

SERFF Tracking Number: CVLA-127013547 State: Arkansas
Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 48338
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: AR Rx Rider and Group Application
Project Name/Number: AR Rx Rider - Group Ap/

Filing at a Glance

Company: Coventry Health and Life Insurance Co.

Product Name: AR Rx Rider and Group Application SERFF Tr Num: CVLA-127013547 State: Arkansas

Application

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- Closed State Tr Num: 48338

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Nancy Bourgeois, Jennifer Leazzo Disposition Date: 03/30/2011

Date Submitted: 03/24/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AR Rx Rider - Group Ap

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 03/30/2011

State Status Changed: 03/30/2011

Created By: Nancy Bourgeois

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Dear Ms. Minor,

We are submitting for your approval a Prescription Drug Rider and a Group Application on behalf of Coventry Health and Life Insurance Company to be used in conjunction with the following Form Numbers:

TNARMS SOB10_CHL (9/2010) approved by the Arkansas Insurance Department on 10/25/10

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Nancy Bourgeois

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TN AR MS-DOMPART-08/2010 approved by the Arkansas Insurance Department on 10/25/10
 TN AR MS Group PPO_COC_10_CHL (9/2010) approved by the Arkansas Insurance Department on 10/25/10

Please do not hesitate to contact me with any issues or questions.

Best regards,
 Nancy G. Bourgeois
 Tel. (504) 834-0840 Ext. 2138

Company and Contact

Filing Contact Information

Alison Dorsey, Regulatory Compliance Analyst abdorsey@cvty.com
 3838 N Causeway Blvd. 504-834-0840 [Phone] 2202 [Ext]
 Suite 3350
 Metairie, LA 70002

Filing Company Information

Coventry Health and Life Insurance Co.	CoCode: 81973	State of Domicile: Delaware
5350 Poplar Ave.	Group Code:	Company Type:
Suite 390	Group Name:	State ID Number:
Memphis, TN 38119	FEIN Number: 75-1296086	
(901) 462-2380 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	Yes
Fee Explanation:	2 forms x \$50.00 = \$100.00. Delaware is our domicile state, and the fee is \$50.00 per form.
Per Company:	No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
1538	\$100.00	03/23/2011

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/30/2011	03/30/2011

SERFF Tracking Number: CVLA-127013547 *State:* Arkansas
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Disposition

Disposition Date: 03/30/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Rev. Rx Rider	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: TN AR MS Group PPO_COC_10_CHL (9/2010)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/30/2011	TN-AR-MS_RX11_CHL	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Rx Rider	Initial			TN-AR-MS Riders Combined- Final and Clean to be filed.pdf
Approved-Closed 03/30/2011	CHTN 00043 (3/11)	Application/ Enrollment Form	Group Application	Initial			recd. 3-23-11 -- CHTN 00043_AppBe nOff.pdf

PRESCRIPTION DRUG RIDER (“Rider”)

This Rider is underwritten and administered by Coventry Health and Life Insurance Company (“CHL”) and made a part of the Group Certificate of Coverage (“COC”) to which it is attached. Accordingly, all definitions, provisions, terms, limitations, exclusions, and conditions of the COC apply to this Rider except to the extent such terms and conditions are explicitly superceded or modified by this Rider.

The additional benefits provided by this Rider become effective on the date that Your Group purchased (“Effective Date”) this supplemental Rider and expires when Group’s Coverage under this Rider terminates.

1. DEFINITIONS

The following definitions apply to this Rider.

- a. Covered Drugs - Prescription Drugs [and Self Administered Injectables] [and Specialty Drugs], which are prescribed by a Participating Physician, included on the then-current Drug Formulary, approved by CHL and not otherwise excluded from Coverage based upon the exclusions listed in the COC and in section 5 of this Rider. Covered Drugs, under this Rider, are those dispensed in generic form, unless a generic equivalent does not exist, or unless the Tier 2 or the Tier 3 benefit is available and is being accessed. Some Covered Drugs may not be authorized as treatment for Your diagnosis. A list of these Covered Drugs can be found on the website along with the criteria for their approval.
- b. Drug Formulary - a listing of specific generic and brand name Prescription Drugs which are approved for use by CHL and which will be dispensed to You through a Participating Pharmacy. This list shall be subject to periodic review and modification by CHL at its discretion.
- c. Experimental Drug(s) - means pharmacological regimes that are:
 - (i) Any drug not approved for use by the United States Food and Drug Administration (“FDA”); any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed medical literature or any drug that is classified as IND (investigational new drug) by the FDA; or
 - (iii) Any health product or service that is subject to Institutional Review Board (IRB) review or approval; or
 - (iv) Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations; or

- (v) Any health product or service that is unproven based on clinical evidence reported by Peer-Reviewed medical literature.
- d. Mail Order - means a 90 day supply through a participating mail order pharmacy.
- e. Monthly Supply - the lesser of:
 - (i) The quantity prescribed in the Prescription Order or Prescription Refill; or
 - (ii) A thirty-one (31) day supply as defined by the Plan; or
 - (iii) The amount necessary to provide a 31 day supply according to the maximum dosage approved by the FDA for the indication for which the drug is prescribed.
 - (iv) Depending on the form and packaging of the product, the following:
 - (a) Tablets/capsules/suppositories - 100
 - (b) Oral liquids - 480 cc;
 - (c) Prepackaged items (i.e., topicals, inhalers, etc.) - 1 unit (i.e., 1 box, 1 tube, 1 inhaler, etc.);
 - (d) [One bottle of insulin;]
 - (e) Any items that are dispensed in the original manufacturer's packaging.
 - (v) An amount as defined by the Plan.
- f. Non-Formulary Drugs - Prescription Drugs that are not subject to an exclusion under the COC or this Rider, and that are not included on the Drug Formulary at the time the Prescription Drug is dispensed by a Participating Pharmacy. Non-Formulary Drugs may include either generic or brand name Prescription Drugs.
- g. Participating Pharmacy - any registered, licensed pharmacy in the State in which it is located that has entered into a written contract with CHL, or on whose behalf a written contract has been made with the Plan to provide services to the Plan's Insured's which is in effect at the time of Services to dispense Prescription Drugs to Members.
- h. Prescription Drug - a drug that is provided for outpatient administration, which has been approved by the Food and Drug Administration for a specific use and which can, under Federal or State law, be dispensed only pursuant to a Prescription Order. A compound substance is considered a Prescription Drug if one or more of the items compounded is a Prescription Drug. This definition includes insulin.
- i. Prescription Order or Refill - the authorization for a Prescription Drug issued by a Participating Physician who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.
- j. Retail - a 31 day supply or less. A Member will be assessed a retail copay for each 31 day or less supply dispensed to a Member.
- k. [Self Administered Injectable – Drugs that as defined by CHL are commonly and customarily administered by the Member and are Covered only when dispensed by

the Specialty Pharmacy or other Pharmacy designated by CHL. Examples of Self-Administered Injectable Drugs include, but are not limited to, the following: multiple sclerosis agents, growth hormones, colony stimulating factors, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents and heparin products. Note: For definition purposes, other injectable drugs that are acquired through the retail pharmacy, injectable diabetes agents (such as insulin and glucagons), bee sting kits, Imitrex and injectable contraceptive are not considered to be Self Administered Injectables.]

- l. [Specialty Drugs – Plan defined, typically high-cost drugs, including the oral, topical, inhaled, and injected routes of administration. Included characteristics of Specialty Medications are:
 - Drugs that are used to treat rare or complex diseases;
 - Require close clinical monitoring and management;
 - Frequently require special handling; and
 - May have limited access or distribution.]
- m. Specialty Pharmacy – a pharmacy designated by the Plan to provide certain medications Covered under the pharmacy benefit, including, but not limited to, [Self Administered Injectable medication] or [Specialty Drugs].
- n. [Transition Rx-Designated pharmacy riders with the Transition Rx program allows new Members within the first 90 days of their effective date a one time fill up to a 30 day supply of certain covered prescription drugs without being subject to the prior authorization, step therapy, and/or once daily quantity limits. Self-administered injectables/Specialty drugs are not included in this program. Members are notified via letter that a transition fill has been obtained, indicating for which drug, and the necessary actions to obtain a refill.]
- o. [Value Formulary drugs are offered at no Insured Responsibility on a **temporary basis** to Insureds that are on or have recently received certain drugs(s) and/or receive a new prescription for certain drug(s), as designated by the Plan to promote effective and efficient use of the Plan drug benefits. These drugs are listed in an addendum to the Formulary, which may be found on the our website at [www.planname.com]. The formulary addendum shall also identify the Plan Criteria applicable to the Value Formulary Drugs. **This formulary addendum may change from time to time without prior notice.** Insureds that appear to meet the Plan criteria for Value Formulary Drugs (as such information is available in Plan’s claims records) will be notified if they qualify for a Value Formulary drug, when such drugs are temporarily added. Please note, just because an Insured fills a prescription for a Value Formulary drug does not qualify him/her to receive such drug at no Insured Responsibility. Rather, only Insureds that meet Plan criteria will receive the selected drug at no Insured Responsibility. If an Insured does not satisfy the Value Formulary drug Plan criteria, the drug shall be subject to its applicable Insured Responsibility]

Note: This Rider applies to outpatient Prescription Drugs only.

2. ELIGIBLE CHARGES/DRUG BENEFIT COVERAGE

2.1 Tier 1

You are entitled to obtain Coverage for Covered Drugs as listed in the Drug Formulary in the quantities specified below from a Participating Pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:
[0-50%] or [\$0 - \$50] Per generic Covered Drug]

[Tier 2

You are entitled to obtain Coverage for formulary drugs in the quantities specified below from a Participating Pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:
[0-50%] or [\$0-\$100]] Per brand name Covered Drug]

[Tier 3

You are entitled to obtain Coverage for non-formulary drugs in the quantities specified below from a Participating Pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:
[0-50%] or [\$0-\$100] Per Non-Formulary Drug]

[Tier 4

You are entitled to obtain Coverage for [preferred] Specialty Drugs in the quantities specified below from a pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:
[0-50%] or [\$0-\$500] Per Specialty Drug

[Benefit limited to [\$2,000-unlimited.]] or [Maximum per individual prescription]

[Tier 5

You are entitled to obtain Coverage for non-preferred Specialty Drugs in the quantities specified below from a pharmacy upon payment of the applicable Copayment [and Deductible].

Copayment:
[0-50%] or [\$0-\$500] Per Specialty Drug

[Benefit limited to [\$2,000-unlimited.]] or [Maximum per individual prescription] **Tier 0** Value Formulary or Tier 0 Drugs are offered at no Copayment on a **temporary** basis to Members that are on or have recently received **certain drug(s) and/or receive a new prescription for certain drug(s), as designated by the Plan (“Plan Criteria”)** to promote effective and efficient use of the Plan drug benefits. These drugs are listed in an addendum to the formulary, found on the Plan’s website. The formulary addendum shall also identify the Plan Criteria applicable to the Value Formulary Drugs. **The formulary addendum may change from time to time without prior notice.** Members that appear to meet the Plan Criteria for Value Formulary Drugs (as such information is available in Plan’s claims records) will be notified if they qualify for a Value Formulary Drug, when such drugs are temporarily added. Please note, just because a Member fills a prescription for a Value Formulary Drug does not qualify him/her for the Value Formulary Drug Copayment. Rather, only Members that meet Plan Criteria will receive the selected drug at Value Formulary Drug Copayment. Therefore, there may be instances where a drug is a Value Formulary Drug and on Tier 1 or Tier 2. If a Member does not satisfy the Value Formulary Drug Plan Criteria, the drug shall be subject to a Tier 1 or Tier 2 Copayment, as applicable.

[Deductible

An annual Deductible, which applies to Tiers [1, 2, 3, 4, 5] must be satisfied each [Contract] [Calendar] Year before a Member may receive coverage for Prescription Drugs under this Rider.

The annual Deductible for an individual plan is \$[50-3000].

The annual Deductible for a family plan is [two times (2x); three times (3x)] the individual Deductible. The Deductible for a two (2) person family will always be two (2) times the individual Deductible.]

[Deductible for QHDHP – The medical Deductible must be satisfied before Pharmacy benefits apply. See Your Schedule of Benefits for Individual and/or Family Deductible amounts.]

2.2 Quantity

- A. The quantity of a Covered Drug dispensed upon payment of a single Copayment shall be limited to a Monthly Supply as defined in Section 1(d).
- B. The Coverage for a Covered Drug or Prescription Drug dispensed pursuant to a Prescription Order on a monthly basis cannot exceed an amount sufficient to provide for a thirty-one (31) day supply.

2.3 Generic Substitution

[When a generic is available and substitution is required, but the pharmacy dispenses the brand name drug for any reason, the Member is to pay the cost difference between CHL’s

contracted price for the brand name drug and CHL's maximum allowed cost for the generic drug in addition to the Tier 2 Copayment]; [or]

[When a generic is available and substitution is required, but the pharmacy dispenses the brand name drug for any reason, the Member is to pay the cost difference between CHL's contracted price for the brand name drug and CHL's maximum allowed cost for the generic drug in addition to the Tier 1 Copayment]; [or]

[When a generic is available, but the pharmacy dispenses the brand name drug for any reason, the Member is not required to pay any additional amount beyond the Tier 3 Copayment]; [or]

[When a generic is available, but the pharmacy dispenses the brand name drug for any reason, the Member is not required to pay any additional amount beyond the Tier 2 Copayment]; [or]

[When a generic is available, but the pharmacy dispenses the brand name drug for any reason other than the doctor specifies substitution with the generic is not allowed, the Member is to pay the difference between CHL's contract price for the brand name drug and CHL's maximum allowed cost for the generic drug in addition to the Tier 2 Copayment]

2.4 Limitations

- 1) [Written proof of loss (i.e. cancelled check, credit card statement, receipt) and a completed claim form must be submitted to the Plan within ninety (90) days of the date of the loss. Failure to furnish such proof within the ninety (90) days shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within the ninety (90) days, provided such proof is furnished as soon as is reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the time proof is otherwise required.]
- 2) [The Plan reserves the right to include only one manufacturer's product on our Drug Formulary when the same drug (i.e., a drug with the same active ingredient) is made by two or more different manufacturers. The product that is listed on the Drug Formulary will be Covered at the applicable Copayment. The product or products of the same drug not listed on the Drug Formulary will be excluded from Coverage.]
- 3) [The Plan reserves the right to include only one dosage or form of a drug on our Drug Formulary when the same drug (i.e., a drug with the same active ingredient) 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 Drug Formulary will be Covered at the applicable Copayment. The product or products, in different forms or dosages, not listed on the Drug Formulary will be excluded from coverage.]

- 4) [The plan reserves the right to exclude coverage for drugs that do not have a Prior Authorization, Step Therapy or Quantity Limit when utilization review is exceeded.]
- 5) [In order to receive this benefit, You must present Your CHL ID card at the time the prescription is filled. Prescriptions filled at Participating Pharmacies must be submitted through the online claims adjudication process. The pharmacy will then charge You the applicable Copayment or Deductible amount up to the cost of the drug. CHL will not reimburse Members who fail to follow this procedure.]
- 6) [CHL does not coordinate benefits with other carriers for services and supplies offered under the Prescription Drug Rider.]
- 7) [If You have pharmacy coverage under more than one insurance plan and CHL is secondary to the other plan (see your COC to determine who is primary), CHL will coordinate benefits and pay Your Copayment or Deductible from the primary plan up to the amount CHL would have paid if it were the primary insurance company. You must use your primary insurance when you have the prescription filled. For CHL to pay secondary, You must use a CHL Participating Pharmacy and the items must be Covered by CHL based on the benefits purchased by Your employer. (Your primary insurance plan's mail order provider is usually not a CHL Participating Provider and therefore Your Member responsibility would not be Covered by CHL.) The pharmacy will not submit Your Member responsibility for You, so after You have received Your prescription and paid You primary coverage Copayment or Deductible, submit the pharmacy bill to CHL for reimbursement.]

3. [Specialty Drugs] [and] [Self-Administered Injectables]

[Specialty Drugs] or [Self-Administered Injectable Drugs] are Covered under this Rider in the amounts described below when they are:

- 1) Ordered by a prescriber for use by a Member; and
- 2) Not limited or excluded elsewhere in this Rider or Your COC; and
- 3) Obtained from a Specialty Pharmacy; and
- 4) Prior Authorized [;and]
- 5) [Listed on Our Formulary]

[Generic drugs will always be substituted when a generic Prescription Drug is available. If you choose to receive a brand name Prescription Drug when a generic Prescription Drug is available, You will be responsible for the difference in cost between the brand and generic plus the Tier [2, 3, 4, or 5] Copayment.]

Filling Your Prescription Order or Refill. [Specialty Drugs] or [Self-Administered Injectable Drugs] are NOT available through the Mail Order Pharmacy program or at Participating Retail Pharmacies. You must fill Your Prescription Order or Refill for [Specialty Drugs] or [Self-Administered Injectable Drugs] through the Specialty Pharmacy.

Depending on the Rider purchased, You may pay the following to a Specialty Pharmacy, as applicable:

- 1) Prescription Drug Deductibles;

- 2) The difference in cost between the brand and generic plus the Tier 2 or Tier 3 Copayment;
- 3) Amounts above the annual maximum; and
- 4) One (1) Self-Administered Injectable Drug Copayment per Prescription Order or Refill.

General Quantity Limits. In general, the quantity of a [Specialty Drug] or [Self-Administered Injectable Drug] dispensed by a Specialty Pharmacy for each Prescription Order or Refill is limited to the lesser of:

- 1) The amount prescribed in the Prescription Order or Refill; or
- 2) The amount determined by the Plan to be Medically Necessary; or
- 3) The amount determined by the Plan to be a thirty-one (31) day supply.

4. MAINTENANCE DRUG PROGRAM

- A. Preferred Copayment Method. The Coverage for a Covered Drug or Prescription Drug dispensed for the purpose of maintenance from either CHL's designated mail order provider or through a maintenance pharmacy contracted to provide a ninety (90) day supply subject to the quantity limits in Section 1(d), Monthly Supply, at the preferred rate upon payment of [1-3] Copayments shall be an amount sufficient to provide for no more than a three (3) month supply. Notwithstanding the foregoing, Prescription Drugs that require close monitoring, Prescription Drugs that are considered controlled substances by federal or state law, or as otherwise determined by CHL may not be ordered through CHL's mail order provider.
- B. Notwithstanding the foregoing, CHL may provide Coverage for any drug dispensed in the original manufacturer packaging which contains a 90 day or 12 week supply or that has a duration of action of 12 weeks or longer upon payment of three (3) Copayments including but not limited to Depo-provera and Seasonale.

5. DISCOUNTS AND REBATES

Member understands and agrees that CHL may receive a retrospective discount or rebate from a Network Provider or vendor related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by Health Plan and its affiliates. Member shall not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered, in the aggregate, in CHL's prospective premium calculations.

6. EXCLUSIONS

The cost of the following drugs is specifically excluded from this benefit provided by this Rider and is not Covered, *even* if prescribed by a Participating Physician and dispensed at a Participating Pharmacy:

- a) Devices or supplies of any type, even though such devices may require a Prescription Order, including, but not limited to, therapeutic devices, artificial appliances, non-disposable hypodermic needles, syringes including pre-filled insulin syringes or devices used to assist in insulin injection (except disposable syringes [, glucose strips, lancets, glucose monitor,] or any other medically necessary, FDA approved medication [which is listed on the Drug Formulary] for use in the treatment of diabetes), support garments, or other devices, regardless of their intended use, except as specifically listed as a Covered Service in the COC or any applicable rider.
- b) Drugs prescribed and administered in the Physician's office or any other drug Covered under Your COC.
- c) Drugs that do not, by Federal or State law, require a prescription, including over-the-counter (OTC) drugs, or Prescription Drugs with OTC equivalents (e.g., Benadryl 25 mg., etc.), even if prescribed in generic form, unless specifically noted in the Drug Formulary.
- d) Experimental or investigational drugs or drugs prescribed for experimental (non-FDA approved/unlabeled) indications.
- e) Drugs used for athletic performance enhancement (such as anabolic steroids) [, sexual dysfunction,] or primarily for cosmetic purposes, including, but not limited to, drugs prescribed for prevention of wrinkles, onychomycosis or hair loss.
- f) The cost of special packaging required for drugs dispensed in nursing homes.
- g) Injectables other than Self Administered Injectables [and Specialty Drugs] (as defined in this rider and designated by the Plan), Glucagon, insulin, Imitrex and bee sting kits. Refer to your COC for information regarding Coverage of injectables as a medical benefit.
- h) Nicorette (nicotine gum), nicotine patches, Zyban, or other drugs primarily used as part of a smoking cessation program.
- i) Vitamins and minerals (both OTC and prescription), except prescription prenatal vitamins for pregnant/nursing females, and liquid or chewable prescription pediatric vitamins for children.
- j) Refill prescription resulting from loss or theft or resulting damage by the Member.
- k) Dietary supplements, appetite suppressants, and other drugs used to treat obesity or assist in weight reduction and malabsorption agents.
- l) Growth hormones with the exception of those prescribed for a congenital anomaly such as Turner's Syndrome.
- m) Prescription drugs not considered as Covered Drugs or related to a Non-Covered Service.
- n) Prescription Drugs taken for travel including but not limited to, medications devices and supplies for motion sickness or travel-related disease (e.g. Relief bands).

- o) Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.
- p) Oral dental preparations and fluoride rinses except fluoride tablets or drops.
- q) Compounded prescriptions are excluded unless all of the following apply:
 - (i) there is no suitable commercially-available alternative available; and
 - (ii) the main active ingredient is a Covered Prescription Drug; and
 - (iii) the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the prescriber; and
 - (iv) the claim is submitted electronically by a Participating Pharmacy.
- r) Prescription Drugs ordered by a dentist or medications prescribed by an oral surgeon in relation to removal of teeth; or Prescription Drugs for the treatment of a dental condition.
- s) Any Prescription Drug that is being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper; and drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Member identification card, including drugs obtained for use by anyone other than the Member identified on the identification card;
- t) Contraceptive implant systems and intrauterine devices (IUDs);
- u) Drugs obtained from non-participating pharmacies in a non-emergency situation.
- v) [Prescription Drugs for the treatment of infertility.]



APPLICATION FOR BENEFITS OFFERINGS

Incomplete information will delay processing application

Application is hereby made to Coventry Health and Life Insurance Company (CHL) by the Applicant named herein for the purpose of making CHL available to provide access to certain health and other benefits as specified below. CHL's issuance of the Group Enrollment Agreement (GEA) shall be based upon the information contained in this application. The GEA, Certificate of Coverage (COC) and Amendments, Enrollment/Change Form, Applicable Riders, Member Handbook, Provider Directory, and Schedule of Benefits will become the definitive agreement relating to the provision of health benefits during the term and any renewal terms of the GEA.

I. Group Information

Group No.:	Effective Date:	SIC Code:	No. of Total Employees:	No. of Eligible Employees:	No of Employees Applying for Coverage:
Type of Organization:			Federal Tax ID #:		
Company Name:					
Company Address: <small>Street</small>		<small>City</small>		<small>State</small> <small>Zip</small>	
Telephone Number: ()		Fax Number: ()		E-Mail Address:	
Billing Address: <small>Street</small>		<small>City</small>		<small>State</small> <small>Zip</small>	
Prior/Current Health Insurer Carrier (for deductible credit):					
Dates of Coverage:		Annual Deductible:		Administered Per: <input type="checkbox"/> Contract Year <input type="checkbox"/> Calendar Year	
Administrative/Billing Contact:			Decision Maker:		
Covered Subsidiaries:					

Employer Contribution	Employee	Employee & Spouse / Employee & One	Employee & Child(ren)	Family	Sold Rates	Employee	Employee & Spouse / Employee & One	Employee & Child(ren)	Family

II. Eligibility Information

<p>Eligible Employee:</p> <input type="checkbox"/> All Full-Time employees working _____ hours <input type="checkbox"/> Other _____ <p>Employer Termination Date of Coverage:</p> <input type="checkbox"/> Date employment ends <input type="checkbox"/> Last day of the month <p>Dependent Children Coverage Terminates:</p> <input type="checkbox"/> Actual birthdate <input type="checkbox"/> Last day of the month <input type="checkbox"/> End of calendar year	<p>Employee Effective:</p> <input type="checkbox"/> The date of hire <input type="checkbox"/> The first of the month following the date of hire <input type="checkbox"/> The first of the month following 30 days of becoming an eligible employee <input type="checkbox"/> The first of the month following 60 days of becoming an eligible employee <input type="checkbox"/> The first of the month following 90 days of becoming an eligible employee <input type="checkbox"/> The first of the month following 120 days of becoming an eligible employee <input type="checkbox"/> The first of the month following 180 days of becoming an eligible employee <input type="checkbox"/> Other _____
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Extended Layoff Coverage:

 Offer an extension of coverage during layoff
 Not to offer an extension of coverage during layoff

III. Average Number of Eligible Employees (The same number as "total employees" field in Benefit Express) : _____

Example: January 1 through December 31, 2009. This average must include all persons employed by the company in the preceding calendar year, whether an employee was full-time, part-time, and/or seasonal. **Important:** the government requires the total average number, regardless of whether employees were eligible to enroll, and/or participated in the group insurance coverage. Only include temporary employees if they are employees of the company (i.e., employees to whom the employer issues a W-2).

The average in the example below equals the total number of employees for 2009 divided by 12 months (e.g. 411 divided by 12 = 34.)

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average
FT Emp.	20	22	23	24	25	27	25	22	23	21	20	18	270	
PT Emp.	2	2	2	2	3	3	2	2	1	3	3	3	28	
Seasonal	1	1	1	0	0	0	0	0	0	30	40	40	113	
Total	23	25	26	26	28	30	27	24	24	54	63	61	411	34

IV. Benefits Selection

Benefits Selected:

 Medical (Select adjacent product & plan) _____
 Prescription Drug Rider # _____
 Dental Rider # _____
 Life: _____
 Other: _____

V. Claims History (Attach additional sheets if necessary)

The Group certifies that this information is complete and true and to the best knowledge of person signing below and that false statements may be grounds for re-rating or cancellation of coverage. It is a crime to knowingly provide false, incomplete or misleading information to an insurance for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. It is understood that Coventry Health and Life Insurance Company intends to rely on this information for the purpose of rating and premium determination and not for the purpose of engaging in activities or inquiries prohibited by federal or state law(s).

Are there any employees who are not actively performing their duties full-time due to a disabling injury or illness? Yes No If Yes, Please explain:

Are there any employees or dependents who are currently incapacitated, confined in a hospital or treatment facility, being treated for a serious illness or had \$5,000 or more in medical expenses in the past twelve (12) months? Yes No If Yes, Please explain:

Are there any employees or dependents on COBRA continuation? Yes No If Yes, Please explain:

VI. Broker Information

Broker/Consultant Name:	Agency:
Broker/Consultant Signature:	Date:

DO NOT CANCEL EXISTING GROUP INSURANCE UNTIL YOU HAVE BEEN NOTIFIED OF YOUR GROUP'S ACCEPTANCE BY CHL.
 No rates shall go into effect until final rates have been determined and accepted.

Company Name:
 Signature of Applicant: _____ Date: _____ Title (Officer of Company): _____
 CHL Representative Signature: _____ Date: _____ CHL Representative Title: _____

VII. Dental Coverage

Employer Contribution	Employee	Employee & Spouse/ Employee & One	Employee & Child(ren)	Family	Sold Rates	Employee	Employee & Spouse/ Employee & One	Employee & Child(ren)	Family

Dental Plan Name: _____ Dental Plan Code: _____ Prior Dental Coverage? Yes No
 Signature of Applicant: _____ Date: _____
 Signature of CHL Representative: _____ Date: _____

SERFF Tracking Number: CVLA-127013547 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Co. State Tracking Number: 48338
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: AR Rx Rider and Group Application
 Project Name/Number: AR Rx Rider - Group Ap/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Please find attached the FLESCHEADING EASE TEST score for the Prescription Drug Rider. Attachment: TN AR MS Rx Rider -- FLESCHEADING EASE TEST CERT..pdf	Approved-Closed	03/30/2011

	Item Status:	Status Date:
Satisfied - Item: Application Comments: This is a new application being submitted under the Form Schedule Tab.	Approved-Closed	03/30/2011

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary Bypass Reason: These forms do not impact PPACA. Comments:	Approved-Closed	03/30/2011

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

2751 Centerville Road, Suite 400
Wilmington, Delaware 19808-1627

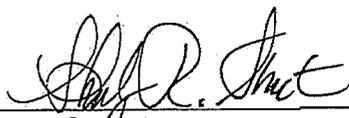
FLESCH READING EASE TEST

This is to certify that the form(s) listed below are in compliance with readability requirements pursuant to Tennessee Code Ann. 56-7-1605 and have a readability score of forty (40) or higher.

The Flesch Test was applied to each form in its entirety, except that any of the following language may have been redacted: name and address of insurer, name or title of policy, table of contents, captions, subcaptions, policy language which was drafted to conform to any applicable law or regulation, any medical terminology or defined terms in the policy.

FORM NUMBER(S)

TN AR MS_RX11_CHL – Prescription Drug Rider (“Rider”)



Secretary

DATE: March 16, 2011