

In consideration of additional premium by the Policyholder, the following benefit is hereby added to the Group Policy/Certificate. Capitalized terms used in this Rider not defined herein shall have the meanings ascribed to such terms in your Certificate of Insurance.

**CALENDAR YEAR MAXIMUM BENEFIT** **\$8,500 per Insured for all drugs on Tiers 1-3**  
**LIFETIME MAXIMUM 4<sup>TH</sup> TIER DRUGS ONLY** **\$50,000 per Insured**

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

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

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

**OUT-OF-NETWORK RETAIL PHARMACY (30-Day Supply)**

The claim is paid at 70% of the actual charges, after they are first reduced by the sum of the applicable In-Network pharmacy Copayment and any required difference in the cost between a Brand Name medication and a Generic medication. Remember, when submitting a claim, You must provide an itemized prescription, a completed claim form and a prescription receipt from the pharmacist. The receipt must include the National Drug Code for the prescription medication dispensed. Call Customer Service at 800-240-3270 to obtain a claim form for pharmacy reimbursement.

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

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

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

**WHAT THIS RIDER COVERS:**

This Rider covers the following medically necessary Prescription Drugs when prescribed for Insured Persons who are not confined in any Facility as follows:

- We provide coverage of Medically Necessary Prescription Drugs including Generic Drugs and drugs listed in the Drug Coverage List (DCL). When a Generic Drug is available and a Brand Name drug on the drug list 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 Limited Brand Name Drug, even if your Physician requires it.
- We also provide coverage for Medically Necessary Prescription Drugs that are not contained in the DCL. These drugs are covered at a higher Copayment.

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- Biologicals and compound medications. Compound medications must contain at least one Legend Drug.
- Prescription Pre-natal vitamins.
- Growth hormone therapy for the treatment of documented growth hormone deficiency in children for which epiphyseal closure has not occurred. We must pre-certify growth hormone therapy.
- Prescription contraceptive drugs and devices.
- Formulas necessary for the treatment of Phenylketonuria or other Heritable Disease.
- 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 Drug Coverage List.
- Certain medications are subject to prior authorization whether or not these medications are contained in the Drug Coverage List. Failure to pre-authorize these medications will reduce the benefit by 50% or \$500 whichever is less.
- Prescription drugs not listed in the Drug Coverage List will be covered with a higher Copayment.
- 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 Mail Order Pharmacy.
- Prescription refills in excess of the number specified by the physician and any refill dispensed more than one year after the physician's order are not covered.
- Prescriptions will not be refilled until at least 70% of the prescription has been used.
- Medications prescribed beyond FDA-approved indications, referred to as off-labeled 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-labeled drug use may be covered if the drug is approved by the FDA for at least one indication; and, is recognized 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:**

- 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 (except for prescription contraceptive devices), health appliances, hypodermic needles or similar items
- Any medication not Medically Necessary.
- Drugs that by law do not require a Prescription.
- 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, and 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.
- Experimental or Investigational drugs.

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- Prescriptions or refills which replace lost, stolen, spilled or are otherwise misplaced prescriptions, are excluded.
- Prescriptions written for the treatment of infertility unless the In Vitro Fertilization Rider is purchased. Please refer to your In Vitro Rider for coverage information.

**GENERAL PROVISIONS:**

The Insured Person(s) will give their FirstCare PPO Identification Card to the Pharmacist when presenting a Prescription Order to an In-Network Pharmacy.

If We request, the Insured Person will authorize and direct an Out-of-Network Pharmacy to provide to Us all information, copies or other records relating to all Prescription Orders concerning the Insured Person, to the extent permitted by state or federal law. We will maintain the confidentiality of all the information.

We are not liable for any claims, injury, demand or judgment based on tort or other grounds (including warranty of drugs), arising out of or in connection with the sale, compounding, dispensing, manufacturing or use of any Prescription Drug whether or not covered under this Rider.

**DEFINITIONS**

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

**Copayment** means the amount that will be charged to the Insured Person by the In-Network Pharmacy or Mail Order Pharmacy for dispensing or refilling any Prescription Order.

**Covered Drugs** means those medications prescribed by a Physician that, under state or federal law, can be dispensed only by a Prescription Order or is a compounded prescription that contains at least one legend ingredient or insulin. The maximum amount dispensed will not exceed an amount required for 30 consecutive days. Medications for chronic conditions may be filled up to a 90-day supply, but only when filled through a Mail Order Pharmacy.

**Drug Coverage List** means a comprehensive list of medications consisting of Generic Equivalent drugs and single source (also referred to as Brand Name) drugs. The list 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.

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*"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.

**Facility** means a health care or residential treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care. Facility also means a treatment center for the diagnosis and/or treatment of Chemical Dependency or Mental Illness.

**Generic Equivalent Prescription Drug**, as defined by First Data Bank or other similar nationally recognized drug classification service, means a prescription drug that is pharmaceutically and therapeutically equivalent to a brand name drug.

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

**In-Network Pharmacy** means a pharmacy with whom We have contracted to provide Prescription Drugs to Insured Persons.

**Insured Person** means either the Employee or his eligible Dependents covered under the Policy.

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

**Mail Order Pharmacy** means a pharmacy providing prescription service by mail that has contracted with Us to provide such services.

**Out-of-Network Pharmacy** means a pharmacy that has not contracted with Us to provide Prescription Drugs.

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

**Prescription Drug** means any Legend Drug approved by the Food & Drug Administration (FDA) that requires a prescription by a duly licensed physician.

**Prescription Order** means an authorization for a Prescription Drug issued by a Physician, who is duly licensed to write the authorization in the ordinary course of his professional practice.