

BlueChoice- PPO Grandfathered Plan

Schedule of Benefits

Covered Plan Participants should carefully review this Schedule of Benefits, which is part of the Evidence of Coverage, to be aware of important information concerning the Covered Plan Participant’s share of the expenses for Covered Services. The Covered Plan Participant’s share of the expenses, including any applicable Deductibles and Coinsurance responsibilities, **will vary** depending upon the Provider the Covered Plan Participant chooses and the setting in which the Services are rendered. References to Deductible are abbreviated as “DED” and references to Benefit Period are abbreviated as “BP”.

Benefit Period (BP) 1/1/10 – 12/31/10

Deductible and Coinsurance Amounts

Benefit Description	PPO	Providers Not Participating in PPO
Individual Deductible (DED) Note: The Individual DED will be waived by BCBSF for Health Care Services rendered by any Independent Clinical Laboratory.	\$750	
Family Benefit Period Deductible (DED)	\$2,250	
Amount Payable by the Plan	80% of the Allowed Amount after DED	60% of the Allowance
Amount Payable by the Plan for Ambulance Services	80% of the Allowance	
Amount Payable by the Plan for Spinal Manipulations	80% of the Allowed Amount after DED	60% of the Allowance after DED
Amount Payable by the Plan for Mammograms	100% of the Allowed Amount, DED waived	
Individual Coinsurance Responsibility Limit per BP	\$2,000	
Family Coinsurance Responsibility Limit per BP	\$6,000	
Note: Coinsurance Responsibility Limits do not include the DED amount, the Hospital PAD amount, the Emergency Room Per Visit Deductible amount, the Copayment, any benefit penalty reduction, non-covered charges or any charges in excess of the Allowed Amount.		

Office Services

Benefit Description	PPO	Providers Not Participating in PPO
Office Services Rendered by Family Physicians with the following Specialties: Family Practice, General Practice, Internal Medicine, and Pediatrics	\$20 Copayment per visit*	60% Allowance after DED
Office Services Rendered by: 1. Physicians other than Family Physicians; and 2. Other health care professionals licensed to perform such services.	\$35 Copayment per visit*	60% Allowance after DED
Well Child Care	100% of the Allowed Amount, DED waived	60% of the Allowance, DED waived
Prenatal Exam	\$20 for the initial visit and then 100% of the Allowed Amount	\$20 for initial visit and then 60% of the Allowed Amount
Allergy testing rendered by: 1. Family Practice, General Practice, Internal Medicine, and Pediatrics 2. Physicians other than Family Physicians; and Other health care professionals licensed to perform such services.	\$20 Copayment per visit* \$35 Copayment per visit*	60% of the Allowance after DED 60% of the Allowance after DED
Allergy Injections Note: Administered at Physician's office	\$0 Copayment per visit*	100% Allowance after DED
Durable Medical Equipment, Prosthetics and Orthotics, and wigs after chemotherapy	80% Allowed Amount after DED	60% Allowance after DED
*These Services are subject to the Copayment only.		
Note: A Covered Plan Participant should verify a Provider's participation status whenever possible prior to receiving Health Care Services. To verify a Provider's specialty or participation status, a Covered Plan Participant may access the PPO Provider directory at our web site at www.bcbsfl.com , contact the local BCBSF office, or review the most recent Provider Directory.		

Other Services

Benefit Description	PPO	Providers Not Participating in PPO
Biofeedback	100% of the Allowed Amount	100% of the Allowance after DED
Outpatient Private Duty Nursing	80% Allowed Amount after DED	60% Allowance after DED
Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies	80% Allowed Amount after DED	60% Allowance after DED
Emergency Room Facility Services (Applies per visit) Copayment waived if admitted	\$50 Copayment per visit*	\$50 Copayment per visit*
Inpatient Facility Services (Applies per admission)	80% of the Allowed Amount after DED	60% of the Allowance after DED

Behavioral Health Services

Benefit Description	PPO	Providers Not Participating in PPO
<p>Mental Health Services</p> <p>Outpatient Facility Services rendered at:</p> <ol style="list-style-type: none"> 1. Emergency Room 2. Hospital 3. Physician Services at Hospital and ER 	<p style="text-align: center;">\$50 Copayment per visit*</p> <p style="text-align: center;">80% of the Allowed Amount after DED</p> <p style="text-align: center;">\$50 Copayment per visit*</p>	<p style="text-align: center;">\$50 Copayment per visit*</p> <p style="text-align: center;">60% Allowance after DED</p> <p style="text-align: center;">\$50 Copayment per visit*</p>
<p>Physician and other health care professionals licensed to perform such Services rendered at:</p> <ol style="list-style-type: none"> 1. Family Physicians Office 2. Specialist Office 3. All other locations other than Hospital and ER 	<p style="text-align: center;">\$20 Copayment per visit*</p> <p style="text-align: center;">\$35 Copayment per visit*</p> <p style="text-align: center;">80% of the Allowed Amount</p>	<p style="text-align: center;">60% Allowance after DED</p> <p style="text-align: center;">60% Allowance after DED</p> <p style="text-align: center;">60% Allowance after DED</p>
<p>Inpatient</p> <ol style="list-style-type: none"> 1. Facility Services 2. Physician and other health care professionals licensed to perform such Services 	<p style="text-align: center;">80% of the Allowed Amount after DED</p> <p style="text-align: center;">\$50 Copayment per visit*</p>	<p style="text-align: center;">60% Allowance after DED</p> <p style="text-align: center;">\$50 Copayment per visit*</p>

Benefit Description	PPO	Providers Not Participating in PPO
<p>Substance Dependency Care and Treatment Services</p> <p>Outpatient Facility Services rendered at:</p> <p>4. Emergency Room</p> <p>5. Hospital</p> <p>6. Physician Services at Hospital and ER</p>	<p>\$50 Copayment per visit*</p> <p>80% of the Allowed Amount after DED</p> <p>\$50 Copayment per visit*</p>	<p>\$50 Copayment per visit*</p> <p>60% Allowance after DED</p> <p>\$50 Copayment per visit*</p>
<p>Physician and other health care professionals licensed to perform such Services rendered at:</p> <p>4. Family Physicians Office</p> <p>5. Specialist Office</p> <p>6. All other locations other than Hospital and ER</p>	<p>\$20 Copayment per visit*</p> <p>\$35 Copayment per visit*</p> <p>80% of the Allowed Amount</p>	<p>60% Allowance after DED</p> <p>60% Allowance after DED</p> <p>60% Allowance after DED</p>
<p>Inpatient</p> <p>3. Facility Services</p> <p>4. Physician and other health care professionals licensed to perform such Services</p>	<p>80% of the Allowed Amount after DED</p> <p>\$50 Copayment per visit*</p>	<p>60% Allowance after DED</p> <p>\$50 Copayment per visit*</p>

Benefit Maximums

Accumulated Total Lifetime Maximum Benefit Per Covered Plan Participant Unlimited

Adult Wellness Per Covered Plan Participant Per BP Unlimited

Covered Services as described below for an adult. For purposes of this benefit an adult is 17 years or older.

Adult Wellness services include:

1. annual physical or gynecological exam (including family planning/contraceptive Services); and
2. related wellness services including, but not limited to, pap smears, Prostate Specific Antigen (PSA), x-rays, laboratory services, and immunizations. Routine vision and hearing examinations and screenings are not covered.

Autism Spectrum Disorder Services

Per Benefit Period Unlimited

Per lifetime Unlimited

Note: The wellness services above are not subject to the DED, but are subject to the Copayment or the applicable Coinsurance based on the location of service and the Provider's participating status.

Bereavement Counseling Per Covered Plan Participant

Per Lifetime 6 visits not to exceed a maximum of \$250

Enteral Formulas Per Covered Plan Participant Per BP \$2,500

Home Health Care Visits Per Covered Plan Participant Per BP 30

Hospice (Combined Inpatient, Outpatient and Home)

Per Covered Plan Participant Per Lifetime Unlimited

Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies Visits Per Covered Plan Participant Per BP 60

Note: Refer to the Evidence of Coverage for reimbursement guidelines.

Skilled Nursing Facility Visits Per Covered Plan Participant Per BP 90

Spinal Manipulations Visits Per Covered Plan Participant Per BP 26

TMJ Visits Per Covered Plan Participant Per BP 18

Transplant Coverage for Lodging, Meals and Transportation

Per Covered Plan Participant Per Lifetime \$10,000

Note: If immediately before the Effective Date of the Group, a Covered Plan Participant was covered under a prior group policy issued by BCBSF to the Group, amounts applied to a Covered Plan Participant's Benefit Period benefit maximums and lifetime maximums under the prior BCBSF policy, will be applied toward the Covered Plan Participant's Benefit Period benefit maximums and lifetime maximums under the Evidence of Coverage.

Admission Certification Requirements

All Hospital admissions in the State of Florida must be certified. The following penalties will apply for admissions within the State of Florida which are not certified.

1. Admissions to a Hospital that is a Preferred Patient Care (PPC) Provider - No penalty for the Covered Plan Participant. It is the responsibility of the PPC Hospital/Physician to obtain admission certification.
2. Hospitals that are not BCBSF Providers - any non-certified admissions in the State of Florida are subject to a 25% benefit penalty reduction. The Covered Plan Participant is responsible for obtaining certification for the admission from BCBSF and for any applicable benefit reductions for failure to obtain such certification.

Prescription Drug Program

The Group may have purchased optional pharmacy coverage from BCBSF. If so, please refer to the pharmacy program Endorsement issued to the Group.

BlueScript[®] Pharmacy Program

Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the BlueScript Pharmacy Program Endorsement, both of which should be reviewed carefully. To verify if a Pharmacy is a Participating Pharmacy, the Covered Plan Participant may access the Pharmacy Program Provider Directory on our website at www.bcbsfl.com or call the customer service phone number on the Identification Card. References to Deductible are abbreviated as “DED” and references to Benefit Period are abbreviated as “BP”.

	Participating Pharmacy
<u>Preferred Generic Prescription Drugs and Covered OTC Drugs purchased at:</u>	
Retail Pharmacy – For up to a One-Month Supply	\$15
Specialty Pharmacy - For up to a One-Month Supply	\$15
Mail Order Pharmacy – For up to a Three-Month Supply	\$30
<u>Preferred Brand Name Prescription Drugs or Supplies purchased at:</u>	
Retail Pharmacy – For up to a One-Month Supply	\$25
Specialty Pharmacy - For up to a One-Month Supply	\$25
Mail Order Pharmacy – For up to a Three-Month Supply	\$50
<u>Non-Preferred Prescription Drugs or Supplies purchased at:</u>	
Retail Pharmacy – For up to a One-Month Supply	\$40
Specialty Pharmacy - For up to a One-Month Supply	\$40
Mail Order Pharmacy – For up to a Three-Month Supply	\$80

Other Important Information affecting what you will pay:

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
 1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; and
 2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

- The Specialty Pharmacies designated, solely by us, are the only “In-Network” suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes under this BlueScript Pharmacy Program.

Some Specialty medications may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.

- You can also 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.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

BlueScript[®] Pharmacy Program Endorsement

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

Introduction

Under this Endorsement, coverage is provided to Covered Plan Participants for Covered Prescription Drugs and Supplies and select Over-the-Counter (“OTC”) Drugs purchased at a Pharmacy. In order to obtain benefits under this Endorsement, Covered Plan Participants must pay, at the time of purchase, the Pharmacy Deductible, if any, and the applicable Copayment or percentage of the Participating Pharmacy Allowance, as applicable, indicated on the BlueScript Pharmacy Program Schedule of Benefits.

In the Medication Guide, are lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs. Covered Plan Participants 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; and 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs.

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 Self-Administered Injectable Prescription Drug, listed in the Medication Guide with a special symbol designating it as a Covered Self-Administered Injectable Prescription Drug;
5. in the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide;
6. a Prescription Drug contained in an anaphylactic kit (e.g., Epi-Pen, Epi-Pen Jr., Ana-Kit);
7. authorized for coverage by BCBSF or Lake County Board of County Commissioners, if prior coverage authorization is required 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 Evidence of Coverage; and
9. 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 or her license;
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, the benefit guidelines set forth below may be applied, as well as any other applicable payment rules specific to particular Covered Services listed in the Evidence of Coverage:

Contraceptive Coverage

All 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 the Covered Plan Participant obtains a Prescription for the OTC Drug from their 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 BCBSF's website at www.bcbsfl.com, or the Covered Plan Participant may call the customer service phone number on the Covered Plan Participant's Identification Card and one will be mailed to the Covered Plan Participant upon request.

Diabetic Coverage

All Prescription Drugs used in the treatment of diabetes will be 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 dispensing Insulin will be covered only when prescribed in conjunction with Insulin.

Note: Other diabetic supplies and equipment (e.g., blood glucose testing strips, lancets, glucose meters etc.) may be covered under other provisions of the Evidence of Coverage which this Endorsement amends although specifically excluded 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

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. Coverage will not extend beyond 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 Covered 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 it's generic or therapeutic equivalent is excluded after age 26.
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 or on the BlueScript Pharmacy Program Schedule of Benefits;
 - b. furnished to a 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, 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 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;

Exclusions

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific 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.
3. 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 and Covered OTC Drugs listed in the Medication Guide.
4. All Supplies other than Covered Prescription Supplies.

- 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; and
 - m. OTC Drugs not listed in the Medication Guide.
8. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Prescription Drugs and Supplies and Covered OTC Drugs subsection.
 9. Any appetite suppressant and/or other Drug indicated, or used, for purposes of weight reduction or control.
 10. Immunization agents, biological sera, blood and blood plasma.
 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: 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. Lake County Board of County Commissioners, in its 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 Lake County Board of County Commissioners, in its sole discretion, decides to waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs.

17. Any amount a Covered Plan Participant is 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.
19. Self-prescribed Drugs or Supplies and Drugs or Supplies prescribed by any person related to the Covered Plan Participant by blood or marriage.
20. Food or medical food products, whether prescribed or not.

Refer to the Medication Guide to determine if a particular Prescription Drug is excluded under this Endorsement.

Payment Rules

Under this Endorsement, the amount which must be paid by the Covered Plan Participant 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 BCBSF's agreement with the Pharmacy selected;
3. whether the Covered Plan Participant has satisfied all or part of the Pharmacy Deductible, if any, and the amount of Copayment or percentage of the Participating Pharmacy Allowance set forth in the BlueScript Pharmacy Program Schedule of Benefits;
4. whether the Prescription Drug is a Brand Name Prescription Drug or a Generic Prescription Drug or Covered OTC Drug;
5. whether the Prescription Drug is on the Preferred Medication List;
6. whether the Prescription Drug was purchased from the Mail Order Pharmacy; and
7. whether the OTC Drug is designated in the Medication Guide as a Covered OTC Drug.

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 purposes of this Endorsement, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

Participating Pharmacies

Participating Pharmacies are Pharmacies participating in BCBSF's BlueScript Pharmacy Program, or a National Network Pharmacy network belonging to BCBSF's Pharmacy Benefit Manager, at the time Covered Prescription Drugs and Supplies and/or Covered OTC Drugs are purchased by a Covered Plan Participant. Participating Pharmacies have agreed not to charge, or collect from, the Covered Plan Participant, for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug, 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 BCBSF;
2. National Network Pharmacies;
3. Specialty Pharmacies; and
4. the Mail Order Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, the Covered Plan Participant may refer to the Pharmacy Program Provider Directory then in effect on BCBSF's website at www.bcbsfl.com, or call the customer service phone number included in the Evidence of Coverage or on the Covered Plan Participant's Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

Prior to purchase, the Covered Plan Participant must present his or her Identification Card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that the Covered Plan Participant is, in fact, covered under this Endorsement.

When charges for Covered Prescription Drugs, and Supplies or Covered OTC Drugs by a Participating Pharmacy are less than the required Copayment, the amount the Covered Plan Participant will be required to pay, depends on the agreement then in effect between the Pharmacy and BCBSF, 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 BCBSF; 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 the Covered Plan Participant has to pay for these medications, while helping to preserve the Covered Plan Participants benefits.

The Specialty Pharmacies designated, solely by BCBSF, are the only "In-Network" suppliers for Specialty Drugs. With BlueScript, the 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 Out-of-Network 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 details on how to order Covered Prescription Drugs and Supplies and Covered 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 BCBSF's BlueScript Participating Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

Payment for Covered Prescription Drugs and Supplies and Covered OTC Drugs is based upon BCBSF's Participating Pharmacy Allowance. Non-Participating Pharmacies have **not** agreed to accept BCBSF's or BCBSF's Pharmacy Benefit Manager's Participating Pharmacy Allowance as payment in full less any applicable cost share amounts due from the Covered Plan Participant.

Covered Plan Participants may be responsible for paying the full cost of the Prescription Drugs and Supplies and Covered OTC Drugs at the time of purchase and must submit a claim to BCBSF for reimbursement. Reimbursement for Covered Prescription Drugs and Supplies and Covered OTC Drugs, will be at 80 percent of the Participating Pharmacy Allowance less the Pharmacy Deductible, if any, and the Copayment or percentage of the Participating Pharmacy Allowance set forth in the BlueScript Pharmacy Program Schedule of Benefits.

In order to be reimbursed for Covered Prescription Drugs and Supplies and Covered OTC Drugs purchased at a Non-Participating 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:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Prescription Drug Program
P. O. Box 1798
Jacksonville, Florida 32231

Pharmacy Utilization Review Programs

BCBSF's pharmacy utilization review programs are intended to encourage the responsible use of Prescription Drugs and Supplies and OTC Drugs.

BCBSF and/or Lake County Board of County Commissioners may, in their sole discretion, require that Prescriptions for select Prescription Drugs and Supplies or OTC Drugs be reviewed under BCBSF's 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, Supply or OTC Drug prescribed.

Note: If coverage is not available, or is limited, this does not mean that the Covered Plan Participant cannot obtain the Prescription Drug, Supply or OTC Drug from the Pharmacy. It only means there is no coverage and payment will not be made for the Prescription Drug, Supply or OTC Drug. The Covered Plan Participant is always free to purchase the Prescription Drug, Supply or OTC Drug at their sole expense.

BCBSF's pharmacy utilization review programs include the following:

Responsible Steps

Under this program, coverage may be excluded for certain Prescription Drugs and OTC Drugs unless the Covered Plan Participant has 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 the Covered Plan Participant's Physician, BCBSF must receive written documentation from the Covered Plan Participant and the Covered Plan Participant's Physician that the designated Drugs in the Medication Guide are not appropriate for the Covered Plan Participant because of a documented allergy, ineffectiveness or side effects.

Prior to filling a Prescription, the Covered Plan Participant's Physician may, but is not required to, contact BCBSF 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, coverage may be excluded for any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide.

Prior Coverage Authorization

The Covered Plan Participant is required to obtain prior coverage authorization from BCBSF 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 BCBSF's pharmacy utilization review programs is published in the Medication Guide at www.bcbsfl.com, or the Covered Plan Participant may call the customer service phone number on the Covered Plan Participant's Identification Card. The Covered Plan Participant's Pharmacist may also advise the Covered Plan Participant if a Prescription Drug or OTC 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 Evidence of Coverage. Ultimately, the final decision concerning whether a Prescription Drug, Supply or OTC Drug should be prescribed must be made by the Covered Plan Participant and the prescribing Physician. Decisions made by BCBSF and/or Lake County Board of County Commissioners in authorizing coverage are made only to determine whether coverage or benefits are available under the Evidence of Coverage and not for the purpose of providing or recommending care or treatment. BCBSF reserves 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 the Covered Plan Participant and the Covered Plan Participant's treating Physician in accordance with the patient/Physician relationship. It is possible that the Covered Plan Participant or the Covered Plan Participant's 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. 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 and/or Lake County Board of County Commissioners 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 "Glossary of Terms" section in the Evidence of Coverage which 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;
2. syringes and needles prescribed in conjunction with insulin, or a covered Self-

Administered Injectable Prescription Drug which is authorized for coverage by BCBSF or Lake County Board of County Commissioners;

3. syringes and needles prescribed in conjunction with a Prescription Drug authorized for coverage by BCBSF or Lake County Board of County Commissioners;
4. syringes and needles which are contained in anaphylactic kits (e.g., Epi-Pen, Epi-Pen, Jr., Ana Kit); and
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.

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 Drug that either: 1) has been approved by the United States Food and Drug Administration (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 , 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 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 BCBSF.

Maximum means the amount designated in BCBSF's Medication Guide as the Maximum, including but not limited to, frequency, dosage and duration of therapy.

Medication Guide means the guide then in effect issued by BCBSF that may designate the following categories of Prescription Drugs: Preferred Generic Prescription Drugs; Covered OTC 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 the Covered Plan Participant's information.

Note: The Medication Guide is subject to change at any time. The Covered Plan Participant may refer to the BCBSF website at www.bcbsfl.com for the most current guide or call the customer service phone number on the Covered Plan Participant's 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.

Non-Participating Pharmacy means a Pharmacy that has not agreed to participate in BCBSF's BlueScript Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

Non-Preferred Prescription Drug means a Generic Prescription Drug or Brand Name Prescription Drug which is not included on the Preferred Medication List then in effect.

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.

Participating Pharmacy means, a Pharmacy that has signed a Participating Pharmacy Provider Agreement with BCBSF 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, Covered 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.

Pharmacy Deductible means the amount of allowed charges for Covered Prescription Drugs and Supplies and Covered OTC Drugs each Covered Plan Participant must actually pay per Calendar Year, in addition to any applicable Copayment or percentage of the Participating Pharmacy Allowance, to a Pharmacy who is recognized for payment under this Endorsement, before payment for Covered Prescription Drugs and Supplies and Covered OTC Drugs under this Endorsement begins.

Pharmacy Out-of-Pocket Maximum means the maximum amount the Covered Plan Participant will be required to pay per Calendar Year for Covered Prescription Drugs and Supplies and Covered OTC Drugs. Any benefit penalty reductions, non-covered charges or any charges in excess of the Participating Pharmacy Allowance will not accumulate toward the pharmacy out-of-pocket maximum.

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, it must 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 the Covered Plan Participant may administer to him or herself, 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 BlueScript 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 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 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 of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Serviced by:

Blue Cross and Blue Shield of Florida, Inc.