

OUTPATIENT PRESCRIPTION DRUG BENEFIT PLAN

This Outpatient Prescription Drug Benefit Plan (the "Plan") contains detailed information about covered prescription drugs and prescription drugs that are excluded or limited. **Please read this document carefully.** To be eligible for the benefits described herein (to be a "Member"), a person must meet all eligibility requirements of and be enrolled in a plan for medical and hospital benefits designated by the employer. The effective date of prescription drug benefits hereunder shall be the same as the effective date of the designated plan for medical and hospital benefits. The Plan does not under any circumstances make treatment decisions. The Plan only makes administrative decisions about the benefits covered under the Plan for payment purposes.

I. Defined Terms. the terms below have the following meanings:

- A. **"Ancillary Charge"** means a charge in addition to the Copayment which the Member is required to pay to a Participating Pharmacy for a covered Brand-Name Prescription Drug when a Generic substitute is available. The Ancillary Charge is calculated as the difference between the contracted reimbursement rate for Participating Pharmacies for the Brand-Name Prescription Drug and the Generic Prescription Drug.
- B. **"Biological Drugs"** means plasma-derived pharmaceuticals that can be infused to treat chronic bleeding disorders (Factor VIII for hemophilia) or autoimmune diseases (intravenous immunoglobulin or IVIG therapies). These products may be manufactured via recombinant technology or sourced from donated human plasma.
- C. **"Biotechnical Drugs"** means protein-based therapeutics (or biologics), manufactured through genetic engineering.
- D. **"Brand-Name"** means a Prescription Drug which is manufactured and marketed under a trademark or name by a specific drug manufacturer.
- E. **"Copayment"** means the amount of payment indicated in Section II that is due and payable by the Member to the Participating Pharmacy at the time a Prescription Drug is received.
- F. **"Deductible"** when a Deductible applies, the Deductible is the amount a Member must pay for covered Prescription Drugs received in a calendar year before the Plan will pay any amount for covered Prescription Drugs received in that year.
- G. **"Generic"** means a Prescription Drug which is chemically equivalent to a Brand-Name drug whose patent has expired.
- H. **"Medically Necessary"** means outpatient prescription drugs determined by the Plan to be:
 - 1) Necessary to meet the basic health care needs of the Member;
 - 2) Rendered in the most cost-efficient manner, setting, supply or level;

- 3) Of demonstrated medical value and consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury;
 - 4) Appropriate in type, frequency, and duration of treatment with regard to recognized standards of good medical practice; and
 - 5) Not solely for the convenience of the Member or other health care provider.
- I. **“Non-Preferred”** means a Brand-Name Prescription Drug that does not appear on the list of Brand Name Drugs designated as Preferred. Members pay a higher Copayment for Non-Preferred Brand-Name Prescription Drugs than for Preferred Brand-Name Prescription Drugs.
 - J. **“Participating Pharmacy”** means a pharmacy which, at the time of dispensing Prescription Drugs under this rider, is under contract to provide Prescription Drugs to Members. A Participating Pharmacy can either be a retail pharmacy or a mail-order pharmacy service.
 - K. **“Preferred” or “Custom”** means a Prescription Drug that appears on the list of Brand-Name Prescription Drugs designated as Preferred or Custom. This list is subject to periodic review and modification by the Plan or its designee. Members may obtain a copy of this list by contacting the Plan or its designee. Members pay a lower Copayment for Preferred Brand-Name Prescription Drugs than for Non-Preferred Brand-Name Prescription Drugs.
 - L. **“Prescription Drug”** means a medication, product or device approved by the Food and Drug Administration which, under federal law, is required to have the legend: "Caution, federal law prohibits dispensing without a prescription" and which, according to state law, may only be dispensed by prescription. In the case of a medication compounded by the pharmacist, a medication which has at least one ingredient that requires the federal legend or is state restricted in a therapeutic amount. Injectable insulin is considered a Prescription Drug.
 - M. **“Prescription Order or Refill”** means the directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such directive.
 - N. **“Prior Approval”** means the process of obtaining authorization from the Plan or its designee prior to dispensing certain Prescription Drugs. The prescribing physician or Participating Pharmacy obtains Prior Approval from the Plan or its designee for any Prescription Drug which appears on the list of Prescription Drugs requiring Prior Approval. The list of Prescription Drugs requiring Prior Approval and approval criteria are subject to periodic review and modification.
 - O. **“Specialty Pharmaceuticals”** means drugs used in the management of chronic or genetic disorders that are often injectable or infused medications. These medications treat more complex and typically less common conditions and may require complex pharmacy management including the appropriateness of treatment, side effect

management, management of additional medications to aid the main medication, lengthier care evaluations, and disease and medication discussions. Specialty Pharmaceuticals may also require coordination of services such as nursing and self-administration education.

II. Benefits. Subject to the limitations set forth below and payment of the applicable Copayments and Deductibles specified in Attachment A or employer summary of benefits, up to a thirty-one day supply (ninety day supply if mail order service option is available and utilized) of Prescription Drugs will be covered when dispensed by a Participating Pharmacy. To be covered, a Prescription Drug must be Medically Necessary or prescribed to prevent conception. Certain Prescription Drugs require Prior Approval from the Plan or its designee to be covered. Members are responsible for the payment of Copayments, Deductibles, and any Ancillary Charges before the Plan makes payment.

III. Annual Maximum, Coinsurance, Deductible, Copayments and Ancillary Charges.

The benefits payable under this outpatient Prescription Drug rider are limited to the Maximum specified in Attachment A or employer summary of benefits, if any. The Member Copayments and Ancillary Charges described below do not count against the Maximum.

The benefits payable under this outpatient Prescription Drug rider are subject to the Deductible(s) per Calendar Year specified in Attachment A or employer summary of benefits. The Member Copayments and Ancillary Charges described below do not count against the Deductible.

For Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals, a Coinsurance may apply. If so, Coinsurance may be limited to an annual out-of-pocket cost per Member per Calendar Year. Please see Attachment A or employer summary of benefits for a description of Coinsurance levels (if applicable) and any out-of-pocket maximum. A list of these drugs can be found on the VIVA Health website at www.vivahealth.com or by calling Customer Service. These medications are limited to a 31-day supply per prescription.

For other outpatient Prescription Drugs, the Member must pay the applicable Copayment amounts specified in Attachment A or employer summary of benefits per Prescription Order or Refill. The Member must also pay the Ancillary Charge if applicable. The Ancillary Charge applies regardless of the reason a Brand name medication is selected over the Generic. If the Prescription Drug cost is less than the Copayment, the Member pays the Prescription Drug cost.

The Plan may receive rebates for certain Brand-Name Prescription Drugs. The Plan is not required to, and does not, pass on amounts payable to the Plan under rebate or similar programs to Members.

- IV. Generic Substitution.** Brand name drugs which have FDA "A" or "AB" rated Generic equivalents available will be dispensed generically. "A" or "AB" rated Generics are those Generics that are proven to be equivalent to the brand name product. If a physician indicates "Dispense as Written" or if a Member insists on a specific Brand-Name for a Prescription Drug with a Generic equivalent available, the Member must pay an Ancillary Charge equal to the difference between the cost of the Generic equivalent and the cost of the Brand-Name drug, in addition to the applicable Copayment.
- V. Identification Card.** In order for Prescription Drugs to be covered, you must show your Member identification card at the time you obtain your Prescription Drug. If you do not show your Member identification card, you will be required to pay the full cost of the Prescription Drug and may then seek reimbursement from the Plan or its designee for the amount that would have been paid under the Plan. Reimbursement is only available for Prescription Drugs that qualify for benefits as described in Section II and must be requested within one hundred and eighty (180) days from the date of purchase. The request must include the Member's name, address, telephone number, identification number, the pharmacy name, address, and telephone number, the date(s) of purchase, and an itemized receipt.
- VI. Termination of Member's Coverage.** Coverage under the Plan will terminate as follows:
- A. The date the Plan is terminated by the Employer.
 - B. If the Member permits the use of his/her or any other Member's identification card by any other person, or uses another person's card, the card shall be surrendered and coverage of the Member may be terminated. The Member shall be liable to the Plan for all costs incurred by the Plan as a result of the misuse of the identification card.
 - C. If a Member engages or attempts to engage in fraudulent or illegal activity related to coverage hereunder, coverage of the Member may be terminated upon fifteen (15) days written notice by the Plan.
 - D. If a Member commits acts of physical or verbal abuse or harassment which pose a threat to Plan representatives, pharmacy employees, or other Members, coverage of the Member may be terminated upon fifteen (15) days written notice by the Plan.
 - E. If a Member, on behalf of himself or another Member, knowingly causes or allows incorrect or incomplete information to be furnished to the Plan which constitutes a material misrepresentation, then the coverage of the Member who either furnished such information and/or on whose behalf such information was furnished, may be terminated from the Plan on the date specified by the Plan. This includes but is not limited to information relating to another person's eligibility for coverage or status as an eligible dependent. In addition, such Member or Members shall be responsible for all costs incurred under the Plan as a result of the misrepresentation or the Plan may rescind coverage under the Plan back to the Member's effective date.

- F. If a Member fails to pay a required Copayment, Coinsurance, or Deductible, coverage may be terminated upon thirty (30) days written notice by the Plan.
- G. Subject to the eligibility requirements and continuation privileges of the designated plan for medical and hospital benefits in which the Member is enrolled, the coverage of any Member who ceases to be eligible shall terminate as of the date on which eligibility ceased; if the coverage of the covered employee terminates for any reason, then the covered dependents enrolled by the employee will cease to be eligible as of the date of the employee's coverage termination.
- H. If the Employer instructs the Plan to terminate coverage of a Member, coverage will terminate on the date requested in such notice. Services received between the date a Member's coverage is terminated by the Employer and the date the Plan is notified by the Employer of the termination are not Covered Services even when such services have been authorized by the Plan. When employment is terminated, most Employers terminate an employee's coverage and the coverage of any covered dependents on the day of employment termination or on the last day of the month in which employment terminated. In the event employment is terminated, please consult with the Employer to determine when your coverage under this Outpatient Prescription Drug Benefit Plan ends. In no case will coverage extend beyond the last day of the month following the month of employment termination.

The covered employee is responsible for immediately notifying any covered dependents of a coverage termination.

VII. Limitations:

- A. Prescription Drugs will be dispensed in a quantity not to exceed a 31-day supply of medication (90-day supply if mail order option is available and utilized). Some Prescription Drugs may be subject to additional supply limits based on coverage criteria developed by the Plan or its designee. The limit may restrict either the amount dispensed per prescription or the amount dispensed per month's supply. A list of Prescription Drugs subject to quantity limits may be obtained by contacting the Plan or its designee. This list is subject to periodic review and modification by the Plan or its designee.
- B. Medications on the Prior Approval list are not covered unless Prior Approval is obtained by the prescribing physician or pharmacy in accordance with the Plan's established procedures. A complete listing of such Prior Approval drugs can be obtained from the Plan or its designee.
- C. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals, as defined by Plan, require Prior Approval. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals generally must be obtained from Plan's specialized pharmacy provider. These drugs include but are not limited to therapies for

growth hormone, Multiple Sclerosis, Antihemophilic Factors, Hepatitis C, Rheumatoid Arthritis, certain oncology agents, and RSV Disease Prevention. A current list of Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals is available by contacting VIVA Health at the telephone number on your Member identification card and on the VIVA Health website at www.vivahealth.com. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals are subject to the Coinsurance (if applicable) specified in Attachment A or employer summary of benefits. The cost of Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals does not apply to any Annual Maximum benefit limit described in Section III. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals are not covered without Prior Approval.

- D. The Plan reserves the right to limit a Member's selection of Participating Pharmacies or to require a Member to select a single Participating Pharmacy to provide and coordinate all pharmacy services for the Member.
- E. Newly approved Prescription Drugs will be covered only after review and approval by the Plan and subject to exclusion VII.B. below.
- F. The Plan reserves the right to limit coverage of certain Prescription Drugs to a particular form or dosage when it is clinically appropriate and more cost effective to do so. In some instances, this may require individuals to comply with a half-tab or proper-dosing program. Some pills may need to be split or administered more frequently (for example, twice daily dosing versus daily dosing).

VIII. Exclusions. The following items are not covered by this Outpatient Prescription Drug Benefit Plan:

- A. Drugs that do not, by federal law, require a prescription order (for example, over-the-counter drugs, except for insulin).
- B. At the Plan's option, Prescription Drugs approved by the FDA in the current term of the Plan.
- C. Any federal legend drug if an equivalent product is available over-the-counter without a prescription (including Schedule V medications).
- D. Prescriptions written or filled fraudulently, illegally, or for use by someone other than the Member. This is also grounds for termination of coverage and the Member will be financially liable to the Plan for all costs associated with any payment made by the Plan for such prescriptions.
- E. Drugs prescribed by a provider with the same legal residence as the Member or who is a member of Member's family, including spouse, brother, sister, parent, or child.

- F. Drugs prescribed for cosmetic purposes (including, but not limited to, Retin-A for wrinkles, Rogaine for hair loss).
- G. Drugs prescribed for the purpose of weight reduction (including, but not limited to, appetite suppressants, amphetamines).
- H. After costs have reached \$2,000 in the Calendar Year, drugs prescribed for the purpose of treating infertility including but not limited to Clomid, Serophene, Metrodin, and Yocon.
- I. Drugs prescribed for the purpose of terminating pregnancy.
- J. Drugs for the treatment of testosterone deficiency and drugs prescribed for the purpose of improving sexual function.
- K. Therapeutic or testing devices (including, but not limited to, glucometers), appliances, medical supplies, support garments or non-medical substances, regardless of their intended use.
- L. Inspirease and other respiratory assistance apparatus.
- M. Any drug dispensed prior to the effective date of this Plan or after this Plan has been terminated.
- N. Refills in excess of the amount specified by the prescribing physician or any refill dispensed after one (1) year from the order of the prescribing physician.
- O. Drugs labeled "Caution, limited by federal law to investigational use" or otherwise designated as experimental drugs and medications used for clinical trials or experimental indications and/or dosage regimens determined by the Plan or its designee to be experimental.
- P. Prescription Drug therapy necessitated by medical or surgical procedures, treatment, or care that are not covered under the designated plan for medical and hospital benefits in which the Member is enrolled.
- Q. Drugs covered under the Member's plan for medical benefits.
- R. Prescriptions dispensed by a non-Participating Pharmacy.
- S. Prescriptions prescribed by non-Participating Physicians, unless authorized by the Plan.
- T. Replacement Prescription Drugs resulting from lost, stolen, broken, or otherwise destroyed Prescription Order or Refill.

- U. Prescription Drugs furnished or otherwise covered by the local, state, or federal government to the extent of such coverage whether or not payment is actually received except as otherwise provided by law.
- V. General and injectable vitamins, except prenatal vitamins, vitamins with fluoride, and B-12 injections.
- W. Unit dose packaging of Prescription Drugs.
- X. Compound drugs when used for an indication that is not FDA-approved or otherwise recognized for treatment of that indication in a source considered to be a standard reference compendia or in the peer review medical literature.
- Y. Prescription Drugs prescribed for the purpose of preventing disease or illness related to international travel.
- Z. Prescription Drugs for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- AA. Drugs when the Member is participating in a clinical trial unless such drugs would otherwise be covered

IX. Mail Order Service for Maintenance Drugs and Oral Contraceptives:

- A. Maintenance Drugs are those covered Prescription Drugs prescribed for a chronic disease state lasting 90 or more days.
- B. Maintenance Drugs and Oral Contraceptives are available in up to a 90-day supply (if mail order service is covered by this Plan).

X. Coordination of Benefits. Prescription Drug benefits are not eligible for coordination of benefits with any other benefit plan.

XI. Complaint Procedure.

If a Member has a question about the services provided, the Member may call the Plan or its designee. Any problem or dispute related to the Plan must be dealt with through this Complaint Procedure. The Complaint Procedure may be revised from time to time. The Complaint Procedure must be initiated by the Member no later than twelve (12) months after the incident or matter in question occurred. The Complaint Procedure consists of the following levels for review:

- A. **Inquiries.** Most problems can be handled simply by discussing the situation with a representative of the Plan or its designee by phone or in person.
- B. **Informal Complaint.** If the Member's problem cannot be resolved to the Member's satisfaction at the Inquiry level, the Member may file an Informal Complaint. Informal Complaints may be made verbally or in writing. A decision regarding an Informal Complaint and the mailing of a written notice to the Member is completed within 45 days of the receipt date of the Informal Complaint. The written notice includes the outcome of the review of the Informal Complaint. In the case of an adverse outcome (in whole or in part), the Member has a right to a second review by filing a Formal Complaint.
- C. **Formal Complaint.** A Formal Complaint is the subsequent written expression of dissatisfaction by or on behalf of a Member regarding the resolution of an Informal Complaint. A Formal Complaint must be filed within 12 months of the Plan's receipt of the original Informal Complaint. The Plan may allow an extension of the 12-month limit due to extenuating circumstances. Formal Complaints may be submitted by written letter sent to:

Manager of Pharmacy Benefits
1222 14th Avenue South
Birmingham, Alabama 35205

A family member, friend, provider, or any other person may act on behalf of the Member after written notification of authorization is received by the Plan from the Member. Formal Complaints are reviewed by the Formal Complaint Committee. The Member or any other party of interest may provide pertinent data to the Formal Complaint Committee in person or in writing. The Formal Complaint Committee issues its decision within 30 days of the receipt date of the Formal Complaint. The Member is given written notification regarding the Formal Complaint Committee's decision within 5 working days of the decision being made.

XII. Miscellaneous Provisions:

The Plan shall not be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any Prescription Drug, or any other item, whether or not covered hereunder.