

FIRSTCARE – The HMO of Choice PRESCRIPTION DRUG RIDER RXGEN15

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.

RETAIL PHARMACY (30-Day Supply)

Generic Drugs

\$15 per Prescription

MAIL ORDER PHARMACY (90-Day Supply)

Generic Drugs

\$45 per Prescription

WHAT THIS RIDER COVERS

This Rider only covers generic Prescription Drugs when they are prescribed by a Primary Care Physician (PCP) or other authorized referral Physician and are filled by a Participating Retail Pharmacy or Participating Mail Order Pharmacy.

- Prescription Generic Equivalent Drugs as defined by First Data Bank or a similar nationally recognized drug classification service.
- Pre-natal vitamins.
- Formulas necessary for the treatment of Phenylketonuria (PKU) or other Heritable Disease.
- Contraceptive prescription drugs.
- Injectable medications recognized by the FDA as appropriate for self-administration (referred to as “Self-Injectable” Drugs), regardless of the Member’s ability to self-administer.
- Immuno-suppressive drugs used for pre-authorized organ transplants.

LIMITATIONS

- Certain medications are subject to dispensing limitations based upon generally accepted medical practice.
- Certain medications are subject to prior authorization.
- Prescriptions covered under this Rider are limited to a 30-day supply. Medications 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. Upon return to the Service Area, 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.

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WHAT IS NOT COVERED

- Brand Name Drugs
- 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.
- Compounded medications.
- 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.
- Over-the-counter products.
- 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.

DEFINITIONS

Heritable Disease: An inherited disease that may result in mental or physical retardation or death.

Legend Drug: A drug that federal law prohibits dispensing without a written prescription.

Participating Mail Service Pharmacy: A pharmacy providing prescription service by mail which has contracted with FIRSTCARE to provide such services.

Participating Pharmacy: A pharmacy that has been approved by FIRSTCARE to provide Prescription Drugs to Members.

Phenylketonuria: An inherited condition that may cause severe mental retardation if not treated.

Prescription Drug: 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.

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