$10/$35/$50 Prescription Drug Plan
$20/$70/$100 Specialty Drug Plan

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Copay</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$10 per prescription, up to 30 day supply</td>
<td>Offer the best value. A generic drug is a safe and effective alternative to a brand name drug. You pay the lowest copay when you choose a generic drug. When your doctor writes your prescription, ask about using a generic drug. Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. The difference? Just the name and price -- and generics cost less. BlueCross BlueShield of Tennessee encourages the use of generic drugs by offering lower copayments when choosing generics.</td>
</tr>
<tr>
<td>Preferred Brand Name Drugs</td>
<td>$35 per prescription, up to 30 day supply</td>
<td>The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs within a therapeutic class. When your doctor prescribes a preferred brand drug, your copay is $35. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.</td>
</tr>
<tr>
<td>Non-preferred Brand Name Drugs</td>
<td>$50 per prescription, up to 30 day supply</td>
<td>When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest copay of $50. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.</td>
</tr>
</tbody>
</table>

The copayment is the amount you pay to a network pharmacy for each prescription you have filled. Your copayment is dependent upon which brand level of drug you choose.

Generic Drugs- your copay is $10
Generic drugs offer the best value. A generic drug is a safe and effective alternative to a brand name drug. You pay the lowest copay when you choose a generic drug. When your doctor writes your prescription, ask about using a generic drug.

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. The difference? Just the name and price -- and generics cost less. BlueCross BlueShield of Tennessee encourages the use of generic drugs by offering lower copayments when choosing generics.

Preferred Brand Drugs- your copay is $35
The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs within a therapeutic class. When your doctor prescribes a preferred brand drug, your copay is $35. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

Non-Preferred Brand Drugs- your copay is $50
When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest copay of $50. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

Pricing at Participating Pharmacies
When a member receives a prescription at a pharmacy, he or she typically pays the appropriate copayment (either generic or brand under a two-tier plan; or generic, preferred brand or non-preferred brand under a three-tier plan). Members pay less than the copayment if the pharmacy's usual price for the drug is less than the copayment.

Choosing a Brand when a Generic Equivalent is Available
You’ll always save money when using generics. In fact, all you pay is the generic copay. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

Limitations
These limitations apply to each prescription order.
Benefits will be provided for
- up to a 30-calendar-day supply of prescription drugs, and/or
- up to a 90-calendar-day supply of prescription drugs obtained through Prescription Home Delivery or the Home Delivery Retail Network.
**Step Therapy**
Step Therapy is a form of Prior Authorization. When Step Therapy is required, You must initially try a drug that has been proven effective for most people with Your condition. This initial drug will be a Covered Generic Drug (if available) or a Preferred Brand Drug.

However, if You have already tried an alternate, less expensive drug and it did not work, or if Your doctor believes that You must take the more expensive drug because of Your medical condition, Your doctor can contact the Plan to request an exception. If the request is approved, the Plan will cover the requested drug.

**Refills**
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.

The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will cover the refill.

**Prescription Home Delivery**
Enjoy the convenience of prescription home delivery. Simply mail a completed form along with the written prescription and payment in one of the envelopes provided or visit the pharmacy section at [www.bcbst.com](http://www.bcbst.com) for other helpful ways to have your prescriptions delivered to your home or another preferred address.

**Home Delivery Retail Network**
Another convenient way to obtain up to a 90-calendar-day supply of drugs is through the Home Delivery Retail network. The Home Delivery Retail Network is a network of retail pharmacies that are permitted to dispense prescription drugs to BlueCross BlueShield of Tennessee members on the same terms as pharmacies in the Home Delivery Network. A directory of the participating Home Delivery Retail Network is available online at [www.bcbst.com](http://www.bcbst.com).

**Out-of-Network Pharmacies**
If a prescription is filled at an out-of-network pharmacy, you must pay all costs. A claim can then be submitted to BlueCross BlueShield of Tennessee. Reimbursement is based on the BlueCross BlueShield of Tennessee allowed charge, less any applicable copay, deductible or coinsurance amount.

**A Broad Network of Retail Pharmacies**
BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. Your pharmacy network provides tremendous accessibility in Tennessee as well as nationally. A directory of participating pharmacies is available online at [www.bcbst.com](http://www.bcbst.com). Click on Find a Pharmacy, and enter the pharmacy network code that appears in the bottom center of your BlueCross BlueShield of Tennessee ID card. This code will start with RX (RX04, for example).

**Self-Administered Specialty Pharmacy Network and Coverage**
You have a separate network for Specialty Drugs: the Specialty Pharmacy Network. You receive the highest level of benefits when you use a Specialty Pharmacy Network provider for your self-administered Specialty Drugs. **Accredo Health Group, Caremark Specialty Pharmacy Services, CuraScript, Inc., and Walgreens Specialty Pharmacy** are experienced in managing high-cost drugs and providing patient support for complex conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.
You may purchase self-administered Specialty Drugs from a retail pharmacy, but your copay will be higher. When purchasing self-administered Specialty Drugs from an Out-of-Network Pharmacy, you must pay all expenses and file a claim for reimbursement with us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.

Please refer to the Specialty Drug List to see which drugs are covered as self-administered specialty Drugs. Go to www.bcbst.com/Pharmacy.

Specialty Drugs are limited to a **30-day supply** per Prescription.

<table>
<thead>
<tr>
<th></th>
<th>Specialty Pharmacy Network</th>
<th>Other Network Pharmacies</th>
<th>Out-of-Network Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Self-Administered Specialty Drug, as indicated on Our Specialty Drug list.</td>
<td>$100 Drug Copayment per Prescription</td>
<td>$200 Drug Copayment per Prescription</td>
<td>You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.</td>
</tr>
<tr>
<td>A Generic Drug that is also a Self-Administered Specialty Drug, as indicated on Our Specialty Drug list.</td>
<td>$20 Drug Copayment per Prescription</td>
<td>$40 Drug Copayment per Prescription</td>
<td>You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.</td>
</tr>
<tr>
<td>A Preferred Brand Drug that is also a Self-Administered Specialty Drug, as indicated on Our Specialty Drug list.</td>
<td>$70 Drug Copayment per Prescription</td>
<td>$140 Drug Copayment per Prescription</td>
<td>You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.</td>
</tr>
</tbody>
</table>

(Please refer to Your EOC for information on benefits for provider-administered Specialty Drugs, which are covered as a Medical benefit.)
Need More Information?
For more information on prescription drug coverage or our pharmacy programs call 1-800-565-9140. You can also visit the pharmacy section at www.bcbst.com.

Benefits will not be provided for:

- drugs for the treatment of onychomycosis (e.g., nail fungus), except for: 1) diabetics; or 2) immuno-compromised patients.
- growth hormones, except for: 1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; 2) patients with “Turner” syndrome; and 3) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- prescription and non-prescription medical supplies, devices and appliances, except for 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 are not Covered, except for blood products required by hemophiliacs.
- injectable drugs, unless: 1) intended for self-administration; or 2) defined by the Plan;
- drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs which exceeds that specified by the Plan’s P & T Committee;
- any Prescription Drug purchased outside the United States, except those authorized by Us;
- any Prescription dispensed by or through a non-retail internet Pharmacy;
- contraceptives which require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- 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;
- allergen extracts;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are 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);
- nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- all newly FDA approved drugs prior to review by the Plan’s P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;
- 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. Vaniqua); and 5) fade cream products;
- any Prescription Drug for which there is an over-the-counter (OTC) equivalent in both dosage and strength, except for insulin;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs;
- Provider-administered Specialty Drugs, as indicated on Our Specialty Drug list; 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 this Rider or the EOC

These exclusions only apply to this Rider. Items that are excluded under the Rider may be Covered as medical supplies under the EOC. Please review your EOC carefully.