



Regence BlueShield is an Independent Licensee  
of the Blue Cross and Blue Shield Association

**Business Health Trust  
All Plans except HSA-Qualified Preferred Plan  
80/80/60**

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**Prescription Drugs - \$10/\$25/\$50**

Effective October 1, 2008, Prescription Drugs benefit of your plan is revised to read as follows:

Prescription drugs (including oral contraceptives) and other covered items will be provided in full as described below after you have paid the specified copay amount. Prescription drugs and other covered items must be furnished by a participating pharmacy or a participating mail order supplier. There are more than 1,200 participating pharmacies in our Washington State network from which to choose, as listed in our current provider directory. A list of these participating pharmacies, along with a list of participating out-of-state pharmacies is available on our Web site at [www.regencerox.com](http://www.regencerox.com). **Benefits will be subject to any applicable waiting periods, limitations, and exclusions, except that Prescription Drugs Benefits will not be subject to the coordination of benefits provisions or to any medical deductible or stoploss described in this plan.**

***Getting Your Prescription Filled:***

- Present your identification card at a participating pharmacy.
- Pay your applicable copay amount.
- Prescription drugs furnished by a participating pharmacy will be limited to a 34-day supply, except as otherwise specified.

***Using Our Mail Order Service:***

- Pay your applicable copay amount.
- Send an order form and the prescription along with your copay amount to the address listed on the mail order service form.

- Prescription drugs furnished by mail order will be limited to a 90-day supply per purchase, except that certain drugs, including but not limited to antidepressants, narcotics, and other select medications may be limited to a lesser supply as indicated on your prescription or as required by the Company.
- Drugs requiring continuous refrigeration may not be available through mail order service.

**Covered Items:** Prescription drugs will be covered when medically necessary for the treatment of an illness, injury, or disability covered under this plan, subject to all provisions described below. Other items covered under this benefit and requiring a prescription include:

- Legend vitamins for prenatal care.
- Smoking cessation prescription drugs and medications, limited to a 90-day lifetime maximum supply.
- Diabetic supplies, including insulin and insulin syringes.
- Oral contraceptive drugs will be provided for a single copay per prepackaged monthly cycle. A maximum of three prepackaged monthly cycles may be purchased at one time for one copay per monthly cycle.

**Formulary:** A formulary is a list of selected generic and brand-name preferred drugs, which is established, reviewed, and updated routinely by the Company. You will be required to pay more if the drug does not appear in the formulary. All drugs are reviewed and selected for inclusion in the Company's formulary by an outside committee of providers, including physicians and pharmacists. Drugs are selected based on published scientific evidence and support proper use and cost-effective medication decisions. If clinical data show several drugs are equally effective, the committee usually chooses the most cost-effective ones. For convenience, the list is available on our Web site at [www.regencrx.com](http://www.regencrx.com).

**Copays:** You will be responsible for paying the appropriate copay level as specified below for each covered prescription or refill.

**Tier 1 - Generic Formulary Drugs** – means drugs included in the formulary that are equivalent to the brand-name version, are marketed and sold by more than one source, and are listed in widely accepted references as a generic drug based on manufacturer and price. Equivalent means the U.S. Food and Drug Administration (FDA) ensures that the generic must: a) have the same active ingredients found in the brand-name version; b) meet FDA specifications for quality, purity, and potency; and c) have the same medical effect as the brand-name version.

Participating Pharmacies .....\$10.00  
Participating Mail Order Service .....\$30.00

**Tier 2 - Brand-Name Formulary Drugs** – means drugs included in the formulary that are under patent and are generally marketed and sold by only one source.

Participating Pharmacies .....\$25.00  
Participating Mail Order Service .....\$75.00

**Tier 3 - Non-Formulary Drugs** – means drugs that do not appear in the formulary list established by the Company.

Participating Pharmacies .....\$50.00  
Participating Mail Order Service .....\$150.00

However, if the allowed amount is less than the appropriate copay you will pay only the allowed amount.

**Limitations:** Benefits for prescription drugs and other covered items will be limited as follows:

- Prescription drugs must be prescribed by a provider covered under the plan who is acting within the scope of his or her license.
- Certain prescription drugs require preauthorization from the Company before they

are covered. Participating pharmacies have been provided with a list of those drugs along with preauthorization requirements.

- Prescription drugs related to transplants are covered under this Prescription Drugs Benefit, however, claims for such drugs will be applied to and are subject to the Transplants Benefit maximum of this plan.
- Certain drugs may be limited to a lesser supply as indicated on your prescription or as determined by the Company. Participating pharmacies have been provided with a list of those drugs.
- Any drug purchased outside the United States must have an equivalent to a prescription drug approved by the FDA to be a covered benefit under this plan, and must be either:
  - Associated with a medical emergency while you are traveling. When submitting a claim for reimbursement, you will be responsible for notifying the Company that the prescription was required for a medical emergency; or
  - When you are residing outside the United States. When submitting a claim for reimbursement, you will be responsible for notifying the Company that your residence is outside the United States. The medication needs to be purchased in the country in which you are residing, except for a medical emergency.
- The Company may require you to obtain all prescriptions from a single participating pharmacy when reasonably necessary.

**Exclusions:** The following items are not covered under this Prescription Drugs Benefit due to Contract exclusions or, as noted, covered under another benefit of this plan:

- Any items limited or excluded by this plan, except where specifically provided.
- Appetite suppressants and drugs for weight loss.
- Drugs or medications used for cosmetic purposes.
- Drugs dispensed by a non-participating pharmacy, except when specifically provided for cases of emergency or outside the service area.

- Inside the United States, any prescription drug that has not been approved by the FDA, including compounded products with active ingredient(s) that have not been approved by the FDA.
- Any drugs or items obtained from a participating pharmacy when you fail to present the identification card.
- Over-the-counter medications (OTC) and any prescription medication with the same active ingredients and in the same strength as an over-the-counter product.
- Replacement prescriptions resulting from loss, theft, or breakage.
- Growth hormone, except as specified in the Growth Hormone Benefit of this plan.
- Injectable drugs, except as specified in the Professional Services Benefit of this plan.
- Any drugs or items in excess of the specific limits described above.

***Your Right to Safe and Effective Pharmacy***

**Services:** State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your Contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or concern about your pharmacy benefit, please contact us at 206-464-3663 or 1-800-458-3523.

**If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your Contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.**

Please keep this insert with your brochure for an up-to-date record of your plan.

Business Health Trust  
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October 1, 2008