

# MediScript<sup>®</sup> Pharmacy Program Endorsement

This Endorsement is to be attached to, and made a part of, the Evidence of Coverage for Covered Plan Participants of School Board of Bay County. The Evidence of Coverage is hereby amended by adding the following BlueScript Pharmacy Program provisions.

## Introduction

Under this Endorsement, Covered Plan Participants will be reimbursed for a portion of what they pay for certain Prescription Drugs and Supplies and select Over-the-Counter (“OTC”) Drugs purchased at a Pharmacy. In order to be eligible for reimbursement under this Endorsement, the Covered Plan Participant must pay for Covered Prescription Drugs and Supplies and Covered OTC Drugs at the time of purchase and submit a claim to BCBSF for reimbursement.

Lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs may be found in the Medication Guide. A Covered Plan Participant may be able to reduce their out-of-pocket expenses by: 1) using Participating Pharmacies; 2) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs; and 4) choosing Generic Prescription Drugs rather than Brand Name Prescription Drugs.

To verify if a Pharmacy is a Participating Pharmacy, a Covered Plan Participant may access the Pharmacy Program Provider Directory on the BCBSF website at [www.floridablue.com](http://www.floridablue.com), call the customer service phone number on their Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

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## The Covered Plan Participant’s Share of Expenses

Coverage under this MediScript Pharmacy Program Endorsement is subject to the following Coinsurance rules:

1. Each One-Month Supply covered under this MediScript Pharmacy Program Endorsement is subject to the Deductible(s) as set forth in your BlueChoice Schedule of Benefits and the following Coinsurance rules:
  - a. **Generic Prescription Drugs and Supplies and Covered OTC Drugs** purchased at a Participating Pharmacy are subject to 80% Coinsurance.
  - b. **Brand Name Prescription Drugs and Supplies** purchased at a Participating Pharmacy are subject to 80% Coinsurance.
  - c. **Non-Preferred Prescription Drugs and Supplies** purchased at a Participating Pharmacy are subject to 80% Coinsurance.

You may get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.

The unpaid percentage of the Participating Pharmacy Allowance is the Covered Plan Participant’s Coinsurance responsibility and will apply toward their **Individual Coinsurance Limit** as specified in the “Deductible and Coinsurance Amounts” section of the BlueChoice Schedule of Benefits.

2. Each Three-Month Supply purchased from the Mail Order for Covered Prescription Drugs, Covered OTC Drugs and/or Covered

Prescription Supplies are not subject to the Deductible(s) as set forth in your BlueChoice Schedule of Benefits and the following Copayment rules apply:

- a. **Generic Prescription Drugs and Supplies and Covered OTC Drugs** purchased at the Mail Order Pharmacy are subject to a \$14 Copayment.
- b. **Brand Name Prescription Drugs and Supplies** purchased at the Mail Order Pharmacy are subject to a \$28 Copayment.
- c. **Non-Preferred Prescription Drugs and Supplies** purchased at the Mail Order Pharmacy are subject to an \$28 Copayment.

Please specifically note that reimbursement for Prescription Drugs and Supplies and Covered OTC Drugs purchased from a Non-Participating Pharmacy will always be based on the Non-Participating Pharmacy Allowance.

### **Covered Prescription Drugs and Supplies and Covered OTC Drugs**

A Prescription Drug, 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. in the case of a vaccine, prescribed and administered by a Pharmacist who is certified in immunization administration;
3. dispensed by a Pharmacist;
4. Medically Necessary; as defined in the Certificate of Coverage and determined by BCBSF in accordance with BCBS's Medical Necessity coverage criteria in effect at the time Services are provided or authorized;
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;
8. authorized for coverage BCBSFL, if prior coverage authorization is required as indicated with a unique identifier in the Medication Guide, then in effect;
9. not specifically or generally limited or excluded herein or by the Evidence of Coverage; and
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.
12. within the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs category listed in this section.

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

1. a Covered Prescription Supply;
2. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license, except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;
3. Medically Necessary; and
4. not specifically or generally limited or excluded herein or by the Evidence of Coverage.

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

In providing benefits under this Endorsement, BCBSF may apply the benefit guidelines set forth below, as well as any other applicable payment rules specific to particular Covered Services listed in the Evidence of Coverage.

### Contraceptive Coverage

Prescription diaphragms, oral contraceptives and contraceptive patches will be covered, subject to the limitations and exclusions listed in this Endorsement.

#### Exclusion:

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

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

Select OTC Drugs, listed in the Medication Guide, may be covered when a Covered Plan Participant obtains a Prescription for the OTC Drug from their Physician. Reimbursement for Covered OTC Drugs will be based on the percentage of the Participating Pharmacy Allowance or the Non-Participating Pharmacy Allowance, as applicable, indicated in the "The Covered Plan Participant's Share of Expenses" subsection of this Endorsement. 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 the BCBSF website at [www.floridablue.com](http://www.floridablue.com), or the Covered Plan Participant may call the customer service phone number on their Identification Card and one will be mailed to the Covered Plan Participant upon request.

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### Diabetic Coverage

All Covered Prescription Drugs and Supplies used in the treatment of diabetes are covered subject to the limitations and exclusions listed in this Endorsement. Insulin is **only** covered if prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license. Syringes and needles for injecting insulin are covered only when prescribed in conjunction with insulin.

#### 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 or her license:

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

#### Exclusion:

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

## Limitations and Exclusions

### Limitations

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 the Evidence of Coverage:

1. More than the maximum supply will not be covered, as set forth in this Endorsement, 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 Covered Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.
4. a Maximum of a Three-Month Supply per Prescription when obtained from the Mail Order Pharmacy;
5. Specialty Drugs (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
6. Retin-A or it's generic or therapeutic equivalent is excluded after age 26.
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.
4. All Supplies other than Covered Prescription Supplies.
5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage for this Endorsement.
6. Therapeutic devices, appliances, medical or other Supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils, and waxes); regardless of the intended use (except for Covered Prescription Supplies).
7. Prescription Drugs and Supplies and OTC Drugs that are:
  - a. in excess of the limitations specified in this Endorsement;
  - b. furnished to the Covered Plan Participant without cost;
  - c. Experimental or Investigational;
  - d. indicated or used for the treatment of infertility;
  - e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova;
  - f. prescribed by a Pharmacist;
  - g. used for smoking cessation (e.g., Chantix, Nicorette, Zyban);
  - h. listed in the Homeopathic Pharmacopoeia;
  - i. not Medically Necessary;
  - j. indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion

### **Exclusions**

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific subsection of the "Covered Services" section of the Evidence of Coverage, 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.

number 11 does not apply to sexual dysfunction Drugs excluded under this paragraph;

- k. purchased from any source (including a pharmacy) outside of the United States;
  - l. prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America; and
8. 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.
  9. Any appetite suppressant, Prescription Drug and/or OTC Drug indicated, or used, for purposes of weight reduction or control.
  10. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection.
  11. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been

approved for any indication are also excluded.

12. Drugs that have not been approved by the FDA as required by federal law for distribution or delivery into interstate commerce.
13. Drugs that do not have a valid National Drug Code.
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) American Medical Association; ii) National Heart Lung and Blood Institute; iii) American Cancer Society; iv) American Heart Association; v) National Institutes of Health; vi) American Gastroenterological Association; vii) Agency for Health Care Policy and Research; or
  - c. BCBSF, in their sole discretion, waives this exclusion with respect to a particular Drug or therapeutic classes of Drugs.
16. Any Drug prescribed in excess of the dosages, frequency of use, or duration of

administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by:

- a. American Medical Association;
- b. National Heart Lung and Blood Institute;
- c. American Cancer Society;
- d. American Heart Association;
- e. National Institutes of Health;
- f. American Gastroenterological Association; or
- g. Agency for Health Care Policy and Research;

unless BCBSF, in their sole discretion, decides to waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs.

17. Any amount the Covered Plan Participant is required to pay under this Endorsement as indicated in the "The Covered Plan Participant's Share of Expenses" subsection of this Endorsement.
18. Any benefit penalty reductions or any charges in excess of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance.
19. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage.
20. Any OTC Drug that is not listed in the Medication Guide as a Covered OTC Drug.
21. Food or medical food products, whether prescribed or not.
22. New Prescription Drugs

## Reimbursement Rules

In order to obtain reimbursement for Covered Prescription Drugs and Supplies and Covered OTC Drugs purchased at a Pharmacy, the Covered Plan Participant must obtain an itemized paid receipt and submit it with a properly completed claim form (with any required documentation) to the address listed on the claim form.

Under this Endorsement, the amount of reimbursement for Covered Prescription Drugs and Supplies or Covered OTC Drugs may vary depending on:

1. the participation status of the Pharmacy where purchased (i.e., Participating Pharmacy versus Non-Participating Pharmacy);
2. the terms of the BCBSF agreement with the Pharmacy selected;
3. whether the Covered Plan Participant has satisfied the Deductible, if applicable, and the Coinsurance percentage set forth in the "The Covered Plan Participant's Share of Expenses" subsection of this Endorsement;
4. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug; and

A Brand Name Prescription Drug included on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug. Non-Preferred Prescription Drugs are subject to a higher cost share amount, as set forth in the BlueScript Pharmacy Program Schedule of Benefits.

BCBSF reserves the right to add, remove or reclassify any Prescription Drug in the Medication Guide at any time.

## Pharmacy Alternatives

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

### Participating Pharmacies

Participating Pharmacies are Pharmacies participating in BCBSF's MediScript Pharmacy Program, or a National Network Pharmacy belonging to BCBSF's Pharmacy Benefit Manager, at the time Covered Prescription Drugs and Supplies and/or Covered OTC Drugs were purchased. Participating Pharmacies have agreed not to charge, or collect more than the Participating Pharmacy Allowance from a Covered Plan Participant, for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug.

With MediScript, there are four types of Participating Pharmacies:

1. Pharmacies in Florida that have signed a MediScript Participating Pharmacy Provider Agreement with BCBSF;
2. National Network Pharmacies;
3. Specialty Pharmacies;
4. The Mail Order Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, a Covered Plan Participant may access the Pharmacy Program Provider Directory on the BCBSF website at [www.floridablue.com](http://www.floridablue.com), call the customer service phone number included in the Evidence of Coverage or on their Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

Prior to purchase, a Covered Plan Participant must present their BCBSF Identification Card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that a Covered Plan Participant is, in fact, covered by BCBSF.

## Mail Order Pharmacy

The Mail Order Pharmacy is a Participating Pharmacy which has entered into a Mail Service Prescription Drug Agreement with BCBSF. Under the Mail Order Pharmacy benefit, you must pay the applicable Copayment, at the time of purchase, for each Prescription for Covered Prescription Drugs, Covered OTC Drugs and/or Covered Prescription Supplies obtained from the Mail Order Pharmacy.

For details on how to obtain Covered Prescription Drugs and Supplies and Covered OTC Drugs from the Mail Order Pharmacy, refer to the Medication Guide. **Note:** Specialty Drugs are not available through the Mail Order 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 a Covered Plan Participant has to pay for these medications, while helping to preserve their benefits.

The Specialty Pharmacies designated, solely by BCBSF, are the only "In-Network" suppliers for Specialty Drugs. With MediScript, a Covered Plan Participant may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by BCBSF as a Specialty Pharmacy is considered "non-participating" for reimbursement purposes, even if such Pharmacy is a Participating Pharmacy for

other Covered Prescription Drugs under this MediScript Pharmacy Program.

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

### **Non-Participating Pharmacies**

A Non-Participating Pharmacy is a Pharmacy that has not agreed to participate in BCBSF's MediScript Participating Pharmacy Program and is not a National Network Pharmacy or Specialty Pharmacy.

Payment for Covered Prescription Drugs and Supplies and Covered OTC Drugs is based upon BCBSF's Non-Participating Pharmacy Allowance. Non-Participating Pharmacies have **not** agreed to accept BCBSF's Participating Pharmacy Allowance or the Pharmacy Benefit Manager's Participating Pharmacy Allowance.

Reimbursement for Covered Prescription Drugs and Supplies and Covered OTC Drugs will be based on the Non-Participating Pharmacy Allowance less the Deductible, if applicable, and the percentage of the Non-Participating Pharmacy Allowance set forth in the "The Covered Plan Participant's Share of Expenses" subsection of this Endorsement.

### **Ultimate Responsibility for Medical Decisions**

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 the Covered Plan Participant and their treating Physician in accordance with the patient/Physician relationship. It is possible that the Covered Plan Participant or their 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 BCBSF. In such cases, it is the Covered Plan Participant's right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if BCBSF has 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 Evidence of Coverage that this Endorsement amends.

**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.

**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 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. syringes and needles which are contained in anaphylactic kits (e.g., Epi-Pen, Epi-Pen, Jr., Ana Kit); and

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

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

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

**Generic Prescription Drug** means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either (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 the amount payable to the Mail Order Pharmacy for each

Covered Prescription Drug, Covered OTC Drug and/or Covered Supply as set forth in this amendment.

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

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

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

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

**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 BCBSF's Pharmacy and Therapeutics Committee. Coverage for all New Prescription Drugs will be delayed until a review is completed by BCBSF's 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 BCBSF's Pharmacy and Therapeutics Committee.  
or
2. December 31<sup>st</sup> of the following Calendar Year.

**Non-Participating Pharmacy** means a Pharmacy that has not agreed to participate in BCBSF's MediScript Pharmacy Program and is not a National Network Pharmacy.

**Non-Preferred Prescription Drug** means a Generic Prescription Drug or Brand Name Prescription that is not included on the Preferred Medication List then in effect. New Prescription Drugs are not a Non-Preferred Prescription Drug. **One-Month Supply** means a maximum quantity per Prescription up to a 31-Day Supply as defined by the Drug manufacturer's dosing recommendations. Certain Drugs, e.g. Specialty Drugs, may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

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

**Participating Pharmacy** means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with BCBSF to participate in the MediScript Pharmacy Program. National Network Pharmacies and Specialty Pharmacies 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, Covered

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Prescription Supply or Covered OTC Drug 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 BCBSF to make such network and/or programs available to Covered Plan Participants.

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

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

**Preferred Medication List** means a list of Preferred Prescription Drugs then in effect, which have been designated by BCBSF as preferred and for which coverage and benefits is provided, subject to the exclusions and limitations of this Endorsement. The Preferred

Medication List is contained within the Medication Guide.

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

**Prescription** 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, BCBSF requires 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 a Covered Plan Participant may administer to their self, 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 BCBSF 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 BCBSF to participate in the MediScript Pharmacy Program, to provide specific Prescription Drug products, as determined by BCBSF. 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 93-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 Evidence of Coverage, 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 Evidence of Coverage, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent as expressed herein.

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