

**FirstCare  
Permian Basin Employer Health Plan Business Cooperative  
Plan A - High**

This Rider is issued to You in connection with and amends Your FirstCare Group Contract Evidence of Coverage. This Rider is effective as of the date of Your Group Contract Evidence of Coverage. Capitalized terms used in this Rider that are not defined herein shall have the meanings ascribed to such terms in Your Evidence of Coverage.

**CALENDAR YEAR MAXIMUM BENEFIT**                    **\$8,500 per Member for all drugs on Tiers 1-3**

**LIFETIME MAXIMUM 4<sup>th</sup> Tier Drugs Only**                    **\$250,000 per Member**

**CALENDAR YEAR DEDUCTIBLE**                    **\$100 per Member**

**PREFERRED RETAIL PHARMACY (30-Day Supply)**

1 <sup>st</sup> Tier - Generic Drugs	\$15 Copayment per Prescription
2 <sup>nd</sup> Tier - Selected List of Brand Name Drugs	\$35 Copayment per Prescription
3 <sup>rd</sup> Tier - Other Brand Name Drugs not 2 <sup>nd</sup> Tier	\$65 Copayment per Prescription
4 <sup>th</sup> Tier - Injectable Medications, Immunosuppressive Medications, Medically Infused Medications, Chemotherapy and Associated Agents, and High Technology Drugs.*	25% Copayment per Prescription

**PREFERRED MAIL ORDER PHARMACY (90-Day Supply)**

1 <sup>st</sup> Tier - Generic Drugs	\$45 Copayment per Prescription
2 <sup>nd</sup> Tier - Selected List of Brand Name Drugs	\$105 Copayment per Prescription
3 <sup>rd</sup> Tier - Other Brand Name Drugs not 2 <sup>nd</sup> Tier	\$195 Copayment per Prescription
4 <sup>th</sup> Tier - Injectable Medications, Immunosuppressive Medications, Medically Infused Medications, Chemotherapy and Associated Agents, and High Technology Drugs.*	25% Copayment per Prescription

\*The 4<sup>th</sup> Tier benefit is also available through Your medical benefit plan; however, the benefit is non-duplicative. Refer to Your Schedule of Copayments for details.

**WHAT THIS RIDER COVERS**

This Rider covers the following Prescription Drugs included in the approved FirstCare Preferred Drug List (PDL) when they are prescribed by a Primary Care Physician (PCP) or other authorized referral Physician:

- Medically Necessary Prescription Drugs including Generic drugs and drugs listed in the FirstCare PDL. When a Generic Drug is available and the Brand Name is dispensed, You will be responsible for the Generic Drug Copayment plus the difference between the cost of the Generic Drug and the cost of the Brand Name Drug, even if Your Physician prescribes a name brand drug.
- Medically Necessary Prescription Drugs that are not contained in the FirstCare PDL. These drugs are covered at a higher Copayment.
- Compound medications must contain at least one Legend Drug.
- Pre-natal vitamins.
- Formulas necessary for the treatment of Phenylketonuria (PKU) or other Heritable Disease.
- Contraceptive prescription drugs and devices.
- Injectable medications, immunosuppressive medications, medically infused medications, chemotherapy and associated agents, and high technology drugs.

**LIMITATIONS**

- Certain medications are subject to dispensing limitations based upon generally accepted medical practice whether or not these medications are contained in the FirstCare PDL.
- Certain medications are subject to prior authorization whether or not these medications are contained

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in the FirstCare PDL.

- Prescriptions covered under this Rider are limited to a 30-day supply. Medications for chronic conditions may be filled up to a 90-day supply, but only when filled through a Participating Mail Service Pharmacy.
- Prescriptions must be written by a Plan Provider or authorized referral Physician and filled at a Participating Pharmacy. Prescriptions written by non-Plan Providers, or filled by non-Participating Pharmacies will not be covered, except in cases of medical emergency.
- Prescription Drugs that are dispensed by an out-of-area Hospital following an emergency visit will be covered for the initial prescription. Refills or new prescriptions must be filled at a Participating Pharmacy.
- Prescriptions will not be refilled until 70% percent of the prescription has been used.
- Medications prescribed for non-FDA approved indications, referred to as off-label drug use, *are not covered*. This includes experimental, investigational, any disease or condition that is excluded from coverage under this Rider, or that the FDA has determined to be contraindicated for treatment of the current indication. Off-label drug use may be covered if the drug is approved by the FDA for at least one indication, and is recognized by reproducible studies for treatment of the indication for which the drug is prescribed in substantially accepted peer-reviewed national medical professional journals and a nationally recognized medical technology evaluation service.

**WHAT IS NOT COVERED**

- Drugs that by law do not require a prescription. Prescription refills in excess of the number specified by the Physician and any refill dispensed more than one year after the Physician's order.
- Prescriptions written in connection with any treatment or service that is not a covered benefit.
- Devices of any kind, even those requiring a prescription, including but not limited to therapeutic devices, health appliances, hypodermic needles or similar items.
- Any medication that is not Medically Necessary. Denials for medications that are not medically necessary are subject to the Member Complaint and Appeal Procedures outlined in Section 8 of your Evidence of Coverage.
- Over-the-counter vitamins and mineral supplements.
- Appetite suppressants, anti-smoking aids (e.g. Nicorette gum and nicotine patches), medications used for any cosmetic improvement, including wrinkles, uncomplicated nail fungus regardless of ambulation or pain, hair loss, growth or removal, and idiopathic non-growth hormone deficiency short stature.
- Growth hormone drugs for persons 18 years of age or older. However, growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred, are covered when services are pre-authorized.
- Any Prescription Drug for which the actual cost is less than the required Copayment.
- Prescriptions or refills that replace lost, stolen, spoiled, expired, spilled or are otherwise misplaced or mishandled by the Member.
- Prescriptions written for the treatment of infertility.

**GENERAL PROVISIONS**

- The monthly premium rate charged for this Rider is included in the monthly premium charged for the Group Contract. The applicable rate is specified on the rate schedule attached to the Group Employer Agreement and the Group agrees to remit to FirstCare the Rider premium due, including the subscriber contribution, if any, along with and on the same date as its regular premium.
- In the event any Member's coverage under the Group Contract terminates, this Rider will terminate automatically without further action or notice unless otherwise prohibited by applicable law.
- Until further notice, all terms, limitations, exclusions and conditions of the Group Contract Evidence of Coverage remain unchanged except as provided in this Rider.

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- If We place a medication on a higher tier during the plan year, and You have been previously and continue to be taking the drug for a medical condition or mental illness, you will continue to pay the copayment for the drug at the lower cost tier until Your next plan renewal date.

**DEFINITIONS**

**Brand Name** means a drug that has no Generic Equivalent or a drug that is the innovator or original formulation for which the Generic Equivalent forms exist.

**Contract Year Deductible** is the amount of Covered Prescription Drug Expenses You must pay for each Member before any benefits are available.

**Preferred Drug List or PDL** means a comprehensive list of medications consisting of Generic Equivalent drugs and single source (sometimes referred to as Brand Name) drugs. The FirstCare PDL is the list of medications authorized by the FirstCare Pharmacy and Therapeutics Committee to be dispensed through Participating Pharmacies. The PDL may be revised from time to time.

**Experimental or Investigational** means any drug, device, treatment or procedure that would not be used in the absence of the Experimental or Investigational drug, device, treatment or procedure. We consider a drug, device, treatment or procedure to be Experimental or Investigational if:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided; or
- It was reviewed and approved by the treating Facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was requested by federal law to be) reviewed and approved by that committee; or
- Reliable evidence shows that the drug, device, treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigational arm of ongoing Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis;
- The safety and/or efficacy has not been established by reliable, accepted medical evidence; or
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis.

*"Reliable evidence"* includes only published reports and articles in authoritative medical and scientific literature, and written protocols and informed consent forms used by the treating Facility or by another Facility studying substantially the same drug, device, treatment or procedure.

**Generic Equivalent Prescription Drug** means a Prescription Drug that is pharmaceutically and therapeutically equivalent to a Brand Name Drug as classified by First Data Bank or other nationally recognized drug classification service.

**Heritable Disease** means an inherited disease that may result in mental or physical retardation or death.

**Legend Drug** means a drug that federal law prohibits dispensing without a written prescription.

**Participating Mail Service Pharmacy** means a pharmacy providing prescription service by mail which has contracted with FirstCare to provide such services.

**Participating Pharmacy** means a pharmacy that has been approved by FirstCare to provide Prescription Drugs to Members.

**Phenylketonuria** means an inherited condition that may cause severe mental retardation if not treated.

**Prescription Drug** means any Legend Drug that has been approved by the Food & Drug Administration (FDA), is not Experimental or Investigational, and requires a prescription by a duly licensed Physician.