

Choice \$3000 - \$3000/100%/60%

SCHEDULE OF BENEFITS - HIGH DEDUCTIBLE HEALTH PLAN

BENEFITS	MEMBER PAYS	
	In Network (IN)	Out of Network (OON)
Annual Deductible	Individual: \$3,000 Family: \$6,000	Individual: \$6,000 Family: \$12,000
Annual Out-of-Pocket Maximum	Individual: N/A Family: N/A	Individual: \$9,000 Family: \$18,000
Lifetime Maximum Benefit (per Member)	Unlimited	Unlimited
<b>PRIMARY CARE PHYSICIAN (PCP) SERVICES - When performed and billed in physician office</b>		
Office Visit	\$30	Ded + 40%
Allergy Testing, Treatment and Injections	\$30	Ded + 40%
Annual Adult Physical	\$30	Ded + 40%
Annual Well-Woman Exam	\$30	Ded + 40%
Cancer Screenings	\$30	Ded + 40%
Chemotherapy and Radiation	\$30	Ded + 40%
Child Wellness Care	\$30	40%
Family Planning	\$30	Ded + 40%
Immunizations, Vaccines and Infusions	\$30	Ded + 40%
Laboratory Services - When specimen is drawn in physician office	\$30	Ded + 40%
Radiology - When test is performed in physician office	\$30	Ded + 40%
<b>SPECIALIST PHYSICIAN SERVICES - When performed and billed in physician office</b>		
Office Visit	Ded + \$50	Ded + 40%
Allergy Testing, Treatment and Injections	Ded + \$50	Ded + 40%
Annual Adult Physical	Ded + \$50	Ded + 40%
Annual Well-Woman Exam	\$30	Ded + 40%
Cancer Screenings	Ded + \$50	Ded + 40%
Chemotherapy and Radiation	Ded + \$50	Ded + 40%
Family Planning	Ded + \$50	Ded + 40%
Immunizations, Vaccines and Infusions	Ded + \$50	Ded + 40%
Laboratory Services - When specimen is drawn in physician office	Ded + \$50	Ded + 40%
Radiology - When test is performed in physician office	Ded + \$50	Ded + 40%
<b>PHYSICIAN SERVICES - When performed and billed in physician office</b>		
MRIs and MRAs	Ded + \$50	Ded + 40%
Nuclear Stress Tests	Ded + \$50	Ded + 40%
<b>INPATIENT HOSPITAL SERVICES</b>		
Inpatient Hospital Care	Deductible	Ded + 40%
Inpatient Rehabilitation Facility	Deductible	Ded + 40%
Physician Services	Deductible	Ded + 40%
<b>MATERNITY SERVICES</b>		
Physician Services - One-time copayment per pregnancy (for In-Network services)	One-Time \$250 Copay	Ded + 40%
Inpatient Maternity Care	Deductible	Ded + 40%
<b>THERAPY SERVICES - OUTPATIENT</b>		
Cardiac Rehabilitation Therapy - Limited to 30 visits annually	Ded + \$50	Ded + 40%
Pulmonary Rehabilitation Therapy - Limited to 30 visits annually	Ded + \$50	Ded + 40%
Physical and Occupational Therapies - Limited to 20 visits annually (combined)	Ded + \$50	Ded + 40%
Speech Therapy - Limited to 20 visits annually	Ded + \$50	Ded + 40%
<b>URGENT AND EMERGENCY SERVICES</b>		
Urgent Care in Urgent Care Facility	Ded + \$75	IN Ded + \$75
Emergency Services - Copay waived if admitted to hospital	Ded + \$150	IN Ded + \$150
Ambulance	Ded + \$150	IN Ded + \$150
<b>OUTPATIENT SERVICES - When performed and billed in outpatient facility</b>		
Mammograms	No Copay, Coins or Ded	Ded + 40%
Advanced Imaging, including:		
-- MRIs and MRAs	Ded + \$50	Ded + 40%
-- CAT Scans	Ded + \$50	Ded + 40%
-- PET Scans	Ded + \$50	Ded + 40%
-- Nuclear Stress Tests	Ded + \$50	Ded + 40%
Ambulatory Surgery	Ded	Ded + 40%
Cancer Screenings	Deductible	Ded + 40%
Chemotherapy and Radiation Services	Deductible	Ded + 40%
Dialysis	Deductible	Ded + 40%
Family Planning	Deductible	Ded + 40%
Laboratory Services - When specimen is drawn in outpatient facility	Deductible	Ded + 40%
Radiology - When test is performed in outpatient facility	Ded + \$50	Ded + 40%
<b>OTHER SERVICES</b>		
Convenience Clinic Care	\$30	\$30
Durable Medical Equipment (DME) - Coinsurance does not apply to Out-of-Pocket Maximum	50%	50%
Orthotics - Coinsurance does not apply to Out-of-Pocket Maximum	50%	50%
Prosthetics - Coinsurance does not apply to Out-of-Pocket Maximum	50%	50%
Home Health Care - Limited to 60 visits annually	Deductible	Ded + 40%
Hospice	Deductible	Ded + 40%
Skilled Nursing Facility - Limited to 60 days annually	Deductible	Ded + 40%
Infertility Services - Limited to \$1,500 annual benefit maximum	No Copay, Coins or Ded	Ded + 40%

This Schedule of Benefits is part of your Certificate of Coverage but does not replace it. Many words are defined elsewhere in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Certificate. A complete list of covered services, exclusions, and limitations can be found in your Certificate of Coverage.

Prior authorization may be required for specific services.

- The applicable Copayment, Deductible and/or Coinsurance applies to every physician office visit.
- OON Deductible and Coinsurance amounts apply to Out-of-Pocket Maximum, *except* for DME, Orthotics and Prosthetics.
- Deductible *must* be satisfied first, before Copays and Coinsurance apply.
- All visit and day limits are counted by combining In-Network and Out-of-Network services.

Important note about Out-of-Network services:

Payment to Out-of-Network providers is based on the Out-of-Network Rate (ONR). The ONR is determined by a percentage of Medicare. Please see your Certificate of Coverage for more information on ONR.



# PRESCRIPTION DRUG RIDER - \$10/\$30/\$60/\$100

This Rider for Prescription Drugs coverage is an amendment to the Coventry Health Care of Georgia, Inc. (Health Plan) Certificate of Coverage.

## ARTICLE 1 - PRESCRIPTION DRUG BENEFITS

Subject to the benefit information, limitations, exclusions, Copayments and Deductible 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).

**PLAN DEDUCTIBLE REQUIREMENTS:** You must pay the Plan Deductible each Benefit Year before You may receive Coverage for:

- Tier 2 Prescription Drugs
- Tier 3 Prescription Drugs
- Tier 4 Self-Administered Injectable Drugs and Specialty Pharmacy Drugs

The Plan Deductible amount is indicated in Your Schedule of Benefits.

Your Copayment for up to a thirty-one (31) day supply of Prescription Drugs *other* than Self-Administered Injectable Drugs and Specialty Pharmacy Drugs is:

- \$10 for Tier 1 Prescription Drugs
- \$30 for Tier 2 Prescription Drugs
- \$60 for Tier 3 Prescription Drugs

Your Copayment for Self-Administered Injectable Drugs and Specialty Pharmacy Drugs is:

- \$100 for Tier 4 Self-Administered Injectable Drugs and Specialty Pharmacy Drugs.

Your Mail Order Copayment for a ninety-three (93) day supply of Prescription Drugs is:

- \$10 for Tier 1 Prescription Drugs
- \$60 for Tier 2 Prescription Drugs
- \$180 for Tier 3 Prescription Drugs
- Mail order is not available for Tier 4 Self-Administered Injectable Drugs and Specialty Pharmacy Drugs

The following also apply:

- One (1) Copayment is due each time a prescription is filled or refilled up to a thirty-one (31) days 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).
- 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.
- If a Tier 2 Prescription Drug is dispensed, and an equivalent Tier 1 Prescription Drug is available, You must pay the Tier 3 Prescription Drug Copayment.
- If a Tier 3 Prescription Drug is dispensed, and an equivalent Tier 1 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.
- 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 Tier 1 Covered benefits under this Rider, at the pharmacy and mail order, do not count toward the Deductible or Out-of-Pocket Maximum under the Plan. Payments made for Tier 2, 3 and 4 prescription drugs do count toward the Deductible or Out-of-Pocket Maximum under the Plan. The 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. Appeals should be directed to the Health Plan.
- There is no coordination of benefits for outpatient Prescription Drugs with other health plans except for Medicare. This means that if You have primary drug coverage with another plan, We do not cover any portion of Your drug coverage under this Rider.

## ARTICLE 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 Therapeutic 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:
  - New clinical studies provide additional or new evidence that can either benefit the patient's outcome or that identifies potential harm to the patient;
  - When multiple Similar Drugs become available, such as other drugs within a specific drug class (for example anti-inflammatory drugs, anti-depressants or corticosteroid asthma inhalers);
  - When a brand name drug loses its patent and its generic becomes available; or
  - When a brand name drug becomes 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.

**Specialty Pharmacy Drugs.** Specialty Pharmacy Drugs are available via mail order and are shipped directly to You or Your Provider. Your treatment plan and specific prescription shall determine where administration of the drug will occur and by whom. In order to better support Your treatment plan, Specialty Pharmacy Drug prescriptions that exceed a 31 day supply may be dispensed in more than one shipment. When this occurs, please note that Your total cost for multiple shipments will not exceed the amount You would have incurred for a single shipment.

Additionally, Your Copayment and/or Coinsurance may be prorated to support the method of distribution and treatment. Please be aware that Your Provider may charge an administration fee for Specialty Pharmacy Drugs, and that amount is separate from the cost of the mail order shipment(s).

You may obtain the list of Specialty Pharmacy Drugs by contacting Customer Service at 1-800-395-2545.



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### ARTICLE 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 (e.g., vitamins);
8. Injectable medications, except those designated by the Health Plan and the Self-Administered Injectable Drugs defined in this rider;
9. 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);
10. Prescription contraceptives not approved by the FDA and nonprescription contraceptive devices (e.g., condoms, spermicidal agents, etc.);
11. Nicorette gum and smoking cessation skin patches;
12. Drugs used primarily for hair restoration;
13. Dietary supplements, appetite suppressants, malabsorption agents, and other drugs used to treat obesity or assist in weight reduction or weight gain;
14. Fertility drugs;
15. Medications used for cosmetic purposes;
16. Medications used to enhance athletic performance; and
17. 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.
18. 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.**
19. 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.**

### ARTICLE 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 Article 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 Prescription Drug 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. Please note that Self-Administered Injectable Drugs administered by a provider or in a provider's office are not Covered. 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. 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 Pharmacy Drugs.** Specialty Pharmacy Drugs are high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Pharmacy Drugs are dispensed by preferred pharmacies designated by the Health Plan in the most common dosage strength and form, and typically cost on average \$500 per month or more. Most Self-Administered Injectable Drugs qualify as Specialty Pharmacy Drugs. Specialty Pharmacy Drugs require Prior Authorization, and often require special handling such as temperature-controlled packaging and expedited delivery. You may obtain the list of Specialty Pharmacy Drugs by contacting Customer Service at 1-800-395-2545.

**Specialty Providers.** The Health Plan is able to provide Members with certain oral and Self-Administered Injectable Drugs and Specialty Pharmacy Drugs 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.

**Therapeutic Equivalent.** Therapeutic Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition. Therapeutic 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.



Chief Executive Officer  
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