

<b>TIER IV CALENDAR YEAR OUT-OF-POCKET MAXIMUM</b>	\$4,000
<b>CALENDAR YEAR DEDUCTIBLE</b>	None

This Rider is issued to You in connection with and amends Your Allegian Insurance Company (AIC) dba Allegian Health Plans (AHP) Group Contract Certificate of Insurance. This Rider is effective as of the date of Your Group Contract Certificate of Insurance. Capitalized terms used in this Rider that are not defined herein shall have the meanings ascribed to such terms in Your Certificate of Insurance.

In consideration of additional premium by the Policyholder, the following benefit is hereby added to the Group Policy/Certificate.

	<b>PARTICIPATING RETAIL PHARMACY</b> <i>Standard Drugs 30-day supply</i>	<b>PARTICIPATING MAIL ORDER / PREFERRED RETAIL PHARMACY</b> <i>Maintenance Drugs 90-day supply</i>
<b>Tier I</b>	\$10 per Prescription	\$30 per Prescription
<b>Tier II</b>	\$35 per Prescription	\$105 per Prescription
<b>Tier III</b>	\$60 per Prescription	\$180 per Prescription
<b>Tier IV</b>	20% per Prescription	Not Covered
<b>Diabetic Supplies</b>		
Preferred	\$10 per Prescription	\$30 per Prescription
Non-Preferred	\$60 per Prescription	\$180 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. When submitting a claim, You must submit a completed claim form and an itemized prescription receipt from the pharmacy. The receipt must include the National Drug Code for the prescription medication dispensed. Call Customer Service at (800) 829-6440 or visit [www.allegianhealthplans.com](http://www.allegianhealthplans.com) to obtain a claim form for pharmacy reimbursement.

### **WHAT THIS RIDER COVERS**

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

- Medically Necessary Prescription Drugs listed in the AIC PDL.
- Diabetic Medication
- Diabetic Supplies, which include Blood Glucose Monitors, Glucagon Emergency Kits, Biohazard Containers, Test Strips, Lancets and Lancet Devices, Urine Testing Strips, Insulin Syringes, and Injection Aids.
- Compound medications must contain at least one covered Legend Drug.
- Legend Pre-natal vitamins.
- Growth hormone therapy for the treatment of documented growth hormone deficiency in children, under 18 years of age, for which epiphyseal closure has not occurred.

- Formulas necessary for the treatment of Phenylketonuria (PKU) or other Heritable Disease.
- Contraceptive legend drugs.
- Injectable medications recognized by the FDA as appropriate for self-administration (referred to as “Self-Injectable” drugs), regardless of the Insured’s ability to self-administer.

## **LIMITATIONS**

- Certain medications contained in the AIC PDL are subject to dispensing limitations based upon generally accepted medical practice.
- Certain medications contained in the AIC PDL are subject to prior authorization.
- New FDA approved medications (unique chemical entities) will require prior authorization until they have been reviewed by the AHP P&T committee, and their coverage status is determined.
- Medications covered under this Rider are limited to a 30-day supply. Maintenance medications may be filled up to a 90-day supply through a Preferred Participating Retail Pharmacy or Mail Order Pharmacy.
- Prescriptions must be written by a Plan Provider or authorized referral Prescriber 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 a non-Participating Pharmacy are not covered unless authorized for emergency purposes. Refills or new prescriptions must be filled at a Participating Pharmacy.
- Prescriptions will not be refilled until 75% percent of the prescription has been used.
- Medications prescribed for non-FDA approved indications are not covered. This includes experimental and investigational drugs, used to treat, 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 will 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 peerreviewed national medical professional journals and a nationally recognized medical technology evaluation service. The medication must be contained in the AIC PDL.
- One vacation override is allowed each calendar year.

## **WHAT IS NOT COVERED**

- Medications not listed on the PDL.
- 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, not listed on the DCL, or experimental / investigational drugs. Denials for these medications are subject to the Member Complaint and Appeal Procedures outlined in Section 9 of your Evidence of Coverage.
- Any over-the-counter medications.
- Vitamins, minerals, and/or nutritional supplements (regardless of whether or not these are legend or over-the-counter).
- 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, idiopathic non-growth hormone deficiency short stature, and DESI Drugs.
- 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 and adults, are covered when services are pre-authorized.
- 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.
- Any medication covered under Your medical plan, unless determined otherwise by Case Management.
- Any copays or cost differentials do not apply to the Medical Out-of-Pocket Maximum.

### 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 AHP 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.
- If We place a medication on a higher tier during the plan year, you will continue to pay the copayment for the drug at the lower cost tier until Your next plan renewal date.
- If a medication is removed from the PDL during the plan year, it will continue to be covered at the tier copayment the drug was originally listed at, until the next Employer Group's plan renewal date.
- This prescription benefit requires the use of generic equivalent drugs ("required generic"). If the Member receives a name brand drug when a generic equivalent is available, the Member shall pay no more than the generic's copayment plus the difference between the cost of the generic drug and the cost of the name brand drug, even when the prescription is written "dispense as written."
- This prescription benefit uses a single formulary. The formulary is reviewed on a quarterly basis. To determine whether a specific drug is included on the formulary, contact Customer Service.
- Inclusion of a drug on the AIC PDL does not guarantee Your healthcare provider will prescribe this medication.
- We will disclose to a Member on request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary. To determine whether a specific drug is included on the formulary contact Customer Service.

### DEFINITIONS

**Annual** means a 12-month period, coinciding with the calendar year, starting on January 1st and continuing through December 31st. This can also be known as "Calendar Year".

**Brand Name Drug** 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** means a 12-month period beginning with the effective date of coverage for a Group, and each succeeding 12-month period thereafter that the Employer Group Contract is effective.

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

**Copayment** means the amount that will be charged to the Insured Person by the 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, may 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. Refer to formulary for mMedications for chronic conditions that may be filled up to a 90-day supply.

**DESI Drugs:** Any drug targeted in the FDA's Drug Efficacy Study Implementation (DESI) which demonstrates a lack of evidence supporting the drug's efficacy.

**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.

**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.

**Formulary** is a list of covered drugs selected by Allegian Health Plans in consultation with a team of health care professionals that represents the prescription therapies believed to be a necessary part of a value based high quality treatment program.

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

**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.

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

**Maintenance Drug** means medication prescribed for a chronic long term condition and is taken on a regular recurring basis. Conditions that may require maintenance drugs are high blood pressure and diabetes. Refer to formulary for drugs included as maintenance.

**Member** means either the Employee or his eligible Dependents covered under the Plan.

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

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

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

**Phenylketonuria** means an inherited condition that may cause developmental deficiency, seizures, or tumors if not treated.

**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 Health Plan PDL is the list of medications authorized by the AIC Pharmacy and Therapeutics Committee to be dispensed through Participating Pharmacies. The PDL may be revised from time to time.

**Preferred Participating Retail Pharmacy** means a retail pharmacy, providing prescription service for a 90-day supply of maintenance drugs at the Participating Mail Order Pharmacy rate, which has contracted with AHP to provide such services.



## Prescription Drug Rider PL10X000

**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.

**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.

**Standard Drug** means a FDA approved medication that requires a written prescription by a licensed physician.

For more information contact Our Customer Service Department at (800) 829-6440.

**Allegian Insurance Company dba  
Allegian Health Plans  
2005 Ed Carey Drive  
Harlingen, TX 78550  
(956) 389-2273  
(800) 829-6440**