



## Coventry Health Care of Georgia, Inc. Coventry Health and Life Insurance Company

### PRESCRIPTION DRUG RIDER

This Prescription Drug Rider is an attachment to the Coventry Health Care of Georgia, Inc. ("Health Plan") Certificate of Coverage or the Coventry Health and Life Insurance Company ("Health Plan") Certificate of Insurance.

#### SECTION 1 – PRESCRIPTION DRUG BENEFITS

Subject to the benefit information, limitations, exclusions, Copayments and Coinsurance described below, outpatient Prescription Drugs will be covered when:

- written by a Prescribing Provider, and
- filled at a pharmacy, including a mail order pharmacy, designated by the Health Plan (except for Emergency or Urgent Care Services, out of the service area).

**COPAYMENTS:** Your Copayment for up to a 31 day supply of Prescription Drugs *other than* Self-Administered Injectable Drugs is:

- \$3 for Tier 1A Prescription Drugs
- \$15 for Tier 1 Prescription Drugs
- \$35 for Tier 2 Prescription Drugs
- \$65 for Tier 3 Prescription Drugs

Your coinsurance for Self-Administered Injectable or Specialty Pharmacy Tier 4 Prescription Drugs is:

- 10% Coinsurance, up to a \$2,500 Annual Out-of-Pocket Rider maximum

Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order Copayment for a 93 day supply. Your Mail Order Copayment for a 93 day supply of Prescription Drugs is:

- 2x the copayment for Tier 1 or Tier 1A Prescription Drugs
- 2.5 the copayment for Tier 2 Prescription Drugs
- 3x the copayment for Tier 3 Prescription Drugs
- Mail order is not available for Tier 4 Prescription Drugs
- Mail order is not available for Specialty Medications

The following rules also apply:

- One (1) Copayment is due each time a prescription is filled or refilled up to a 31 day supply or the lesser of:
  - (1) Tablets/capsules: 100 (or as defined by a specific quantity limit); or
  - (2) Oral liquids: 480cc (or as defined by a specific quantity limit); or
  - (3) One (1) commercially prepared container (e.g., inhaler, topicals and vials);
  - (4) Insulin and diabetic supplies needed for 31 days.
- The mail order Prescription Drug benefit is available through a mail order pharmacy designated by the Health Plan and/or certain Participating retail pharmacies. Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order Copayment for a ninety-three (93) day supply. Please note that not all Participating pharmacies provide this benefit. Please call Customer Service at 1-800-395-2545 for information on mail order pharmacies.

- Specialty Medications will only be available through Specialty Providers designated by the Health Plan.
- If a Tier 2 Prescription Drug is dispensed, and a Therapeutically Equivalent Tier 1 or Tier 1A Prescription Drug is available, You must pay the Tier 3 Prescription Drug Copayment.
- If a Tier 3 Prescription Drug is dispensed, and a Therapeutically Equivalent Tier 1 or Tier 1A Prescription Drug is available, You must pay the Tier 3 Prescription Drug Copayment.
- Coverage is subject to drug utilization guidelines including quantity limits and/or Prior Authorization. If a drug requires Prior Authorization or exceeds a specific quantity limit, the Prescribing Provider must contact the Health Plan *before* a prescription is filled or refilled. Please see Section 2 for more information.
- Payment for covered Prescription Drugs is limited to the contracted amount the Health Plan would normally pay, less the Member's applicable Copayment and/or Deductible.
- Payments You make for covered benefits under this Rider do not count toward the Deductible or Out-of-Pocket Maximum under the Health Plan. The Health Plan Deductible and Out-of-Pocket Maximum amounts are listed in Your Schedule of Benefits.
- You have the right to appeal any decision made by the Health Plan. You may obtain information on how to file an appeal by visiting our website at [www.chcga.com](http://www.chcga.com) or calling Customer Service at 1-800-395-2545.

## SECTION 2 – BENEFIT INFORMATION

**Formulary Information.** Members and prospective Members are entitled to a copy of the Health Plan's Formulary upon request. You may obtain a copy by visiting our website at [www.chcga.com](http://www.chcga.com), or by calling Customer Service at 1-800-395-2545.

The Health Plan may modify the Formulary only for the following reasons:

- To add new drugs, including generics, as they become available.
- To remove drugs that have been withdrawn from the marketplace, based on FDA guidance or the manufacturer's decision.
- To re-classify drugs to non-Formulary status when Therapeutically Equivalent drugs are available, including over the counter drugs.
- To re-classify drugs from Formulary to non-Formulary, or vice versa. All drug reclassifications are overseen by the Health Plan's Pharmacy and Therapeutics Committee. These changes may occur only in the following situations:
  - Ø Clinical studies provide additional or new evidence that can either benefit the patient's outcome or that identifies potential harm to the patient;
  - Ø When multiple Similar Drugs are available, such as other drugs within a specific drug class (for example anti-inflammatory drugs, anti-depressants or corticosteroid asthma inhalers);
  - Ø When a brand name drug loses its patent and its generic is available; or
  - Ø When a brand name drug is available over the counter.

When drugs are changed to non-Formulary status, We will notify You in writing at least 30 days prior to the effective date of the change, if You have had a prescription for that particular drug within the previous 12 months of coverage under Your Rider.

**Quantity Limits.** Some Prescription Drugs are subject to quantity limits and are on the Health Plan's Quantity Limit List. Quantity limits are set on medications for different reasons. Many commonly used once daily drugs have limits since these drugs are proven to be safe and effective when taken once daily. Secondly, the different strengths of many of these drugs cost the same amount of money. Because of these two facts, taking two pills daily instead of one doubles the cost of therapy without necessarily improving the benefit. Other drugs are on the Quantity Limit List as a safeguard to make sure that

members do not receive a prescription for a quantity that exceeds recommended limits. Limits are set because some medications have either a maximum limit recommended by the FDA or a maximum dose.

Quantity limits are reviewed and determined by clinical staff, pharmacy directors, and/or the Health Plan's Pharmacy and Therapeutics Committee. The quantity limits are based on FDA approved dosing schedules and the medical literature related to the particular drug.

Your Physician should contact the Health Plan to request approval of an exception to a particular quantity limit.

To obtain a copy of the Quantity Limit List, please visit our website at [www.chcga.com](http://www.chcga.com) or call Customer Service at 1-800-395-2545.

**Prior Authorization Process.** Some Prescription Drugs require Prior Authorization for Medical Necessity. If Prior Authorization is not obtained, then the drug will not be covered. To determine if a drug requires Prior Authorization, please call Customer Service at 1-800-395-2545.

#### **Value Formulary ("Tier 0") Copay Waiver Program.**

Value Formulary or Tier 0 Drugs are offered at no Copayment on a temporary basis to qualified Members. Qualified Members are those that meet the "Plan Criteria" applicable to each Tier 0 Drug, as designated by Us to promote effective and efficient drug therapy. Members who are on or have recently received certain Prescription Drugs, or who receive a new Prescription Order for certain Prescription Drugs, as designated by Us, may qualify for Tier 0 Benefit coverage.

Tier 0 Drugs and their Plan Criteria are listed in the formulary addendum, Value Formulary Tier 0 Drugs, found on Our website at [www.chcga.com](http://www.chcga.com). Members can also call Member Services at the telephone number on the back of their ID card to get a current listing of the Value Formulary Tier 0 Drugs. **The Value Formulary Tier 0 Drugs formulary addendum may change from time to time without prior notice.**

**Please note, just because a Member fills a Prescription Order or Refill for a Tier 0 Drug, does not qualify him/her for the Tier 0 Copayment.** Rather, only Members that meet Plan Criteria will receive the selected drug at the Tier 0 Copayment. Therefore, there may be instances where a drug is on Tier 0 and on Tier 1 or Tier 2. If a member does not satisfy the Tier 0 criteria, the drug shall be subject to a Tier 1 or Tier 2 Copayment, as applicable. Refer to the current formulary addendum, Value Formulary Tier 0 Drugs, for Plan Criteria.

**Disease Management Program or Case Management Program:** If you are enrolled in our Disease Management program or our Case Management program you could be eligible for reduced or \$0 copays for some of your prescriptions in specific situations.

## **SECTION 3 – EXCLUSIONS**

The following are ***Excluded***:

1. Prescription Drugs related to a non-Covered Service;
2. Experimental products, including those labeled "Caution – Limited by Federal Law to Investigational use," and products found by the FDA to be ineffective unless the conditions listed under the next bullet are met;
3. Products not approved by the FDA, medications with no FDA approved indications, and DESI Drugs except when both of the following conditions are met: (1) the drug is recognized for treatment of the indication in at least one standard reference compendium; and (2) the drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in peer reviewed professional medical journal published in either the United States or Great Britain;
4. Prescription Drugs for a use unrelated to an approved FDA indication or for a non-approved FDA indication, except when all of the following criteria are demonstrated by the Prescribing Provider: (1) the Prescription Drug has been approved by the FDA; and (2) the Prescription Drug is prescribed for the treatment of a life threatening disease or condition, a chronic and seriously debilitating disease or condition, or a disease or condition in a child where the drug has been approved by the FDA for similar conditions in adults; and (3) the Prescription Drug has been recognized for such treatment in (2) above by one or more of the following: the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information; the US Pharmacopoeia Dispensing Information, Vol. 1, or two articles from major peer reviewed medical journals that present data supporting the off-label use as generally safe and

effective unless there is clear and convincing evidence presented in a major peer reviewed journal;

5. Any Prescription Drug which is to be administered, in whole or in part, while a Member is in a Hospital, medical office or other health care facility or correctional facility;
6. Compounded prescriptions whose only ingredients do not require a prescription or whose major ingredients are not FDA approved for the treatment of the indication;
7. Legend drugs for which there is non-Prescription Drug equivalent;
8. Vitamins and minerals, both over-the-counter and legend, except legend prenatal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium;
9. Injectable medications, except those designated by the Health Plan and the Self-Administered Injectable Drugs defined in this rider;
10. Over-the-counter products not requiring a prescription to be dispensed (e.g., aspirin, antacids, oxygen, cosmetics, health and beauty aids, medicated soaps, food supplements, and bandages);
11. Prescription contraceptives not approved by the FDA and nonprescription contraceptive devices (e.g., condoms, spermicidal agents, etc.);
12. Nicorette gum, smoking cessation skin patches and other smoking cessation products;
13. Drugs used primarily for hair restoration;
14. Dietary supplements, appetite suppressants, malabsorption agents, and other drugs used to treat obesity or assist in weight reduction or weight gain;
15. Fertility drugs;
16. Medications used for cosmetic purposes;
17. Medications used to enhance athletic performance; and
18. Any Prescription Drug that is being used or abused in a manner that is determined to be contributing to an addiction to a habit-forming substance.
19. The Health Plan reserves the right to include only one manufacturer's product on the Formulary when a Pharmaceutical Alternative is made by two or more different manufacturers. The product that is listed on the Formulary will be covered at the applicable Copayment level. **The Pharmaceutical Alternative not listed on the Formulary will be excluded from coverage.**
20. The Health Plan reserves the right to include only one dosage or form of a drug on the Formulary when a Pharmaceutical Alternative is available in different dosages or forms (i.e., dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product, in the dosage or form that is listed on the Formulary, will be covered at the applicable Copayment level. **The Pharmaceutical Alternative not listed on the Formulary will be excluded from coverage.**
21. Refill of prescriptions resulting from loss or theft.

## SECTION 4 – DEFINITIONS

**Formulary.** A list that sets forth the rules regarding Prescription Drug coverage, which may include but is not limited to:

- (1) Prescription Drugs that are covered under this Rider;
- (2) Prescription Drugs that have quantity limits; and
- (3) Prescription Drugs that require Prior Authorization.

The Formulary is subject to periodic review and modification by the Health Plan, at its sole discretion. If a Member selects a drug that is not listed in the Formulary, that drug may not be covered.

**Mail Order Copayment.** The amount that will be charged to You by the mail order pharmacy to dispense or refill any prescription order or refill. You shall be required to pay the applicable Mail Order Copayment for each prescription order or refill. You are responsible for payment of the Mail Order Copayment directly to the mail order pharmacy at the time of service. The Mail Order Copayment amount is set forth in Section 1.

**Mail Order Drug List.** The list of Prescription Drugs, designated by the Health Plan, which are available through the mail order pharmacy and/or at certain Participating retail pharmacies.

**Pharmaceutical Alternative(s).** Any medication or drug which contains the same active ingredient as a covered Prescription Drug, but has a different chemical structure or different inactive ingredients or is a different dosage form or strength. Different dosage forms and strengths within a product line by a single manufacturer may also be Pharmaceutical Alternatives, as are extended-release products when compared with immediate- or standard-release formulations of the same active ingredient.

**Prescribing Provider.** A doctor of medicine or other health care professional who:

- is duly licensed under the laws of the jurisdiction in which Prescription Drugs are received; and
- may, in the usual course of business, legally prescribe Prescription Drugs.

**Prescription Drug(s).** Any medication or drug which:

- is provided for outpatient administration;
- has been approved by the Food and Drug Administration; and
- under federal or state law, is dispensed pursuant to a prescription order (legend drug).

This definition includes medically appropriate and necessary equipment, supplies and medications used to treat diabetes. A compound substance is considered a Prescription Drug if one or more of the items compounded is a Prescription Drug.

**Self-Administered Injectable Drug(s).** A Specialty Medication that is given by injection under the skin or into the muscle that is commonly and customarily administered by the patient or caregiver in the home setting. Examples of Self-Administered Injectable Drugs include but are not limited to the following: multiple sclerosis agents, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and certain anticoagulant products. Please note that the term "Self-Administered Injectable Drugs" does not apply to injectable diabetes agents (such as insulin and glucagon), bee-sting kits, Imitrex, and injectable contraceptives, methotrexate injection, heparin, Byetta, and Symlin. Some of these drugs may require Prior Authorization.

**Similar Drugs.** Similar Drugs are drugs within the same therapeutic class or type, such as insomnia drugs, oral contraceptives, seizure drugs, anti-inflammatory drugs, anti-depressants or corticosteroid asthma inhalers.

**Specialty Medications.** The group of drugs defined by the Health Plan that are typically high-cost drugs, including but not limited to the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of Specialty Medications are:

- drugs that are used to treat and diagnose rare or complex diseases;
- require close clinical monitoring and management;
- frequently require special handling;
- may have limited access or distribution.
- Except in urgent situations, all Specialty Medications are distributed by a Plan approved Specialty Provider.

**Specialty Providers.** The Health Plan is able to provide Members with certain oral and Self-Administered Injectable Drugs and Specialty Medications only through specific Specialty Providers who have agreed to provide these medications to Health Plan Members. You must call the Customer Service Department at 1-800-395-2545 for instructions on how to obtain these drugs from Specialty Providers.

**Therapeutically Equivalent.** Therapeutically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition. Therapeutically Equivalent determinations are based on industry standards and reviewed by such organizations as the Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services.

**Value Formulary Drugs or Tier 0 Drugs.** The group of medications on the formulary addendum, Value Formulary Tier 0 Drugs, that are available for a limited period of time at no Copayment to Members who meet the plan criteria specified in the

formulary addendum.

**Tier 1A Drugs.** Formulary Generic Drugs are a select list of Tier 1 drugs determined by Us to be available for a reduced Copayment. These drugs are noted as such in the member formulary.

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Chief Executive Officer  
Coventry Health Care of Georgia, Inc.

Vice President  
Coventry Health and Life Insurance Company