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# **BLUE SELECT**

## **SUMMARY OF MATERIAL MODIFICATION**

**Clarksville – Montgomery County**  
**Employees Insurance Trust**  
Active Employees



**BlueCross BlueShield**  
**of Tennessee**

An Independent Licensee of the  
BlueCross BlueShield Association

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**Employer Sponsored Plan  
Administered by BlueCross BlueShield of Tennessee, Inc. (BCBST)**

**NOTICE**

**PLEASE READ THIS SUMMARY OF MATERIAL MODIFICATION (SMM) CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR BENEFITS AS ADMINISTERED BY BLUECROSS BLUESHIELD OF TENNESSEE, INC. THIS SMM IS EFFECTIVE JANUARY 1, 2009.**

**THE EOC YOU RECEIVED IS MODIFIED BY REPLACING THE PRESCRIPTION DRUG PROGRAM WITH THE FOLLOWING PRESCRIPTION DRUG PROGRAM.**

**IF YOU HAVE ANY QUESTIONS ABOUT THIS SMM OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:**

**CUSTOMER SERVICE DEPARTMENT  
BLUECROSS BLUESHIELD OF TENNESSEE, INC.,  
ADMINISTRATOR  
801 PINE ST.  
CHATTANOOGA, TENNESSEE 37402-2555  
(800) 565-9140**

## PRESCRIPTION DRUG PROGRAM

### Definitions

1. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
2. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
3. **Compound Drug** – An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and which contains at least one ingredient classified as an outpatient Prescription Drug.
4. **Covered Drug Expenses** – Covered Drug Expenses will be the lesser of: (a) the Maximum Allowable Charge (MAC) plus any dispensing fees and applicable sales tax; or (b) the Average Wholesale Price less any negotiated discounts plus any applicable dispensing fees and applicable sales tax.
5. **Drug Copayment** - the amount of the Covered Drug Expense of a Prescription Drug, which is the obligation of the Member. The Drug Copayment is paid directly to the Participating Pharmacy at the time the covered Prescription Drug is dispensed. The Drug Copayment is determined by the type of drug purchased, and must be paid for each Prescription Drug.
6. **Drug Formulary** - a list designating which Prescription Drugs and drug products are approved for reimbursement. This list is subject to periodic review and modification by BCBST.
7. **Experimental and/or Investigational Drugs** – Drugs or medicines, which are labeled: Caution – limited by federal law to Investigational use.
8. **Generic Drug** - a Prescription Drug included in the Approved Manufacturers List of the Tennessee Department of Health and Environment and which can be legally substituted for a trade or Brand Name Drug prescribed under applicable law. Generic Drugs must be AB rated by the FDA.
9. **Home Delivery Network** – BlueCross BlueShield of Tennessee’s (BCBST) network of mail service pharmacy facilities.
10. **Home Delivery Retail Network** – BCBST’s network of retail pharmacies that are permitted to dispense prescription drugs to BCBST Members on the same terms as pharmacies in the Home Delivery Network.
11. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, “Caution: Federal law prohibits dispensing without a Prescription.
12. **Maintenance Drug** – Prescription Drugs most commonly used for selected disease states that are considered long term, chronic, and stable. BCBST maintains a list of Maintenance Drugs, which is reviewed periodically by Our Pharmacy and Therapeutics Committee. In keeping with accepted standards of medical practice, not all-therapeutic classes are included on the Maintenance Drug Prescription list.
13. **Managed Dosage Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
14. **Maximum Allowable Charge** – the amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan’s contract with a Participating Provider or the amount payable

based on the Plan's fee schedule for the Covered Services rendered by Non-Participating Providers.

15. **Non-Participating Pharmacy** - a Pharmacy which has not entered into a service agreement with BCBST or its agent to provide benefits at specified rates to Members.
16. **Non-Preferred Brand Drug or Elective Drug** - a Brand Name Drug that is not considered a Preferred Drug by the administrator. Usually there are lower cost alternatives to some Brand Name Drugs.
17. **Participating Pharmacy** - a Pharmacy which has entered into a Participating Pharmacy Agreement with BCBST or its agent to provide Prescription Drug benefits to Members, either in person or through home delivery.
18. **Pharmacy** - a state or federally licensed establishment which is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription to the general public by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.
19. **Pharmacy and Therapeutics Committee or P&T Committee**— A panel of BCBST participating pharmacists, Participating Providers, medical directors and pharmacy directors which reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: (1) Drug Formulary; (2) Preferred Brand Drug list; (3) Maintenance Drug list; (4) Prior Authorization Drugs list; and (5) Managed Dosage Limitation list. The P&T Committee may also set dispensing limits on medications.
20. **Preferred Brand Drug** - Brand Name Drugs that the Plan has reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness. The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.
21. **Prescription Drug** - a medication containing at least one Legend Drug which may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
22. **Prescription** - a written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure to a pharmacist for a drug, or drug product to be dispensed.
23. **Prior Authorization Drugs**- Prescription Drugs which are only eligible for reimbursement after prior approval from BCBST as determined by the P&T Committee.

### **Covered Services**

Prescription Drugs prescribed to a Member who is not confined in a hospital or other facility. Prescription Drugs must be:

- prescribed on or after the Member's coverage begins;
- approved for use by the Food and Drug Administration (FDA);
- dispensed by a licensed pharmacist;
- listed on the Drug Formulary; and
- not available for purchase without a Prescription.

Treatment of Phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.

Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring upon Prescription.

### **Benefit Payment**

After a Calendar Year Drug Deductible of \$50 per Member, benefit payment for Covered Services will be determined as follows:

- *Generic Drug.* We will determine the lesser of the billed charge or Maximum Allowable Charge, and pay 100%, up to the Maximum Allowable Charge. The Deductible will be waived for Generic Drugs.
- *Preferred Brand Drug.* We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Drug Copayment of 10% for Active Employees and pay the difference up to the Maximum Allowable Charge.
- *Non-Preferred Brand Name Drug.* We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Drug Copayment of 20% for Active Employees and pay the difference up to the Maximum Allowable Charge.

Benefits will be provided for up to a 30 calendar day supply of Prescription Drugs or up to a 90 calendar day supply of Maintenance Drugs or up to a 90 calendar day supply of Prescription Drugs obtained through home delivery or home delivery at retail. Coverage for Maintenance Drugs and Prescription Drugs obtained through home delivery is subject to a copayment equal to 2 times the Drug Copayment. Some products may be subject to additional Managed Dosage limitations as adopted by BCBST.

If a Member has a Prescription filled at a Non-Participating Pharmacy, the Member must pay all expenses and file a claim for reimbursement with BCBST. The Member will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Deductible and/or Drug Copayment amount.

Subject to a Calendar Year Out-of-Pocket Maximum of \$500 per Member, including Drug Deductible.

### **Limitations**

- Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.
- Drugs for the treatment of onychomycosis (e.g., nail fungus) are not Covered, except for: (1) diabetics; or (2) immuno-compromised drugs.
- Growth hormones are not Covered, except for: (1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; and (2) patients with "Turner" syndrome, including the drugs, (1) Genotropin; (2) Humatrope; (3) Norditropin; (4) Nutropin; (5) Saizen; (6) Serostim; (7) Somatropin; and (8) Protropin (Somatrem);
- Any Prescription and non-Prescription medical supplies, devices and appliances, other than syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- Immunizations or immunological agents, including but not limited to: (1) biological sera, (2) blood, (3) blood plasma; or (4) other blood products except as required by hemophiliacs; and,
- Injectable drugs, except when: (1) intended for self-administration; or (2) defined by the Plan.

- Compound Drugs are Covered only when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the Plan's pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for at least one ingredient in the Compound Drug.

## **Exclusions**

In addition to the limitations and exclusions specified in the EOC, benefits are not available for the following:

- drugs which are prescribed, dispensed or intended for use while the Member is confined in a hospital, skilled nursing facility or similar facility;
- any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law are excluded except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs which exceed that specified by BCBST Pharmacy and Therapeutics Committee;
- any Prescription Drug purchased outside the United States, except those authorized by BCBST;
- non-oral contraceptives, contraceptive materials, Norplant and other implantable products, injectables, or devices; including those medications intended to terminate a pregnancy (e.g. RU-486);
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs a Member is entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- drugs dispensed by a Provider other than a Pharmacy;
- administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- all newly FDA approved drugs prior to review by BCBST's Pharmacy & Therapeutic Committee;
- Compound Drugs filled or refilled at an Out-of-Network Pharmacy and not containing at least one ingredient requiring a Prescription or refill, identified with a valid national drug code (NDC) number;
- any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- Prescription Drugs used for cosmetic purposes including, but not limited to: (1) drugs used to reduce wrinkles (e.g. Renova); (2) drugs to promote hair-growth; (3) drugs

used to control perspiration; (4) drugs to remove hair (e.g. Vaniqa); and (5) fade cream products;

- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs; and
- Prescription Drugs or refills dispensed:
  - in quantities in excess of amounts specified in the Benefit payment section;
  - without Our Prior Authorization when required; or
  - which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in the EOC.

Use this space for information You'll need when asking about Your coverage.

The company office or person to contact about coverage is:

Name:

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Address:

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Phone:

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The BlueCross BlueShield Plan to contact is:

Address: BlueCross BlueShield of Tennessee  
801 Pine Street  
Chattanooga, TN 37402-2555

The Subscriber Number shown on my identification card is:

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The "Effective Date" when my coverage begins is:

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