

BlueScript[®] Generic Choices Pharmacy Program Endorsement

This Endorsement and the BlueScript Generic Choices Pharmacy Program Schedule of Benefits (herein “Pharmacy 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 or complaints 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 insulin and certain Generic and Brand Name Prescription Drugs and Supplies and select Over-the-Counter (“OTC”) Drugs only when purchased at an Exclusive Pharmacy. In order to obtain benefits under this Endorsement, you must pay the applicable Cost Share amount indicated on the Pharmacy Schedule of Benefits at the time of purchase.

To verify if a Pharmacy is an Exclusive Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com or call the customer service phone number on your ID Card.

Cost Share Tiers

All Drugs and Supplies covered under this Endorsement are assigned to a Cost Share tier. The Cost Share tiers that apply to your plan are described below:

Tier 1: Generic Prescription Drugs and Supplies, insulin and Covered OTC Drugs.

Tier 2: Select Brand Name Prescription Drugs indicated as covered in the Medication Guide.

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.

Preventive Medications

Certain medications may be available at no Cost Share when purchased from an Exclusive Pharmacy if they are considered a Preventive Service as outlined in the WHAT IS COVERED? section. Please see the Medication Guide for a list of these medications.

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 Cost Share would also be split between the two fills.

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. insulin, a Generic Prescription Drug or, in the case of a Brand Name Prescription Drug, indicated as covered in the Medication Guide;
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. dispensed by a Pharmacist;
4. 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;
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, indicated as covered in the Medication Guide;
7. 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;
8. not specifically or generally limited or excluded herein or by the Benefit Booklet.
9. approved by the FDA, and assigned a National Drug Code, except for New Prescription Drugs;
10. reviewed by our Pharmacy and Therapeutics Committee; and
11. within the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs category listed in this Endorsement.

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

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

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

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

Contraceptive Coverage

Generic Prescription diaphragms, oral contraceptives and contraceptive patches are covered 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 an Exclusive 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 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.

Covered OTC Drugs are listed in the most current Medication Guide and can be viewed on our web site 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.

Diabetic Coverage

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

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

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

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.

Note: The Drugs in this category may be available at no Cost Share if they are considered a Preventive Service as outlined in the “What Is Not Covered?” section of your Booklet when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

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 your Benefit Booklet:

1. We will not cover more than the Maximum supply, as set forth in the Pharmacy 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 Covered Prescription Drugs and Supplies and Covered OTC Drugs may 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. Retinoids (e.g., Retin-A) and their generic or therapeutic equivalents are excluded after age 26.
6. We reserve the right to cover the Biosimilar Prescription Drug as an alternative to coverage of the referenced Brand Name Prescription Drug.

Exclusions

Expenses for the following are excluded:

1. Brand Name Prescription Drugs, except those indicated as covered in the Medication Guide.
2. Drugs that are covered and payable under the "What Is Covered?" section of your Booklet, which this Endorsement amends (e.g., Prescription Drugs which are dispensed and billed by a Hospital).
3. 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.
4. Any Drug or Supply which can be purchased over-the-counter without a Prescription, even though a written Prescription is provided (e.g., Drugs which do not require a Prescription) except for insulin, emergency contraceptives, and Covered OTC Drugs listed in the Medication Guide.
5. All Supplies other than Covered Prescription Supplies.
6. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage of this Endorsement.
7. 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).
8. Drugs and Supplies that are:
 - a. in excess of the limitations specified in this Endorsement or on the Pharmacy Schedule of Benefits;
 - b. furnished to you without cost;
 - c. Experimental or Investigational;
 - d. indicated or used for the treatment of infertility;
 - e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova.
 - f. prescribed by a Pharmacist, except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;
 - g. 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;
 - h. listed in the Homeopathic Pharmacopoeia;
 - i. not Medically Necessary;
 - j. indicated or used for sexual dysfunction such as Cialis, Levitra, Viagra and Caverject.;
 - 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
 - m. OTC Drugs, Brand Name Prescription Drugs and Supplies not listed in the Medication Guide; and

9. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and OTC Drugs subsection.
10. Any appetite suppressant Prescription Drug and/or OTC Drug indicated, or used, for purposes of weight reduction or control.
11. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Drugs and Supplies and Covered OTC Drugs subsection.
12. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are 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 do not have a valid National Drug Code.
15. Drugs that are compounded even when one or more active ingredients are Covered Prescription Drugs under this Endorsement.
16. Drugs and Supplies purchased from an Out-of-Network Pharmacy, except for Emergency Services or when authorized in advance by us.
17. 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: 1) American Medical Association; 2) National Heart Lung and Blood Institute; 3) American Cancer Society; 4) American Heart Association; 5) National Institutes of Health; 6) American Gastroenterological Association; 7) 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.
18. 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 we, in our sole discretion, decide to waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs.

- 19. Any amount you are required to pay under this Endorsement as indicated on the Pharmacy Schedule of Benefits.
- 20. Any benefit penalty reductions.
- 21. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage.
- 22. Food or medical food products, whether prescribed or not.
- 23. 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 or an effective alternative 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.

- 24. New Prescription Drug(s).
- 25. 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.

Pharmacy Alternatives

For purposes of this Endorsement, there are two types of Pharmacies: Exclusive Pharmacies and Out-of-Network Pharmacies.

Exclusive Pharmacies

Exclusive Pharmacies are Pharmacies participating in our BlueScript Pharmacy Program, which include:

- 1. Pharmacies in Florida that have signed a BlueScript Pharmacy Provider Agreement with us;
- 2. National Network Pharmacies;

3. Specialty Pharmacies; and
4. the Mail Order Pharmacy.

The Pharmacy must be participating in the BlueScript Pharmacy Program at the time Covered Prescription Drugs and Supplies and/or Covered OTC Drugs are purchased by you to be considered an Exclusive Pharmacy. Exclusive Pharmacies have agreed not to charge, or collect from, you, more than the amount set forth in the Pharmacy Schedule of Benefits for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug.

To verify if a Pharmacy is an Exclusive Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com, call the customer service phone number on your ID Card.

Prior to purchase, you must pay your Cost Share amount as listed in the Pharmacy Schedule of Benefits and present your BCBSF ID Card and the 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 an Exclusive Pharmacy are less than the required Copayment, 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 an Exclusive 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.

These Specialty Drugs can only be purchased from a Specialty Pharmacy. Specialty Pharmacies are a subset of Exclusive Pharmacies and are designated solely by us, as the Pharmacies where you can purchase Specialty Drugs under this Pharmacy Program. Any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for Specialty Drugs, even if such Pharmacy is an Exclusive 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 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.

Out-of-Network Pharmacies

A Prescription Drug, OTC Drug or Self-Administered Injectable Prescription Drug purchased from an Out-of-Network Pharmacy is covered under this Pharmacy Program **only** if for Emergency Services or authorized by us.

An Out-of-Network Pharmacy is 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.

When Covered Prescription Drugs and Supplies or Covered OTC Drugs are purchased from an Out-of-Network Pharmacy for Emergency Services or when authorized by us, you may have to pay the full cost of the Drug at the time of purchase.

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

Accessing Services Outside of the Service Area

Services subject to an Exclusive Provider Provision, as identified on your Schedule of Benefits, must be provided by Exclusive Pharmacies that are generally found within the Service Area. If, however, you are traveling outside the Service Area and need Emergency Services to treat an Emergency Medical Condition and Exclusive Pharmacies are not reasonably available to provide Services subject to an Exclusive Provider Provision, we will cover such Services as if they had been provided by an Exclusive Provider.

Quality Assurance

Quality assurance is a formal methodology and set of activities designed to assess the quality of Health Care Services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy identified deficiencies and evaluation of actions taken. We have a quality assurance program in place to assess the Services of Exclusive Pharmacies.

Pharmacy Utilization Review Programs

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

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 Drug or Supply Prescribed.

Note: If coverage is not available, or is limited, this does not mean that you cannot obtain the Drug or Supply from the Pharmacy. It only means that we will not cover or pay for the Drug or Supply. You are always free to purchase the Prescription Drug or Supply at your sole expense.

Our pharmacy utilization review programs include the following:

Responsible Steps Program

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 by following the procedures for prior coverage authorization outlined in the Medication Guide.

Responsible Quantity 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.floridablue.com, or you may call the customer service phone number on your ID 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 Drugs and Supplies will be provided under the applicable terms of the Benefit Booklet. Ultimately, the final decision concerning whether a Drug or Supply 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 Drug or Supply 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 Drug or Supply is needed, appropriate, or desirable, even though such Drug or Supply may not be authorized for coverage by us. In such cases, it is your right and responsibility to decide whether the Drug or Supply should be purchased even if we have indicated that coverage and payment will not be made for such Prescription Drug or Supply.

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.

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 (known 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.

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.

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

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

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

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

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

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

1. Prescription diaphragms 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 indicated as covered in the Medication Guide.

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.

Exclusive Pharmacy means a Pharmacy that is either: (1) participating in the network for this Pharmacy Program and has signed a BlueScript Participating Pharmacy Provider Agreement; (2) a National Network Pharmacy; (3) a Specialty Pharmacy; or (4) the Mail Order Pharmacy.

Exclusive Pharmacy Allowance means the maximum amount allowed to be charged by an Exclusive Pharmacy per Prescription for a Covered Prescription Drug, Covered OTC Drug or Covered Prescription Supply under the Pharmacy Program.

FDA means the United States Food and Drug Administration.

Generic Choices Medication Guide means the guide then in effect issued by us that may designate the following categories of Prescription Drugs: Generic Prescription Drugs Covered OTC Drugs and Brand Name Prescription Drugs. **Note:** The Medication Guide is subject to change at any time. Please refer to our website at www.floridablue.com for the most current guide or you may call the customer service phone number on your ID Card for current information.

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

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

Maximum means the amount designated in our 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.

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. 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 for the Prescription Drug;
- or
2. December 31st of the following Calendar Year.

One-Month Supply means a maximum quantity per Prescription up to a 30-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.

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

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, emergency contraceptives and insulin are considered Prescription Drugs because, in order to be covered, we require that they be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

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.

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 an Exclusive Pharmacy Provider Agreement with us to participate in the BlueScript Pharmacy Program, to provide specific Specialty Drugs, as determined by us. The fact that a Pharmacy is an Exclusive 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 as expressed herein.