50 mg titration kit (Lamictal odt)	1		
lamotrigine tab disint 42 x 50mg & 14 x 100mg titration kit (Lamictal odt)	1		
lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit (Lamictal odt)	1		
lamotrigine tab er 24hr 25 mg, 50 mg, 100 mg, 200 mg, 250 mg, 300 mg (Lamictal xr)	1		

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lamotrigine tab 25 mg, 100 mg, 150 mg, 200 mg (Lamictal)	1		
lamotrigine tab 35 x 25 mg starter kit (Lamictal starter/tak)	1		
lamotrigine tab 25 mg (42) & 100 mg (7) starter kit (Lamictal starter/not)	1		
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit (Lamictal starter/tak)	1		
levetiracetam oral soln 100 mg/ml (Keppra)	1		
levetiracetam tab er 24hr 500 mg, 750 mg (Keppra xr)	1		
levetiracetam tab 250 mg, 500 mg, 750 mg, 1000 mg (Keppra)	1		
LYRICA - pregabalin soln 20 mg/ml	3		ST, QL (900 mls/30 days)
methsuximide cap 300 mg (Celontin)	1		
MOTPOLY XR - lacosamide cap er 24hr 100 mg, 150 mg, 200 mg	3		
NAYZILAM - midazolam nasal spray soln 5 mg/0.1 ml	3		QL (10 bottles/30 days)
NEURONTIN - gabapentin cap 100 mg, 300 mg, 400 mg	3		
NEURONTIN - gabapentin tab 600 mg, 800 mg	3		
NEURONTIN - gabapentin oral soln 250 mg/5ml	3		
ONFI - clobazam tab 10 mg, 20 mg	3		
ONFI - clobazam suspension 2.5 mg/ml	3		
oxcarbazepine susp 300 mg/5ml (60 mg/ml) (Trileptal)	1		
oxcarbazepine tab 150 mg, 300 mg, 600 mg (Trileptal)	1		
OXTELLAR XR - oxcarbazepine tab er 24hr 150 mg, 300 mg, 600 mg	3		
phenytoin chew tab 50 mg (Dilantin infatabs)	1		
phenytoin sodium extended cap 100 mg (Dilantin)	1		
phenytoin sodium extended cap 200 mg, 300 mg (Phenytek)	1		
phenytoin susp 125 mg/5ml (Dilantin-125)	1		
pregabalin cap 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg (Lyrica)	1		QL (90 capsules/30 days)
pregabalin cap 225 mg, 300 mg (Lyrica)	1		QL (60 capsules/30 days)
pregabalin soln 20 mg/ml (Lyrica)	1		QL (900 mls/30 days)
primidone tab 50 mg, 250 mg (Mysoline)	1		
QUDEXY XR - topiramate cap er 24hr sprinkle 25 mg, 50 mg, 100 mg, 150 mg	3		PA, QL (30 capsules/30 days)
QUDEXY XR - topiramate cap er 24hr sprinkle 200 mg	3		PA, QL (60 capsules/30 days)
rufinamide susp 40 mg/ml (Banzel)	1		

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rufinamide tab 200 mg, 400 mg (Banzel)	1		
SABRIL - vigabatrin tab 500 mg	3	SP	LD
SABRIL - vigabatrin powd pack 500 mg	3	SP	LD
SYMPAZAN - clobazam oral film 5 mg, 10 mg, 20 mg	2		
TEGRETOL - carbamazepine tab 200 mg	3		
TEGRETOL - carbamazepine susp 100 mg/5ml	3		
TEGRETOL-XR - carbamazepine tab er 12hr 100 mg, 200 mg, 400 mg	3		
tiagabine hcl tab 2 mg, 4 mg, 12 mg, 16 mg (Gabitril)	1		
TOPAMAX - topiramate tab 25 mg, 50 mg, 100 mg, 200 mg	3		
TOPAMAX SPRINKLE - topiramate sprinkle cap 15 mg, 25 mg	3		
topiramate cap er 24hr sprinkle 25 mg, 50 mg, 100 mg, 150 mg (Qudexy xr)	1		PA, QL (30 capsules/30 days)
topiramate cap er 24hr sprinkle 200 mg (Qudexy xr)	1		PA, QL (60 capsules/30 days)
topiramate cap er 24hr 25 mg, 50 mg, 100 mg (Trokendi xr)	1		PA, QL (30 capsules/30 days)
topiramate cap er 24hr 200 mg (Trokendi xr)	1		PA, QL (60 capsules/30 days)
topiramate sprinkle cap 15 mg, 25 mg (Topamax sprinkle)	1		
topiramate tab 25 mg, 50 mg, 100 mg, 200 mg (Topamax)	1		
TRILEPTAL - oxcarbazepine tab 150 mg, 300 mg, 600 mg	3		
TRILEPTAL - oxcarbazepine susp 300 mg/5ml (60 mg/ml)	3		
TROKENDI XR - topiramate cap er 24hr 25 mg, 50 mg, 100 mg	3		PA, QL (30 capsules/30 days)
TROKENDI XR - topiramate cap er 24hr 200 mg	3		PA, QL (60 capsules/30 days)
valproate sodium oral soln 250 mg/5ml (base equiv)	1		
valproic acid cap 250 mg	1		
VALTOCO 10 MG DOSE - diazepam nasal spray 10 mg/0.1 ml	3		QL (10 bottles/30 days)
VALTOCO 15 MG DOSE - diazepam nasal spray ther pack 2 x 7.5 mg/0.1ml (15 mg dose)	3		QL (10 bottles/30 days)
VALTOCO 20 MG DOSE - diazepam nasal spray ther pack 2 x 10 mg/0.1ml (20 mg dose)	3		QL (10 bottles/30 days)
VALTOCO 5 MG DOSE - diazepam nasal spray 5 mg/0.1 ml	3		QL (10 bottles/30 days)
vigabatrin powd pack 500 mg (Sabril)	1	SP	LD
vigabatrin tab 500 mg (Sabril)	1	SP	LD

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VIMPAT - lacosamide tab 50 mg, 100 mg, 150 mg, 200 mg	3		
VIMPAT - lacosamide oral solution 10 mg/ml	3		
XCOPRI - cenobamate tab 25 mg, 50 mg, 100 mg, 150 mg, 200 mg	3		
XCOPRI - cenobamate tab titration pack 14 x 12.5 mg & 14 x 25 mg, 14 x 50 mg & 14 x 100 mg, 14 x 150 mg & 14 x 200 mg	3		
XCOPRI - cenobamate tab pack 100 mg & 150 mg tabs (250 mg daily dose)	3		
XCOPRI - cenobamate tab pack 150 mg & 200 mg tabs (350 mg daily dose)	3		
ZARONTIN - ethosuximide cap 250 mg	3		
ZARONTIN - ethosuximide soln 250 mg/5ml	3		
ZONEGRAN - zonisamide cap 25 mg, 100 mg	3		
zonisamide cap 25 mg, 100 mg (Zonegran)	1		
zonisamide cap 50 mg	1		
ZTALMY - ganaxolone susp 50 mg/ml	3	SP	PA, LD, QL (1100 mls/30 days)
ANTIPARKINSON AGENTS			
amantadine hcl cap 100 mg	1		
amantadine hcl soln 50 mg/5ml	1		
amantadine hcl tab 100 mg	1		
APOKYN - apomorphine hcl soln cartridge 30 mg/3ml	3	SP	PA, LD
apomorphine hcl soln cartridge 30 mg/3ml (Apokyn)	1	SP	PA
benztropine mesylate tab 0.5 mg, 1 mg, 2 mg	1		
bromocriptine mesylate cap 5 mg (base equivalent) (Parlodel)	1		
bromocriptine mesylate tab 2.5 mg (base equivalent) (Parlodel)	1		
carbidopa & levodopa tab er 25-100 mg, 50-200 mg	1		
carbidopa & levodopa tab 10-100 mg, 25-100 mg (Sinemet)	1		
carbidopa & levodopa tab 25-250 mg	1		
carbidopa tab 25 mg (Lodosyn)	1		
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg (Stalevo 50)	1		
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg (Stalevo 75)	1		
carbidopa-levodopa-entacapone tabs 25-100-200 mg (Stalevo 100)	1		
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg (Stalevo 125)	1		

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carbidopa-levodopa-entacapone tabs 37.5-150-200 mg (Stalevo 150)	1		
carbidopa-levodopa-entacapone tabs 50-200-200 mg (Stalevo 200)	1		
CARBIDOPA/LEVODOPA ODT - carbidopa & levodopa orally disintegrating tab 10-100 mg, 25-100 mg, 25-250 mg	3		
entacapone tab 200 mg (Comtan)	1		
INBRIJA - levodopa inhal powder cap 42 mg	2	SP	PA, LD
LODOSYN - carbidopa tab 25 mg	3		
NEUPRO - rotigotine td patch 24hr 1 mg/24hr, 2 mg/24hr, 3 mg/24hr, 4 mg/24hr, 6 mg/24hr, 8 mg/24hr	3		
NOURIANZ - istradefylline tab 20 mg, 40 mg	3	SP	PA, LD
PARLODEL - bromocriptine mesylate cap 5 mg (base equivalent)	3		
PARLODEL - bromocriptine mesylate tab 2.5 mg (base equivalent)	3		
pramipexole dihydrochloride tab er 24hr 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg (Mirapex er)	1		
pramipexole dihydrochloride tab 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1		
rasagiline mesylate tab 0.5 mg (base equiv), 1 mg (base equiv) (Azilect)	1		
ropinirole hydrochloride tab er 24hr 2 mg (base equivalent), 4 mg (base equivalent), 6 mg (base equivalent), 8 mg (base equivalent), 12 mg (base equivalent)	1		
ropinirole hydrochloride tab 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1		
selegiline hcl cap 5 mg	1		
selegiline hcl tab 5 mg	1		
SINEMET - carbidopa & levodopa tab 10-100 mg, 25-100 mg	3		
TASMAR - tolcapone tab 100 mg	3		
tolcapone tab 100 mg (Tasmar)	1		
TRIHEXYPHENIDYL HCL - trihexyphenidyl hcl oral soln 0.4 mg/ml	3		
trihexyphenidyl hcl tab 2 mg, 5 mg	1		
NEUROMUSCULAR AGENTS			
DAYBUE - trofinetide oral soln 200 mg/ml	3	SP	PA, LD, QL (3600 mls/30 days)
EVRYSDI - risdiplam for soln 0.75 mg/ml	3	SP	PA, LD, QL (80 mls/12 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
EXSERVAN - riluzole oral film 50 mg	3	SP	PA, LD, QL (60 films/30 days)
RADICAVA ORS - edaravone oral susp 105 mg/5ml	3	SP	PA, LD, QL (50 mls/28 days)
RADICAVA ORS STARTER KIT - edaravone oral susp 105 mg/5ml	3	SP	PA, LD, QL (70 mls/180 days)
RELYVRIO - sodium phenylbutyrate-taurursodiol powd pack 3-1 gm	3	SP	PA, LD, QL (56 packets/28 days)
riluzole tab 50 mg (Rilutek)	1		
SKYCLARYS - omaveloxolone cap 50 mg	3	SP	PA, QL (90 capsules/30 days)
TEGLUTIK - riluzole susp 50 mg/10ml	3	SP	PA, QL (600 mls/30 days)
MUSCULOSKELETAL THERAPY AGENTS			
BACLOFEN - baclofen tab 15 mg	3		
baclofen susp 25 mg/5ml (Fleqsuvy)	1		
baclofen tab 10 mg, 20 mg	1		
carisoprodol tab 350 mg (Soma)	1		
chlorzoxazone tab 500 mg	1		
cyclobenzaprine hcl tab 5 mg, 10 mg	1		
DANTRIUM - dantrolene sodium cap 25 mg	3		
dantrolene sodium cap 25 mg (Dantrium)	1		
dantrolene sodium cap 50 mg, 100 mg	1		
metaxalone tab 400 mg, 800 mg	1		
methocarbamol tab 500 mg, 750 mg	1		
orphenadrine citrate tab er 12hr 100 mg	1		
SOHONOS - palovarotene cap 1 mg, 1.5 mg	3	SP	PA, LD, QL (112 capsules/28 days)
SOHONOS - palovarotene cap 2.5 mg	3	SP	PA, LD, QL (140 capsules/28 days)
SOHONOS - palovarotene cap 5 mg	3	SP	PA, LD, QL (84 capsules/28 days)
SOHONOS - palovarotene cap 10 mg	3	SP	PA, LD, QL (56 capsules/28 days)
tizanidine hcl tab 2 mg (base equivalent)	1		
tizanidine hcl tab 4 mg (base equivalent) (Zanaflex)	1		
ZANAFLEX - tizanidine hcl tab 4 mg (base equivalent)	3		
ANTIMYASTHENIC AGENTS			
FIRDAPSE - amifampridine phosphate tab 10 mg (base equivalent)	3	SP	PA, LD, QL (240 tablets/30 days)
pyridostigmine bromide oral soln 60 mg/5ml (Mestinon)	1		
pyridostigmine bromide tab er 180 mg (Mestinon timespan)	1		
pyridostigmine bromide tab 60 mg (Mestinon)	1		
NUTRITIONAL PRODUCTS			
VITAMINS			
cholecalciferol cap 1.25 mg (50000 unit)	1		

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DRISDOL - ergocalciferol cap 1.25 mg (50000 unit)	3		
ergocalciferol cap 1.25 mg (50000 unit) (Drisdol)	1		
phytonadione tab 5 mg (Mephyton)	1		
MULTIVITAMINS			
ATABEX OB - prenatal vit w/ fe bisglycinate chelate-fa tab 29-1 mg	3		
CITRANATAL B-CALM - prenat w/o a w/fecbn-feglu-fa tab 20-1 mg & vit b6 tab pak	3		
CITRANATAL MEDLEY - prenat w/o a w/fe fum-fe cbn-fa-dha cap 27-1-200 mg	3		
CO-NATAL FA - prenatal vit w/ fe fumarate-fa tab 29-1 mg	2		
COMPLETE NATAL DHA - prenat-fe bis-fe prot succ-fa-ca tab & omega 3 cap 200 pk	2		
COMPLETENATE - prenatal vit w/ fe fumarate-fa chew tab 29-1 mg	2		
CONCEPT DHA - prenatal w/fe fum-fe poly -fa-omega 3 cap 53.5-38-1 mg	2		
CONCEPT OB - prenatal w/o a w/fe fum-fe poly-fa cap 130-92.4-1 mg	2		
FOLIVANE-OB - prenatal w/o a w/fe fum-fe poly-fa cap 85-1 mg	2		
INATAL GT - prenatal vit w/ dss-iron carbonyl-fa tab 90-1 mg	3		
JENLIVA PRENATAL/POSTNATA - prenatal multivitamins & minerals w/ iron & fa cap 1 mg	3		
M-NATAL PLUS - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
NATALVIT - prenatal vit w/ fe fumarate-fa tab 75-1 mg	3		
NEONATAL COMPLETE - prenatal vit w/ fe fumarate-fa tab 27-1 mg, 29-1 mg	2		
NEONATAL PLUS - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
NESTABS - prenatal vit w/o vit a w/ fe bisglycinate-fa tab 32-1 mg	3		
NIVA-PLUS - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
OBSTETRIX EC - prenatal vit w/ iron carbonyl-fa tab delayed rel 29-1 mg	3		
ONE VITE WOMENS PRENATAL - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
PNV PRENATAL PLUS MULTIVI - prenat w/ fe fum-fa tab 27-1 mg & omega 3 cap 312 mg pak	2		

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PNV-DHA+DOCUSATE - prenatal w/o vit a w/ fe fum-dss-fa-dha cap 27-1.25-300 mg	3		
PNV-OMEGA - prenat w/o a w/ fe fumarate-methylfolate-fa-omega 3 cap	3		
PRENAISSANCE - prenatal w/o vit a w/ fe fum-dss-fa-dha cap 29-1.25-325 mg	3		
PRENATAL - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
PRENATAL PLUS - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
PRENATAL PLUS VITAMIN AND - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
PRENATAL 19 - prenatal vit w/ fe fumarate-fa chew tab 29-1 mg	2		
PRENATAL 19 - prenatal vit w/ dss-fe fumarate-fa tab 29-1 mg	2		
PRENATAL-U - prenatal w/o a vit w/ fe fumarate-fa cap 106.5-1 mg	2		
PROVIDA OB - prenatal w/o a w/fe fum-fe poly-fa cap 20-20-1.25 mg	2		
SE-NATAL 19 - prenatal vit w/ fe fumarate-fa chew tab 29-1 mg	2		
SE-NATAL 19 - prenatal vit w/ dss-fe fumarate-fa tab 29-1 mg	2		
SELECT-OB - prenatal vit w/ fe polysac cmplx-fa chew tab 29-1 mg	3		
TARON-C DHA - prenatal w/fe fum-fe poly -fa-omega 3 cap 35-1 mg	2		
THRIVITE RX - prenatal vit w/ iron carbonyl-fa tab 29-1 mg	2		
TRICARE - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
TRINATAL RX 1 - prenatal vit w/ fe fumarate-fa tab 60-1 mg	2		
TRINATE - prenatal vit w/ fe fumarate-fa tab 28-1 mg	2		
VINATE II - prenatal vit w/ fe bisglycinate chelate-fa tab 29-1 mg	3		
VINATE ONE - prenatal vit w/ fe fumarate-fa tab 60-1 mg	2		
VITAFOL STRIPS - prenatal w/ b6-b12-cholecalciferol-folic acid film 1 mg	3		
VITATHELY/GINGER - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
WESCAP-C DHA - prenatal w/fe fum-fe poly -fa-omega 3 cap 53.5-38-1 mg	2		

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WESNATAL DHA COMPLETE - prenat-fe bis-fe prot succ-fa-ca tab & omega 3 cap 200 pk	3		
WESTAB PLUS - prenatal vit w/ fe fumarate-fa tab 27-1 mg	2		
MINERALS and ELECTROLYTES			
FLORIVA - sodium fluoride-vitamin d liqd drops 0.25 mg/ml-400 unit/ml	3		
GALZIN - zinc acetate cap 25 mg (elemental zinc), 50 mg (elemental zinc)	3		
K-PHOS - potassium phosphate monobasic tab 500 mg	3		
K-PHOS NEUTRAL - pot phos monobasic w/sod phos di & monobas tab 155-852-130mg	3		
K-TAB - potassium chloride tab er 20 meq (1500 mg)	3		
POKONZA - potassium chloride powder packet 10 meq	3		
pot phos monobasic w/sod phos di & monobas tab 155-852-130mg (K-phos neutral)	1		
potassium chloride cap er 8 meq, 10 meq	1		
POTASSIUM CHLORIDE ER - potassium chloride tab er 8 meq (600 mg)	3		
potassium chloride microencapsulated crys er tab 10 meq, 15 meq, 20 meq	1		
potassium chloride oral soln 10% (20 meq/15ml), 20% (40 meq/15ml)	1		
potassium chloride tab er 8 meq (600 mg)	1		
potassium chloride tab er 10 meq, 20 meq (1500 mg) (K-tab)	1		
potassium phosphate monobasic tab 500 mg (K-phos)	1		
SODIUM FLUORIDE - sodium fluoride tab 0.5 mg f (from 1.1 mg naf), 1 mg f (from 2.2 mg naf)	2		
sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf), 0.5 mg f (from 1.1 mg naf), 1 mg f (from 2.2 mg naf)	1		
sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)	1		
NUTRIENTS			
DOJOLVI - triheptanoin oral liquid 100%	3	SP	PA, LD
HEMATOLOGICAL AGENTS			
HEMATOPOIETIC AGENTS			
ARANESP ALBUMIN FREE - darbepoetin alfa soln prefilled syringe 10 mcg/0.4ml, 25 mcg/0.42ml, 40 mcg/0.4ml, 60 mcg/0.3ml, 100 mcg/0.5ml,	2	SP	PA

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150 mcg/0.3ml, 200 mcg/0.4ml, 300 mcg/0.6ml, 500 mcg/ml			
ARANESP ALBUMIN FREE - darbepoetin alfa soln inj 25 mcg/ml, 40 mcg/ml, 60 mcg/ml, 100 mcg/ml, 200 mcg/ml	2	SP	PA
carbonyl iron susp 15 mg/1.25ml (elemental iron)	1		
CERDELGA - eliglustat tartrate cap 84 mg (base equivalent)	2	SP	PA, LD, QL (60 capsules/30 days)
cyanocobalamin inj 1000 mcg/ml	1		
DOPTELET - avatrombopag maleate tab 20 mg (base equiv)	2	SP	PA, LD, QL (30 tablets/30 days)
DROXIA - hydroxyurea cap 200 mg, 300 mg, 400 mg	2		
ENDARI - glutamine (sickle cell) powd pack 5 gm	3	SP	PA, LD
EPOGEN - epoetin alfa inj 2000 unit/ml, 3000 unit/ml, 4000 unit/ml, 10000 unit/ml, 20000 unit/ml	3	SP	PA
ferrous sulfate soln 75 mg/ml (15 mg/ml elemental fe), 220 mg/5ml (44 mg/5ml elemental fe)	1		
folic acid tab 400 mcg, 800 mcg, 1 mg	1		
FULPHILA - pegfilgrastim-jmdb soln prefilled syringe 6 mg/0.6ml	2	SP	PA, QL (2 syringes/28 days)
FYLNETRA - pegfilgrastim-pbbk soln prefilled syringe 6 mg/0.6ml	2	SP	PA, QL (2 syringes/28 days)
LEUKINE - sargramostim lyophilized for inj 250 mcg	3	SP	PA
miglustat cap 100 mg (Zavesca)	1	SP	PA, LD, QL (90 capsules/30 days)
MIRCERA - methoxy peg-epoetin beta soln prefilled syr 30 mcg/0.3ml, 50 mcg/0.3ml, 75 mcg/0.3ml, 100 mcg/0.3ml, 120 mcg/0.3ml, 150 mcg/0.3ml, 200 mcg/0.3ml	3	SP	PA
MULPLETA - lusutrombopag tab 3 mg	3	SP	PA, QL (7 tablets/7 days)
NEULASTA - pegfilgrastim soln prefilled syringe 6 mg/0.6ml	2	SP	PA, QL (2 syringes/28 days)
NIVESTYM - filgrastim-aafi soln prefilled syringe 300 mcg/0.5ml, 480 mcg/0.8ml	2	SP	PA
NIVESTYM - filgrastim-aafi inj 300 mcg/ml, 480 mcg/1.6ml (300 mcg/ml)	2	SP	PA
NYVEPRIA - pegfilgrastim-apgf soln prefilled syringe 6 mg/0.6ml	2	SP	PA, QL (2 syringes/28 days)
OXBRYTA - voxelotor tab 300 mg, 500 mg	3	SP	PA, LD, QL (90 tablets/30 days)
OXBRYTA - voxelotor tab for oral susp 300 mg	3	SP	PA, LD, QL (90 tablets/30 days)
PROCRIT - epoetin alfa inj 2000 unit/ml, 3000 unit/ml, 4000 unit/ml, 10000 unit/ml, 20000 unit/ml, 40000 unit/ml	2	SP	PA

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Drug Name	Drug Tier	Specialty	Requirements/Limits
PROMACTA - eltrombopag olamine tab 12.5 mg (base equiv), 25 mg (base equiv), 50 mg (base equiv), 75 mg (base equiv)	3	SP	PA, QL (30 tablets/30 days)
PROMACTA - eltrombopag olamine powder pack for susp 25 mg (base equiv), 12.5 mg (base eq)	3	SP	PA, QL (30 packets/30 days)
RETACRIT - epoetin alfa-epbx inj 2000 unit/ml, 3000 unit/ml, 4000 unit/ml, 10000 unit/ml, 20000 unit/ml, 40000 unit/ml	2	SP	PA
STIMUFEND - pegfilgrastim-fpgk soln prefilled syringe 6 mg/0.6ml	3	SP	PA, QL (2 syringes/28 days)
UDENYCA - pegfilgrastim-cbqv soln auto-injector 6 mg/0.6ml	2	SP	PA, QL (2 pens/28 days)
UDENYCA - pegfilgrastim-cbqv soln prefilled syringe 6 mg/0.6ml	2	SP	PA, QL (2 syringes/28 days)
ZARXIO - filgrastim-sndz soln prefilled syringe 300 mcg/0.5ml, 480 mcg/0.8ml	2	SP	PA
ZAVESCA - miglustat cap 100 mg	3	SP	PA, LD, QL (90 capsules/30 days)
ZIEXTENZO - pegfilgrastim-bmez soln prefilled syringe 6 mg/0.6ml	2	SP	PA, QL (2 syringes/28 days)
ANTICOAGULANTS			
dabigatran etexilate mesylate cap 75 mg (etexilate base eq), 150 mg (etexilate base eq) (Pradaxa)	1		QL (60 capsules/30 days)
dabigatran etexilate mesylate cap 110 mg (etexilate base eq) (Pradaxa)	1		QL (120 capsules/30 days)
ELIQUIS - apixaban tab 2.5 mg	2		QL (60 tablets/30 days)
ELIQUIS - apixaban tab 5 mg	2		QL (74 tablets/30 days)
ELIQUIS STARTER PACK - apixaban tab starter pack 5 mg	2		QL (1 pack/180 days)
enoxaparin sodium inj soln pref syr 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml, 100 mg/ml, 120 mg/0.8ml, 150 mg/ml (Lovenox)	1		
enoxaparin sodium inj 300 mg/3ml (Lovenox)	1		
fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml, 10 mg/0.8ml (Arixtra)	1		
FRAGMIN - dalteparin sodium soln prefilled syr 2500 unit/0.2ml, 5000 unit/0.2ml, 7500 unit/0.3ml, 10000 unit/ml, 12500 unit/0.5ml, 15000 unit/0.6ml, 18000 unit/0.72ml	3		
FRAGMIN - dalteparin sodium subcutaneous soln 10000 unit/4ml, 95000 unit/3.8ml	3		
HEPARIN SODIUM - heparin sodium (porcine) pf inj 5000 unit/ml	3		

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heparin sodium (porcine) inj 5000 unit/ml, 10000 unit/ml	1		
PRADAXA - dabigatran etexilate mesylate cap 75 mg (etexilate base eq), 150 mg (etexilate base eq)	3		QL (60 capsules/30 days)
PRADAXA - dabigatran etexilate mesylate cap 110 mg (etexilate base eq)	3		QL (120 capsules/30 days)
PRADAXA - dabigatran etexilate mesylate pellet pack 20 mg, 150 mg	3		QL (60 packets/30 days)
PRADAXA - dabigatran etexilate mesylate pellet pack 30 mg, 40 mg, 50 mg, 110 mg	3		QL (120 packets/30 days)
warfarin sodium tab 1 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg, 10 mg	1		
XARELTO - rivaroxaban for susp 1 mg/ml	2		QL (620 mls/30 days)
XARELTO - rivaroxaban tab 2.5 mg, 15 mg	2		QL (60 tablets/30 days)
XARELTO - rivaroxaban tab 10 mg, 20 mg	2		QL (30 tablets/30 days)
XARELTO STARTER PACK - rivaroxaban tab starter therapy pack 15 mg & 20 mg	2		QL (1 pack/30 days)
HEMOSTATICS			
aminocaproic acid oral soln 0.25 gm/ml (Amicar)	1		
aminocaproic acid tab 500 mg, 1000 mg (Amicar)	1		
tranexamic acid tab 650 mg (Lysteda)	1		
HEMATOLOGICAL AGENTS - MISC.			
ADVATE - antihemophilic factor recomb (rahf-pfm) for inj 250 unit, 500 unit, 1000 unit, 1500 unit, 2000 unit, 3000 unit, 4000 unit	2	SP	PA
ADYNOVATE - antihemophilic factor recomb pegylated for inj 250 unit, 500 unit, 750 unit, 1000 unit, 1500 unit, 2000 unit, 3000 unit	2	SP	PA
AFSTYLA - antihemophilic fact rcmb single chain for inj kit 250 unit, 500 unit, 1000 unit, 1500 unit, 2000 unit, 2500 unit, 3000 unit	2	SP	PA, LD
AGRYLIN - anagrelide hcl cap 0.5 mg	3		
ALPHANATE - antihemophilic factor/vwf (human) for inj 250 unit, 500 unit, 1000 unit, 1500 unit, 2000 unit	2	SP	PA, LD
ALPHANINE SD - coagulation factor ix for inj 500 unit, 1000 unit, 1500 unit	2	SP	PA
ALPROLIX - coagulation factor ix (recomb) (rfixfc) for inj 250 unit, 500 unit, 1000 unit, 2000 unit, 3000 unit, 4000 unit	2	SP	PA, LD
ALTUVIIIO - antihemophilic fact rcmb fc-vwf-xten-ehtl for inj 250 unit, 500 unit, 1000 unit, 2000 unit, 3000 unit, 4000 unit	2	SP	PA
anagrelide hcl cap 0.5 mg (Agrylin)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
anagrelide hcl cap 1 mg	1		
aspirin-dipyridamole cap er 12hr 25-200 mg	1		
BENEFIX - coagulation factor ix (recombinant) for inj kit 250 unit, 500 unit, 1000 unit, 2000 unit, 3000 unit	2	SP	PA
BERINERT - c1 esterase inhibitor (human) for iv inj kit 500 unit	3	SP	PA, LD, QL (16 vials/30 days)
BRILINTA - ticagrelor tab 60 mg, 90 mg	2		
CABLIVI - caplacizumab-yhdp for inj kit 11 mg	3	SP	PA, LD, QL (30 kits/30 days)
cilostazol tab 50 mg, 100 mg	1		
CINRYZE - c1 esterase inhibitor (human) for iv inj 500 unit	2	SP	PA, LD, QL (20 vials/30 days)
clopidogrel bisulfate tab 75 mg (base equiv) (Plavix)	1		
clopidogrel bisulfate tab 300 mg (base equiv)	1		
COAGADEX - coagulation factor x (human) for inj 250 unit, 500 unit	2	SP	PA, LD
CORIFACT - factor xiii concentrate (human) for inj kit 1000-1600 unit	2	SP	PA, LD
dipyridamole tab 25 mg, 50 mg, 75 mg	1		
ELOCTATE - antihemophilic factor rcmb (bdd-rfviiifc) for inj 250 unit, 500 unit, 750 unit, 1000 unit, 1500 unit, 2000 unit, 3000 unit, 4000 unit, 5000 unit, 6000 unit	2	SP	PA
EMPAVELI - pegcetacoplan subcutaneous soln 1080 mg/20ml (54 mg/ml)	2	SP	PA, LD, QL (8 vials/28 days)
ESPEROCT - antihemophilic factor recomb glycopeg-exei for inj 500 unit, 1000 unit, 1500 unit, 2000 unit, 3000 unit	3	SP	PA, LD
FEIBA - antiinhibitor coagulant complex for iv soln 500 unit, 1000 unit, 2500 unit	2	SP	PA
FIBRYGA - fibrinogen conc (human) inj approximately 1 gm (900-1300 mg)	2	SP	PA
HAEGARDA - c1 esterase inhibitor (human) for subcutaneous inj 2000 unit, 3000 unit	2	SP	PA, LD, QL (16 vials/30 days)
HEMLIBRA - emicizumab-kxwh subcutaneous soln 12 mg/0.4ml (30 mg/ml), 30 mg/ml, 60 mg/0.4ml (150 mg/ml), 105 mg/0.7ml (150 mg/ml), 150 mg/ml, 300 mg/2ml (150 mg/ml)	2	SP	PA, LD
HEMOFIL M - antihemophilic factor (human) for inj 250 unit, 500 unit, 1000 unit, 1700 unit	2	SP	PA
HUMATE-P - antihemophilic factor/vwf (human) for inj 250-600 unit, 500-1200 unit, 1000-2400 unit	2	SP	PA
icatibant acetate subcutaneous soln pref syr 30 mg/3ml (Firazyr)	1	SP	PA, LD, QL (12 syringes/30 days)

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IDELVION - coagulation factor ix (recomb) (rix-fp) for inj 250 unit, 500 unit, 1000 unit, 2000 unit, 3500 unit	2	SP	PA
IXINITY - coagulation factor ix (recombinant) for inj 250 unit, 500 unit, 1000 unit, 1500 unit, 2000 unit, 3000 unit	2	SP	PA, LD
JIVI - antihemophil fact rcmb(bdd-rfviii peg-aucl) for inj 500 unit	2	SP	PA
JIVI - antihemophil fact rcmb(bdd-rfviii peg-aucl)for inj 1000 unit, 2000 unit, 3000 unit	2	SP	PA
KALBITOR - ecallantide inj 10 mg/ml	3	SP	PA, LD, QL (12 vials/30 days)
KOATE - antihemophilic factor (human) for inj 250 unit, 500 unit, 1000 unit	2	SP	PA
KOATE-DVI - antihemophilic factor (human) for inj 500 unit, 1000 unit	2	SP	PA
KOGENATE FS - antihemophilic factor recomb (rfviii) for inj kit 250 unit, 500 unit, 1000 unit, 2000 unit, 3000 unit	2	SP	PA
KOVALTRY - antihemophilic factor recomb (rahf-pfm) for inj 250 unit, 500 unit, 1000 unit, 2000 unit, 3000 unit	2	SP	PA
NOVOEIGHT - antihemophilic fact rcmb (bd trunc-rfviii) for inj 250 unit, 500 unit, 1000 unit, 1500 unit, 2000 unit, 3000 unit	2	SP	PA
NOVOSEVEN RT - coagulation factor viia (recomb) for inj 1 mg (1000 mcg), 2 mg (2000 mcg), 5 mg (5000 mcg), 8 mg (8000 mcg)	2	SP	PA, LD
NUWIQ - antihemophilic factor rcmb (bdd-rfviii,sim) for inj 250 unit, 500 unit	2	SP	PA, LD
NUWIQ - antihemophilic fact rcmb (bdd-rfviii,sim) for inj 1000 unit, 1500 unit, 2000 unit, 2500 unit, 3000 unit, 4000 unit	2	SP	PA, LD
NUWIQ - antihemophil fact rcmb (bdd-rfviii,sim) for inj kit 250 unit, 500 unit	2	SP	PA, LD
NUWIQ - antihemophil fact rcmb(bdd-rfviii,sim) for inj kit 1000 unit, 1500 unit, 2000 unit, 2500 unit, 3000 unit, 4000 unit	2	SP	PA, LD
OBIZUR - antihemophilic factor (recomb porc) rpfviii for inj 500 unit	2	SP	PA, LD
ORLADEYO - berotralstat hcl cap 110 mg, 150 mg	3	SP	PA, LD, QL (30 capsules/30 days)
pentoxifylline tab er 400 mg	1		
prasugrel hcl tab 5 mg (base equiv), 10 mg (base equiv) (Effient)	1		
PROFILNINE - factor ix complex for inj 500 unit, 1000 unit, 1500 unit	2	SP	PA
PYRUKYND - mitapivat sulfate tab 5 mg, 20 mg, 50 mg	3	SP	PA, LD, QL (56 tablets/28 days)

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PYRUKYND TAPER PACK - mitapivat sulfate tab therapy pack 5 mg, 7 x 20 mg & 7 x 5 mg, 7 x 50 mg & 7 x 20 mg	3	SP	PA, LD, QL (1 pack/365 days)
REBINYN - coagulation factor ix recomb glycopegylated for inj 500 unt, 1000 unt, 2000 unt, 3000 unt	2	SP	PA, LD
RECOMBINATE - antihemophilic factor recomb (rfviii) for inj 220-400 unit, 401-800 unit, 801-1240 unit, 1241-1800 unit, 1801-2400 unit	2	SP	PA
RIASTAP - fibrinogen conc (human) inj approximately 1 gm (900-1300 mg)	2	SP	PA, LD
RIXUBIS - coagulation factor ix (recombinant) for inj 250 unit, 500 unit, 1000 unit, 2000 unit, 3000 unit	2	SP	PA
RUCONEST - c1 esterase inhibitor (recombinant) for iv inj 2100 unit	3	SP	PA, LD, QL (16 vials/30 days)
RYPLAZIM - plasminogen, human-tvmh for iv soln 68.8 mg	3	SP	PA, LD
SEVENFACT - coagulation factor viia (recom)-jncw for inj 1 mg (1000 mcg), 5 mg (5000 mcg)	3	SP	PA, LD
TAKHZYRO - lanadelumab-flyo soln pref syringe 150 mg/ml, 300 mg/2ml (150 mg/ml)	2	SP	PA, LD, QL (2 syringes/28 days)
TAKHZYRO - lanadelumab-flyo inj 300 mg/2ml (150 mg/ml)	2	SP	PA, LD, QL (2 vials/28 days)
TAVALISSE - fostamatinib disodium tab 100 mg (base equivalent), 150 mg (base equivalent)	3	SP	PA, LD, QL (60 tablets/30 days)
TAVNEOS - avacopan cap 10 mg	3	SP	PA, LD, QL (180 capsules/30 days)
TRETTEN - coagulation factor xiii a-subunit for inj 2500 unit	2	SP	PA, LD
VONVENDI - von willebrand factor (recombinant) for inj 650 unit, 1300 unit	2	SP	PA
WILATE - antihemophilic factor/vwf (human) for inj 500-500 unit kit	2	SP	PA
WILATE - antihemophilic factor/vwf (human) for inj 1000-1000 unit kit	2	SP	PA
XYNTHA - antihemophil fact rcmb (bdd-rfviii,mor) for inj kit 250 unit, 500 unit	2	SP	PA
XYNTHA - antihemophil fact rcmb(bdd-rfviii,mor) for inj kit 1000 unit, 2000 unit	2	SP	PA
XYNTHA SOLOFUSE - antihemophil fact rcmb (bdd-rfviii,mor) for inj kit 250 unit, 500 unit	2	SP	PA
XYNTHA SOLOFUSE - antihemophil fact rcmb(bdd-rfviii,mor) for inj kit 1000 unit, 2000 unit, 3000 unit	2	SP	PA
ZONTIVITY - vorapaxar sulfate tab 2.08 mg (base equivalent)	3		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
TOPICAL PRODUCTS			
OPHTHALMIC AGENTS			
ACULAR - ketorolac tromethamine ophth soln 0.5%	3		
ACULAR LS - ketorolac tromethamine ophth soln 0.4%	3		
AKTEN - lidocaine hcl ophth gel 3.5%	3		
ALOCRIL - nedocromil sodium ophth soln 2%	3		
ALOMIDE - lodoxamide tromethamine ophth soln 0.1%	3		
ALPHAGAN P - brimonidine tartrate ophth soln 0.15%	3		
ALREX - loteprednol etabonate ophth susp 0.2%	3		
APRACLONIDINE - apraclonidine hcl ophth soln 0.5% (base equivalent)	2		
ATROPINE SULFATE - atropine sulfate ophth soln 1%	3		
atropine sulfate ophth soln 1% (Atropine sulfate)	1		
azelastine hcl ophth soln 0.05%	1		
BACITRACIN - bacitracin ophth oint 500 unit/gm	2		
bacitracin-polymyxin b ophth oint	1		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	1		
bepotastine besilate ophth soln 1.5% (Bepreve)	1		
BEPREVE - bepotastine besilate ophth soln 1.5%	3		
BESIVANCE - besifloxacin hcl ophth susp 0.6% (base equiv)	3		
BETADINE OPHTHALMIC PREP - povidone-iodine ophth soln 5%	3		
BETAXOLOL HCL - betaxolol hcl ophth soln 0.5%	2		
bimatoprost ophth soln 0.03%	1		QL (2.5 mls/30 days)
brimonidine tartrate ophth soln 0.15% (Alphagan p)	1		
brimonidine tartrate ophth soln 0.2%	1		
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5% (Combigan)	1		
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)	1		
CARTEOLOL HCL - carteolol hcl ophth soln 1%	3		
CEQUA - cyclosporine (ophth) soln 0.09% (pf)	3		PA, QL (60 vials/30 days)
ciprofloxacin hcl ophth soln 0.3% (base equivalent)	1		
CROMOLYN SODIUM - cromolyn sodium ophth soln 4%	2		
CYCLOGYL - cyclopentolate hcl ophth soln 0.5%, 2%	2		
CYCLOGYL - cyclopentolate hcl ophth soln 1%	3		
CYCLOMYDRIL - cyclopentolate w/ phenylephrine ophth soln 0.2-1%	3		
cyclopentolate hcl ophth soln 1% (Cyclogyl)	1		

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CYSTADROPS - cysteamine hcl ophth soln 0.37% (base equivalent)	3	SP	PA, LD, QL (20 mls/28 days)
CYSTARAN - cysteamine hcl ophth soln 0.44% (base equivalent)	3	SP	PA, LD, QL (60 mls/28 days)
DEXAMETHASONE SODIUM PHOS - dexamethasone sodium phosphate ophth soln 0.1%	3		
diclofenac sodium ophth soln 0.1%	1		
difluprednate ophth emulsion 0.05% (Durezol)	1		
dorzolamide hcl ophth soln 2% (Trusopt)	1		
dorzolamide hcl-timolol maleate ophth soln 2-0.5% (Cosopt)	1		
dorzolamide hcl-timolol maleate pf ophth soln 2-0.5% (Cosopt pf)	1		
DUREZOL - difluprednate ophth emulsion 0.05%	3		
epinastine hcl ophth soln 0.05%	1		
ERYTHROMYCIN - erythromycin ophth oint 5 mg/gm	3		
erythromycin ophth oint 5 mg/gm	1		
FLAREX - fluorometholone acetate ophth susp 0.1%	3		
fluorometholone ophth susp 0.1% (Fml liquifilm)	1		
FLURBIPROFEN SODIUM - flurbiprofen sodium ophth soln 0.03%	3		
FML FORTE - fluorometholone ophth susp 0.25%	3		
FML LIQUIFILM - fluorometholone ophth susp 0.1%	3		
gatifloxacin ophth soln 0.5% (Zymaxid)	1		
gentamicin sulfate ophth soln 0.3%	1		
ILEVRO - nepafenac ophth susp 0.3%	2		
IOPIDINE - apraclonidine hcl ophth soln 1% (base equivalent)	3		
ketorolac tromethamine ophth soln 0.4% (Acular ls)	1		
ketorolac tromethamine ophth soln 0.5% (Acular)	1		
LACRISERT - artificial tear ophth insert	3		
latanoprost ophth soln 0.005% (Xalatan)	1		QL (2.5 mls/30 days)
LEVOBUNOLOL HCL - levobunolol hcl ophth soln 0.5%	3		
LEVOFLOXACIN - levofloxacin ophth soln 1.5%	3		
LOTEMAX - loteprednol etabonate ophth oint 0.5%	2		
LOTEMAX - loteprednol etabonate ophth susp 0.5%	3		
LOTEMAX - loteprednol etabonate ophth gel 0.5%	3		
LOTEMAX SM - loteprednol etabonate ophth gel 0.38%	2		
loteprednol etabonate ophth gel 0.5% (Lotemax)	1		
loteprednol etabonate ophth susp 0.2% (Alrex)	1		
loteprednol etabonate ophth susp 0.5% (Lotemax)	1		

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LUMIGAN - bimatoprost ophth soln 0.01%	2		QL (2.5 mls/30 days)
MAXIDEX - dexamethasone ophth susp 0.1%	3		
MAXITROL - neomycin-polymyxin-dexamethasone ophth susp 0.1%	3		
MAXITROL - neomycin-polymyxin-dexamethasone ophth oint 0.1%	3		
moxifloxacin hcl ophth soln 0.5% (base equiv) (Vigamox)	1		
MYDRIACYL - tropicamide ophth soln 1%	3		
NATACYN - natamycin ophth susp 5%	2		
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	1		
neomycin-polymyxin-dexamethasone ophth oint 0.1% (Maxitrol)	1		
neomycin-polymyxin-dexamethasone ophth susp 0.1% (Maxitrol)	1		
NEOMYCIN/POLYMYXIN/GRAMIC - neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	3		
OCUFLOX - ofloxacin ophth soln 0.3%	3		
ofloxacin ophth soln 0.3% (Ocuflox)	1		
OXERVATE - cenegermin-bkbj ophth soln 0.002% (20 mcg/ml)	3	SP	PA, LD, QL (56 vials/28 days)
phenylephrine hcl ophth soln 2.5%, 10%	1		
PHOSPHOLINE IODIDE - echothiophate iodide ophth for soln 0.125%	3		LD
pilocarpine hcl ophth soln 1%, 2%, 4%	1		
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1% (Polytrim)	1		
PRED MILD - prednisolone acetate ophth susp 0.12%	3		
PREDNISOLONE ACETATE - prednisolone acetate ophth susp 1%	2		
PREDNISOLONE SODIUM PHOSP - prednisolone sodium phosphate ophth soln 1%	3		
proparacaine hcl ophth soln 0.5% (Alcaine)	1		
RESTASIS - cyclosporine (ophth) emulsion 0.05%	2		PA, QL (60 vials/30 days)
RHOPRESSA - netarsudil dimesylate ophth soln 0.02%	3		QL (2.5 mls/30 days)
ROCKLATAN - netarsudil dimesylate-latanoprost ophth soln 0.02-0.005%	3		QL (2.5 mls/30 days)
SIMBRINZA - brinzolamide-brimonidine tartrate ophth susp 1-0.2%	2		
SULFACETAMIDE SODIUM - sulfacetamide sodium ophth oint 10%	3		

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sulfacetamide sodium ophth soln 10%	1		
SULFACETAMIDE SODIUM/PRED - sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	3		
tafluprost preservative free (pf) ophth soln 0.0015% (Zioptan)	1		QL (30 containers/30 days)
tetracaine hcl ophth soln 0.5%	1		
timolol maleate ophth gel forming soln 0.25%, 0.5% (Timoptic-xe)	1		
timolol maleate ophth soln 0.25%, 0.5% (Timoptic)	1		
timolol maleate ophth soln 0.5% (once-daily) (Istalol)	1		
timolol maleate preservative free ophth soln 0.25%, 0.5% (Timoptic ocudose)	1		
TOBRADEX - tobramycin-dexamethasone ophth oint 0.3-0.1%	2		
TOBRADEX ST - tobramycin-dexamethasone ophth susp 0.3-0.05%	3		
tobramycin ophth soln 0.3%	1		
tobramycin-dexamethasone ophth susp 0.3-0.1% (Tobradex)	1		
TOBREX - tobramycin ophth oint 0.3%	3		
TRAVATAN Z - travoprost ophth soln 0.004% (benzalkonium free) (bak free)	3		QL (2.5 mls/30 days)
travoprost ophth soln 0.004% (benzalkonium free) (bak free) (Travatan z)	1		QL (2.5 mls/30 days)
TRIFLURIDINE - trifluridine ophth soln 1%	2		
tropicamide ophth soln 0.5%	1		
tropicamide ophth soln 1% (Mydriacyl)	1		
TYRVAYA - varenicline tartrate nasal soln 0.03 mg/act	3		PA, QL (2 bottles/30 days)
XIIDRA - lifitegrast ophth soln 5%	3		PA, QL (60 vials/30 days)
ZERVIATE - cetirizine hcl ophth soln 0.24% (base equiv)	3		PA, QL (60 vials/30 days)
ZIRGAN - ganciclovir ophth gel 0.15%	3		
OTIC AGENTS			
acetic acid otic soln 2%	1		
CIPRO HC - ciprofloxacin-hydrocortisone otic susp 0.2-1%	3		
CIPROFLOXACIN - ciprofloxacin hcl otic soln 0.2% (base equivalent)	3		
ciprofloxacin-dexamethasone otic susp 0.3-0.1% (Ciprodex)	1		
CORTISPORIN-TC - neomycin-colistin-hc-thonzonium otic susp 3.3-3-10-0.5 mg/ml	3		
DERMOTIC - fluocinolone acetonide (otic) oil 0.01%	3		

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fluocinolone acetonide (otic) oil 0.01% (Dermotic)	1		
hydrocortisone w/ acetic acid otic soln 1-2% (Hydrocortisone/aceti)	1		
HYDROCORTISONE/ACETIC ACI - hydrocortisone w/ acetic acid otic soln 1-2%	3		
neomycin-polymyxin-hc otic soln 1%	1		
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	1		
ofloxacin otic soln 0.3%	1		
MOUTH/THROAT/DENTAL AGENTS			
cevimeline hcl cap 30 mg (Evoxac)	1		
chlorhexidine gluconate soln 0.12% (Peridex)	1		
clotrimazole troche 10 mg	1		
DENTA 5000 PLUS SENSITIVE - sodium fluoride-potassium nitrate paste 1.1-5%	3		
FLUORIDEX SENSITIVITY REL - sodium fluoride-potassium nitrate paste 1.1-5%	3		
FLUORIMAX 5000 SENSITIVE - sodium fluoride-potassium nitrate paste 1.1-5%	3		
LIDOCAINE HCL - lidocaine hcl laryngotracheal soln 4%	3		
lidocaine hcl viscous soln 2%	1		
NYSTATIN - nystatin susp 100000 unit/ml	3		
nystatin susp 100000 unit/ml	1		
ORAVIG - miconazole buccal tab 50 mg (mouth-throat)	3		
PERIDEX - chlorhexidine gluconate soln 0.12%	3		
pilocarpine hcl tab 5 mg, 7.5 mg (Salagen)	1		
PREVIDENT RINSE - sodium fluoride rinse 0.2%	2		
SALAGEN - pilocarpine hcl tab 5 mg, 7.5 mg	3		
sodium fluoride cream 1.1% (Prevident 5000 plus)	1		
sodium fluoride gel 1.1% (0.5% f) (Prevident fluoride)	1		
sodium fluoride paste 1.1% (Prevident 5000 boost)	1		
stannous fluoride gel 0.4%	1		
triamcinolone acetonide dental paste 0.1%	1		
ANORECTAL AGENTS			
ANALPRAM HC - hydrocortisone acetate w/ pramoxine perianal cream 2.5-1%	3		
ANALPRAM HC SINGLES - hydrocortisone acetate w/ pramoxine perianal cream 2.5-1%	3		
ANALPRAM-HC - hydrocortisone acetate w/ pramoxine perianal lotn 2.5-1%	3		

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ANALPRAM-HC - hydrocortisone acetate w/ pramoxine perianal cream 1-1%	3		
ANUSOL-HC - hydrocortisone perianal cream 2.5%	3		
CORTENEMA - hydrocortisone enema 100 mg/60ml	3		
CORTIFOAM - hydrocortisone acetate perianal foam 10% (90 mg/dose)	3		
HYDROCORTISONE ACETATE/PR - hydrocortisone acetate w/ pramoxine perianal cream 1-1%	2		
hydrocortisone enema 100 mg/60ml (Cortenema)	1		
hydrocortisone perianal cream 1% (Proctocort)	1		
hydrocortisone perianal cream 2.5% (Anusol-hc)	1		
nitroglycerin oint 0.4% (Rectiv)	1		
PROCTOFOAM HC - hydrocortisone acetate w/ pramoxine perianal foam 1-1%	2		
RECTIV - nitroglycerin oint 0.4%	3		
DERMATOLOGICALS			
acitretin cap 10 mg, 17.5 mg, 25 mg	1		
acyclovir oint 5% (Zovirax)	1		
adapalene gel 0.1%	1		
ADBRY - tralokinumab-ldrm subcutaneous soln prefilled syr 150 mg/ml	2	SP	PA, LD, QL (4 syringes/28 days)
AFTERTEST TOPICAL PAIN RE - benzocaine stick 10%	3		
alclometasone dipropionate cream 0.05%	1		QL (120 grams/30 days)
alclometasone dipropionate oint 0.05%	1		QL (120 grams/30 days)
azelaic acid gel 15% (Finacea)	1		
BENZAMYCIN - benzoyl peroxide-erythromycin gel 5-3%	3		
benzoyl peroxide-erythromycin gel 5-3% (Benzamycin)	1		
BETAMETHASONE DIPROPIONAT - betamethasone dipropionate augmented gel 0.05%	3		ST, QL (200 grams/28 days)
betamethasone dipropionate augmented cream 0.05%	1		QL (200 grams/28 days)
betamethasone dipropionate augmented lotion 0.05%	1		QL (210 mls/30 days)
betamethasone dipropionate augmented oint 0.05% (Diprolene)	1		QL (200 grams/28 days)
betamethasone dipropionate cream 0.05%	1		QL (135 grams/30 days)
betamethasone dipropionate lotion 0.05%	1		QL (120 mls/30 days)
betamethasone dipropionate oint 0.05%	1		QL (135 grams/30 days)
betamethasone valerate cream 0.1% (base equivalent)	1		QL (135 grams/30 days)

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betamethasone valerate lotion 0.1% (base equivalent)	1		QL (120 mls/30 days)
betamethasone valerate oint 0.1% (base equivalent)	1		QL (135 grams/30 days)
bexarotene gel 1% (Targretin)	1	SP	PA
brimonidine tartrate gel 0.33% (base equivalent) (Mirvaso)	1		
calcipotriene cream 0.005% (Dovonex)	1		QL (120 grams/30 days)
calcipotriene oint 0.005%	1		QL (120 grams/30 days)
calcipotriene soln 0.005% (50 mcg/ml)	1		QL (120 mls/30 days)
calcipotriene-betamethasone dipropionate oint 0.005-0.064% (Taclonex)	1		QL (120 grams/30 days)
calcipotriene-betamethasone dipropionate susp 0.005-0.064% (Taclonex)	1		QL (120 grams/30 days)
CALCITRIOL - calcitriol oint 3 mcg/gm	3		QL (200 grams/30 days)
CIBINQO - abrocitinib tab 50 mg, 100 mg, 200 mg	2	SP	PA, QL (30 tablets/30 days)
ciclopirox gel 0.77%	1		
ciclopirox olamine cream 0.77% (base equiv) (Loprox)	1		
ciclopirox olamine susp 0.77% (base equiv) (Loprox)	1		
ciclopirox shampoo 1% (Loprox shampoo)	1		
ciclopirox solution 8% (Penlac Nail Lacquer)	1		QL (6.6 mls/30 days)
CLEOCIN-T - clindamycin phosphate lotion 1%	3		
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	1		
clindamycin phosphate gel 1% (Clindagel)	1		
clindamycin phosphate lotion 1% (Cleocin-t)	1		
clindamycin phosphate soln 1%	1		QL (120 grams/30 days)
clindamycin phosphate swab 1%	1		
clindamycin phosphate-benzoyl peroxide gel 1-5%	1		
clobetasol propionate cream 0.05%	1		QL (210 grams/28 days)
clobetasol propionate emollient base cream 0.05%	1		QL (210 grams/28 days)
clobetasol propionate gel 0.05%	1		QL (210 grams/28 days)
clobetasol propionate oint 0.05%	1		QL (210 grams/28 days)
clobetasol propionate soln 0.05%	1		QL (200 mls/28 days)
clocortolone pivalate cream 0.1% (Cloderm)	1		QL (135 grams/30 days)
CLODERM - clocortolone pivalate cream 0.1%	3		ST, QL (135 grams/30 days)
clotrimazole w/ betamethasone cream 1-0.05%	1		
CONDYLOX - podofilox gel 0.5%	3		
CORDRAN - flurandrenolide tape 4 mcg/sqcm	3		ST, QL (1 box/30 days)
COSENTYX - secukinumab subcutaneous soln prefilled syringe 75 mg/0.5ml, 150 mg/ml	2	SP	PA, LD, QL (1 syringe/28 days)

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COSENTYX - secukinumab subcutaneous pref syr 150 mg/ml (300 mg dose)	2	SP	PA, LD, QL (2 syringes/28 days)
COSENTYX SENSOREADY PEN - secukinumab subcutaneous soln auto-injector 150 mg/ml	2	SP	PA, LD, QL (1 pen/28 days)
COSENTYX SENSOREADY PEN - secukinumab subcutaneous auto-inj 150 mg/ml (300 mg dose)	2	SP	PA, LD, QL (2 pens/28 days)
COSENTYX UNOREADY - secukinumab subcutaneous soln auto-injector 300 mg/2ml	2	SP	PA, LD, QL (1 pen/28 days)
CROTAN - crotamiton lotion 10%	3		
DERMA-SMOOTHE/FS BODY - fluocinolone acetonide oil 0.01% (body oil)	3		ST, QL (118.28 mls/30 days)
DERMA-SMOOTHE/FS SCALP - fluocinolone acetonide oil 0.01% (scalp oil)	3		ST, QL (118.28 mls/30 days)
desonide cream 0.05% (Desowen)	1		QL (120 grams/30 days)
desonide oint 0.05%	1		QL (120 grams/30 days)
desoximetasone cream 0.05%, 0.25% (Topicort)	1		QL (120 grams/30 days)
desoximetasone gel 0.05% (Topicort)	1		QL (120 grams/30 days)
desoximetasone oint 0.05%, 0.25% (Topicort)	1		QL (120 grams/30 days)
desoximetasone spray 0.25% (Topicort)	1		QL (100 mls/30 days)
diclofenac sodium soln 1.5%	1		QL (150 mls/30 days)
DIPROLENE - betamethasone dipropionate augmented oint 0.05%	3		ST, QL (200 grams/28 days)
doxepin hcl cream 5% (Prudoxin)	1		PA, QL (45 grams/30 days)
DUPIXENT - dupilumab subcutaneous soln pen-injector 200 mg/1.14ml, 300 mg/2ml	2	SP	PA, QL (2 pens/28 days)
DUPIXENT - dupilumab subcutaneous soln prefilled syringe 200 mg/1.14ml, 300 mg/2ml	2	SP	PA, QL (2 syringes/28 days)
DYCLOPRO - dyclonine hcl soln 0.5%	3		
econazole nitrate cream 1%	1		QL (120 grams/30 days)
EFUDEX - fluorouracil cream 5%	3		PA, QL (240 grams/84 days)
EPIFOAM - pramoxine-hc aerosol foam 1-1%	3		
ERTACZO - sertaconazole nitrate cream 2%	3		PA
ERY - erythromycin pads 2%	3		
ERYGEL - erythromycin gel 2%	3		
erythromycin gel 2% (Erygel)	1		
erythromycin soln 2%	1		
EXELDERM - sulconazole nitrate solution 1%	3		PA
EXELDERM - sulconazole nitrate cream 1%	3		PA
FLUOCINOLONE ACETONIDE - fluocinolone acetonide cream 0.01%	2		ST, QL (120 grams/30 days)
fluocinolone acetonide cream 0.025% (Synalar)	1		QL (120 grams/30 days)

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fluocinolone acetonide oil 0.01% (body oil) (Derma-smoothe/fs bod)	1		QL (118.28 mls/30 days)
fluocinolone acetonide oil 0.01% (scalp oil) (Derma-smoothe/fs sca)	1		QL (118.28 mls/30 days)
fluocinolone acetonide oint 0.025% (Synalar)	1		QL (120 grams/30 days)
fluocinolone acetonide soln 0.01% (Synalar)	1		QL (120 mls/30 days)
fluocinonide cream 0.05%	1		QL (120 grams/30 days)
fluocinonide emulsified base cream 0.05%	1		QL (120 grams/30 days)
fluocinonide gel 0.05%	1		QL (120 grams/30 days)
fluocinonide oint 0.05%	1		QL (120 grams/30 days)
fluocinonide soln 0.05%	1		QL (120 mls/30 days)
FLUOROURACIL - fluorouracil soln 2%	3		
fluorouracil cream 5% (Efudex)	1		PA, QL (240 grams/84 days)
fluorouracil soln 5%	1		
fluticasone propionate cream 0.05%	1		QL (120 grams/30 days)
fluticasone propionate oint 0.005%	1		QL (120 grams/30 days)
gentamicin sulfate cream 0.1%	1		QL (60 grams/30 days)
gentamicin sulfate oint 0.1%	1		
halcinonide cream 0.1% (Halog)	1		QL (120 grams/30 days)
halobetasol propionate cream 0.05%	1		QL (200 grams/28 days)
HALOG - halcinonide soln 0.1%	3		ST, QL (120 mls/30 days)
HALOG - halcinonide oint 0.1%	3		ST, QL (120 grams/30 days)
HYDROCORTISONE - hydrocortisone lotion 2.5%	3		
HYDROCORTISONE BUTYRATE - hydrocortisone butyrate soln 0.1%	3		ST, QL (120 mls/30 days)
HYDROCORTISONE BUTYRATE - hydrocortisone butyrate cream 0.1%	3		ST, QL (135 grams/30 days)
hydrocortisone butyrate oint 0.1%	1		QL (135 grams/30 days)
hydrocortisone cream 2.5%	1		QL (454 grams/30 days)
hydrocortisone oint 2.5%	1		QL (454 grams/30 days)
hydrocortisone valerate cream 0.2%	1		QL (120 grams/30 days)
hydrocortisone valerate oint 0.2%	1		QL (120 grams/30 days)
HYFTOR - sirolimus gel 0.2%	3		PA, LD, QL (70 grams/84 days)
imiquimod cream 5%	1		QL (48 packets/112 days)
isotretinoin cap 10 mg, 20 mg, 30 mg, 40 mg (Absorica)	1		
ivermectin cream 1% (Soolantra)	1		PA
ketoconazole cream 2%	1		QL (120 grams/30 days)
ketoconazole shampoo 2%	1		
KLARON - sulfacetamide sodium lotion 10% (acne)	3		

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KLISYRI - tirbanibulin ointment 1%	3		PA, QL (5 packets/90 days)
lidocaine hcl soln 4%	1		QL (150 mls/30 days)
lidocaine hcl urethral/mucosal gel prefilled syringe 2%	1		
lidocaine patch 5% (Lidoderm)	1		PA, QL (90 patches/30 days)
lidocaine-prilocaine cream 2.5-2.5%	1		QL (60 grams/30 days)
LITFULO - ritlecitinib tosylate cap 50 mg (base equiv)	3	SP	PA, LD, QL (28 capsules/28 days)
mafenide acetate packet for topical soln 5% (50 gm) (Sulfamylon)	1		
malathion lotion 0.5% (Ovide)	1		
METHOXSALEN - methoxsalen rapid cap 10 mg	3		
METROGEL - metronidazole gel 1%	3		
METROLOTION - metronidazole lotion 0.75%	3		
metronidazole cream 0.75% (Metrocream)	1		
metronidazole gel 0.75%	1		
metronidazole gel 1% (Metrogel)	1		
metronidazole lotion 0.75% (Metrolotion)	1		
mometasone furoate cream 0.1%	1		QL (135 grams/30 days)
mometasone furoate oint 0.1%	1		QL (135 grams/30 days)
mometasone furoate solution 0.1% (lotion)	1		QL (120 mls/30 days)
mupirocin oint 2%	1		
NATROBA - spinosad susp 0.9%	3		
NEO-SYNALAR - neomycin sulfate-fluocinolone acetonide cream 0.5-0.025%	3		
nystatin cream 100000 unit/gm	1		
nystatin oint 100000 unit/gm	1		
nystatin topical powder 100000 unit/gm	1		
nystatin-triamcinolone cream 100000-0.1 unit/gm-%	1		
nystatin-triamcinolone oint 100000-0.1 unit/gm-%	1		
OPZELURA - ruxolitinib phosphate cream 1.5%	3		PA, QL (60 grams/30 days)
OVIDE - malathion lotion 0.5%	3		
oxiconazole nitrate cream 1% (Oxistat)	1		PA
PANRETIN - alitretinoin gel 0.1%	3		
penciclovir cream 1% (Denavir)	1		
permethrin cream 5%	1		
pimecrolimus cream 1% (Elidel)	1		ST, QL (100 grams/30 days)
PODOFILOX - podofilox soln 0.5%	2		
podofilox gel 0.5% (Condylox)	1		
REGRANEX - becaplermin gel 0.01%	3		
RETIN-A - tretinoin gel 0.01%, 0.025%	3		

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SANTYL - collagenase oint 250 unit/gm	2		QL (90 grams/30 days)
selenium sulfide lotion 2.5%	1		
SILIQ - brodalumab subcutaneous soln prefilled syringe 210 mg/1.5ml	3	SP	PA, QL (2 syringes/28 days)
SILVADENE - silver sulfadiazine cream 1%	3		
silver sulfadiazine cream 1% (Silvadene)	1		
SKYRIZI - risankizumab-rzaa soln prefilled syringe 150 mg/ml	2	SP	PA, QL (1 syringe/84 days)
SKYRIZI PEN - risankizumab-rzaa soln auto-injector 150 mg/ml	2	SP	PA, QL (1 pen/84 days)
SOOLANTRA - ivermectin cream 1%	2		
SOTYKTU - deucravacitinib tab 6 mg	3	SP	PA, LD, QL (30 tablets/30 days)
SPINOSAD - spinosad susp 0.9%	3		
STELARA - ustekinumab inj 45 mg/0.5ml	2	SP	PA, QL (1 vial/84 days)
STELARA - ustekinumab soln prefilled syringe 45 mg/0.5ml	2	SP	PA, QL (1 syringe/84 days)
STELARA - ustekinumab soln prefilled syringe 90 mg/ml	2	SP	PA, QL (1 syringe/56 days)
SULCONAZOLE NITRATE - sulconazole nitrate solution 1%	3		PA
SULCONAZOLE NITRATE - sulconazole nitrate cream 1%	3		PA
sulfacetamide sodium lotion 10% (acne) (Klaron)	1		
SULFAMYLON - mafenide acetate packet for topical soln 5% (50 gm)	3		
SULFAMYLON - mafenide acetate cream 85 mg/gm	3		
tacrolimus oint 0.03%, 0.1% (Protopic)	1		ST, QL (100 grams/30 days)
TALTZ - ixekizumab subcutaneous soln auto-injector 80 mg/ml	3	SP	PA, LD, QL (1 pen/28 days)
TALTZ - ixekizumab subcutaneous soln prefilled syringe 80 mg/ml	3	SP	PA, LD, QL (1 syringe/28 days)
tazarotene cream 0.1% (Tazorac)	1		QL (120 grams/30 days)
tazarotene gel 0.05%, 0.1% (Tazorac)	1		QL (100 grams/30 days)
TAZORAC - tazarotene cream 0.05%	2		QL (120 grams/30 days)
TAZORAC - tazarotene gel 0.05%, 0.1%	3		QL (100 grams/30 days)
TOLAK - fluorouracil cream 4%	3		PA, QL (40 grams/28 days)
TOPICORT - desoximetasone cream 0.25%	3		ST, QL (120 grams/30 days)
TOPICORT - desoximetasone gel 0.05%	3		ST, QL (120 grams/30 days)
TOPICORT - desoximetasone oint 0.25%	3		ST, QL (120 grams/30 days)
TREMFYA - guselkumab soln pen-injector 100 mg/ml	2	SP	PA, QL (1 pen/56 days)
TREMFYA - guselkumab soln prefilled syringe 100 mg/ml	2	SP	PA, QL (1 syringe/56 days)

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tretinoin cream 0.025%, 0.05%, 0.1% (Retin-a)	1		
tretinoin gel 0.01%, 0.025% (Retin-a)	1		
triamcinolone acetonide aerosol soln 0.147 mg/gm (Kenalog)	1		QL (126 grams/30 days)
triamcinolone acetonide cream 0.025%, 0.1%, 0.5%	1		QL (454 grams/30 days)
triamcinolone acetonide lotion 0.025%, 0.1%	1		QL (120 mls/30 days)
triamcinolone acetonide oint 0.025%, 0.1%	1		QL (454 grams/30 days)
triamcinolone acetonide oint 0.5%	1		QL (120 grams/30 days)
VALCHLOR - mechlorethamine hcl gel 0.016% (base equivalent)	2	SP	LD
MISCELLANEOUS PRODUCTS			
ANTIDOTES			
CHEMET - succimer cap 100 mg	2	SP	PA
deferasirox granules packet 90 mg, 180 mg, 360 mg (Jadenu sprinkle)	1	SP	
deferasirox tab for oral susp 125 mg, 250 mg, 500 mg (Exjade)	1	SP	
deferasirox tab 90 mg, 180 mg, 360 mg (Jadenu)	1	SP	
deferiprone tab 500 mg, 1000 mg (Ferriprox)	1	SP	
EXJADE - deferasirox tab for oral susp 125 mg, 250 mg, 500 mg	3	SP	
FERRIPROX - deferiprone tab 500 mg, 1000 mg	3	SP	LD
FERRIPROX - deferiprone oral soln 100 mg/ml	3	SP	LD
JADENU - deferasirox tab 90 mg, 180 mg, 360 mg	3	SP	
JADENU SPRINKLE - deferasirox granules packet 90 mg, 180 mg, 360 mg	3	SP	
KLOXXADO - naloxone hcl nasal spray 8 mg/0.1ml	2		QL (4 bottles/30 days)
naloxone hcl inj 0.4 mg/ml	1		QL (4 vials/30 days)
naloxone hcl inj 4 mg/10ml	1		QL (1 vial/30 days)
naloxone hcl nasal spray 4 mg/0.1ml (Narcan)	1		QL (4 bottles/30 days)
naloxone hcl soln prefilled syringe 2 mg/2ml	1		QL (4 vials/30 days)
NALOXONE HYDROCHLORIDE - naloxone hcl soln cartridge 0.4 mg/ml	3		QL (4 cartridges/30 days)
naltrexone hcl tab 50 mg	1		
NARCAN - naloxone hcl nasal spray 4 mg/0.1ml	3		QL (4 bottles/30 days)
OPVEE - nalmefene hcl nasal spray 2.7 mg/0.1ml (base equiv)	2		QL (4 bottles/30 days)
RADIOGARDASE - prussian blue insoluble cap 0.5 gm	3		
VISTOGARD - uridine triacetate oral granules packet 10 gm	3	SP	PA, LD

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Drug Name	Drug Tier	Specialty	Requirements/Limits
VIVITROL - naltrexone for im extended release susp 380 mg	3	SP	
ZIMHI - naloxone hcl soln prefilled syringe 5 mg/0.5ml	3		QL (4 syringes/30 days)
DIAGNOSTIC PRODUCTS			
ACCU-CHEK AVIVA PLUS - glucose blood test strip	3		PA, QL (204 strips/30 days)
ACCU-CHEK COMPACT STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
ACCU-CHEK COMPACT TEST DR - glucose blood test strip	3		PA, QL (204 strips/30 days)
ACCU-CHEK GUIDE - glucose blood test strip	3		PA, QL (204 strips/30 days)
ACCU-CHEK GUIDE TEST STRI - glucose blood test strip	3		PA, QL (204 strips/30 days)
ACCU-CHEK SMARTVIEW STRIP - glucose blood test strip	3		PA, QL (204 strips/30 days)
ACCUTREND GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
ADVANCE INTUITION TEST ST - glucose blood test strip	3		PA, QL (204 strips/30 days)
ADVANCE MICRO-DRAW TEST S - glucose blood test strip	3		PA, QL (204 strips/30 days)
ADVOCATE REDI-CODE - glucose blood test strip	3		PA, QL (204 strips/30 days)
ADVOCATE REDI-CODE+ TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
ADVOCATE TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
AGAMATRIX AMP NO CODE TES - glucose blood test strip	3		PA, QL (204 strips/30 days)
AGAMATRIX JAZZ TEST STRIP - glucose blood test strip	3		PA, QL (204 strips/30 days)
AGAMATRIX KEYNOTE TEST ST - glucose blood test strip	3		PA, QL (204 strips/30 days)
AGAMATRIX PRESTO TEST STR - glucose blood test strip	3		PA, QL (204 strips/30 days)
ASSURE II - glucose blood test strip	3		PA, QL (204 strips/30 days)
ASSURE II CHECK STRIP - glucose blood test strip	3		PA, QL (204 strips/30 days)
ASSURE II TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
ASSURE PLATINUM TEST STRI - glucose blood test strip	3		PA, QL (204 strips/30 days)
ASSURE PRISM MULTI TEST S - glucose blood test strip	3		PA, QL (204 strips/30 days)
ASSURE PRO TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
ASSURE 3 TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
ASSURE 4 TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
AT LAST TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
BIOTEL CARE BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
BLOOD GLUCOSE TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
BLULINK GLUCOSE TEST STRI - glucose blood test strip	3		PA, QL (204 strips/30 days)
CAREONE BLOOD GLUCOSE TES - glucose blood test strip	3		PA, QL (204 strips/30 days)
CARESENS N BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
CARETOUCH BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
CHEMSTRIP-K - acetone (urine) test strip	2		
CLEVER CHEK AUTO-CODE TES - glucose blood test strip	3		PA, QL (204 strips/30 days)
CLEVER CHEK AUTO-CODE VOI - glucose blood test strip	3		PA, QL (204 strips/30 days)
CLEVER CHEK TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
CLEVER CHOICE AUTO-CODE P - glucose blood test strip	3		PA, QL (204 strips/30 days)
CLEVER CHOICE MICRO TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
CLEVER CHOICE NO CODING T - glucose blood test strip	3		PA, QL (204 strips/30 days)
CLEVER CHOICE TALK NO COD - glucose blood test strip	3		PA, QL (204 strips/30 days)
CONTOUR BLOOD GLUCOSE TES - glucose blood test strip	2		QL (204 strips/30 days)
CONTOUR NEXT BLOOD GLUCOS - glucose blood test strip	2		QL (204 strips/30 days)
COOL BLOOD GLUCOSE TEST S - glucose blood test strip	3		PA, QL (204 strips/30 days)
CVS ADVANCED GLUCOSE METE - glucose blood test strip	3		PA, QL (204 strips/30 days)
CVS GLUCOSE METER TEST ST - glucose blood test strip	3		PA, QL (204 strips/30 days)
DIATHRIVE BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
DIATHRIVE+ BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
DIATRUE PLUS BLOOD GLUCOS - glucose blood test strip	3		PA, QL (204 strips/30 days)
DUO-CARE TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
EASY PLUS II BLOOD GLUCOS - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASY STEP TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASY TALK BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASY TALK PLUS II BLOOD G - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASY TOUCH GLUCOSE TEST S - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASY TOUCH HEALTHPRO GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASY TRAK BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASY TRAK II BLOOD GLUCOS - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASYGLUCO - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASYMAX TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASYMAX 15 TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASYPRO BLOOD GLUCOSE TES - glucose blood test strip	3		PA, QL (204 strips/30 days)
EASYPRO PLUS - glucose blood test strip	3		PA, QL (204 strips/30 days)
ELEMENT COMPACT TEST STRI - glucose blood test strip	3		PA, QL (204 strips/30 days)
ELEMENT TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
EMBRACE BLOOD GLUCOSE TES - glucose blood test strip	3		PA, QL (204 strips/30 days)
EMBRACE EVO BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
EMBRACE PRO BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
EMBRACE TALK BLOOD GLUCOS - glucose blood test strip	3		PA, QL (204 strips/30 days)
EMBRACE WAVE BLOOD GLUCOS - glucose blood test strip	3		PA, QL (204 strips/30 days)
EQ BLOOD GLUCOSE TEST STR - glucose blood test strip	3		PA, QL (204 strips/30 days)
EVENCARE BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
EVOLUTION AUTOCODE - glucose blood test strip	3		PA, QL (204 strips/30 days)
FIFTY50 GLUCOSE TEST STRI - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA BLOOD GLUCOSE TEST S - glucose blood test strip	3		PA, QL (204 strips/30 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
FORA D15G BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA D20 BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA D40/G31 BLOOD GLUCOS - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA GD20 TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA GD50 BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA GTEL BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA G20 BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA G30/PREMIUM V10 BLOO - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA TN'G ADVANCE PRO BLO - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA TN'G/TN'G VOICE BLOO - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA V10 BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA V12 BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA V20 BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA V30A BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA 6 CONNECT - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORA 6 CONNECT/GTEL BLOOD - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORACARE GD40 - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORACARE PREMIUM V10 TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
FORACARE TEST N GO TEST S - glucose blood test strip	3		PA, QL (204 strips/30 days)
FREESTYLE INSULINX BLOOD - glucose blood test strip	3		PA, QL (204 strips/30 days)
FREESTYLE LITE TEST STRIP - glucose blood test strip	3		PA, QL (204 strips/30 days)
FREESTYLE PRECISION NEO B - glucose blood test strip	3		PA, QL (204 strips/30 days)
FREESTYLE TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
GENULTIMATE TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
GE100 BLOOD GLUCOSE TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
GHT TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCAGEN DIAGNOSTIC - glucagon hcl (rdna) diagnostic for inj 1 mg (base equiv)	3		
GLUCO PERFECT 3 TEST STRI - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCOCARD EXPRESSION BLOO - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCOCARD SHINE TEST STRI - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCOCARD VITAL TEST STRI - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCOCARD X-SENSOR - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCOCARD 01 SENSOR PLUS - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCOCOM TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCONAVII BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
GLUCOSE METER TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
GNP EASY TOUCH GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
GNP TRUE METRIX SELF MONI - glucose blood test strip	3		PA, QL (204 strips/30 days)
GNP TRUETRACK BLOOD GLUCO - glucose blood test strip	3		PA, QL (204 strips/30 days)
GNP TRUETRACK SMART SYSTE - glucose blood test strip	3		PA, QL (204 strips/30 days)
GOJJI BLOOD GLUCOSE TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
GOODSENSE PREMIUM BLOOD G - glucose blood test strip	3		PA, QL (204 strips/30 days)
HW EMBRACE PRO BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
HW EMBRACE TALK BLOOD GLU - glucose blood test strip	3		PA, QL (204 strips/30 days)
IGLUCOSE BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
IN TOUCH BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
INFINITY BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
INFINITY VOICE - glucose blood test strip	3		PA, QL (204 strips/30 days)
KETOCARE - acetone (urine) test strip	2		
KETONE - acetone (urine) test strip	2		
KETONE TEST STRIPS - acetone (urine) test strip	2		
KETOSTIX - acetone (urine) test strip	2		
KROGER BLOOD GLUCOSE TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
KROGER HEALTHPRO GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
KROGER PREMIUM BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
LIBERTY NEXT GENERATION B - glucose blood test strip	3		PA, QL (204 strips/30 days)
LIBERTY TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
MEIJER BLOOD GLUCOSE TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
MEIJER ESSENTIAL BLOOD GL - glucose blood test strip	3		PA, QL (204 strips/30 days)
MEIJER TRUETEST BLOOD GLU - glucose blood test strip	3		PA, QL (204 strips/30 days)
MEIJER TRUETRACK BLOOD GL - glucose blood test strip	3		PA, QL (204 strips/30 days)
METOPIRONE - metyrapone cap 250 mg	3	SP	LD
MICRODOT TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
MICRODOT XTRA TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
MM BLULINK GLUCOSE TEST S - glucose blood test strip	3		PA, QL (204 strips/30 days)
MM EASY TOUCH GLUCOSE TES - glucose blood test strip	3		PA, QL (204 strips/30 days)
MYGLUCOHEALTH BLOOD GLUCO - glucose blood test strip	3		PA, QL (204 strips/30 days)
NEUTEK 2TEK TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
NOVA MAX GLUCOSE TEST STR - glucose blood test strip	3		PA, QL (204 strips/30 days)
ON CALL EXPRESS BLOOD GLU - glucose blood test strip	3		PA, QL (204 strips/30 days)
ONE DROP BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
ONETOUCH ULTRA - glucose blood test strip	2		QL (204 strips/30 days)
ONETOUCH ULTRA TEST STRIP - glucose blood test strip	2		QL (204 strips/30 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
ONETOUCH VERIO TEST STRIP - glucose blood test strip	2		QL (204 strips/30 days)
OPTIUMEZ TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
PHARMACIST CHOICE AUTOCOD - glucose blood test strip	3		PA, QL (204 strips/30 days)
PHARMACIST CHOICE NO CODI - glucose blood test strip	3		PA, QL (204 strips/30 days)
PIP BLOOD GLUCOSE TEST ST - glucose blood test strip	3		PA, QL (204 strips/30 days)
POCKETCHEM EZ BLOOD GLUCO - glucose blood test strip	3		PA, QL (204 strips/30 days)
POGO AUTOMATIC TEST CARTR - glucose blood test automatic cartridge	3		PA, QL (200 strips/30 days)
PRECISION SOF-TACT TEST S - glucose blood test strip	3		PA, QL (204 strips/30 days)
PRECISION XTRA BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
PREMIUM BLOOD GLUCOSE TES - glucose blood test strip	3		PA, QL (204 strips/30 days)
PRO VOICE V8/V9 BLOOD GLU - glucose blood test strip	3		PA, QL (204 strips/30 days)
PRODIGY NO CODING BLOOD G - glucose blood test strip	3		PA, QL (204 strips/30 days)
PTS PANELS EGLU - glucose blood test strip	3		PA, QL (204 strips/30 days)
QUICKTEK TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
QUINTET AC BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
QUINTET BLOOD GLUCOSE TES - glucose blood test strip	3		PA, QL (204 strips/30 days)
REFUAH PLUS BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
RELION CONFIRM/MICRO TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
RELION KETONE TEST STRIPS - acetone (urine) test strip	2		
RELION PREMIER BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
RELION PRIME BLOOD GLUCOS - glucose blood test strip	3		PA, QL (204 strips/30 days)
RELION TRUE METRIX BLOOD - glucose blood test strip	3		PA, QL (204 strips/30 days)
RELION ULTIMA BLOOD GLUCO - glucose blood test strip	3		PA, QL (204 strips/30 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
REXALL BLOOD GLUCOSE TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
RIGHTEST GS100 BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
RIGHTEST GS300 BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
RIGHTEST GS333 BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
RIGHTEST GS550 BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
RIGHTEST GT333 BLOOD GLUC - glucose blood test strip	3		PA, QL (204 strips/30 days)
SMART SENSE PREMIUM BLOOD - glucose blood test strip	3		PA, QL (204 strips/30 days)
SMART SENSE VALUE BLOOD G - glucose blood test strip	3		PA, QL (204 strips/30 days)
SMARTEST BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
SOLUS V2 AUDIBLE TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
SUPREME TEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
TGT BLOOD GLUCOSE TEST ST - glucose blood test strip	3		PA, QL (204 strips/30 days)
TRUE FOCUS SELF MONITORIN - glucose blood test strip	3		PA, QL (204 strips/30 days)
TRUE METRIX BLOOD GLUCOSE - glucose blood test strip	3		PA, QL (204 strips/30 days)
TRUE METRIX SELF MONITORI - glucose blood test strip	3		PA, QL (204 strips/30 days)
TRUETEST STRIPS - glucose blood test strip	3		PA, QL (204 strips/30 days)
TRUETRACK BLOOD GLUCOSE T - glucose blood test strip	3		PA, QL (204 strips/30 days)
TRUETRACK TEST - glucose blood test strip	3		PA, QL (204 strips/30 days)
UNISTRIP1 GENERIC - glucose blood test strip	3		PA, QL (204 strips/30 days)
VERASENS BLOOD GLUCOSE TE - glucose blood test strip	3		PA, QL (204 strips/30 days)
VIVAGUARD INO BLOOD GLUCO - glucose blood test strip	3		PA, QL (204 strips/30 days)
MEDICAL DEVICES			
ACCU-CHEK AVIVA PLUS - blood glucose monitoring kit w/ device	3		
ACCU-CHEK FASTCLIX LANCET - lancets	2		
ACCU-CHEK FASTCLIX LANCET - lancets kit	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
ACCU-CHEK GUIDE - blood glucose monitoring kit w/ device	3		
ACCU-CHEK GUIDE ME - blood glucose monitoring kit w/ device	3		
ACCU-CHEK SAFE-T-PRO LANC - lancets	2		
ACCU-CHEK SAFE-T-PRO PLUS - lancets	2		
ACCU-CHEK SOFTCLIX LANCET - lancets	2		
ACCU-CHEK SOFTCLIX LANCET - lancets kit	2		
ACTI-LANCE LANCETS 28G - lancets	2		
ACTI-LANCE LITE SAFETY LA - lancets	2		
ACTI-LANCE SPECIAL SAFETY - lancets	2		
ACTI-LANCE UNIVERSAL SAFE - lancets	2		
ADJUSTABLE LANCING DEVICE - lancet devices	2		
ADVANCE INTUITION BLOOD G - blood glucose monitoring devices	3		
ADVANCE INTUITION BLOOD G - blood glucose monitoring kit w/ device	3		
ADVANCE MICRO-DRAW METER - blood glucose monitoring devices	3		
ADVANCED MOBILE LANCET 30 - lancets	2		
ADVOCATE BLOOD GLUCOSE MO - blood glucose monitoring devices	3		
ADVOCATE BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
ADVOCATE INSULIN PEN NEED - insulin pen needle 29 g x 12.7 mm (1/2")	2		
ADVOCATE INSULIN PEN NEED - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
ADVOCATE INSULIN PEN NEED - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
ADVOCATE INSULIN PEN NEED - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
ADVOCATE INSULIN SYRINGE/ - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
ADVOCATE LANCETS - lancets	2		
ADVOCATE LANCETS 30G - lancets	2		
ADVOCATE LANCING DEVICE - lancet devices	2		
ADVOCATE RAPID-SAFE LANCI - lancet devices	2		

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ADVOCATE REDI-CODE - blood glucose monitoring devices	3		
ADVOCATE REDI-CODE+ BLOOD - blood glucose monitoring devices	3		
ADVOCATE REDI-CODE/TALKIN - blood glucose monitoring kit w/ device	3		
ADVOCATE SAFETY LANCETS 2 - lancets	2		
AEROCHAMBER HOLDING CHAMB - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER MINI AEROSOL - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER MV - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER PLUS FLOW VU - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER PLUS FLOW-VU/ - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER Z-STAT PLUS V - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER Z-STAT PLUS/F - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER Z-STAT PLUS/L - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER Z-STAT PLUS/M - spacer/aerosol-holding chambers - device	2		
AEROCHAMBER Z-STAT PLUS/S - spacer/aerosol-holding chambers - device	2		
AF LANCETS SUPER THIN - lancets	2		
AGAMATRIX AMP NO CODE ADV - blood glucose monitoring devices	3		
AGAMATRIX JAZZ WIRELESS 2 - blood glucose monitoring kit w/ device	3		
AGAMATRIX PRESTO - blood glucose monitoring kit w/ device	3		
AGAMATRIX PRESTO PRO METE - blood glucose monitoring devices	3		
AGAMATRIX ULTRA-THIN LANC - lancets	2		
AIMSCO LUBRICATED - condoms latex lubricated	3		
AIMSCO TWIST LANCETS 32G - lancets	2		
AIMSCO TWIST LANCETS 33G - lancets	2		
AQ INSULIN SYRINGE/0.5ML/ - insulin syringe/needle u-100 1/2 ml 30 x 5/16"	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
AQ INSULIN SYRINGE/1ML/29 - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
AQ INSULIN SYRINGE/1ML/31 - insulin syringe/needle u-100 1 ml 31 x 5/16"	2		
AQINJECT PEN NEEDLE/31G X - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
AQINJECT PEN NEEDLE/32G X - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
ASSURE COMFORT LANCETS UL - lancets	2		
ASSURE ID DUO PRO SAFETY - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
ASSURE ID PRO SAFETY PEN - insulin pen needle 30 g x 5 mm (1/5" or 3/16")	2		
ASSURE ID SAFETY PEN NEED - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
ASSURE LANCE LANCETS - lancets	2		
ASSURE LANCE LANCETS 21G - lancets	2		
ASSURE LANCE PLUS SAFETY - lancets	2		
ASSURE LANCE SAFETY LANCE - lancets	2		
ASSURE PLATINUM BLOOD GLU - blood glucose monitoring devices	3		
ASSURE PRISM MULTI BLOOD - blood glucose monitoring devices	3		
ASSURE PRO BLOOD GLUCOSE - blood glucose monitoring devices	3		
ASSURE 3 METER - blood glucose monitoring kit	3		
ASSURE 4 BLOOD GLUCOSE ME - blood glucose monitoring devices	3		
AT LAST BLOOD GLUCOSE SYS - blood glucose monitoring kit	3		
AT LAST LANCETS - lancets	2		
AUM INSULIN SAFETY PEN NE - insulin pen needle 31 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16")	2		
AUM MINI INSULIN PEN NEED - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
AUM MINI INSULIN PEN NEED - insulin pen needle 33 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
AUM PEN NEEDLE/32GX4MM - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
AUM PEN NEEDLE/32GX5MM - insulin pen needle 32 g x 5 mm (1/5" or 3/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
AUM PEN NEEDLE/32GX6MM - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
AUM PEN NEEDLE/33GX4MM - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
AUM PEN NEEDLE/33GX5MM - insulin pen needle 33 g x 5 mm (1/5" or 3/16")	2		
AUM PEN NEEDLE/33GX6MM - insulin pen needle 33 g x 6 mm (1/4" or 15/64")	2		
AUM READYGARD DUO SAFETY - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
AUM SAFETY PEN NEEDLE/31 - insulin pen needle 31 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16")	2		
AURORA LANCET SUPER THIN - lancets	2		
AURORA LANCET THIN 23G - lancets	2		
AURORA PEN NEEDLES 29GX12 - insulin pen needle 29 g x 12 mm (1/2")	2		
AURORA PEN NEEDLES 31G X - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
AUTO-LANCET - lancet devices	2		
AUTO-LANCET MINI - lancet devices	2		
AUTOLET IMPRESSION LANCIN - lancet devices	2		
AUTOLET LANCING DEVICE - lancet devices	2		
AUTOLET MINI - lancet devices	2		
AUTOLET PLUS - lancet devices	2		
AUTOPEN - injection device for insulin	3		
B-D INSULIN SYRINGE MICRO - insulin syringe/needle u-100 1 ml 28 x 1/2"	2		
B-D INSULIN SYRINGE ULTRA - insulin syringe/needle u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 0.3 ml 31 x 5/16"	2		
BD LO-DOSE INSULIN SYRIN - insulin syringe/needle u-100 1/2 ml 28 x 1/2"	2		
BD ALLERGY SYRINGE 0.5ML/ - tuberculin/allergy syringe/needle (disp) 1/2 ml 27 x 1/2", 1/2 ml 27 x 3/8"	3		
BD ALLERGY SYRINGE 1ML/27 - tuberculin/allergy syringe/needle (disp) 1 ml 27 x 3/8"	3		
BD ALLERGY SYRINGE/NEEDLE - tuberculin/allergy syringe/needle (disp) 1 ml 27 x 3/8"	3		
BD ALLERGY/SYRINGE/NEEDLE - tuberculin/allergy syringe/needle (disp) 1 ml 28 x 1/2"	3		
BD AUTOSHIELD DUO 30G X 5 - insulin pen needle 30 g x 5 mm (1/5" or 3/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
BD BLUNT FILL NEEDLE/18G - needle (disp) 18 x 1-1/2"	3		
BD DISPOSABLE NEEDLE REGU - needle (disp) 25 x 1"	2		
BD DISPOSABLE NEEDLE 23GX - needle (disp) 23 x 1"	2		
BD ECLIPSE NEEDLE 21G X 1 - needle (disp) 21 x 1", 21 x 1-1/2"	3		
BD ECLIPSE NEEDLE 25G X 1 - needle (disp) 25 x 1-1/2"	3		
BD ECLIPSE NEEDLE 25GX1" - needle (disp) 25 x 1"	2		
BD ECLIPSE NEEDLE 27G X 1 - needle (disp) 27 x 1/2"	3		
BD ECLIPSE NEEDLE/LUER-LO - needle (disp) 30 x 1/2"	3		
BD ECLIPSE NEEDLE/18G X 1 - needle (disp) 18 x 1-1/2"	3		
BD ECLIPSE NEEDLE/23G X 1 - needle (disp) 23 x 1"	3		
BD ECLIPSE NEEDLE/25G X - needle (disp) 25 x 5/8"	3		
BD ECLIPSE 18G X 1-1/2" - needle (disp) 18 x 1-1/2"	3		
BD ECLIPSE 23G X 1" NEEDL - needle (disp) 23 x 1"	3		
BD HYPODERMIC NEEDLE REGU - needle (disp) 18 x 1-1/2"	2		
BD HYPODERMIC NEEDLES 16G - needle (disp) 16 x 1"	3		
BD HYPODERMIC NEEDLES 18G - needle (disp) 18 x 1"	2		
BD HYPODERMIC NEEDLES 18G - needle (disp) 18 x 1-1/2"	3		
BD HYPODERMIC NEEDLES 19G - needle (disp) 19 x 1", 19 x 1-1/2"	3		
BD HYPODERMIC NEEDLES 21G - needle (disp) 21 x 1"	2		
BD HYPODERMIC NEEDLES 21G - needle (disp) 21 x 2"	3		
BD HYPODERMIC NEEDLES 22G - needle (disp) 22 x 1", 22 x 1-1/2"	2		
BD HYPODERMIC NEEDLES 23G - needle (disp) 23 x 3/4", 23 x 1"	3		
BD HYPODERMIC NEEDLES 25G - needle (disp) 25 x 1-1/2"	3		
BD HYPODERMIC NEEDLES 26G - needle (disp) 26 x 1/2"	2		
BD INSULIN SYRINGE LUER-L - insulin syringe (disp) u-100 1 ml	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
BD INSULIN SYRINGE MICROF - insulin syringe/needle u-100 0.3 ml 28 x 1/2", u-100 1/2 ml 28 x 1/2", u-100 1 ml 27 x 5/8", u-100 1 ml 28 x 1/2"	2		
BD INSULIN SYRINGE SAFETY - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
BD INSULIN SYRINGE ULTRA - insulin syringe/needle u-100 1 ml 30 x 1/2"	2		
BD INSULIN SYRINGE ULTRA- - insulin syringe/needle u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
BD INSULIN SYRINGE ULTRAF - insulin syringe/needle u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 1/2", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
BD INSULIN SYRINGE/U-100/ - insulin syringe/needle u-100 1 ml 27 x 1/2", u-100 2 ml 27.5 x 5/8"	2		
BD INSULIN SYRINGE/U-500/ - insulin syringe/needle u-500 0.5 ml 31g x 6mm (15/64")	2		
BD INSULIN SYRINGE/0.3ML/ - insulin syringe/needle u-100 0.3 ml 29 x 1/2"	2		
BD INSULIN SYRINGE/0.5ML/ - insulin syringe/needle u-100 1/2 ml 29 x 1/2"	2		
BD INSULIN SYRINGE/1ML/27 - insulin syringe/needle u-100 1 ml 27 x 1/2"	2		
BD INSULIN SYRINGE/1ML/29 - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
BD INTEGRA RETRACTABLE NE - needle (disp) 23 x 1"	3		
BD INTEGRA SYRINGE/3ML/22 - syringe/needle (disp) 3 ml 22 x 1-1/2"	2		
BD LATITUDE DIABETES MANA - blood glucose monitoring kit w/ device	3		
BD LOGIC BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
BD LUER LOCK SYRINGE/1ML/ - syringe/needle (disp) 1 ml 20 x 1"	2		
BD MAGNI-GUIDE MAGNIFIER - blood glucose monitoring supplies	3		
BD MICROTAINER LANCETS - lancets	2		
BD NEEDLE BLUNT 5 MICRON - needle (disp) 18 x 1-1/2"	3		
BD NEEDLE SAFETYGLIDE/27G - needle (disp) 27 x 5/8"	3		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
BD NEEDLE 30G X 1" - needle (disp) 30 x 1"	3		
BD NEEDLE/16G X 1-1/2" - needle (disp) 16 x 1-1/2"	3		
BD NEEDLE/18G 1-1/2" - needle (disp) 18 x 1-1/2"	2		
BD NEEDLE/19G X 1" - needle (disp) 19 x 1"	3		
BD NEEDLE/20G X 1-1/2" - needle (disp) 20 x 1-1/2"	3		
BD NEEDLE/20G X 1" - needle (disp) 20 x 1"	2		
BD NEEDLE/21G 1-1/2" - needle (disp) 21 x 1-1/2"	2		
BD NEEDLE/22G X 1-1/2" - needle (disp) 22 x 1-1/2"	2		
BD NEEDLE/25G X 5/8" - needle (disp) 25 x 5/8"	2		
BD NEEDLE/25G X 7/8" - needle (disp) 25 x 7/8"	2		
BD NEEDLE/27G X 1/2" - needle (disp) 27 x 1/2"	2		
BD NEEDLE/30G X 1/2" - needle (disp) 30 x 1/2"	2		
BD NOKOR NEEDLE ADMIX THI - needle (disp) 18 x 1-1/2"	3		
BD NOKOR VENTED NEEDLE 18 - needle (disp) 18 x 1"	3		
BD PEN - injection device for insulin	3		
BD PEN MINI - injection device for insulin	3		
BD PEN NEEDLE/MICRO/ULTRA - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
BD PEN NEEDLE/MINI/ULTRA- - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
BD PEN NEEDLE/NANO 2ND GE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
BD PEN NEEDLE/NANO/ULTRA - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
BD PEN NEEDLE/ORIGINAL/UL - insulin pen needle 29 g x 12.7 mm (1/2")	2		
BD PEN NEEDLE/SHORT/ULTRA - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
BD PLASTIPAK SYRINGES ALL - tuberculin/allergy syringe/needle (disp) 1 ml 28 x 1/2"	3		
BD PRECISIONGLIDE NEEDLE - needle (disp) 27 x 3/8", 27 x 1-1/2"	3		
BD PRECISIONGLIDE 23GX1-1 - needle (disp) 23 x 1-1/2"	3		
BD SAFETY-GLIDE INSULIN S - insulin syringe/needle u-100 1/2 ml 29 x 1/2"	2		
BD SAFETYGLIDE HYPODERMIC - needle (disp) 18 x 1-1/2"	3		
BD SAFETYGLIDE HYPODERMIC - needle (disp) 25 x 5/8"	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
BD SAFETYGLIDE INSULIN SY - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 0.3 ml 31 x 15/64", u-100 0.3 ml 31 x 5/16", u-100 1/2 ml 31 x 15/64", u-100 1 ml 31 x 15/64"	2		
BD SAFETYGLIDE NEEDLE 25G - needle (disp) 25 x 1"	3		
BD SAFETYGLIDE NEEDLE/SHI - needle (disp) 22 x 1-1/2"	3		
BD SAFETYGLIDE SHIELDED N - needle (disp) 23 x 1"	3		
BD SAFETYGLIDE SYRINGE 5M - syringe/needle (disp) 5 ml 22 x 1-1/2"	2		
BD SAFETYGLIDE 21G X 1-1/ - needle (disp) 21 x 1-1/2"	3		
BD SAFETYGLIDE 21G X 1" - needle (disp) 21 x 1"	3		
BD SYRINGE BLUNT PLASTIC - syringe (disposable) 10 ml	2		
BD SYRINGE LUER-LOK/1ML - syringe (disposable) 1 ml	2		
BD SYRINGE 10ML/20G X 1" - syringe/needle (disp) 10 ml 20 x 1"	2		
BD TB SYRINGE/NEEDLE/1ML/ - tuberculin/allergy syringe/needle (disp) 1 ml 27 x 3/8"	3		
BD TUBERCULIN SYRINGE/NEE - tuberculin/allergy syringe/needle (disp) 1 ml 21 x 1"	3		
BD VEO INSULIN SYRINGE UL - insulin syringe/needle u-100 0.3 ml 31 x 15/64", u-100 1/2 ml 31 x 15/64", u-100 1 ml 31 x 15/64"	2		
BD 1/2ML TUBERCULIN SYRIN - tuberculin/allergy syringe/needle (disp) 1/2 ml 27 x 1/2"	3		
BD 1ML ALLERGY SYRINGE SA - tuberculin/allergy syringe/needle (disp) 1 ml 27 x 1/2"	3		
BD 1ML SLIP TIP SYRINGE 2 - tuberculin/allergy syringe/needle (disp) 1 ml 25 x 5/8", 1 ml 26 x 3/8"	2		
BD 1ML TUBERCULIN SYRINGE - tuberculin/allergy syringe/needle (disp) 1 ml 26 x 3/8", 1 ml 27 x 1/2"	2		
BD 10ML LUER-LOK SYRINGE - syringe/needle (disp) 10 ml 21 x 1"	2		
BD 10ML SYRINGE/DUAL CANN - syringe (disposable) 10 ml	2		
BD 3ML LUER-LOK SYRINGE 1 - syringe/needle (disp) 3 ml 18 x 1-1/2"	2		
BD 3ML LUER-LOK SYRINGE/2 - syringe/needle (disp) 3 ml 20 x 1", 3 ml 23 x 1-1/2", 3 ml 25 x 1", 3 ml 26 x 5/8"	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
BD 3ML SYRINGE LUER-LOK 2 - syringe/needle (disp) 3 ml 21 x 1-1/2", 3 ml 22 x 1", 3 ml 22 x 1-1/2", 3 ml 23 x 1", 3 ml 25 x 5/8", 3 ml 25 x 1-1/2"	2		
BD 5ML LUER-LOK SYRINGE/2 - syringe/needle (disp) 5 ml 20 x 1", 5 ml 21 x 1-1/2", 5 ml 22 x 1", 5 ml 22 x 1-1/2"	2		
BIGFOOT UNITY PROGRAM KIT - blood glucose monitor kit w/ monitor device & digital app	3		
BIOTEL CARE BLOOD GLUCOSE - blood glucose monitoring kit w/ device	3		
BIOTEL CARE CONNECTED BLO - blood glucose monitoring kit w/ device	3		
BLOOD GLUCOSE MONITORING - blood glucose monitoring devices	3		
BLOOD GLUCOSE MONITORING - blood glucose monitoring kit w/ device	3		
BLOOD GLUCOSE SYSTEM PAK - blood glucose monitoring kit w/ device	3		
BLULINK BLOOD GLUCOSE MON - blood glucose monitoring devices	3		
CARDIOCOM LANCING DEVICE - lancet devices	2		
CAREFINE PEN NEEDLE 32GX4 - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
CAREFINE PEN NEEDLES 29GX - insulin pen needle 29 g x 12 mm (1/2")	2		
CAREFINE PEN NEEDLES 30GX - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
CAREFINE PEN NEEDLES 31GX - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
CAREFINE PEN NEEDLES 32GX - insulin pen needle 32 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
CAREONE ADVANCED LANCING - lancet devices	2		
CAREONE BLOOD GLUCOSE MON - blood glucose monitoring kit w/ device	3		
CAREONE INSULIN SYRINGES/ - insulin syringe/ needle u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
CAREONE LANCET SUPER THIN - lancets	2		
CAREONE LANCET THIN - lancets	2		
CAREONE LANCET ULTRA THIN - lancets	2		
CAREONE UNIFINE PENTIPS P - insulin pen needle 29 g x 12 mm (1/2")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
CAREONE UNIFINE PENTIPS P - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
CAREONE UNIFINE PENTIPS P - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
CAREONE UNIFINE PENTIPS P - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
CAREPOINT PRECISION POLY - needle (disp) 18 x 1", 18 x 1-1/2", 20 x 1", 21 x 1", 21 x 1-1/2", 22 x 1", 22 x 1-1/2", 23 x 1", 23 x 1-1/2", 25 x 5/8", 25 x 1", 25 x 1-1/2", 27 x 1/2", 30 x 1/2"	3		
CAREPOINT PRECISION SYRIN - tuberculin/allergy syringe/needle (disp) 1 ml 25 x 5/8"	3		
CAREPOINT SAFETY 1ST NEED - needle (disp) 23 x 1", 23 x 1-1/2", 25 x 5/8", 25 x 1", 25 x 1-1/2"	3		
CARESENS LANCETS - lancets	2		
CARESENS N BLOOD GLUCOSE - blood glucose monitoring devices	3		
CARESENS N FELIZ - blood glucose monitoring devices	3		
CARESENS N FELIZ BT - blood glucose monitoring devices	3		
CARESENS N GLUCOSE MONITO - blood glucose monitoring devices	3		
CARESENS N VOICE BLOOD GL - blood glucose monitoring devices	3		
CARETOUCH BLOOD GLUCOSE M - blood glucose monitoring kit w/ device	3		
CARETOUCH HYPODERMIC NEED - needle (disp) 18 x 1-1/2", 20 x 1", 22 x 1", 23 x 1", 23 x 1-1/2", 25 x 5/8", 25 x 1", 25 x 1-1/2", 26 x 1", 27 x 1-1/2"	3		
CARETOUCH INSULIN SYRINGE - insulin syringe/ needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1 ml 28 x 5/16", u-100 1 ml 29 x 5/16", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
CARETOUCH LANCING DEVICE - lancet devices	2		
CARETOUCH PEN NEEDLE 29GX - insulin pen needle 29 g x 12 mm (1/2")	2		
CARETOUCH PEN NEEDLE 33GX - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
CARETOUCH PEN NEEDLES 31 - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
CARETOUCH PEN NEEDLES 31G - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
CARETOUCH PEN NEEDLES 32G - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16")	2		
CARETOUCH SAFETY LANCETS/ - lancets	2		
CARETOUCH TWIST LANCETS M - lancets	2		
CARETOUCH TWIST LANCETS 2 - lancets	2		
CARETOUCH TWIST LANCETS 3 - lancets	2		
CAYA - diaphragm arc-spring	3		
CHEMSTRIP BG LOG BOOK - blood glucose monitoring misc.	3		
CHOSEN LANCETS 30G - lancets	2		
CHOSEN LANCING DEVICE - lancet devices	2		
CHOSEN SAFETY LANCETS 28G - lancets	2		
CLEANLET LANCETS 28G - lancets	2		
CLEVER CHEK AUTO CODE VOI - blood glucose monitoring devices	3		
CLEVER CHEK AUTO-CODE BLO - blood glucose monitoring devices	3		
CLEVER CHEK AUTO-CODE VOI - blood glucose monitoring devices	3		
CLEVER CHEK BLOOD GLUCOSE - blood glucose monitoring kit w/ device	3		
CLEVER CHEK LANCETS ULTRA - lancets	2		
CLEVER CHOICE AUTO-CODE P - blood glucose monitoring devices	3		
CLEVER CHOICE COMFORT EZ - insulin syringe/ needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
CLEVER CHOICE COMFORT EZ - insulin pen needle 29 g x 12 mm (1/2")	2		
CLEVER CHOICE COMFORT EZ - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
CLEVER CHOICE COMFORT EZ - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
CLEVER CHOICE COMFORT EZ - insulin pen needle 33 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
CLEVER CHOICE COMFORT EZ - lancets	2		
CLEVER CHOICE MICRO BLOOD - blood glucose monitoring kit w/ device	3		
CLEVER CHOICE MINI BLOOD - blood glucose monitoring devices	3		
CLEVER CHOICE TALK BLOOD - blood glucose monitoring devices	3		
CLICKFINE PEN NEEDLE UNIV - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
CLICKFINE PEN NEEDLE 32GX - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
CLICKFINE PEN NEEDLES 31G - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
CLICKFINE PEN NEEDLES 32G - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
CLICKFINE UNIVERSAL PEN N - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
COAGUCHEK LANCETS - lancets	2		
COMFORT ASSIST INSULIN SY - insulin syringe/needle u-100 0.3 ml 31 x 5/16"	2		
COMFORT ASSURED LANCETS M - lancets	2		
COMFORT ASSURED LANCETS S - lancets	2		
COMFORT EZ INSULIN SYRING - insulin syringe/ needle u-100 1/2 ml 31 x 5/16", u-100 1 ml 31 x 5/16"	2		
COMFORT EZ MICRO/32G X 4M - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
COMFORT EZ PRO SAFETY PEN - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
COMFORT EZ PRO SAFETY PEN - insulin pen needle 31 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16")	2		
COMFORT EZ SHORT/31G X 8M - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
COMFORT EZ/31G X 5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
COMFORT EZ/31G X 6MM - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
COMFORT LANCETS - lancets	2		
COMFORT TOUCH LANCETS ULT - lancets	2		
COMFORT TOUCH PEN NEEDLES - insulin pen needle 31 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
COMFORT TOUCH PEN NEEDLES - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
COMFORT TOUCH PEN NEEDLES - insulin pen needle 33 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
COMFORT TOUCH PLUS SAFETY - lancets	2		
COMFORT TOUCH TWIST LANCE - lancets	2		
CONDOMS - condoms - male	3		
CONTOUR BLOOD GLUCOSE MON - blood glucose monitoring devices	2		
CONTOUR NEXT BLOOD GLUCOS - blood glucose monitoring kit w/ device	2		
CONTOUR NEXT EZ BLOOD GLU - blood glucose monitoring kit w/ device	2		
CONTOUR NEXT GEN BLOOD GL - blood glucose monitoring devices	2		
CONTOUR NEXT GEN BLOOD GL - blood glucose monitoring kit w/ device	2		
CONTOUR NEXT LINK BLOOD G - blood glucose monitoring kit w/ device	2		
CONTOUR NEXT LINK WIRELES - blood glucose monitoring kit w/ device	2		
CONTOUR NEXT LINK 2.4 WIR - blood glucose monitoring kit w/ device	3		
CONTOUR NEXT ONE BLOOD GL - blood glucose monitoring devices	2		
CONTOUR NEXT ONE BLOOD GL - blood glucose monitoring kit	2		
COOL BLOOD GLUCOSE MONITO - blood glucose monitoring devices	3		
COOL BLOOD GLUCOSE MONITO - blood glucose monitoring kit w/ device	3		
CVS ADVANCED GLUCOSE METE - blood glucose monitoring kit w/ device	3		
CVS LANCETS MICRO THIN 33 - lancets	2		
CVS LANCETS MICRO-THIN 33 - lancets	2		
CVS LANCETS ORIGINAL - lancets	2		
CVS LANCETS THIN 26G - lancets	2		
CVS LANCETS ULTRA THIN 30 - lancets	2		
CVS LANCETS ULTRA-THIN 30 - lancets	2		
CVS LANCETS 21G - lancets	2		
CVS LANCING DEVICE - lancet devices	2		

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CVS ULTRA THIN LANCETS - lancets	2		
D-CARE GLUCOMETER KIT/GLU - blood glucose monitoring kit w/ device	3		
DEXCOM G6 RECEIVER - continuous glucose system receiver	2		ST, QL (1 receiver/365 days)
DEXCOM G6 SENSOR - continuous glucose system sensor	2		ST, QL (3 sensors/30 days)
DEXCOM G6 TRANSMITTER - continuous glucose system transmitter	2		ST, QL (1 transmitter/90 days)
DEXCOM G7 RECEIVER - continuous glucose system receiver	2		ST, QL (1 receiver/365 days)
DEXCOM G7 SENSOR - continuous glucose system sensor	2		ST, QL (3 sensors/30 days)
DIABETES MONITORING DIGIT - blood glucose monitor kit w/ monitor device & digital app	3		
DIATHRIVE BLOOD GLUCOSE M - blood glucose monitoring devices	3		
DIATHRIVE LANCETS - lancets	2		
DIATHRIVE LANCETS ULTRA T - lancets	2		
DIATHRIVE LANCING DEVICE - lancet devices	2		
DIATHRIVE PEN NEEDLE/31 G - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
DIATHRIVE PEN NEEDLE/31G - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
DIATHRIVE PEN NEEDLE/32G - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
DIATHRIVE+ BLOOD GLUCOSE - blood glucose monitoring devices	3		
DIATRUE PLUS BLOOD GLUCOS - blood glucose monitoring devices	3		
DROPLET GENTEEL LANCING D - lancet devices	2		
DROPLET INSULIN SYRINGE U - insulin syringe/needle u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 0.3 ml 31 x 15/64", u-100 0.3 ml 30 x 15/64", u-100 0.5 ml 30 x 15/64", u-100 1 ml 30 x 15/64", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16", u-100 1 ml 31 x 15/64"	2		
DROPLET INSULIN SYRINGE 0 - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 1/2 ml 29 x 1/2"	2		
DROPLET INSULIN SYRINGE 1 - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
DROPLET INSULIN SYRINGE/U - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 0.3 ml 31 x 15/64", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16", u-100 1/2 ml 31 x 15/64", u-100 1 ml 31 x 15/64"	2		
DROPLET LANCETS ULTRA THI - lancets	2		
DROPLET LANCING DEVICE - lancet devices	2		
DROPLET MICRON 34G X 9/64 - insulin pen needle 34 g x 3.5 mm (9/64")	2		
DROPLET PEN NEEDLE/MICRON - insulin pen needle 34 g x 3.5 mm (9/64")	2		
DROPLET PEN NEEDLES 29G X - insulin pen needle 29 g x 12 mm (1/2")	2		
DROPLET PEN NEEDLES 29GX1 - insulin pen needle 29 g x 10 mm, x 12 mm (1/2")	2		
DROPLET PEN NEEDLES 30G X - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
DROPLET PEN NEEDLES 31G X - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
DROPLET PEN NEEDLES 31GX5 - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
DROPLET PEN NEEDLES 31GX6 - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
DROPLET PEN NEEDLES 31GX8 - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
DROPLET PEN NEEDLES 32G X - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
DROPLET PEN NEEDLES 32GX4 - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
DROPLET PEN NEEDLES 32GX5 - insulin pen needle 32 g x 5 mm (1/5" or 3/16")	2		
DROPLET PEN NEEDLES 32GX6 - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
DROPLET PEN NEEDLES 32GX8 - insulin pen needle 32 g x 8 mm (1/3" or 5/16")	2		
DROPLET PERSONAL LANCETS - lancets	2		
DROPSAFE INSULIN SAFETY S - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 0.3 ml 31 x 15/64", u-100 1 ml 29 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16", u-100 1/2 ml 31 x 15/64", u-100 1 ml 31 x 15/64"	2		
DROPSAFE SAFETY PEN NEEDL - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		

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DROPSAFE SAFTEY PEN NEEDL - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
DROPSAFE SICURA - needle (disp) 25 x 1"	3		
DRUG MART LANCETS THIN - lancets	2		
DRUG MART LANCETS ULTRA T - lancets	2		
DRUG MART ON-THE-GO LANCE - lancets	2		
DRUG MART UNIFINE PENTIPS - insulin pen needle 29 g x 12 mm (1/2")	2		
DRUG MART UNIFINE PENTIPS - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
DRUG MART UNIFINE PENTIPS - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
DRUG MART UNILET LANCETS - lancets	2		
DRUG MART UNILET MICRO TH - lancets	2		
DUANE READE LANCET ALTERN - lancets	2		
DUANE READE LANCET SUPER - lancets	2		
DUANE READE LANCET ULTRA - lancets	2		
DUANE READE UNIFINE PENTI - insulin pen needle 29 g x 12 mm (1/2")	2		
DUANE READE UNIFINE PENTI - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
DUREX EXTRA SENSITIVE THI - condoms latex lubricated	3		
DUREX REALFEEL NON-LATEX - condoms non-latex lubricated	3		
E-Z JECT LANCETS - lancets	2		
E-Z JECT LANCETS COLOR - lancets	2		
E-Z JECT LANCETS SUPER TH - lancets	2		
E-Z JECT LANCETS THIN 26G - lancets	2		
E-Z JECT LANCETS 21G - lancets	2		
E-ZJECT LANCETS MICRO-THI - lancets	2		
EASY COMFORT INSULIN SYRI - insulin syringe/ needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 0.3 ml 31 x 1/2", u-100 0.5 ml 32 x 5/16", u-100 1 ml 32 x 5/16", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
EASY COMFORT PEN NEEDLES - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
EASY COMFORT PEN NEEDLES - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		

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EASY COMFORT PEN NEEDLES - insulin pen needle 33 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
EASY COMFORT SAFETY PEN N - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
EASY COMFORT SAFETY PEN N - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
EASY GLIDE PEN NEEDLES 33 - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
EASY MINI EJECT LANCING D - lancet devices	2		
EASY MINI LANCING DEVICE - lancet devices	2		
EASY PLUS II BLOOD GLUCOS - blood glucose monitoring devices	3		
EASY STEP BLOOD GLUCOSE M - blood glucose monitoring devices	3		
EASY TALK BLOOD GLUCOSE M - blood glucose monitoring devices	3		
EASY TOUCH ALLERGY TRAY S - tuberculin/allergy syringe/needle (disp) 1 ml 26 x 3/8", 1 ml 27 x 1/2"	3		
EASY TOUCH FLIPLOCK NEEDL - needle (disp) 18 x 1", 18 x 1-1/2", 19 x 1", 19 x 1-1/2", 20 x 1", 20 x 1-1/2", 21 x 1", 21 x 1-1/2", 22 x 3/4", 22 x 1", 22 x 1-1/2", 23 x 5/8", 23 x 1", 23 x 1-1/2", 25 x 5/8", 25 x 1", 25 x 1-1/2", 26 x 1/2", 27 x 1/2", 27 x 1" (25 mm), 28 x 1/2" (12.7 mm), 29 x 1/2" (12.7 mm), 30 x 5/16" (8 mm), 30 x 1/2", 31 x 5/16" (8 mm)	3		
EASY TOUCH FLIPLOCK SAFET - insulin syringe/ needle u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16"	2		
EASY TOUCH GLUCOSE MONITO - blood glucose monitoring kit w/ device	3		
EASY TOUCH HEALTHPRO GLUC - blood glucose monitoring kit w/ device	3		
EASY TOUCH HYPODERMIC NEE - needle (disp) 16 x 1", 16 x 1-1/2", 18 x 1", 18 x 1.25" (30 mm), 18 x 1-1/2", 19 x 1", 19 x 1-1/2", 20 x 1", 20 x 1-1/2", 21 x 1", 21 x 1-1/2", 22 x 1", 22 x 1-1/2", 23 x 3/4", 23 x 1", 23 x 1-1/4", 23 x 1-1/2", 24 x 1", 24 x 1.25" (30 mm), 25 x 5/8", 25 x 1", 25 x 1-1/2", 26 x 3/8", 26 x 1/2", 26 x 5/8", 27 x 1/2", 27 x 1-1/4", 27 x 1-1/2", 30 x 1/2", 30 x 1", 31 x 5/16" (8 mm), 32 x 5/16" (8 mm)	3		
EASY TOUCH INSULIN SYRING - insulin syringe/ needle u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 27 x 1/2", u-100 1/2 ml 31 x 5/16", u-100	2		

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1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 27 x 1/2", u-100 1 ml 27 x 5/8", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"			
EASY TOUCH LANCETS 21G/PR - lancets	2		
EASY TOUCH LANCETS 23G/PR - lancets	2		
EASY TOUCH LANCETS 26G/PR - lancets	2		
EASY TOUCH LANCETS 26G/PU - lancets	2		
EASY TOUCH LANCETS 28G/PR - lancets	2		
EASY TOUCH LANCETS 28G/PU - lancets	2		
EASY TOUCH LANCETS 28G/TW - lancets	2		
EASY TOUCH LANCETS 30G/BU - lancets	2		
EASY TOUCH LANCETS 30G/PR - lancets	2		
EASY TOUCH LANCETS 30G/PU - lancets	2		
EASY TOUCH LANCETS 30G/TW - lancets	2		
EASY TOUCH LANCETS 32G/PR - lancets	2		
EASY TOUCH LANCETS 32G/PU - lancets	2		
EASY TOUCH LANCETS 32G/TW - lancets	2		
EASY TOUCH LANCETS 33G/TW - lancets	2		
EASY TOUCH LANCING DEVICE - lancet devices	2		
EASY TOUCH PEN NEEDLE 30 - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
EASY TOUCH PEN NEEDLE/30 - insulin pen needle 30 g x 5 mm (1/5" or 3/16")	2		
EASY TOUCH PEN NEEDLES 29 - insulin pen needle 29 g x 12 mm (1/2")	2		
EASY TOUCH PEN NEEDLES 31 - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
EASY TOUCH PEN NEEDLES 32 - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
EASY TOUCH PEN NEEDLES/31 - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
EASY TOUCH SAFETY LANCETS - lancets	2		
EASY TOUCH SAFETY PEN NEE - insulin pen needle 29 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
EASY TOUCH SAFETY PEN NEE - insulin pen needle 30 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
EASY TOUCH SHEATHLOCK SAF - insulin syringe/ needle u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16"	2		

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EASY TOUCH TUBERCULIN FLI - tuberculin/allergy syringe/needle (disp) 1 ml 27 x 1/2", 1 ml 28 x 1/2"	3		
EASY TOUCH TUBERCULIN SHE - tuberculin/allergy syringe/needle (disp) 1 ml 25 x 5/8", 1 ml 27 x 1/2", 1 ml 28 x 1/2"	3		
EASY TOUCH 32GX5MM - insulin pen needle 32 g x 5 mm (1/5" or 3/16")	2		
EASY TOUCH 32GX6MM - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
EASY TRAK BLOOD GLUCOSE M - blood glucose monitoring devices	3		
EASY TRAK II BLOOD GLUCOS - blood glucose monitoring devices	3		
EASYGLUCO - blood glucose monitoring kit	3		
EASYMAX NG SELF-MONITORIN - blood glucose monitoring devices	3		
EASYMAX NG SELF-MONITORIN - blood glucose monitoring kit w/ device	3		
EASYMAX V BLOOD GLUCOSE S - blood glucose monitoring devices	3		
EASYPOINT NEEDLE 23G X 1" - needle (disp) 23 x 1"	3		
EASYPOINT NEEDLE 25G X 1" - needle (disp) 25 x 1"	3		
EASYPOINT NEEDLE 25G X 5/ - needle (disp) 25 x 5/8"	3		
EASYPOINT NEEDLE 25GX1-1/ - needle (disp) 25 x 1-1/2"	3		
EASYPOINT NEEDLE/18G X 1- - needle (disp) 18 x 1-1/2"	3		
EASYPOINT NEEDLE/18G X 1" - needle (disp) 18 x 1"	3		
EASYPOINT NEEDLE/20G X 1- - needle (disp) 20 x 1-1/2"	3		
EASYPOINT NEEDLE/20G X 1" - needle (disp) 20 x 1"	3		
EASYPOINT NEEDLE/21G X 1- - needle (disp) 21 x 1-1/2"	3		
EASYPOINT NEEDLE/21G X 1" - needle (disp) 21 x 1"	3		
EASYPOINT NEEDLE/22G X 1- - needle (disp) 22 x 1-1/2"	3		
EASYPOINT NEEDLE/22G X 1" - needle (disp) 22 x 1"	3		
EASYPRO BLOOD GLUCOSE MON - blood glucose monitoring kit w/ device	3		
EASYPRO PLUS - blood glucose monitoring kit w/ device	3		
ELEMENT AUTOCODE SYSTEM - blood glucose monitoring kit w/ device	3		

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ELEMENT COMPACT BLOOD GLU - blood glucose monitoring devices	3		
ELEMENT COMPACT V BLOOD - blood glucose monitoring devices	3		
ELEMENT PLUS BLOOD GLUCOS - blood glucose monitoring devices	3		
EMBRACE BLOOD GLUCOSE MON - blood glucose monitoring devices	3		
EMBRACE EVO BLOOD GLUCOSE - blood glucose monitoring kit w/ device	3		
EMBRACE EVO COMPACT BLOOD - blood glucose monitoring devices	3		
EMBRACE LANCETS ULTRA THI - lancets	2		
EMBRACE LANCING DEVICE WI - lancet devices	2		
EMBRACE PEN NEEDLES/29G X - insulin pen needle 29 g x 12 mm (1/2")	2		
EMBRACE PEN NEEDLES/30G X - insulin pen needle 30 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
EMBRACE PEN NEEDLES/31G X - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
EMBRACE PEN NEEDLES/32G X - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
EMBRACE PRESSURE ACTIVATE - lancets	2		
EMBRACE PRO BLOOD GLUCOSE - blood glucose monitoring devices	3		
EMBRACE TALK BLOOD GLUCOS - blood glucose monitoring devices	3		
EMBRACE TALK BLOOD GLUCOS - blood glucose monitoring kit w/ device	3		
EMBRACE WAVE BLOOD GLUCOS - blood glucose monitoring devices	3		
EQL COLOR LANCETS MICRO T - lancets	2		
EQL COLOR LANCETS 21G - lancets	2		
EQL INSULIN SYRINGE/0.3ML - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
EQL INSULIN SYRINGE/0.5ML - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16"	2		
EQL INSULIN SYRINGE/1ML/2 - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
EQL INSULIN SYRINGE/1ML/3 - insulin syringe/needle u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16"	2		
EQL SHORT PEN NEEDLES 31G - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
EQL SUPER THIN LANCETS 30 - lancets	2		
EQL THIN LANCETS 26G - lancets	2		
EQL ULTRA SHORT PEN NEEDL - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
EVENCARE BLOOD GLUCOSE MO - blood glucose monitoring kit	3		
EVOLUTION AUTOCODE - blood glucose monitoring devices	3		
EZ-LETS LANCETS 21G - lancets	2		
EZ-LETS LANCETS 26G SUPER - lancets	2		
EZ-LETS LANCETS 28G ULTRA - lancets	2		
EZ-LETS LANCETS 30G - lancets	2		
FANTASY LUBRICATED - condoms latex lubricated	3		
FANTASY LUBRICATED/SPERMI - condoms latex lubricated	3		
FC2 FEMALE CONDOM - condoms - female	3		
FEMCAP - cervical cap 22 mm, 26 mm, 30 mm	3		
FIFTY50 GLUCOSE METER 2.0 - blood glucose monitoring kit w/ device	3		
FIFTY50 PEN NEEDLES 31G X - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
FIFTY50 PEN NEEDLES 31GX5 - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
FIFTY50 PEN NEEDLES/31GX8 - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
FIFTY50 PEN NEEDLES/32GX4 - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
FIFTY50 PEN NEEDLES/32GX6 - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
FIFTY50 SAFETY SEAL LANCE - lancets	2		
FIFTY50 SUPERIOR COMFORT - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
FIFTY50 UNILET LANCETS 33 - lancets	2		
FINGERSTIX LANCETS - lancets	2		
FLOW-EZE VENTED NEEDLE - hypodermic needles (disposable)	3		

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FORA GD20 BLOOD GLUCOSE M - blood glucose monitoring devices	3		
FORA GD50 BLOOD GLUCOSE M - blood glucose monitoring devices	3		
FORA GTEL BLOOD GLUCOSE M - blood glucose monitoring devices	3		
FORA G20 BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
FORA G30A BLOOD GLUCOSE M - blood glucose monitoring devices	3		
FORA LANCETS - lancets	2		
FORA LANCING DEVICE - lancet devices	2		
FORA LANCING DEVICE/CLEAR - lancet devices	2		
FORA PREMIUM V10 BLE BLOO - blood glucose monitoring devices	3		
FORA TEST N' GO VOICE BLO - blood glucose monitoring devices	3		
FORA TN'G VOICE BLOOD GLU - blood glucose monitoring kit w/ device	3		
FORA V10 BLOOD GLUCOSE MO - blood glucose monitoring devices	3		
FORA V10/V12/D10/D20 BLOO - blood glucose monitoring kit	3		
FORA V12 BLOOD GLUCOSE MO - blood glucose monitoring devices	3		
FORA V20 BLOOD GLUCOSE MO - blood glucose monitoring devices	3		
FORA V30A BLOOD GLUCOSE M - blood glucose monitoring devices	3		
FORA V30A BLOOD GLUCOSE M - blood glucose monitoring kit w/ device	3		
FORACARE GD40 BLOOD GLUCO - blood glucose monitoring devices	3		
FORACARE PREMIUM V10 BLOO - blood glucose monitoring devices	3		
FORACARE TEST N GO BLOOD - blood glucose monitoring devices	3		
FREESTYLE FREEDOM LITE - blood glucose monitoring kit w/ device	3		
FREESTYLE LANCETS - lancets	2		
FREESTYLE LIBRE 14 DAY/RE - continuous glucose system receiver	2		ST, QL (1 reader/365 days)

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Drug Name	Drug Tier	Specialty	Requirements/Limits
FREESTYLE LIBRE 14 DAY/SE - continuous glucose system sensor	2		ST, QL (2 sensors/28 days)
FREESTYLE LIBRE 2/READER/ - continuous glucose system receiver	2		ST, QL (1 reader/365 days)
FREESTYLE LIBRE 2/SENSOR/ - continuous glucose system sensor	2		ST, QL (2 sensors/28 days)
FREESTYLE LIBRE 3/READER/ - continuous glucose system receiver	2		ST, QL (1 reader/365 days)
FREESTYLE LIBRE 3/SENSOR/ - continuous glucose system sensor	2		ST, QL (2 sensors/28 days)
FREESTYLE LIBRE/READER/FL - continuous glucose system receiver	2		ST, QL (1 reader/365 days)
FREESTYLE LITE BLOOD GLUC - blood glucose monitoring devices	3		
FREESTYLE LITE BLOOD GLUC - blood glucose monitoring kit w/ device	3		
FREESTYLE PRECISION NEO B - blood glucose monitoring kit w/ device	3		
FREESTYLE UNISTICK II LAN - lancets	2		
GENTEEL BUTTERFLY TOUCH L - lancets	2		
GENTEEL PLUS LANCING DEVI - lancet devices	2		
GENTLE-LET GP LANCETS - lancets	2		
GENTLE-LET LANCETS GENERA - lancets	2		
GENTLE-LET LANCETS SAFETY - lancets	2		
GE100 BLOOD GLUCOSE MONIT - blood glucose monitoring devices	3		
GE100 BLOOD GLUCOSE MONIT - blood glucose monitoring kit w/ device	3		
GHT BLOOD GLUCOSE MONITO - blood glucose monitoring kit w/ device	3		
GLOBAL EASE INJECT PEN NE - insulin pen needle 29 g x 12 mm (1/2")	2		
GLOBAL EASE INJECT PEN NE - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
GLOBAL EASE INJECT PEN NE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
GLOBAL EASY GLIDE INSULIN - insulin syringe/needle u-100 0.3 ml 31 x 15/64", u-100 0.3 ml 31 x 5/16", u-100 1/2 ml 31 x 15/64", u-100 1 ml 31 x 15/64"	2		
GLOBAL EASY GLIDE PEN NEE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
GLOBAL INJECT EASE INSULI - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"			
GLOBAL INJECT EASE LANCET - lancets	2		
GLOBAL INSULIN SYRINGE/U- - insulin syringe/needle u-100 0.3 ml 30 x 1/2"	2		
GLOBAL INSULIN SYRINGES/U - insulin syringe/needle u-100 0.3 ml 30 x 5/16"	2		
GLOBAL LANCING DEVICE - lancet devices	2		
GLUCO PERFECT 3 BLOOD GLU - blood glucose monitoring devices	3		
GLUCOCARD EXPRESSION AUDI - blood glucose monitoring kit w/ device	3		
GLUCOCARD SHINE - blood glucose monitoring devices	3		
GLUCOCARD SHINE - blood glucose monitoring kit w/ device	3		
GLUCOCARD SHINE CONNEX BL - blood glucose monitoring kit w/ device	3		
GLUCOCARD SHINE EXPRESS B - blood glucose monitoring kit w/ device	3		
GLUCOCARD SHINE XL - blood glucose monitoring devices	3		
GLUCOCARD VITAL BLOOD GLU - blood glucose monitoring kit w/ device	3		
GLUCOCARD X-METER - blood glucose monitoring kit w/ device	3		
GLUCOCARD 01 BLOOD GLUCOS - blood glucose monitoring devices	3		
GLUCOCARD 01 BLOOD GLUCOS - blood glucose monitoring kit w/ device	3		
GLUCOCARD 01-MINI BLOOD G - blood glucose monitoring kit w/ device	3		
GLUCOCOM AUTOLINK TELEMON - blood glucose monitoring misc.	3		
GLUCOCOM BLOOD GLUCOSE MO - blood glucose monitoring devices	3		
GLUCOCOM BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
GLUCOCOM LANCETS 28G - lancets	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
GLUCOCOM LANCETS 30G - lancets	2		
GLUCOCOM LANCETS 33G - lancets	2		
GLUCONAVII BLOOD GLUCOSE - blood glucose monitoring kit w/ device	3		
GLUCOPRO INSULIN SYRINGE/ - insulin syringe/ needle u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
GNP CLICKFINE UNIVERSAL P - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
GNP EASY TOUCH GLUCOSE MO - blood glucose monitoring devices	3		
GNP INSULIN SYRINGE/0.3ML - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
GNP INSULIN SYRINGE/0.5ML - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16"	2		
GNP INSULIN SYRINGE/1ML/2 - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
GNP INSULIN SYRINGE/1ML/3 - insulin syringe/needle u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16"	2		
GNP INSULIN SYRINGES/0.3M - insulin syringe/needle u-100 0.3 ml 30 x 5/16"	2		
GNP INSULIN SYRINGES/1/2M - insulin syringe/needle u-100 1/2 ml 29 x 1/2"	2		
GNP INSULIN SYRINGES/1ML/ - insulin syringe/needle u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16"	2		
GNP INSULIN SYRINGES/3ML/ - insulin syringe/needle u-100 0.3 ml 31 x 5/16"	2		
GNP LANCETS THIN 26G - lancets	2		
GNP LANCETS 21G - lancets	2		
GNP LANCING SYSTEM DEVICE - lancet devices	2		
GNP STERILE LANCETS 28G - lancets	2		
GNP STERILE LANCETS 30G - lancets	2		
GNP STERILE LANCETS 33G - lancets	2		
GNP TRUE METRIX AIR SELF - blood glucose monitoring kit w/ device	3		
GNP TRUE METRIX SELF MONI - blood glucose monitoring kit w/ device	3		

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GNP ULTICARE PEN NEEDLES - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
GNP ULTICARE PEN NEEDLES/ - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 6 mm (1/4" or 15/64")	2		
GNP ULTIGUARD SAFEPACK/MI - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
GNP ULTIGUARD SAFEPACK/MI - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 6 mm (1/4" or 15/64")	2		
GNP ULTIGUARD SAFEPACK/SH - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
GNP ULTRA COMFORT INSULIN - insulin syringe/ needle u-100 1 ml 28 x 1/2"	2		
GOJJI LANCING DEVICE/CLEA - lancet devices	2		
GOJJI STERILE LANCETS 30G - lancets	2		
GOODSENSE CLICKFINE SAFET - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
GOODSENSE COLOR LANCETS M - lancets	2		
GOODSENSE LANCETS MICRO-T - lancets	2		
GOODSENSE LANCETS ULTRA-T - lancets	2		
GOODSENSE LANCING DEVICE - lancet devices	2		
GOODSENSE PEN NEEDLE/PENF - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
GOODSENSE PEN NEEDLE/PENF - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 6 mm (1/4" or 15/64")	2		
GOODSENSE PREMIUM BLOOD - blood glucose monitoring kit w/ device	3		
H-E-B IN CONTROL PEN NEED - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
H-E-B IN CONTROL PEN NEED - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
H-E-B IN CONTROL UNIFINE - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
H-E-B IN CONTROL UNIFINE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
H-E-B IN CONTROL UNIFINE - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
H-E-B INCONTROL ADVANCED - lancet devices	2		
H-E-B INCONTROL LANCETS M - lancets	2		
H-E-B INCONTROL LANCETS S - lancets	2		
H-E-B INCONTROL LANCETS U - lancets	2		

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H-E-B INCONTROL PEN NEEDL - insulin pen needle 29 g x 12 mm (1/2")	2		
HAEMOLANCE - lancets	2		
HAEMOLANCE LOW FLOW LANCE - lancets	2		
HAEMOLANCE PLUS - lancets	2		
HAEMOLANCE PLUS HIGH FLOW - lancets	2		
HAEMOLANCE PLUS LOW FLOW - lancets	2		
HAEMOLANCE PLUS MAX FLOW - lancets	2		
HAEMOLANCE PLUS PEDIATRIC - lancets	2		
HEALTH CARE LANCING DEVIC - lancet devices	2		
HEALTHPRO BLOOD GLUCOSE M - blood glucose monitoring kit w/ device	3		
HEALTHWISE INSULIN SYRING - insulin syringe/ needle u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
HEALTHWISE MICRON PEN NEE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
HEALTHWISE MINI PEN NEEDL - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
HEALTHWISE PEN NEEDLES 29 - insulin pen needle 29 g x 12 mm (1/2")	2		
HEALTHWISE SHORT PEN NEED - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
HM ULTICARE INSULIN SYRIN - insulin syringe/needle u-100 1 ml 30 x 1/2", u-100 0.3 ml 31 x 5/16"	2		
HM ULTICARE MINI PEN NEED - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
HM ULTICARE SHORT PEN NEE - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
HW EMBRACE PRO BLOOD GLUC - blood glucose monitoring devices	3		
HW EMBRACE TALK BLOOD GLU - blood glucose monitoring devices	3		
HW EMBRACE TALK BLOOD GLU - blood glucose monitoring kit w/ device	3		
HY-VEE LANCETS - lancets	2		
HY-VEE THIN LANCETS - lancets	2		
HYPODERMIC NEEDLES 18GX1- - needle (disp) 18 x 1-1/2"	3		
HYPODERMIC NEEDLES 18GX1" - needle (disp) 18 x 1"	3		

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HYPODERMIC NEEDLES 20GX1- - needle (disp) 20 x 1-1/2"	3		
HYPODERMIC NEEDLES 20GX1" - needle (disp) 20 x 1"	3		
HYPODERMIC NEEDLES 21GX1- - needle (disp) 21 x 1-1/2"	3		
HYPODERMIC NEEDLES 21GX1" - needle (disp) 21 x 1"	3		
HYPODERMIC NEEDLES 22GX1- - needle (disp) 22 x 1-1/2"	3		
HYPODERMIC NEEDLES 22GX1" - needle (disp) 22 x 1"	3		
HYPODERMIC NEEDLES 23GX1- - needle (disp) 23 x 1-1/2"	3		
HYPODERMIC NEEDLES 23GX1" - needle (disp) 23 x 1"	3		
HYPODERMIC NEEDLES 25GX1- - needle (disp) 25 x 1-1/2"	3		
HYPODERMIC NEEDLES 25GX5/ - needle (disp) 25 x 5/8"	3		
HYPODERMIC NEEDLES 26GX1/ - needle (disp) 26 x 1/2"	3		
HYPODERMIC NEEDLES 27GX1- - needle (disp) 27 x 1-1/2"	3		
HYPODERMIC NEEDLES 27GX1/ - needle (disp) 27 x 1/2"	3		
IGLUCOSE BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
IN TOUCH - blood glucose monitoring devices	3		
IN TOUCH DIABETES MANAGEM - blood glucose monitoring misc.	2		
IN TOUCH LANCING DEVICE - lancet devices	2		
IN TOUCH STERILE LANCETS - lancets	2		
INCONTROL ULTICARE MINI P - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
INCONTROL ULTICARE MINI P - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
INFINITY BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
INFINITY VOICE - blood glucose monitoring kit w/ device	3		
INPEN 100/BLUE/LILLY/HUMA - injection device for insulin	3		

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INPEN 100/BLUE/NOVOLOG/FI - injection device for insulin	3		
INPEN 100/GREY/LILLY/HUMA - injection device for insulin	3		
INPEN 100/GREY/NOVOLOG/FI - injection device for insulin	3		
INPEN 100/PINK/LILLY/HUMA - injection device for insulin	3		
INPEN 100/PINK/NOVOLOG/FI - injection device for insulin	3		
INSUL-TOTE - blood glucose monitoring supplies	3		
INSUL-TOTE JR - blood glucose monitoring supplies	3		
INSULIN SYRINGE 1ML/31G X - insulin syringe/needle u-100 1 ml 31 x 1/4" (6 mm)	2		
INSULIN SYRINGE/NEEDLE 0. - insulin syringe/needle u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
INSULIN SYRINGE/NEEDLE 1M - insulin syringe/needle u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16"	2		
INSULIN SYRINGE/U-100/0.3 - insulin syringe/needle u-100 0.3 ml 29 x 1/2"	2		
INSULIN SYRINGE/U-100/0.5 - insulin syringe/needle u-100 1/2 ml 29 x 1/2"	2		
INSULIN SYRINGE/U-100/1ML - insulin syringe/needle u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16"	2		
INSULIN SYRINGE/0.3ML/30G - insulin syringe/needle u-100 0.3 ml 30 x 5/16"	2		
INSULIN SYRINGE/0.3ML/31G - insulin syringe/needle u-100 0.3 ml 31 x 5/16"	2		
INSULIN SYRINGE/0.5ML/28G - insulin syringe/needle u-100 1/2 ml 28 x 1/2"	2		
INSULIN SYRINGE/0.5ML/30G - insulin syringe/needle u-100 1/2 ml 30 x 5/16"	2		
INSULIN SYRINGE/0.5ML/31G - insulin syringe/needle u-100 1/2 ml 31 x 5/16"	2		
INSULIN SYRINGE/1ML/29G X - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
INSULIN SYRINGE/1ML/30G X - insulin syringe/needle u-100 1 ml 30 x 5/16"	2		
INSULIN SYRINGES 0.3ML/31 - insulin syringe/needle u-100 0.3 ml 31 x 1/4" (6 mm)	2		

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INSULIN SYRINGES 0.5ML/31 - insulin syringe/needle u-100 0.5 ml 31 x 1/4" (6 mm)	2		
INSULIN SYRINGES/U-100/0. - insulin syringe/needle u-100 1/2 ml 27 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16"	2		
INSULIN SYRINGES/U-100/1M - insulin syringe/needle u-100 1 ml 27 x 1/2", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16"	2		
INSUPEN 29G X 12MM - insulin pen needle 29 g x 12 mm (1/2")	2		
INSUPEN 31G X 5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
INSUPEN 31G X 8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
INSUPEN 32G X 4MM - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
INSUPEN 33GX4MM - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
KAMELEON LUBRICATED - condoms latex lubricated	3		
KIMONO COLORS - condoms latex lubricated	3		
KIMONO LUBRICATED - condoms latex lubricated	3		
KIMONO MAXX/LARGE FLARE - condoms latex lubricated	3		
KIMONO MICRO THIN - condoms latex non-lubricated	3		
KIMONO MICRO THIN PLUS SP - condoms latex lubricated	3		
KIMONO PLUS SPERMICIDE LU - condoms latex lubricated	3		
KIMONO PLUS SPERMICIDE/LU - condoms latex lubricated	3		
KIMONO PS LUBRICATED - condoms latex lubricated	3		
KIMONO PS PLUS SPERMICIDE - condoms latex lubricated	3		
KIMONO SENSATION LUBRICAT - condoms latex lubricated	3		
KIMONO SENSATION PLUS SPE - condoms latex lubricated	3		
KIMONO SPECIAL - condoms latex lubricated	3		
KINNEY LANCETS - lancets	2		
KINNEY THIN LANCETS - lancets	2		

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KINRAY INSULIN SYRINGE PR - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
KINRAY INSULIN SYRINGE/0. - insulin syringe/needle u-100 1/2 ml 29 x 1/2"	2		
KMART VALU PLUS INSULIN S - insulin syringe (disp) u-100 0.3 ml, u-100 1/2 ml, u-100 1 ml	2		
KROGER AUTOLET LANCING DE - lancet devices	2		
KROGER BLOOD GLUCOSE MONI - blood glucose monitoring kit w/ device	3		
KROGER HEALTHPRO TWIST LA - lancets	2		
KROGER INSULIN SYRINGE/U- - insulin syringe/needle u-100 0.3 ml 30 x 1/2"	2		
KROGER INSULIN SYRINGE/0. - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
KROGER INSULIN SYRINGE/1M - insulin syringe/ needle u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16"	2		
KROGER LANCETS - lancets	2		
KROGER LANCETS MICRO THIN - lancets	2		
KROGER LANCETS SUPER THIN - lancets	2		
KROGER LANCETS THIN - lancets	2		
KROGER LANCETS THIN 26G - lancets	2		
KROGER LANCETS ULTRATHIN - lancets	2		
KROGER LANCETS 21G - lancets	2		
KROGER LANCING DEVICE - lancet devices	2		
KROGER PEN NEEDLES 29G X - insulin pen needle 29 g x 12 mm (1/2")	2		
KROGER PEN NEEDLES 31G X - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
KROGER PEN NEEDLES 31GX1/ - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
KROGER PEN NEEDLES/31G X - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
KROGER PEN NEEDLES/32G X - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
KROGER PEN NEEDLES/33G X - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
KROGER PREMIUM BLOOD GLUC - blood glucose monitoring kit w/ device	3		

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LANCET DEVICE ADJUSTABLE - lancet devices	2		
LANCET DEVICE WITH EJECTO - lancet devices	2		
LANCETS - lancets	2		
LANCETS MICRO THIN 33G - lancets	2		
LANCETS SUPER THIN 28G - lancets	2		
LANCETS THIN - lancets	2		
LANCETS ULTRA THIN 30G - lancets	2		
LANCETS 28G - lancets	2		
LANCETS 30G - lancets	2		
LANCETS 30G TWIST TOP - lancets	2		
LANCETS 30G/TWIST TOP - lancets	2		
LANCETS 33G EXTRA FINE - lancets	2		
LANCETS 33G UNIVERSAL DES - lancets	2		
LANCING DEVICE - lancet devices	2		
LANZO - lancet devices	2		
LEADER ADVANCED LANCING D - lancet devices	2		
LEADER INSULIN SYRINGE/0. - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
LEADER INSULIN SYRINGE/1M - insulin syringe/needle u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16"	2		
LEADER LANCETS COLORED - lancets	2		
LEADER SUPER THIN LANCET - lancets	2		
LEADER THIN LANCETS - lancets	2		
LEADER UNIFINE PENTIPS PL - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
LEADER UNIFINE PENTIPS/MI - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
LEADER UNIFINE PENTIPS/NA - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
LEADER UNIFINE PENTIPS/PL - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
LIBERTY BLOOD GLUCOSE MET - blood glucose monitoring devices	3		
LIBERTY MEDICAL LANCETS 3 - lancets	2		
LIBERTY MINI LANCING DEVI - lancet devices	2		
LIBERTY NEXT GENERATION B - blood glucose monitoring devices	3		
LIFESCAN UNISTIK 2 DEEP P - lancets	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
LITE TOUCH LANCETS - lancets	2		
LITE TOUCH LANCING PEN - lancet devices	2		
LITETOUCH INSULIN PEN NEE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
LITETOUCH INSULIN SYRINGE - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
LITETOUCH LANCETS MICRO T - lancets	2		
LITETOUCH PEN NEEDLES 29G - insulin pen needle 29 g x 12.7 mm (1/2")	2		
LITETOUCH PEN NEEDLES 31G - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
LITETOUCH PEN NEEDLES/31 - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
LITETOUCH PEN NEEDLES/31G - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
LIVE BETTER ADVANCED LANC - lancet devices	2		
LIVE BETTER LANCET SUPER - lancets	2		
LIVE BETTER LANCET ULTRA - lancets	2		
LIVE BETTER PEN NEEDLES 2 - insulin pen needle 29 g x 12 mm (1/2")	2		
LIVE BETTER PEN NEEDLES 3 - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
LONGS INSULIN SYRINGE/0.5 - insulin syringe/needle u-100 1/2 ml 31 x 5/16"	2		
LONGS LANCETS STANDARD - lancets	2		
LONGS LANCETS THIN - lancets	2		
LONGS LANCETS ULTRA THIN - lancets	2		
MAGELLAN INSULIN SAFETY S - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16"	2		
MAGELLAN TUBERCULIN SAFET - tuberculin/allergy syringe/needle (disp) 1 ml 27 x 1/2", 1 ml 28 x 1/2"	3		
MARATHON MEDICAL PENTIPS - insulin pen needle 29 g x 12 mm (1/2")	2		
MARATHON MEDICAL PENTIPS - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
MARATHON MEDICAL PENTIPS - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		

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MAXI-COMFORT INSULIN SYRI - insulin syringe/needle u-100 1/2 ml 28 x 1/2", u-100 1 ml 28 x 1/2"	2		
MAXI-COMFORT SAFETY PEN N - insulin pen needle 29 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
MAXICOMFORT II PEN NEEDLE - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
MAXICOMFORT INSULIN SYRIN - insulin syringe/ needle u-100 1/2 ml 27 x 1/2", u-100 1 ml 27 x 1/2"	2		
MAXX LUBRICATED - condoms latex lubricated	3		
MAXX PLUS SPERMICIDE LUBR - condoms latex lubricated	3		
MEDIC INSULIN SYRINGE/0.3 - insulin syringe/needle u-100 0.3 ml 30 x 5/16"	2		
MEDIC INSULIN SYRINGE/0.5 - insulin syringe/needle u-100 1/2 ml 30 x 5/16"	2		
MEDICHOICE PRE-SET SAFETY - lancets	2		
MEDICHOICE SAFETY LANCET - lancets	2		
MEDICINE SHOPPE LANCETS - lancets	2		
MEDICINE SHOPPE LANCETS T - lancets	2		
MEDICINE SHOPPE PEN NEEDL - insulin pen needle 29 g x 12 mm (1/2")	2		
MEDICINE SHOPPE PEN NEEDL - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
MEDLANCE PLUS EXTRA LANCE - lancets	2		
MEDLANCE PLUS LANCETS LIT - lancets	2		
MEDLANCE PLUS LITE LANCET - lancets	2		
MEDLANCE PLUS SPECIAL LAN - lancets	2		
MEDLANCE PLUS SUPERLITE 3 - lancets	2		
MEDLANCE PLUS UNIVERSAL L - lancets	2		
MEDLANCE PLUS/LITE 25G - lancets	2		
MEIJER BLOOD GLUCOSE MONI - blood glucose monitoring kit w/ device	3		
MEIJER COLOR LANCETS UNIV - lancets	2		
MEIJER ESSENTIAL BLOOD GL - blood glucose monitoring kit w/ device	3		
MEIJER LANCETS - lancets	2		
MEIJER LANCETS THIN - lancets	2		
MEIJER LANCETS UNIVERSAL - lancets	2		
MEIJER PEN NEEDLES 29G X - insulin pen needle 29 g x 12 mm (1/2")	2		
MEIJER PEN NEEDLES 31G X - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
MEIJER PREMIUM BLOOD GLUC - blood glucose monitoring kit w/ device	3		
MEIJER SUPER THIN LANCETS - lancets	2		
MEIJER TRUERESULT BLOOD G - blood glucose monitoring kit w/ device	3		
MEIJER TRUETRACK BLOOD GL - blood glucose monitoring kit w/ device	3		
MEIJER TRUE2GO BLOOD GLUC - blood glucose monitoring kit w/ device	3		
MICRODOT BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
MICRODOT PEN NEEDLE/31G X - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
MICRODOT PEN NEEDLE/32G X - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
MICRODOT PEN NEEDLE/33G X - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
MICROLET LANCETS - lancets	2		
MICROLET NEXT - lancet devices	2		
MINI LANCING DEVICE - lancet devices	2		
MM BLOOD GLUCOSE MONITORI - blood glucose monitoring kit	3		
MM BLOOD GLUCOSE MONITORI - blood glucose monitoring kit w/ device	3		
MM BLULINK GLUCOSE MONITO - blood glucose monitoring devices	3		
MM EASY TOUCH BLOOD GLUCO - blood glucose monitoring kit w/ device	3		
MM INSULIN SYRINGE/U-100/ - insulin syringe/needle u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
MM LANCING DEVICE - lancet devices	2		
MM PEN NEEDLES 31G X 1/4" - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
MM PEN NEEDLES 31G X 3/16 - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
MM PEN NEEDLES 31G X 5/16 - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
MM PEN NEEDLES 32G X 5/32 - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
MM TWIST LANCETS - lancets	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
MONOJECT BLUNT CANNULA/20 - needle (disp) 20 x 1-1/2"	3		
MONOJECT BLUNT CANNULA/21 - needle (disp) 21 x 1"	3		
MONOJECT HYPO/ALUM HUB/LU - needle (disp) 14 x 1", 14 x 2", 16 x 5/8", 16 x 3/4", 16 x 1-1/2", 19 x 1", 19 x 1-1/2", 20 x 1", 22 x 1", 22 x 1-1/2", 23 x 1", 25 x 5/8", 25 x 1-1/4", 25 x 2", 27 x 1/2", 27 x 1-1/4"	3		
MONOJECT HYPO/ALUM HUB/LU - needle (disp) 18 x 1", 18 x 1-1/2", 20 x 1-1/2"	2		
MONOJECT HYPO/ALUM HUB/16 - needle (disp) 16 x 1"	3		
MONOJECT HYPO/ALUM HUB/18 - needle (disp) 18 x 1-1/2"	2		
MONOJECT HYPO/POLYPROPYLE - needle (disp) 18 x 1", 18 x 1-1/2", 19 x 1", 19 x 1-1/2", 20 x 1", 20 x 1-1/2", 21 x 1", 21 x 1-1/2", 22 x 1", 22 x 1-1/2", 23 x 3/4", 23 x 1", 25 x 5/8", 25 x 1", 25 x 1-1/2", 26 x 1/2", 27 x 1/2", 30 x 3/4"	3		
MONOJECT HYPODERMIC NEEDL - needle (disp) 18 x 1", 27 x 1-1/2", 30 x 3/4"	3		
MONOJECT INSULIN SYRINGE - insulin syringe (disp) u-100 1 ml	2		
MONOJECT INSULIN SYRINGE/ - insulin syringe (disp) u-100 1 ml	2		
MONOJECT INSULIN SYRINGE/ - insulin syringe/ needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 25 x 5/8", u-100 1 ml 27 x 1/2", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16"	2		
MONOJECT MAGELLAN SAFETY - needle (disp) 18 x 1", 18 x 1-1/2", 20 x 1", 20 x 1-1/2", 21 x 5/8", 21 x 1", 21 x 1-1/2", 22 x 1", 22 x 1-1/2", 23 x 5/8", 23 x 1", 25 x 5/8", 25 x 1"	2		
MONOJECT MAGELLAN SAFETY - needle (disp) 19 x 1", 19 x 1-1/2"	3		
MONOJECT MEDICATION TRANS - hypodermic needles (disposable)	3		
MONOJECT STANDARD HYPODER - needle (disp) 14 x 1-1/2", 18 x 1", 18 x 1-1/2", 19 x 1", 19 x 1-1/2", 20 x 1", 20 x 1-1/2", 21 x 1", 21 x 1-1/2", 21 x 2", 22 x 1", 22 x 1-1/2", 23 x 1", 25 x 5/8", 25 x 1", 25 x 1-1/2", 26 x 1-1/2", 27 x 1/2"	3		

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MONOJECT SYRINGE PHARMACY - syringe (disposable) 1 ml	2		
MONOJECT TB SYRINGE-NDL 1 - tuberculin/allergy syringe/needle (disp) 1 ml 26 x 3/8", 1 ml 27 x 1/2"	3		
MONOJECT TUBERCULIN SAFET - tuberculin/allergy syringe/needle (disp) 1 ml 25 x 5/8", 1 ml 28 x 1/2"	3		
MONOJECT TUBERCULIN SYRIN - syringe (disposable) 1 ml	2		
MONOJECT TUBERCULIN SYRIN - tuberculin/allergy syringe/needle (disp) 1 ml 25 x 5/8"	2		
MONOJECT TUBERCULIN SYRIN - tuberculin/allergy syringe/needle (disp) 1 ml 26 x 3/8", 1 ml 27 x 1/2", 1 ml 28 x 1/2"	3		
MONOJECT ULTRA COMFORT IN - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 0.3 ml 31 x 5/16"	2		
MONOJECT 1ML LUER LOCK TU - syringe (disposable) 1 ml	2		
MONOLET LANCETS - lancets	2		
MONOLET OPD LANCETS - lancets	2		
MONOLETTOR SAFETY LANCETS - lancets	2		
MS INSULIN SYRINGE/0.3ML/ - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
MS INSULIN SYRINGE/0.5ML/ - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16"	2		
MS INSULIN SYRINGE/1ML/29 - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
MS INSULIN SYRINGE/1ML/30 - insulin syringe/needle u-100 1 ml 30 x 5/16"	2		
MS INSULIN SYRINGE/1ML/31 - insulin syringe/needle u-100 1 ml 31 x 5/16"	2		
MULTI-LANCET DEVICE - lancet devices	2		
MYGLUCOHEALTH BLOOD GLUCO - blood glucose monitoring kit w/ device	3		
MYGLUCOHEALTH MGH SOFTLAN - lancets	2		
NOVA MAX BLOOD GLUCOSE MO - blood glucose monitoring devices	3		
NOVA MAX BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
NOVA SAFETY LANCETS 23G - lancets	2		
NOVA SAFETY LANCETS 28G - lancets	2		
NOVA SUREFLEX LANCETS - lancets	2		
NOVA SUREFLEX LANCING DEV - lancet devices	2		
NOVOFINE PEN NEEDLE 32G X - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
NOVOFINE PLUS PEN NEEDLE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
NOVOPEN ECHO - injection device for insulin	3		
OMNIFLEX DIAPHRAGM - diaphragms	3		
OMNIPOD CLASSIC PODS (GEN - insulin infusion disposable pump reservoir	3		QL (30 pods/30 days)
OMNIPOD DASH INTRO KIT (G - insulin infusion disposable pump kit	3		QL (1 kit/720 days)
OMNIPOD DASH PODS (GEN 4) - insulin infusion disposable pump reservoir	3		QL (30 pods/30 days)
OMNIPOD GO 10 UNITS/DAY - insulin infusion disposable pump kit 10 unit/24hr	3		QL (10 kits/30 days)
OMNIPOD GO 15 UNITS/DAY - insulin infusion disposable pump kit 15 unit/24hr	3		QL (10 kits/30 days)
OMNIPOD GO 20 UNITS/DAY - insulin infusion disposable pump kit 20 unit/24hr	3		QL (10 kits/30 days)
OMNIPOD GO 25 UNITS/DAY - insulin infusion disposable pump kit 25 unit/24hr	3		QL (10 kits/30 days)
OMNIPOD GO 30 UNITS/DAY - insulin infusion disposable pump kit 30 unit/24hr	3		QL (10 kits/30 days)
OMNIPOD GO 35 UNITS/DAY - insulin infusion disposable pump kit 35 unit/24hr	3		QL (10 kits/30 days)
OMNIPOD GO 40 UNITS/DAY - insulin infusion disposable pump kit 40 unit/24hr	3		QL (10 kits/30 days)
OMNIPOD 5 G6 INTRO KIT (G - insulin infusion disposable pump kit	3		QL (1 kit/720 days)
OMNIPOD 5 G6 PODS (GEN 5) - insulin infusion disposable pump reservoir	3		QL (30 pods/30 days)
OMNIPOD 5 G7 INTRO KIT (G - insulin infusion disposable pump kit	3		QL (1 kit/720 days)
OMNIPOD 5 G7 PODS (GEN 5) - insulin infusion disposable pump reservoir	3		QL (30 pods/30 days)
ON CALL EXPRESS BLOOD GLU - blood glucose monitoring kit w/ device	3		
ONE DROP BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
ONETOUCH DELICA LANCETS E - lancets	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
ONETOUCH DELICA LANCETS F - lancets	2		
ONETOUCH DELICA LANCING D - lancet devices	2		
ONETOUCH DELICA PLUS LANC - lancets	2		
ONETOUCH DELICA PLUS LANC - lancet devices	2		
ONETOUCH DELICA SAFETY LA - lancets	2		
ONETOUCH LANCETS - lancets	2		
ONETOUCH ULTRA 2 - blood glucose monitoring kit w/ device	2		
ONETOUCH ULTRASOFT 2 LANC - lancets	2		
ONETOUCH VERIO - blood glucose monitoring kit w/ device	2		
ONETOUCH VERIO FLEX BLOOD - blood glucose monitoring kit w/ device	2		
ONETOUCH VERIO IQ BLOOD G - blood glucose monitoring kit w/ device	2		
ONETOUCH VERIO REFLECT - blood glucose monitoring kit w/ device	2		
PC UNIFINE PENTIPS 29G X - insulin pen needle 29 g x 12 mm (1/2")	2		
PC UNIFINE PENTIPS 31G X - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
PEN NEEDLES - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
PEN NEEDLES 29GX12MM - insulin pen needle 29 g x 12 mm (1/2")	2		
PEN NEEDLES 30GX5MM - insulin pen needle 30 g x 5 mm (1/5" or 3/16")	2		
PEN NEEDLES 30GX8MM - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
PEN NEEDLES 31G X 3/16" - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
PEN NEEDLES 31G X 5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
PEN NEEDLES 31G X 6MM - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
PEN NEEDLES 31G X 8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
PEN NEEDLES 31GX5/16" - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
PEN NEEDLES 31GX5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		

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PEN NEEDLES 31GX6MM (1/4" - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
PEN NEEDLES 31GX8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
PEN NEEDLES 31GX8MM (5/16 - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
PEN NEEDLES 32G X 4MM - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
PEN NEEDLES 32G X 5MM - insulin pen needle 32 g x 5 mm (1/5" or 3/16")	2		
PEN NEEDLES 32G X 6MM - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
PEN NEEDLES 32GX4MM - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
PEN NEEDLES 33G X 5/32" - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
PEN NEEDLES/29G X 1/2" - insulin pen needle 29 g x 12 mm (1/2")	2		
PEN NEEDLES/31G X 1/4" - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
PEN NEEDLES/31G X 3/16" - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
PEN NEEDLES/31G X 5/16" - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
PEN NEEDLES/31G X 6MM - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
PEN NEEDLES/32G X 5/32" - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
PENTIPS 29G X 12MM - insulin pen needle 29 g x 12 mm (1/2")	2		
PENTIPS 29GX12MM - insulin pen needle 29 g x 12 mm (1/2")	2		
PENTIPS 31G X 5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
PENTIPS 31G X 8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
PENTIPS 31GX5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
PENTIPS 31GX6MM - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
PENTIPS 31GX8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
PENTIPS 32G X 4MM - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		

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PENTIPS 32GX4MM - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
PENTIPS 32GX6MM - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
PERFECT LANCETS 30G - lancets	2		
PERFECT PRESSURE ACTIVATE - lancets	2		
PHARMACIST CHOICE AUTOCOD - blood glucose monitoring kit w/ device	3		
PHARMACIST CHOICE MINI BL - blood glucose monitoring devices	3		
PHARMACIST CHOICE SELECT - lancets	2		
PHARMACIST CHOICE ULTRA T - lancets	2		
PHARMACY COUNTER LANCETS - lancets	2		
PIP BLOOD GLUCOSE MONITOR - blood glucose monitoring devices	3		
PIP LANCETS/28G - lancets	2		
PIP LANCETS/30G - lancets	2		
PIP PEN NEEDLES 31G X 5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
PIP PEN NEEDLES 32G X 4MM - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
POCKETCHEM EZ BLOOD GLUCO - blood glucose monitoring kit w/ device	3		
POGO AUTOMATIC BLOOD GLUC - blood glucose monitoring devices	3		
POLY HUB NEEDLE/18G X 1-1 - needle (disp) 18 x 1-1/2"	3		
POLY HUB NEEDLE/18G X 1" - needle (disp) 18 x 1"	3		
POLY HUB NEEDLE/21G X 1-1 - needle (disp) 21 x 1-1/2"	3		
POLY HUB NEEDLE/21G X 1" - needle (disp) 21 x 1"	3		
POLY HUB NEEDLE/22G X 1-1 - needle (disp) 22 x 1-1/2"	3		
POLY HUB NEEDLE/22G X 1" - needle (disp) 22 x 1"	3		
POLY HUB NEEDLE/23G X 1-1 - needle (disp) 23 x 1-1/2"	3		
POLY HUB NEEDLE/23G X 1" - needle (disp) 23 x 1"	3		
POLY HUB NEEDLE/25G X 1-1 - needle (disp) 25 x 1-1/2"	3		
POLY HUB NEEDLE/25G X 1" - needle (disp) 25 x 1"	3		
POLY HUB NEEDLE/25G X 5/8 - needle (disp) 25 x 5/8"	3		

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POLY HUB NEEDLE/27G X 1-1 - needle (disp) 27 x 1-1/4"	3		
POLY HUB NEEDLE/27G X 1/2 - needle (disp) 27 x 1/2"	3		
POLY HUB NEEDLE/30G X 1/2 - needle (disp) 30 x 1/2"	3		
PRECISION SURE-DOSE INSUL - insulin syringe/ needle u-100 0.3 ml 30 x 5/16"	2		
PRECISION THINS GP LANCET - lancets	2		
PRECISION XTRA - blood glucose monitoring kit w/ device	3		
PREFERRED PLUS INSULIN SY - insulin syringe/ needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16"	2		
PREFERRED PLUS LANCETS CO - lancets	2		
PREFERRED PLUS LANCETS SU - lancets	2		
PREFERRED PLUS LANCETS TH - lancets	2		
PREFERRED PLUS UNIFINE PE - insulin pen needle 29 g x 12 mm (1/2")	2		
PREFERRED PLUS UNIFINE PE - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
PREVENT DROPSAFE SAFETY P - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
PREVENT SAFETY PEN NEEDLE - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
PRO COMFORT INSULIN SYRIN - insulin syringe/ needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16"	2		
PRO COMFORT PEN NEEDLES/ - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
PRO COMFORT PEN NEEDLES/ - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
PRO COMFORT SAFETY LANCET - lancets	2		
PRO VOICE V8 BLOOD GLUCOS - blood glucose monitoring devices	3		
PRO VOICE V9 BLOOD GLUCOS - blood glucose monitoring devices	3		
PRODIGY AUTOCODE BLOOD GL - blood glucose monitoring devices	3		
PRODIGY AUTOCODE BLOOD GL - blood glucose monitoring kit w/ device	3		

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PRODIGY INSULIN SYRING/U- - insulin syringe/needle u-100 0.3 ml 31 x 5/16"	2		
PRODIGY INSULIN SYRINGE/1 - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1 ml 28 x 1/2"	2		
PRODIGY LANCING DEVICE - lancet devices	2		
PRODIGY NO CODING BLOOD G - blood glucose monitoring kit w/ device	3		
PRODIGY POCKET BLOOD GLUC - blood glucose monitoring kit w/ device	3		
PRODIGY PRESSURE ACTIVATE - lancets	2		
PRODIGY SAFETY LANCETS - lancets	2		
PRODIGY TWIST TOP LANCETS - lancets	2		
PRODIGY VOICE BLOOD GLUCO - blood glucose monitoring kit w/ device	3		
PSS SELECT GP LANCETS - lancets	2		
PSS SELECT SAFETY LANCETS - lancets	2		
PURE COMFORT PEN NEEDLE 3 - insulin pen needle 32 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
PURE COMFORT PEN NEEDLE/3 - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16")	2		
PURE COMFORT SAFETY PEN N - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
PURE COMFORT SAFETY PEN N - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
PX ADVANCED LANCING DEVIC - lancet devices	2		
PX EXTRA SHORT PEN NEEDLE - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
PX INSULIN SYRINGE/U-100/ - insulin syringe/needle u-100 1/2 ml 30 x 1/2"	2		
PX LANCETS MICROTHIN 33G - lancets	2		
PX LANCETS ULTRA THIN - lancets	2		
PX LANCETS ULTRA THIN 28G - lancets	2		
PX MINI PEN NEEDLES 31GX5 - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
PX PEN NEEDLE 29GX12MM - insulin pen needle 29 g x 12 mm (1/2")	2		
PX PEN NEEDLE 31GX8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
QC ADVANCED LANCING DEVIC - lancet devices	2		
QC INSULIN SYRINGE/0.3ML/ - insulin syringe/needle u-100 0.3 ml 29 x 1/2"	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
QC INSULIN SYRINGE/0.5ML/ - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2"	2		
QC INSULIN SYRINGE/1ML/29 - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
QC INSULIN SYRINGE/1ML/31 - insulin syringe/needle u-100 1 ml 31 x 5/16"	2		
QC LANCETS SUPER THIN - lancets	2		
QC LANCETS ULTRA THIN - lancets	2		
QC PEN NEEDLES 29G X 12MM - insulin pen needle 29 g x 12 mm (1/2")	2		
QC PEN NEEDLES 31G X 6MM - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
QC PEN NEEDLES 31G X 8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
QC UNIFINE PENTIPS 32GX4M - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
QC UNILET LANCETS 28G/ULT - lancets	2		
QC UNILET LANCETS 33G/MIC - lancets	2		
QUICKTEK - blood glucose monitoring kit	3		
QUICKTEK - blood glucose monitoring kit w/ device	3		
QUINTET AC BLOOD GLUCOSE - blood glucose monitoring devices	3		
QUINTET BLOOD GLUCOSE MON - blood glucose monitoring devices	3		
RA E-ZJECT LANCETS THIN 2 - lancets	2		
RA E-ZJECT LANCETS ULTRA - lancets	2		
RA E-ZJECT LANCETS 28G - lancets	2		
RA INSULIN SYRINGE/U-100/ - insulin syringe/needle u-100 1/2 ml 30 x 5/16", u-100 1 ml 30 x 5/16"	2		
RA INSULIN SYRINGE/0.5ML/ - insulin syringe/needle u-100 1/2 ml 29 x 1/2"	2		
RA INSULIN SYRINGE/1ML/29 - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
RA PEN NEEDLES 31G X 5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
RA PEN NEEDLES 31G X 8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
RAYA SURE PEN NEEDLE 29G - insulin pen needle 29 g x 12 mm (1/2")	2		
RAYA SURE PEN NEEDLE 31G - insulin pen needle 31 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
READYLANCE SAFETY LANCETS - lancets	2		

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REALITY INSULIN SYRINGE/U - insulin syringe/needle u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2"	2		
REALITY LANCETS - lancets	2		
REALITY LATEX CONDOMS/LUB - condoms latex lubricated	3		
REALITY LATEX/ULTRA TEXTU - condoms latex lubricated	3		
REALITY LATEX/ULTRA THIN - condoms latex lubricated	3		
REALITY TRIGGER LANCETS - lancets	2		
REFUAH PLUS BLOOD GLUCOSE - blood glucose monitoring kit w/ device	3		
RELION CONFIRM BLOOD GLUC - blood glucose monitoring kit w/ device	3		
RELION INSULIN SYRINGE 0. - insulin syringe/needle u-100 1/2 ml 31 x 15/64"	2		
RELION INSULIN SYRINGE 1M - insulin syringe/needle u-100 1 ml 31 x 15/64"	2		
RELION INSULIN SYRINGE/U- - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 0.3 ml 31 x 15/64", u-100 1 ml 29 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16", u-100 1 ml 31 x 15/64"	2		
RELION LANCETS - lancets	2		
RELION LANCETS MICRO-THIN - lancets	2		
RELION LANCETS THIN 26G - lancets	2		
RELION LANCETS ULTRA-THIN - lancets	2		
RELION LANCING DEVICE - lancet devices	2		
RELION MICRO BLOOD GLUCOS - blood glucose monitoring kit w/ device	3		
RELION MINI PEN NEEDLES 3 - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
RELION PEN NEEDLES 29GX12 - insulin pen needle 29 g x 12 mm (1/2")	2		
RELION PEN NEEDLES 31G X - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
RELION PEN NEEDLES 31GX5/ - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
RELION PEN NEEDLES 31GX6M - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
RELION PEN NEEDLES 31GX8M - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
RELION PEN NEEDLES 32G X - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
RELION PEN NEEDLES 32GX4M - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
RELION PEN NEEDLES/31G X - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
RELION PREMIER BLU BLOOD - blood glucose monitoring devices	3		
RELION PREMIER CLASSIC BL - blood glucose monitoring devices	3		
RELION PREMIER COMPACT BL - blood glucose monitoring kit w/ device	3		
RELION PREMIER VOICE BLOO - blood glucose monitoring devices	3		
RELION PRIME BLOOD GLUCOS - blood glucose monitoring devices	3		
RELION SHORT PEN NEEDLES - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
RELION THIN LANCETS - lancets	2		
RELION TRUE METRIX AIR BL - blood glucose monitoring kit w/ device	3		
RELION ULTIMA BLOOD GLUCO - blood glucose monitoring kit w/ device	3		
RELION ULTRA THIN LANCETS - lancets	2		
RELION ULTRA THIN PLUS LA - lancets	2		
RELION 2-IN-1 LANCET DEV - lancets	2		
RELION 2-IN-1 LANCING DEV - lancets	2		
REXALL BLOOD GLUCOSE MONI - blood glucose monitoring kit w/ device	3		
REXALL LANCETS ULTRA THIN - lancets	2		
RIGHTEST GD500 LANCING DE - lancet devices	2		
RIGHTEST GL300 LANCETS - lancets	2		
RIGHTEST GM100 BLOOD GLUC - blood glucose monitoring kit w/ device	3		
RIGHTEST GM300 BLOOD GLUC - blood glucose monitoring kit w/ device	3		
RIGHTEST GM550 BLOOD GLUC - blood glucose monitoring kit w/ device	3		
RIGHTEST GT333 BLOOD GLUC - blood glucose monitoring devices	3		
SAFE-T-LANCE LOW FLOW 25G - lancets	2		
SAFE-T-LANCE NORMAL FLOW - lancets	2		

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SAFE-T-LANCE PLUS SAFETY - lancets	2		
SAFETY LANCETS - lancets	2		
SAFETY LANCETS 21G - lancets	2		
SAFETY LANCETS 23G - lancets	2		
SAFETY LANCETS 28G - lancets	2		
SAFETY LANCETS/PRESSURE A - lancets	2		
SAFETY PEN NEEDLES/30G X - insulin pen needle 30 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
SAPS HEALTH CARE TWIST TO - lancets	2		
SAPS HEALTH PLUS TWIST TO - lancets	2		
SAPS HEALTH TWIST TOP LAN - lancets	2		
SAPSCARE TWIST TOP LANCET - lancets	2		
SB INSULIN SYRINGE/U-100/ - insulin syringe/needle u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16"	2		
SB LANCETS THIN - lancets	2		
SB LANCETS ULTRA THIN - lancets	2		
SCHNUCKS INSULIN SYRINGE - insulin syringe/needle u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16"	2		
SECURESAFE SAFETY HYPODER - needle (disp) 19 x 1", 19 x 1-1/2", 21 x 1-1/2", 22 x 1", 25 x 1-1/2", 26 x 1/2", 27 x 1/2"	3		
SECURESAFE SAFETY INSULIN - insulin syringe/ needle u-100 1/2 ml 29 x 1/2", u-100 1 ml 29 x 1/2"	2		
SECURESAFE SAFETY PEN NEE - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
SELECT-LITE LANCING DEVIC - lancet devices	2		
SIMPLE DIAGNOSTICS LANCIN - lancet devices	2		
SINGLE-LET - lancets	2		
SM MICRO THIN LANCETS 33G - lancets	2		
SM TRUEDRAW LANCING DEVIC - lancet devices	2		
SMART DIABETES VANTAGE LA - lancet devices	2		
SMART SENSE COLOR LANCETS - lancets	2		
SMART SENSE PREMIUM BLOOD - blood glucose monitoring kit w/ device	3		
SMART SENSE STANDARD LANC - lancets	2		
SMART SENSE SUPER THIN LA - lancets	2		
SMART SENSE THIN LANCETS - lancets	2		
SMART SENSE VALUE BLOOD - blood glucose monitoring kit w/ device	3		

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SMARTEST EJECT BLOOD GLUC - blood glucose monitoring devices	3		
SMARTEST EJECT STARTER KI - blood glucose monitoring kit w/ device	3		
SMARTEST LANCETS 28G - lancets	2		
SMARTEST PERSONA STARTER - blood glucose monitoring kit w/ device	3		
SMARTEST PRONTO STARTER - blood glucose monitoring kit w/ device	3		
SMARTEST PROTEGE BLOOD GL - blood glucose monitoring devices	3		
SMARTEST PROTEGE STARTER - blood glucose monitoring kit w/ device	3		
SOLUS V2 AUDIBLE BLOOD GL - blood glucose monitoring devices	3		
SOLUS V2 AUDIBLE BLOOD GL - blood glucose monitoring kit w/ device	3		
SOLUS V2 LANCING DEVICE - lancet devices	2		
SOLUS V2 PRESSURE ACTIVAT - lancets	2		
SOLUS V2 TWIST LANCETS 30 - lancets	2		
STERILANCE TL - lancets	2		
SUPER THIN LANCETS - lancets	2		
SUPREME II CONFIDENCE PAD - blood glucose monitoring misc.	3		
SURE COMFORT AUTOKEEPER S - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
SURE COMFORT AUTOKEEPER S - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
SURE COMFORT INSULIN SYRI - insulin syringe/ needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 0.3 ml 31 x 1/4" (6 mm), u-100 0.5 ml 31 x 1/4" (6 mm), u-100 1 ml 31 x 1/4" (6 mm), u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
SURE COMFORT LANCETS 18G - lancets	2		
SURE COMFORT LANCETS 21G - lancets	2		
SURE COMFORT LANCETS 23G - lancets	2		
SURE COMFORT LANCETS 28G - lancets	2		
SURE COMFORT LANCETS 30G - lancets	2		
SURE COMFORT LANCING PEN - lancet devices	2		

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SURE COMFORT PEN NEEDLES - insulin pen needle 29 g x 12.7 mm (1/2")	2		
SURE COMFORT PEN NEEDLES - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
SURE COMFORT PEN NEEDLES - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
SURE COMFORT PEN NEEDLES - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 6 mm (1/4" or 15/64")	2		
SURELITE LANCETS - lancets	2		
TECHLITE AST LANCETS - lancets	2		
TECHLITE INSULIN SYRINGE - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 0.3 ml 31 x 15/64", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16", u-100 1/2 ml 31 x 15/64", u-100 1 ml 31 x 15/64"	2		
TECHLITE LANCETS - lancets	2		
TECHLITE LANCETS 26G - lancets	2		
TECHLITE PEN NEEDLES 31G - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
TECHLITE PEN NEEDLES/31G - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
TECHLITE PEN NEEDLES/32G - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
TECHLITE PLUS PEN NEEDLES - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
TEMPO REFILL - blood glucose monitoring kit	3		
TEMPO SMART BUTTON - blood glucose monitoring misc.	3		
TEMPO WELCOME - blood glucose monitoring kit w/ device	3		
TGT ADVANCED LANCING DEVI - lancet devices	2		
TGT BLOOD GLUCOSE MONITOR - blood glucose monitoring kit w/ device	3		
TGT LANCET ALTERNATE SITE - lancets	2		
TGT LANCET MICRO THIN 33G - lancets	2		
TGT LANCET SUPER THIN 30G - lancets	2		
TGT LANCET THIN 23G - lancets	2		
TGT LANCET THIN 26G - lancets	2		
TGT LANCET ULTRA THIN 28G - lancets	2		
TGT LANCET ULTRA THIN 30G - lancets	2		
TGT LANCING DEVICE - lancet devices	2		
THINLETS GP LANCETS - lancets	2		

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TODAYS HEALTH ADVANCED LA - lancet devices	2		
TODAYS HEALTH ORIGINAL PE - insulin pen needle 29 g x 12 mm (1/2")	2		
TODAYS HEALTH SHORT PEN N - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
TODAYS HEALTH SUPER THIN - lancets	2		
TODAYS HEALTH ULTRA THIN - lancets	2		
TOPCARE CLICKFINE UNIVERS - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
TOPCARE LANCETS MICRO-THI - lancets	2		
TOPCARE ULTRA COMFORT INS - insulin syringe/ needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
TRACER II 3 VOLT BATTERY - blood glucose monitoring misc.	3		
TRAVEL LANCETS ADVANCED 2 - lancets	2		
TRUE COMFORT INSULIN SYRI - insulin syringe/ needle u-100 1/2 ml 31 x 5/16", u-100 1 ml 31 x 5/16"	2		
TRUE COMFORT PEN NEEDLES - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
TRUE COMFORT PEN NEEDLES - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
TRUE COMFORT PRO INSULIN - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 0.5 ml 32 x 5/16", u-100 1 ml 32 x 5/16", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16"	2		
TRUE COMFORT PRO PEN NEED - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
TRUE COMFORT PRO PEN NEED - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
TRUE COMFORT PRO PEN NEED - insulin pen needle 33 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
TRUE COMFORT SAFETY INSUL - insulin syringe/ needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 32 x 5/16", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16"	2		
TRUE COMFORT SAFETY LANCE - lancets	2		

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TRUE COMFORT SAFETY PEN N - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
TRUE COMFORT SAFETY PEN N - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
TRUE COMFORT TWIST TOP LA - lancets	2		
TRUE COVER - condoms latex lubricated	3		
TRUE FOCUS BLOOD GLUCOSE - blood glucose monitoring devices	3		
TRUE METRIX - blood glucose monitoring devices	3		
TRUE METRIX AIR BLOOD GLU - blood glucose monitoring devices	3		
TRUE METRIX AIR BLOOD GLU - blood glucose monitoring kit w/ device	3		
TRUE METRIX AIR W/BLUETOO - blood glucose monitoring kit w/ device	3		
TRUE METRIX BLOOD GLUCOSE - blood glucose monitoring kit w/ device	3		
TRUE METRIX GO BLOOD GLUC - blood glucose monitoring kit w/ device	3		
TRUEDRAW LANCING DEVICE - lancet devices	2		
TRUEPLUS INSULIN SYRINGE - insulin syringe/needle u-100 1 ml 29 x 1/2"	2		
TRUEPLUS INSULIN SYRINGE/ - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 28 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
TRUEPLUS LANCETS 26G - lancets	2		
TRUEPLUS LANCETS 28G - lancets	2		
TRUEPLUS LANCETS 28G SUPE - lancets	2		
TRUEPLUS LANCETS 30G - lancets	2		
TRUEPLUS LANCETS 30G ULTR - lancets	2		
TRUEPLUS LANCETS 33G - lancets	2		
TRUEPLUS LANCETS 33G MICR - lancets	2		
TRUEPLUS PEN NEEDLES 29GX - insulin pen needle 29 g x 12 mm (1/2")	2		
TRUEPLUS PEN NEEDLES 31GX - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
TRUEPLUS PEN NEEDLES 32GX - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
TRUEPLUS SAFETY LANCETS 2 - lancets	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
TRUEPLUS 5-BEVEL PEN NEED - insulin pen needle 29 g x 12.7 mm (1/2")	2		
TRUEPLUS 5-BEVEL PEN NEED - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
TRUEPLUS 5-BEVEL PEN NEED - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
TRUERESULT BLOOD GLUCOSE - blood glucose monitoring kit w/ device	3		
TRUETRACK BLOOD GLUCOSE M - blood glucose monitoring devices	3		
TRUETRACK BLOOD GLUCOSE M - blood glucose monitoring kit w/ device	3		
TRUETRACK SMART SYSTEM - blood glucose monitoring kit w/ device	3		
TRUSTEX COLOR CONDOMS + L - condoms latex lubricated	3		
TRUSTEX LUBRICATED - condoms latex lubricated	3		
TRUSTEX LUBRICATED EXTRA - condoms latex lubricated	3		
TRUSTEX LUBRICATED/RIBBED - condoms latex lubricated	3		
TRUSTEX LUBRICATED/SPERMI - condoms latex lubricated	3		
TRUSTEX NATURAL CONDOMS + - condoms latex lubricated	3		
TRUSTEX NON-LUBRICATED - condoms latex non-lubricated	3		
TRUSTEX WITH NONOXYNOL-9/ - condoms latex lubricated	3		
TRUSTEX/RIA LUBRICATED - condoms latex lubricated	3		
TRUSTEX/RIA LUBRICATED SP - condoms latex lubricated	3		
TRUSTEX/RIA LUBRICATED/SP - condoms latex lubricated	3		
TRUSTEX/RIA NON-LUBRICATE - condoms latex non-lubricated	3		
TWIST TOP LANCETS 30G - lancets	2		
ULTI-LANCE AUTOMATIC/ CLE - lancet devices	2		
ULTICARE INSULIN SAFETY S - insulin syringe/needle u-100 1/2 ml 29 x 1/2", u-100 1 ml 29 x 1/2"	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
ULTICARE INSULIN SYRINGE - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
ULTICARE INSULIN SYRINGE/ - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 28 x 1/2", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 28 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
ULTICARE MICRO PEN NEEDLE - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
ULTICARE MICRO PEN NEEDLE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
ULTICARE MINI PEN NEEDLES - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
ULTICARE MINI PEN NEEDLES - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
ULTICARE MINI SAFETY PEN - insulin pen needle 30 g x 5 mm (1/5" or 3/16")	2		
ULTICARE ORIGINAL PEN NEE - insulin pen needle 29 g x 12.7 mm (1/2")	2		
ULTICARE PEN NEEDLES 31G - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
ULTICARE PEN NEEDLES/29G - insulin pen needle 29 g x 12.7 mm (1/2")	2		
ULTICARE SHORT PEN NEEDLE - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
ULTICARE SHORT SAFETY PEN - insulin pen needle 30 g x 8 mm (1/3" or 5/16")	2		
ULTICARE TUBERCULIN SAFET - tuberculin/allergy syringe/needle (disp) 1 ml 25 x 5/8", 1 ml 25 x 1"	2		
ULTICARE U-100 INSULIN SY - insulin syringe/needle u-100 0.3 ml 31 x 1/4" (6 mm), u-100 0.5 ml 31 x 1/4" (6 mm), u-100 1 ml 31 x 1/4" (6 mm)	2		
ULTIGUARD INSULIN SYRINGE - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16"	2		
ULTIGUARD SAFEPACK INSULI - insulin syringe/needle u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 30 x 1/2", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
ULTIGUARD SAFEPACK MINI P - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
ULTIGUARD SAFEPACK PEN NE - insulin pen needle 29 g x 12.7 mm (1/2")	2		
ULTIGUARD SAFEPACK/MICRO - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
ULTIGUARD SAFEPACK/MINI P - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
ULTIGUARD SAFEPACK/MINI P - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
ULTIGUARD SAFEPACK/SHORT - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
ULTIGUARD SAFEPACK/SYRING - insulin syringe/ needle u-100 1/2 ml 31 x 5/16"	2		
ULTILET CLASSIC LANCETS - lancets	2		
ULTILET LANCETS - lancets	2		
ULTILET LANCETS 33G - lancets	2		
ULTILET PEN NEEDLE 29GX12 - insulin pen needle 29 g x 12.7 mm (1/2")	2		
ULTILET PEN NEEDLE 31GX5M - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
ULTILET PEN NEEDLE 31GX8M - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
ULTILET PEN NEEDLE 32GX4M - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
ULTILET SAFETY LANCETS 21 - lancets	2		
ULTILET SAFETY LANCETS 23 - lancets	2		
ULTILET SHORT PEN NEEDLES - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
ULTRA COMFORT INSULIN SYR - insulin syringe/ needle u-100 0.3 ml 30 x 5/16"	2		
ULTRA FLO INSULIN PEN NEE - insulin pen needle 29 g x 12 mm (1/2")	2		
ULTRA FLO INSULIN PEN NEE - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
ULTRA FLO INSULIN PEN NEE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
ULTRA FLO INSULIN PEN NEE - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
ULTRA FLO INSULIN SYRINGE - insulin syringe/needle u-100 0.3 ml 29 x 1/2", u-100 0.3 ml 30 x 5/16", u-100 0.3 ml 30 x 1/2", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"			
ULTRA INSULIN SYRINGE/U-1 - insulin syringe/needle u-100 1/2 ml 29 x 1/2"	2		
ULTRA THIN LANCETS 28G - lancets	2		
ULTRA THIN LANCETS 31G - lancets	2		
ULTRA THIN PEN NEEDLES 32 - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
ULTRA-THIN II AUTO LANCET - lancets	2		
ULTRA-THIN II INSULIN SYR - insulin syringe/needle u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1/2 ml 30 x 5/16", u-100 1 ml 29 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
ULTRA-THIN II LANCETS 28G - lancets	2		
ULTRA-THIN II LANCETS 30G - lancets	2		
ULTRA-THIN II MINI PEN NE - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
ULTRA-THIN II PEN NEEDLES - insulin pen needle 29 g x 12.7 mm (1/2")	2		
ULTRA-THIN II PEN NEEDLES - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
ULTRACARE INSULIN SYRINGE - insulin syringe/needle u-100 0.3 ml 30 x 5/16", u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
ULTRACARE PEN NEEDLES/31G - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
ULTRACARE PEN NEEDLES/32G - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64")	2		
ULTRACARE PEN NEEDLES/33G - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
ULTRATRAK ACTIVE - blood glucose monitoring devices	3		
UNIFINE PENTIPS PLUS 29GX - insulin pen needle 29 g x 12 mm (1/2")	2		
UNIFINE PENTIPS PLUS 31GX - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
UNIFINE PENTIPS PLUS 32GX - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
UNIFINE PENTIPS PLUS 33G - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
UNIFINE PENTIPS PLUS 33GX - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
UNIFINE PENTIPS PLUS/30G - insulin pen needle 30 g x 5 mm (1/5" or 3/16")	2		
UNIFINE PENTIPS 29GX12MM - insulin pen needle 29 g x 12 mm (1/2")	2		
UNIFINE PENTIPS 31G X 3/1 - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
UNIFINE PENTIPS 31G X 6MM - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
UNIFINE PENTIPS 31G X 8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
UNIFINE PENTIPS 31GX5MM - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
UNIFINE PENTIPS 31GX6MM - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
UNIFINE PENTIPS 31GX8MM - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
UNIFINE PENTIPS 32GX4MM - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
UNIFINE PENTIPS 32GX6MM - insulin pen needle 32 g x 6 mm (1/4" or 15/64")	2		
UNIFINE PENTIPS 33GX4MM - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
UNIFINE PENTIPS/30G X 3/1 - insulin pen needle 30 g x 5 mm (1/5" or 3/16")	2		
UNIFINE PROTECT SAFETY PE - insulin pen needle 30 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
UNIFINE PROTECT SAFETY PE - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
UNIFINE SAFECONTROL PEN N - insulin pen needle 30 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
UNIFINE SAFECONTROL PEN N - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
UNIFINE SAFECONTROL PEN N - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
UNIFINE ULTRA PEN NEEDLE/ - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
UNIFINE ULTRA PEN NEEDLE/ - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
UNILET COMFORTOUCH LANCET - lancets	2		
UNILET EXCELITE - lancets	2		
UNILET EXCELITE II - lancets	2		
UNILET G.P. LANCET - lancets	2		
UNILET G.P. SUPERLITE LAN - lancets	2		
UNILET GP 28 ULTRA THIN - lancets	2		
UNILET LANCET - lancets	2		
UNILET LANCETS MICRO-THIN - lancets	2		
UNILET LANCETS SUPER-THIN - lancets	2		
UNILET LANCETS ULTRA-THIN - lancets	2		
UNILET SUPERLITE LANCET - lancets	2		
UNISTIK PRO SAFETY LANCET - lancets	2		
UNISTIK SAFETY LANCETS 28 - lancets	2		
UNISTIK SAFETY LANCETS 30 - lancets	2		
UNISTIK TOUCH SAFETY LANC - lancets	2		
UNISTIK 3 GENTLE - lancets	2		
UNIVERSAL 1 LANCETS THIN - lancets	2		
UNIVERSAL 1 LANCETS ULTRA - lancets	2		
UNIVERSAL 1 LANCETS/33G/M - lancets	2		
V-GO 20 - insulin infusion disposable pump kit 20 unit/24hr	3		QL (30 systems/30 days)
V-GO 30 - insulin infusion disposable pump kit 30 unit/24hr	3		QL (30 systems/30 days)
V-GO 40 - insulin infusion disposable pump kit 40 unit/24hr	3		QL (30 systems/30 days)
VALUE HEALTH INSULIN SYRI - insulin syringe/needle u-100 1/2 ml 29 x 1/2", u-100 1 ml 29 x 1/2"	2		
VALUE PLUS LANCETS STANDA - lancets	2		
VALUE PLUS LANCETS SUPER - lancets	2		
VALUE PLUS LANCETS THIN 2 - lancets	2		
VALUE PLUS LANCING DEVICE - lancet devices	2		
VALUMARK LANCET SUPER THI - lancets	2		
VALUMARK LANCET ULTRA THI - lancets	2		
VALUMARK PEN NEEDLES 29GX - insulin pen needle 29 g x 12 mm (1/2")	2		
VALUMARK PEN NEEDLES 31G - insulin pen needle 31 g x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
VANISHPOINT INSULIN SYRIN - insulin syringe/needle u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2", u-100	2		

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1 ml 30 x 3/16" (5 mm), u-100 0.5 ml 30 x 3/16" (5 mm), u-100 1 ml 29 x 1/2", u-100 1 ml 29 x 5/16", u-100 1 ml 30 x 5/16"			
VANISHPOINT SAFETY SYRING - syringe/needle (disp) 3 ml 20 x 1", 3 ml 20 x 1-1/2", 3 ml 21 x 1", 3 ml 21 x 1-1/2", 3 ml 22 x 1", 3 ml 22 x 1-1/2", 3 ml 23 x 1", 3 ml 23 x 1-1/2", 3 ml 25 x 5/8", 3 ml 25 x 1", 3 ml 25 x 1-1/2", 5 ml 21 x 1", 5 ml 21 x 1-1/2", 5 ml 22 x 1-1/2", 10 ml 21 x 1-1/2"	2		
VANISHPOINT TUBERCULIN SY - tuberculin/allergy syringe/needle (disp) 1 ml 25 x 5/8", 1 ml 27 x 1/2"	3		
VERASENS BLOOD GLUCOSE MO - blood glucose monitoring devices	3		
VERASENS BLOOD GLUCOSE MO - blood glucose monitoring kit w/ device	3		
VERIFINE INSULIN PEN NEED - insulin pen needle 29 g x 12 mm (1/2")	2		
VERIFINE INSULIN PEN NEED - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
VERIFINE INSULIN PEN NEED - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 6 mm (1/4" or 15/64")	2		
VERIFINE INSULIN SYRINGE - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
VERIFINE INSULIN SYRINGE/ - insulin syringe/needle u-100 1/2 ml 31 x 5/16", u-100 1/2 ml 29 x 1/2", u-100 1 ml 29 x 1/2", u-100 1 ml 31 x 5/16", u-100 0.3 ml 31 x 5/16"	2		
VERIFINE PLUS INSULIN PEN - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 8 mm (1/3" or 5/16")	2		
VERIFINE PLUS INSULIN PEN - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
VERIFINE PLUS PEN NEEDLE/ - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
VERIFINE SAFETY LANCET MI - lancets	2		
VERIFINE UNIVERSAL LANCET - lancets	2		
VIVAGUARD INO BLOOD GLUCO - blood glucose monitoring devices	3		
VIVAGUARD INO BLOOD GLUCO - blood glucose monitoring kit	3		
VIVAGUARD INO SMART BLOOD - blood glucose monitoring devices	3		
VIVAGUARD LANCETS - lancets	2		

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VIVAGUARD LANCETS 30G - lancets	2		
VIVAGUARD LANCING DEVICE - lancet devices	2		
VIVAGUARD SAFETY LANCETS - lancets	2		
VIVAGUARD SAFETY LANCETS/ - lancets	2		
VP INSULIN SYRINGE/U-100/ - insulin syringe/needle u-100 0.3 ml 29 x 1/2"	2		
WALGREENS COMFORT ASSURED - lancets	2		
WALGREENS LANCETS - lancets	2		
WALGREENS THIN LANCETS - lancets	2		
WALGREENS ULTRA THIN LANC - lancets	2		
WAVESENSE AMP - blood glucose monitoring kit w/ device	3		
WEGMANS UNIFINE PENTIPS P - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
WEGMANS UNIFINE PENTIPS P - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
WIDE-SEAL SILICONE DIAPHR - diaphragm wide seal 60 mm, 65 mm, 70 mm, 75 mm, 80 mm, 85 mm, 90 mm, 95 mm	3		
YALE NEEDLES 21G X 1-1/4" - needle (disp) 21 x 1-1/4"	3		
ZEVRX INSULIN SYRINGE/0.5 - insulin syringe/needle u-100 1/2 ml 30 x 5/16", u-100 1/2 ml 30 x 1/2"	2		
ZEVRX INSULIN SYRINGE/1ML - insulin syringe/needle u-100 1 ml 30 x 5/16", u-100 1 ml 30 x 1/2"	2		
ZEVRX PEN NEEDLES 31G X 5 - insulin pen needle 31 g x 5 mm (1/5" or 3/16")	2		
ZEVRX PEN NEEDLES 31G X 6 - insulin pen needle 31 g x 6 mm (1/4" or 15/64")	2		
ZEVRX PEN NEEDLES 31G X 8 - insulin pen needle 31 g x 8 mm (1/3" or 5/16")	2		
ZEVRX PEN NEEDLES 32G X 4 - insulin pen needle 32 g x 4 mm (1/6" or 5/32")	2		
ZEVRX TWIST TOP LANCETS 3 - lancets	2		
1ML VANISHPOINT TUBERCULI - tuberculin/allergy syringe/needle (disp) 1 ml 25 x 5/8", 1 ml 25 x 1", 1 ml 27 x 1/2"	2		
1ST CHOICE LANCETS SUPER - lancets	2		
1ST CHOICE LANCETS THIN - lancets	2		
1ST CHOICE LANCETS ULTRA - lancets	2		
1ST TIER UNIFINE PENTIPS - insulin pen needle 29 g x 12 mm (1/2")	2		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
1ST TIER UNIFINE PENTIPS - insulin pen needle 31 g x 5 mm (1/5" or 3/16"), x 6 mm (1/4" or 15/64"), x 8 mm (1/3" or 5/16")	2		
1ST TIER UNIFINE PENTIPS - insulin pen needle 32 g x 4 mm (1/6" or 5/32"), x 6 mm (1/4" or 15/64")	2		
1ST TIER UNIFINE PENTIPS - insulin pen needle 33 g x 4 mm (1/6" or 5/32")	2		
10ML SYRINGE LUER-LOK TIP - syringe (disposable) 10 ml	2		
ASSORTED CLASSES			
ASTAGRAF XL - tacrolimus cap er 24hr 0.5 mg, 1 mg, 5 mg	3		
azathioprine tab 50 mg (Imuran)	1		
BENLYSTA - belimumab subcutaneous solution auto-injector 200 mg/ml	3	SP	PA, LD, QL (4 pens/28 days)
BENLYSTA - belimumab subcutaneous solution prefilled syringe 200 mg/ml	3	SP	PA, LD, QL (4 syringes/28 days)
CELLCEPT - mycophenolate mofetil cap 250 mg	3		
CELLCEPT - mycophenolate mofetil tab 500 mg	3		
CELLCEPT - mycophenolate mofetil for oral susp 200 mg/ml	3		
cyclosporine cap 25 mg, 100 mg (Sandimmune)	1		
cyclosporine modified cap 25 mg, 100 mg (Neoral)	1		
cyclosporine modified cap 50 mg	1		
cyclosporine modified oral soln 100 mg/ml (Neoral)	1		
ENSPRYNG - satralizumab-mwge subcutaneous soln pref syringe 120 mg/ml	3	SP	PA, LD, QL (1 syringe/28 days)
ENVARSUS XR - tacrolimus tab er 24hr 0.75 mg, 1 mg, 4 mg	3		
everolimus tab 0.25 mg, 0.5 mg, 0.75 mg, 1 mg (Zortress)	1		
IMURAN - azathioprine tab 50 mg	3		
irrigation solution, physiological	1		
JOENJA - leniolisib phosphate tab 70 mg	3	SP	PA, LD, QL (60 tablets/30 days)
lactated ringer's for irrigation	1		
lenalidomide caps 2.5 mg (Revlimid)	1	SP	PA, QL (30 capsules/30 days)
lenalidomide cap 5 mg, 10 mg, 15 mg, 20 mg, 25 mg (Revlimid)	1	SP	PA, QL (30 capsules/30 days)
LOKELMA - sodium zirconium cyclosilicate for susp packet 5 gm, 10 gm	2		
LUPKYNIS - voclosporin cap 7.9 mg	3	SP	PA, LD, QL (180 capsules/30 days)
mycophenolate mofetil cap 250 mg (Cellcept)	1		

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Drug Name	Drug Tier	Specialty	Requirements/Limits
mycophenolate mofetil for oral susp 200 mg/ml (Cellcept)	1		
mycophenolate mofetil tab 500 mg (Cellcept)	1		
mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv), 360 mg (mycophenolic acid equiv) (Myfortic)	1		
MYFORTIC - mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv), 360 mg (mycophenolic acid equiv)	3		
NEORAL - cyclosporine modified cap 25 mg, 100 mg	3		
NEORAL - cyclosporine modified oral soln 100 mg/ml	3		
penicillamine tab 250 mg (Depen titratabs)	1	SP	PA
PROGRAF - tacrolimus cap 0.5 mg, 1 mg, 5 mg	3		
PROGRAF - tacrolimus packet for susp 0.2 mg, 1 mg	3		
RAPAMUNE - sirolimus tab 0.5 mg, 1 mg, 2 mg	3		
RAPAMUNE - sirolimus oral soln 1 mg/ml	3		
REVLIMID - lenalidomide caps 2.5 mg	2	SP	PA, LD, QL (30 capsules/30 days)
REVLIMID - lenalidomide cap 5 mg, 10 mg, 15 mg, 20 mg, 25 mg	2	SP	PA, LD, QL (30 capsules/30 days)
REZUROCK - belumosudil mesylate tab 200 mg	3	SP	PA, LD, QL (30 tablets/30 days)
ringer's solution for irrigation	1		
SANDIMMUNE - cyclosporine cap 25 mg, 100 mg	3		
SANDIMMUNE - cyclosporine oral soln 100 mg/ml	3		
sirolimus oral soln 1 mg/ml (Rapamune)	1		
sirolimus tab 0.5 mg, 1 mg, 2 mg (Rapamune)	1		
sodium polystyrene sulfonate powder	1		
SPS - sodium polystyrene sulfonate oral susp 15 gm/60ml	3		
SYPRINE - trientine hcl cap 250 mg	3	SP	PA
tacrolimus cap 0.5 mg, 1 mg, 5 mg (Prograf)	1		
THALOMID - thalidomide cap 50 mg	2	SP	PA, LD, QL (90 capsules/30 days)
THALOMID - thalidomide cap 100 mg	2	SP	PA, LD, QL (120 capsules/30 days)
trientine hcl cap 250 mg (Syprine)	1	SP	PA
TRIENTINE HYDROCHLORIDE - trientine hcl cap 500 mg	3	SP	PA
VELTASSA - patiromer sorbitex calcium for susp packet 8.4 gm (base eq), 16.8 gm (base eq), 25.2 gm (base eq)	2		
water for irrigation, sterile irrigation soln	1		
ZOKINVY - lonafarnib cap 50 mg, 75 mg	2	SP	PA, LD

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Drug Name	Drug Tier	Specialty	Requirements/Limits
ZORTRESS - everolimus tab 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	3		

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Drugs that are Not Covered*

Current 7/1/24

In addition to this list, newly marketed prescription medications may not be covered until the Pharmacy & Therapeutics Committee has had an opportunity to review the medication, to determine whether the medication will be covered and if so, which tier will apply based on safety, efficacy and the availability of other products within that class of medications. The current list of newly marketed drugs can be found on our New to Market Drug list.

Note: Drugs FDA approved for weight loss, cosmetic use or lifestyle modification are not included in this list. They are not covered on your policy unless specifically purchased separately.

Abilify tablets
Abilify MyCite tablets
Abrilada injection
Absorica capsules
Absorica LD capsules
Acanya gel and pump gel
Accrufer capsules
Accupril tablets
acetaminophen 320.5 mg/caffeine 30 mg/dihydrocodeine 16 mg capsules (authorized generic for Trezix)
acetaminophen 325 mg/caffeine 30 mg/dihydrocodeine 16 mg
Aciphex tablets
Aciphex Sprinkle capsules
Acticlate tablets
Activella tablets
Actonel tablets
Actoplus Met tablets
Actos tablets
Acuvail eye drops
acyclovir 5% topical cream
Aczone 5% and 7.5% gels
Adalimumab-aacf injection (unbranded Idacio)
Adalimumab-adaz injection (unbranded)
Adalimumab-adbm injection (unbranded)
Adalimumab-adbm injection (Quallent NDC's beginning with 82009)
Adalimumab-fkjp injection (unbranded)
Adalimumab-ryvk injection (Quallent NDC's beginning with 82009)
adapalene 0.1% cream
adapalene 0.1% lotion
adapalene 0.1% pads
adapalene 0.1% topical solution
adapalene 0.3% gel
adapalene/benzoyl peroxide gel 0.1-2.5% gel
adapalene/benzoyl peroxide gel 0.3-2.5% gel
Adcirca tablets
Adhansia XR capsules
Adlarity patches
Adlyxin injection
Admelog vials
Admelog SoloStar injection
Adoxa tablets
Adoxa Pak tablets
Adrenaclick injection
Advair Diskus
Adzenys XR tablets
Aerospan inhaler
AirDuo Digihaler inhaler
AirDuo RespiClick inhaler
Airsupra inhaler
Aklief cream
Ala-cort 1% cream
Ala-Scalp lotion
albuterol HFA inhaler (authorized generic for Ventolin HFA inhaler)
Aldactone tablets
Aldara cream
Alkindi sprinkle capsules
Allopurinol 200 mg tablets
Allzital tablets
Alogliptin tablets
Alogliptin/Metformin tablets
alogliptin/pioglitazone tablets (authorized generic for Oseni)
Alphagan P 0.1% eye drops
Altace capsules
Altoprev tablets
Altreno lotion
Alvesco inhaler
Amaryl tablets
Ambien tablets
Ambien CR tablets
amcinonide 0.1% cream and ointment
Amerge tablets
Amicar tablets
Amicar solution
Amitiza capsules
Amjevita injection
amlodipine/atorvastatin tablets
ammonium lactate 12% cream and lotion
amphetamine/dextroamphetamine 12.5 mg, 25 mg, 37.5 mg 50 mg ER capsules (generic Mydayis)
amphetamine sulfate tablets
Ampyra tablets
Amrix ER capsules
Amzeeq foam
Anafranil capsules
Androderm patches
AndroGel 1% and 1.62% gel
Android capsules
Annovera vaginal ring
Antara capsules
Antivert 25 mg chewable tablets
Antivert 50 mg tablets
Apadaz 6.12/325 mg tablets
Apadaz 8.16/325 mg tablets
Apexicon E cream
Apidra vials
Apidra SoloStar injection
Aplenzin tablets
Apo-Varenicline tablets
Apriso capsules
Arava tablets
Arazlo lotion
Aricept tablets
Aricept ODT
Arimidex tablets
Arixtra injection
ArmonAir Digihaler inhaler
ArmonAir Respiclick inhaler
Aromasin tablets
Arthrotec 50 and 75 tablets
Asacol HD tablets
aspirin/omeprazole DR tablets (authorized generic for Yosprala)
Aspruzyo sprinkle
Atacand tablets
Atacand HCT tablets
Atelvia tablets

If available, a generic version of a listed brand product is covered unless the generic is also listed (e.g., Abilify tabs are excluded but aripiprazole tabs are covered)

*Please check member benefit documentation to determine inclusion in the Drugs Not Covered program.

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Drugs that are Not Covered*

Ativan tablets
Atorvaliq oral suspension
Atralin gel
Aurovela 24 Fe tablets
Auryxia tablets
Auvelity tablets
Avalide tablets
Avapro tablets
Avodart capsules
Azasan tablets
Azasite eye drops
azathioprine 75 mg and 100 mg tablets
azelastine 0.15% nasal spray
azelastine/fluticasone nasal spray
Azelex cream
Azilect tablets
Azopt eye drops
Azor tablets
B-12 Compliance Injection
baclofen 5 mg tablets
baclofen oral solution (authorized generic for Ozobax and Ozobax DS)
Bactroban cream
Bafiertam capsules
Balcoltra tablets
Baraclude tablets
Beconase AQ nasal spray
Benicar tablets
Benicar HCT tablets
BenzaClin gel and gel pump
benzhydrocodne/APAP 6.12/325 mg tablets
benzhydrocodne/APAP 8.16/325 mg tablets
benzonatate 150 mg capsules
betamethasone valerate 0.12% foam
Betapace AF tablets
Betapace tablets
Betimol 0.25% and 0.5% eye drops
Betoptic S eye drops
Bexagliflozin tablets
Bimzelx injection
Bismuth/metronidazole/tetracycline capsules
Blisovi 24 Fe tablets
Boniva tablets
Brenzavvy tablets
Brexafemme tablets
brimonidine 0.1% eye drops
brinzolamide 1% eye drops
Brisdelle capsules
bromfenac 0.7% eye drops
bromfenac 0.075% eye drops
BromSite eye drops
Bryhali lotion
budesonide-formoterol fumarate inhalation aerosol (authorized generic for Symbicort)
budesonide rectal foam
Bupap tablets
Buphenyl powder for solution
bupropion 450 mg ER tablets
butalbital 25 mg/acetaminophen 325 mg tablets
butalbital 50 mg/acetaminophen 300 mg capsules and tablets
butalbital 50 mg/acetaminophen 300 mg/caffeine 40 mg capsules
butalbital 50 mg/acetaminophen 325 mg/caffeine 40 mg capsules
Butrans patches
Byetta injection
Bystolic tablets
Cabtreo gel
Caduet tablets
Cambia powder packets
Canasa suppositories
Capex shampoo
captopril-hydrochlorothiazide tablets
Carac cream
Carafate oral suspension
Carafate tablets
carbinoxamine 6 mg tablets
carbinoxamine oral solution (Genus Life NDC beginning with 64950)
Cardizem tablets
Cardizem CD capsules
Cardizem LA tablets
Cardura tablets
Cardura XL tablets
carisoprodol 250 mg tablets
carisoprodol/ASA/codeine tablets
CaroSpir oral suspension
Casodex tablets
Catapres TTS patches
carvedilol ER capsules
Cefaclor ER 500 mg tablets
Celebrex capsules
Celexa tablets
cephalexin 750 mg capsules
cephalexin tablets
Cervidil vaginal insert
Cetraxal ear drops
Charlotte 1/20 (24) chewable tablets
chlordiazepoxide/clidinium capsules
chlorzoxazone 250 mg tablets
chlorzoxazone 375 mg tablets
chlorzoxazone 500 mg tablets (Axis brand ONLY)
chlorzoxazone 750 mg tablets
Ciloxan eye ointment
cimetidine tablets
Cipro tablets
citalopram 30 mg capsules
Clarinex tablets
Clarinex-D tablets
clemastine oral syrup
Clenpiq oral solution
Climara patches
Clindacin foam
Clindagel gel
clindamycin 1% foam
clindamycin 1.2%/benzoyl peroxide 2.5% gel and pump gel
clindamycin 1.2%/benzoyl peroxide 3.75% gel
clindamycin/tretinoin gel
clobetasol foams, liquids, lotions, shampoos, and sprays
Clobex lotion, shampoo, and spray
Clodan shampoo
Clonidine ER 0.17 mg tablets
clotrimazole 1% cream and solution
clotrimazole/betamethasone dipropionate 1-0.05% lotion
Clozaril tablets
Colazal capsules
colchicine capsules (authorized generic for Mitigare)
Colcrys tablets
Combigan eye drops
Conjupri tablets
Consensi tablets
Conzip capsules
Copaxone injection
Cordran cream, lotion, and ointment
Coreg tablets

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Drugs that are Not Covered*

Coreg CR capsules
Coremino ER tablets
Cortef tablets
Cortrophin gel injection
Cosopt eye drops
Cosopt PF eye drops
Cotempla XR-ODT
Coxanto capsules
Cozaar tablets
Crestor tablets
Crinone 8% vaginal gel
Cuprimine capsules
Cutaquig injection
Cutivate 0.05% lotion
Cuvitru injection
Cuvrior tablets
cyanocobalamin nasal spray
cyclobenzaprine 7.5 mg tablets
cyclobenzaprine ER capsules
cyclosporine 0.05% eye drops (generic for Restasis)
Cyltezo injection
Cymbalta capsules
Cytomel tablets
Daliresp tablets
Daklinza tablets
Dapagliflozin tablets (authorized generic for Farxiga)
Dapagliflozin/Metformin tablets (authorized generic for Xigduo XR)
dapsone 5% gel
dapsone 7.5% gel
Dartisla ODT
Daytrana patches
Dayvigo tablets
DDAVP tablets
Demerol tablets
Demser capsules
Denavir cream
Depen Titra 250 mg tablets
desloratadine ODT
desonide 0.05% gel
desonide 0.05% lotion
DesOwen cream
Detrol tablets
Detrol LA capsules
dexamethasone 1.5 mg 6-day, 10-day, and 13-day blister packs
Dexedrine Spansules
Dexilant capsules
dexlansoprazole capsules
dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg, and 30 mg tablets
Dhivy tablets
diclofenac 1% topical gel
diclofenac 2% topical solution
diclofenac 3% gel
diclofenac epolamine patches
diclofenac potassium 25 mg tablets
diclofenac potassium 25 mg liquid filled capsules
diclofenac powder (migraine) packets
diclofenac sodium ER 100 mg tablets
Differin 0.1% cream and lotion
Differin 0.3% gel and gel pump
diflorasone cream and ointment
Diflucan tablets
Dilaudid tablets
diltiazem 120 mg, 180 mg, 240 mg, 300 mg, 360 mg ER tablets
Diovan tablets
Diovan HCT tablets
Dipentum capsules
diphenhydramine elixir
diphenoxylate/atropine oral liquid
Ditropan XL tablets
Doral tablets
Doryx tablets
Doryx MPC tablets
doxycycline (all non-generic products)
doxycycline biphasic-release 40 mg capsules
doxycycline hyclate 75 mg and 150 mg tablets (generic Acticlate)
doxycycline hyclate DR tablets (generic Doryx)
doxycycline monohydrate 75 and 150 mg capsules
doxycycline monohydrate 150 mg tablets
Drizalma Sprinkle capsules
droxidopa capsules
Duaklir Pressair inhaler
Duetact tablets
Duexis tablets
duloxetine 40 mg enteric-coated capsules (generic for Irenka)
Duobrii lotion
Durlaza capsules
Dutoprol tablets
Dyanavel XR chewable tablets
Dyanavel XR oral suspension
Dymista nasal spray
Dxevo tablets
EC-Naprosyn tablets
EC-naproxen tablets
Ecoza foam
Edarbi tablets
Edarbyclor tablets
Edluar sublingual tablets
Effexor XR capsules
Effient tablets
Elavil tablets
Elepsia XR tablets
Elidel cream
Elyxyb oral solution
Enstilar foam
Entadfi capsules
Entocort EC capsules
Epiduo Forte gel
Epiduo gel
EpiPen injection
EpiPen Jr injection
Epsolay cream
Ergomar sublingual tablets
Esgic tablets
esomeprazole magnesium 20 mg capsules
esomeprazole strontium capsules
Estrostep Fe tablets
Eucrisa ointment
Evekeo ODT
Evekeo tablets
Evista tablets
Evoclin foam
Evoxac capsules
Exforge HCT tablets
Exforge tablets
Extavia injection
Extina foam
Eysuvis eye drops
Ezallor Sprinkle capsules
ezetimibe/rosuvastatin tablets (authorized generic for Roszet)
Fabhalta capsules
Fabior foam
Femara tablets

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Drugs that are Not Covered*

Femring vaginal ring
fenofibrate 40 and 120 mg tablets
Fenofibrate 50 and 150 mg capsules
fenofibrate micronized 30 mg and 90 mg capsules (authorized generic of Antara)
fenofibric acid tablets (authorized generic for Fibricor)
Fenoglide tablets
fenoprofen 200 and 400 mg capsules
Fenortho 200 and 400 mg capsules
fentanyl 37.5, 62.5, and 87.5 mcg patches
fentanyl buccal tablets (authorized generic for Fentora)
Fentora buccal tablets
Ferriprox Twice-a-Day tablets
Fexmid tablets
Fiasp Pumpcart
Fibricor tablets
Finacea foam
Finzala 1/20 (24) chewable tablets
Fioricet capsules and tablets
Fioricet with Codeine capsules
Firazyr injection
Flector topical patches
Fleqsuvy oral suspension
Flomax capsules
Flolipid oral suspension
Flovent Diskus
Flovent HFA
fluocinonide 0.1% cream
fluorouracil 0.5% cream (authorized generic of Carac)
fluoxetine tablets
flurandrenolide cream, lotion, and ointment
fluticasone propionate lotion
fluticasone/salmeterol HFA inhalers (authorized generic for Advair HFA)
fluvoxamine ER capsules
Focalin XR capsules
Forfivo XL tablets
formoterol nebulizer solution
Forteo injection
Fortesta gel
Fosamax Plus D tablets
Frova tablets
gabapentin (once daily) tablet [generic Gralise]
Gastrocrom oral solution
Gelnique gel
Gemtesa tablets
Geodon capsules
Gilenya capsules
Gimoti nasal spray
Gleevec tablets
Gloperba oral solution
Glucophage tablets
Glucotrol XL tablets
Glumetza tablets
Glycate tablets
glycopyrrolate 1.5 mg tablets
Gocovri capsules
GoNitro sublingual powder packets
Gralise tablets
Granix injection
Hailey 24 Fe tablets
Halcion tablets
halobetasol propionate 0.05% foam
halobetasol propionate 0.05% ointment
Halog cream
Hemady tablets
Hemangeol 4.28 mg/mL oral solution
Hepsera tablets
Hetlioz capsules
Horizant ER tablets
Hulio injection
Humalog cartridge
Humalog vials
Humalog Junior KwikPen injection
Humalog KwikPen injection
Humalog KwikPen Mix 50/50 injection
Humalog KwikPen Mix 75/25 injection
Humalog Mix 50/50 vials
Humalog Mix 75/25 vials
Humalog Tempo Pen
Humatrope injection
Humira (Cordavis NDC's beginning with 83457) [Abbvie is covered]
Humulin 70/30 vials
Humulin 70/30 KwikPen injection
Humulin N vials
Humulin N KwikPen injection
Humulin R 100 units/mL vials
Hycet oral solution
Hyrimoz injection
hydrocodone/acetaminophen 5-300 mg, 7.5-300 mg, 10-300 mg tablets
hydrocodone/ibuprofen 10-200 mg tablets
hydrocortisone 1% cream and ointment
hydrocortisone butyrate lipid cream (lipocream)
hydrocortisone butyrate lotion
Hysingla ER tablets
Hyzaar tablets
Ibsrela tablets
Ibudone tablets
ibuprofen 100 mg/5 mL oral suspension
ibuprofen/famotidine tablets
icosapent ethyl capsules
Idacio injection
Imbruvica 560 mg tablets
imipramine pamoate capsules
imiquimod 3.75% cream pump
imiquimod 3.75% cream
Imitrex injection, nasal spray, and tablets
Imitrex Statdose injection
Impeklo lotion
Impoyz cream
Inderal LA capsules
Inderal XL capsules
Indocin suppositories
Incodin oral suspension
Indomethacin 20 mg capsules
Indomethacin suppositories
indomethacin oral suspension
Innopran XL capsules
Inpefa tablets
Inspra tablets
Insulin Aspart Flexpen
Insulin Aspart Penfill
Insulin Aspart vial
Insulin Aspart Protamine/Insulin Aspart Flexpen
Insulin Aspart Protamine/Insulin Aspart vial
Insulin glargine-yfgn 100 units/mL (Biocon)
Insulin lispro KwikPen injection
Insulin lispro vials
Intuniv tablets
Inveltys eye drops

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Drugs that are Not Covered*

Invokana tablets
Invokamet tablets
Invokamet XR tablets
Irenka capsules
Isordil tablets
isosorbide dinitrate 40 mg tablets
isotretinoin 25 mg capsules
isotretinoin 35 mg capsules
Istalol eye drops
Iyuzeh eye drops
Jalyn capsules
Jatenzo capsules
Javygtor 100 mg tablet
Javygtor powder for solution
Jentadueto tablets
Jentadueto XR tablets
Jornay PM capsules
joyeaux tablets (generic Balcoltra)
Jublia topical solution
Junel Fe 24 tablets
Jylamvo oral solution
Kapspargo Sprinkle capsules
Kapvay tablets
Karbinal ER oral suspension
Katerzia oral suspension
Kazano tablets
Kenalog topical spray
Kerydin topical solution
ketoconazole foam
Ketodan foam
ketoprofen 25 mg capsules
ketoprofen 50 mg capsules
ketoprofen 200 mg ER capsules
ketorolac nasal spray
Klonopin tablets
Klor-Con 20 mEq powder packets
Kombiglyze XR tablets
Konvomep oral suspension
Kristalose powder packets
Kyzatrex capsules
lactulose powder packets
Lamisil AT spray
lancets (certain high-cost manufacturers not covered)
lansoprazole 15 mg capsules
lansoprazole ODT
lansoprazole/amoxicillin/clarithromycin triple therapy blister pack (generic for Prevpac)
Larin 24 Fe tablets
Latuda tablets
Lazanda nasal spray
Lescol XL tablets
levalbuterol inhaler
Levamlodipine tablets (authorized generic for Conjupri)
levonorgestrel 0.1 mg/ethinyl estradiol 20 mcg/ferrous fumarate (21) (generic Balcoltra)
levorphanol 3 mg tablets
levocetirizine oral solution
Lexapro tablets
Lexette foam
Lialda tablets
Librax capsules
Licart 1.3% patch
lidocaine 2% mucosal/urethral gel and prefilled syringe
lidocaine 5% ointment
lidocaine/tetracaine cream
Lidoderm patch
Likmez oral suspension
Linzess capsules
Lipitor tablets
Lipofen capsules
LiQrev oral suspension
Livalo tablets
Lofena 25 mg tablets
Locoid cream and lotion
Locoid lipocream
Lodoco tablet
Loestrin 1.5/30 21-day tablets
Loestrin 1/20 21-day tablets
Loestrin Fe 1/20 28-day tablets
Lofibra 160 mg tablets
Lomedia 24 Fe tablets
Lonhala Magnair inhalation solution
loperamide 2 mg capsules
Loprox shampoo
Loreev XR capsules
Lortab elixir
Lorzone tablets
LoSeasonique tablets
Lotrel capsules
Lotronex tablets
Lovaza capsules
Lovenox injections
luliconazole cream (authorized generic for Luzu)
Lunesta tablets
Luxiq foam
Luzu cream
Lymepak tablets
Lyrica capsules
Lyrica CR tablets
Lyumjev vials 100 units/mL
Lyumjev Kwikpen 100 units/mL
Lyumjev Kwikpen 200 units/mL
Lyumjev Tempo Pen
Lyvispah granules
Malarone tablets
Malarone Pediatric tablets
Marinol capsules
Matzim 120 mg, 180 mg, 240 mg, 300 mg, 360 mg LA tablets
Maxalt tablets
Maxalt MLT tablets
meclizine 25 mg chewable tablets
meclizine 50 mg tablets
megestrol acetate 625 mg/ 5mL oral suspension
mefenamic acid 250 mg capsules
meloxicam capsules
memantine ER capsules
meperidine tablets
mesalamine 500 mg ER capsules (generic for Pentasa)
Mestinon 60 mg tablets
Mestinon oral solution
Mestinon Timespan 180 mg tablets
metformin ER osmotic laser drilled (generic Fortamet) tablets
metformin ER modified release (generic Glumetza) tablets
metformin IR 625 mg tablets
Methocarbamol 1,000 mg tablets
methotrexate 2.5 mg tablets (antirheumatic version only)
methylphenidate ER capsules (generic for Aptensio XR only)
methylphenidate 45 mg ER tablets
methylphenidate 63 mg ER tablets
methylphenidate 72 mg ER tablets
methylphenidate patches
metoclopramide ODT
Metozolv ODT

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Drugs that are Not Covered*

MetroCream 0.75% cream
metyrosine capsules
Mibelas 24 Fe chewable tablets
Micardis tablets
Micardis HCT tablets
MiCort-HC cream
Microgestin 24 tablets FE 1/20
Miebo eye drops
Migranal nasal spray
Minastrin 24 Fe chewable tablets
Minivelle patches
Minocin capsules
minocycline ER tablets
minocycline ER capsules
minocycline 50 mg, 75 mg, and 100 mg tablets
Minolira tablets
Mirapex ER tablets
Mircette 28-day tablets
Mirvaso gel and gel pump
Mitigare 0.6 mg capsules
Mobic tablets
mometasone nasal spray
Monodox capsules
montelukast oral granules packet
morphine sulfate ER capsules (generic for Kadian)
Motegrity tablets
Motofen tablets
Moxeza 0.5% eye drops
moxifloxacin 0.5% eye drops (generic for Moxeza)
MS Contin tablets
mupirocin 2% cream
Mydayis capsules
Mysoline tablets
naftifine cream and gel
Naftin gel
Nalfon 200 mg capsules
Nalfon 400 mg capsules
Nalfon 600 mg tablets
Nalocet tablets
Namenda tablets
Namenda XR capsules
Namzaric ER capsules/titration pack
Naprelan tablets
Naprosyn oral suspension
naproxen DR tablets
naproxen oral suspension
naproxen sodium ER / CR tablets (generic for Naprelan)
naproxen/esomeprazole magnesium delayed-release tablets
Nascobal nasal spray
Natesto nasal gel
Neomycin/polymyxin/hydrocortisone suspension eye drops
Nesina tablets
Neupogen injection
Nevanac eye drops
Nexiclon XR tablets
Nexium capsules
Nexium 10 mg, 20 mg, and 40 mg granules
Nextstellis tablets
Ngenla injection
Niacin tablets (authorized generic for Niacor)
Niacor tablets
Niaspan tablets
Niravam ODT
Nitrofurantoin 50 mg/5 mL oral suspension
Nocdurna sublingual tablets
Noctiva nasal spray
Nolix cream and lotion
norethindrone acetate 1 mg/ethinyl estradiol 20 mcg/ferrous fumarate (24) chewable tablets
Norgesic tablets
Norgesic Forte tablets
Norliqva oral solution
Noritate cream
Northera capsules
Norvasc tablets
Nucynta IR tablets
Nutropin AQ injection
Nuvessa gel
Nuvigil tablets
Obredon oral solution
olanzapine/fluoxetine capsules
olopatadine 0.1% eye drops
olopatadine 0.2% eye drops
Olpruva packets for suspension
Olux foam
Olux E foam
Omeclamox-Pak blister packet
omeprazole/sodium bicarbonate capsules and powder for suspension (generic Zegerid)
Omnaris nasal spray
Omvoh injection
Onexton gel
Ongentys capsules
Onglyza tablets
Onzetra Xsail nasal powder
Oracea capsules
Oralair sublingual tablets
Orapred ODT disintegrating tablets
Orbivan capsules
orphenadrine 50 mg/aspirin 770 mg/caffeine 60 mg tablets
orphenadrine 25 mg/aspirin 385 mg/caffeine 30 mg tablets
Orphengesic Forte tablets
Ortikos capsules
Oseni tablets
Osmolex ER tablets
OsmoPrep tablets
Otovel ear drops
Ovcon-35 tablets
Ovcon-50 tablets
oxandrolone tablets
Oxaprozin 300 mg capsules
Oxaydo tablets
Oxecta tablets
Oxistat cream and lotion
Oxybutynin 5 mg/5 mL oral syrup
Oxybutynin 2.5 mg tablet
oxycodone ER tablets (authorized generic for OxyContin)
oxycodone/acetaminophen 5-300, 7.5-300,10-300 mg tablets
oxycodone/acetaminophen oral solution 10-300 mg/5mL
OxyContin tablets
oxymorphone ER tablets
oxymorphone tablets
Oxytrol patches
Oxytrol for Women patches
Ozobax oral solution
Ozobax DS oral solution
Pancreaze capsules
Pancelipase 5,000 unit DR capsules
Pandel cream
paroxetine ER tablets

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Drugs that are Not Covered*

Pataday eye drops
Patanase nasal spray
Paxil tablets
Paxil CR tablets
Paxil oral suspension
penicillamine 250 mg capsules
Pennsaid 2% solution
Pentasa capsules
Pepcid tablets
Percocet tablets
Perforomist nebulizer solution
Pertzye capsules
Pexeva tablets
pioglitazone/glimepiride tablets
Plavix tablets
Pliaglis cream
Plixda 0.1% Pads
potassium chloride (KCl) 20 mEq powder packets
Praluent injection
Pramosone cream
Pramosone lotion
Prandin tablets
Pred Forte eye drops
prednisolone sodium phosphate 10 mg/5 mL and 20 mg/5 mL oral solutions
pregabalin ER tablets
prenatal vitamins (certain products only – see Appendix A)
Prepidil vaginal gel
Prestalia tablets
Prevacid capsules
Prevacid 24H capsules
Prevacid Solutab tablets
Prevpac blister packet
Prilosec capsules and granules for suspension
Primidone 125 mg tablets
Pristiq tablets
ProAir Digihaler inhaler
Proair HFA inhaler
Proair Respiclick inhaler
Procardia XL tablets
Proctocort rectal cream
Prolate oral solution
Prolate tablets
Prolensa eye drops
Prometrium capsules
Protonix granules for suspension and tablets
Protopic ointment
Proventil HFA inhaler
Provigil tablets
Prozac capsules
Prudoxin cream
Pulmicort Flexhaler inhaler
Pulmicort Respules
Pylera blister packet
pyridostigmine 30 mg tablets
Qbrelis oral solution
Qbrexza topical cloth
Qdolo oral solution
Qelbree capsules
Qnasl nasal spray
Qnasl Children's nasal spray
Qtern tablets
Quartette extended-cycle tablets
Quazepam tablets
ranitidine (all dosage forms)
Rasuvo autoinjectors
Rayaldee capsules
Rayos tablets
Recorlev tablets
Releuko prefilled syringe
Releuko vials
Relexxii tablets
Relistor injection and tablets
Relafen DS tablets
Relpax tablets
Reltone capsules
Remeron tablets
Remeron Soltab tablets
Renvela powder packets and tablets
Reprexain tablets
Restasis multidose bottle
Restoril capsules
Retin-A creams
Retin-A Micro gel and gel pump
Revatio tablets
Revatio oral suspension
Rezvoglar injection
Rhofade cream
Rilutek tablets
Riomet oral solution
Risperdal oral solution and tablets
Risperdal M-Tab ODT
Ritalin LA capsules
Robinul tablets
Robinul Forte tablets
Roszet tablets
Roxicodone tablets
RoxyBond tablets
Ryaltris nasal spray
RyClora oral solution
Rytary capsules
Rythmol SR capsules
RyVent tablets
Ryzolt tablets
Saizen injection
Samsca 30 mg tablets
Sanctura tablets
Savaysa tablets
Seglentis tablets
Segluromet tablets
Semglee pen injection
Semglee vials
Sernivo topical spray
Seroquel tablets
Seroquel XR tablets
Sertraline 150 mg and 200 mg capsules
Seysara tablets
Siklos tablets
Singulair chewable tablets, granules, and tablets
Sitavig buccal tablets
Skelaxin tablets
Skytrofa injection
Soaanz tablets
Sodium Oxybate (Amneal) [hikma pharmaceuticals covered]
Sogroya injection
Solaraze 3% gel
Solosec oral granules
Solodyn tablets
Soma tablets
Sorilux foam
Sotylize oral solution
Sovuna tablets
spironolactone oral suspension
Spritam ODT
Sprix nasal spray
Stalevo tablets
Steglujan tablets
Strattera capsules
Steglatro tablets

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Drugs that are Not Covered*

Striant buccal system
Suboxone oral film
Subsys sublingual spray
sucralfate oral suspension
sumatriptan/naproxen sodium tablets
Sumavel Dosepro injection
Symbyax capsules
Symjepi injection
Synalar cream, ointment, and topical solution
Syndros oral solution
Taclonex ointment and topical suspension
Tadliq oral suspension
Talicia capsules
Talzenna 0.5 mg capsules
TaperDex 6-Day, 7-Day, and 12-Day blister packs
Targretin gel
Tazarotene foam
Tarina 24 Fe tablets
Tascenso ODT 0.5 mg tablets
tavaborole topical solution
Taytulla capsules
Tazorac 0.1% cream
Tecfidera capsules and starter pack
Tekturna HCT tablets
Tenormin tablets
Testim gel
testosterone 1% gel and gel pump (generics for Testim and Vogelxo ONLY)
testosterone 1.62% packets ONLY (pump is covered)
testosterone 30 mg buccal tablets
tetracycline tablets
Testred capsules
Texacort topical solution
Thalitone tablets
Tiazac capsules
Tikosyn capsules
Timpotic eye drops
Timoptic Ocudose eye drops
Tirosint capsules
Tirosint-Sol oral solution
Tivorbex capsules
tizanidine capsules
Tlando capsules
Tobi nebulizer solution
Tolsura capsules
Topicort 0.05% cream and ointment
Topicort sprayTosymra nasal spray
Toviaz tablets
Tradjenta tablets
tramadol ER capsules
tramadol ER tablets
tramadol IR 25 mg tablets
tramadol IR 100 mg tablets
tramadol oral solution 5 mg/mL (authorized generic for Qdolo)
Tranxene T-Tab tablets
trazodone 300 mg tablets
Tretin-X cream
tretinoin microsphere gel
tretinoin 0.05% gel
Trexall tablets
Treximet tablets
Trezix 320.5-30-16 mg capsules
triamcinolone 0.05% ointment
Trianex ointment
triazolam tablets
Tribenzor tablets
Tridesilon cream
Trilipix capsules
Trudhesa nasal spray
Tudorza Pressair inhaler
TussiCaps capsules
Tuxarin ER tablets
Tuzistra XR oral suspension
Twirla patches
Twyneo cream
Tyzine Pediatric 0.05% nasal drops
Uceris rectal foam
Uceris tablets
Ukoniq tablets
Uloric tablets
Ultracet tablets
Ultram tablets
Ultram ER tablets
Ultravate cream
Ultravate lotion
Ultravate ointment
Uroxatral tablets
Urso 250 tablets
Urso Forte tablets
Vagifem vaginal tablets
Valcyte oral solution and tablets
Valium tablets
Valsartan oral solution
Valtrex tablets
vancomycin 250 mg/5 mL oral solution
Vanos cream
Vaseretic tablets
Vasotec tablets
Vectical ointment
Velsipity tablets
Veltin gel
venlafaxine ER tablets
Veozah tablets
Verdeso foam
Veregen ointment
Verelan PM capsules
Verkazia eye drops
Vesicare LS oral suspension
Vevye eye drops
Vibramycin capsules and powder for suspension
Vicodin tablets
Vicoprofen tablets
Victoza injection
Viekira Pak tablets
Vigamox eye drops
Viibryd tablets
Vijoice tablets
Vimovo tablets
Viokace tablets
Vivelle Dot patches
Vogelxo gel and gel pump
Voltaren 1% topical gel
Voquezna Dual Pak
Voquezna tablets
Voquezna Triple Pak
Vtama cream
Vumerity capsules
Vusion ointment
Vytorin tablets
Vyzulta eye drops
Welchol tablets
Welchol Pak 3.75 gram
Wellbutrin tablets
Wellbutrin SR tablets
Wellbutrin XL tablets
Winlevi cream
Wymzya Fe chewable tablets
Wynzora cream
Xaciato 2% gel
Xadago tablets

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Drugs that are Not Covered*

Xalatan eye drops
Xanax tablets
Xanax XR tablets
Xartemis XR tablets
Xatmep oral solution
Xdemvy eye drops
Xeloda tablets
Xelpros eye drops
Xelstrym patches
Xembify injection
Xenazine tablets
Xepi cream
Xerese cream
Ximino capsules
Xodol tablets
Xolegel topical gel
Xopenex nebulizer solution
Xopenex HFA inhaler
Xyosted autoinjector
Xyrem oral solution
Yosprala tablets
Yuflyma injection
Yupelri nebulizer solution
Yusimry injection
Zanaflex capsules
Zavzpret nasal spray
Zecuity transdermal system
Zegerid capsules and powder for suspension
Zelapar ODT
Zelnorm tablets
Zembrace SymTouch injection
Zenzedi 2.5 mg, 7.5 mg, 15 mg, 20 mg and 30 mg tablets
Zepatier tablets
Zestoretic tablets
Zestril tablets
Zetia tablets
Zetonna nasal spray
Ziac tablets
Ziana gel
Zilxi foam
Zinbryta injection
Zioptan eye drops
Zipsor capsules
Zithromax oral suspension
Zithromax tablets
Zocor tablets
Zoloft tablets
zolpidem sublingual tablets
zolpidem tartrate 7.5 mg capsules
Zolpimist oral spray
Zomacton injection
Zomig tablets
Zonalon cream
Zonisade oral suspension
Zorbtive injection
Zorvolex capsules
Zoryve cream
Zovirax cream and ointment
ZTlido patch
Zuplenz oral film
Zyclara cream and cream pump
Zyflo tablets
Zylet eye drops
Zyloprim tablets
Zypitamag tablets
Zyprexa tablets
Zyprexa Zydis ODT
Zytiga 250 mg and 500 mg tablets
Zyvox oral suspension and tablets

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Drugs that are Not Covered*

Appendix A: Excluded Prenatal Vitamins

Azesco
CitraNatal Assure
CitraNatal Bloom
CitraNatal DHA
CitraNatal Harmony
CitraNatal Mis
CitraNatal Mis DHA
C-Nate DHA
Duet DHA 400
Duet DHA Balanced
Elite-OB
Enbrace HR
Kosher Prentate Plus Iron
Mutli-Mac
Natachew
Natal PNV
Neevo DHA
Neonatal Plus
Nestabs DHA
Nestabs One
OB Complete
OB Complete DHA
OB Complete One
OB Complete Petite
OB Complete Premier
PNV-DHA
PNV-select
PNV 20-1
Pregen DHA
PreGenna
Prena1 pearl
Prenaissance Plus
Prenara
Prenate chew
Prenate AM
Prenate DHA
Prenate Elite
Prenate Enhance
Prenate Essential
Prenate Mini
Prenate Pixie
Prenate Restore
Prenatrix
Primacare
Relnate DHA
Select-OB
Select-OB + DHA
Tristart DHA
Tristart Free
Tristart One
Virt-nate DHA
Virt-PN DHA
Vitafol FE+
Vitafol Gummies
Vitafol Ultra
Vitafol Nano
Vitafol-OB
Vitafol-OB+ DHA
Vitafol-One
VitaMed MD One Rx
VitaMedMD Rx RediChew Rx
Vitapearl
Vitatrue
Viva DHA
VP-PNV-DHA
Wescap-PN DHA
Westnate DHA
Zalvit
Zatean-PN
Ziphex

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