PRESCRIPTION DRUG RIDER
OUTPATIENT PRESCRIPTION DRUG BENEFIT PLAN
ADMINISTERED BY VIVA HEALTH ADMINISTRATION, L.L.C.
FOR THE UAB BLUE CROSS AND BLUE SHIELD OF ALABAMA 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:

"Adverse Benefit Determination" means a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit or is a rescission of coverage.

"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. Ancillary Charges do not count toward the Out-of-Pocket Maximum.

"Appeal" means a Complaint regarding an adverse benefit determination.

"Biological Drugs" or **"Biologics"** means drugs derived from living organisms or their components, such as proteins or living cells. Unlike traditional drugs, which are small chemically synthesized molecules, biologics are large complex biological molecules. They are typically administered via injection or infusion and are used to treat a wide variety of disease states from autoimmune disorders to cancer.

"Biosimilar(s)" means a Biologic that is highly similar to an original Biologic, called the reference product, with no clinically meaningful differences in terms of safety and effectiveness. Unlike generics, Biosimilars are similar but not chemically identical to the reference product due to their complex biological nature.

"Brand-Name" means a Prescription Drug which is manufactured and marketed under a trademark or name by a specific drug manufacturer.

"Clinical Trial" means a phase I, phase II, phase III, or phase IV Clinical Trial that is conducted in relation to the prevention, detection, or treatment of an acute, chronic, or life-threatening disease or condition.

"Coinsurance" means, when Coinsurance applies, the charge that the Member is required to pay for certain Covered Services provided under the Plan. Coinsurance is a Copayment that is charged as a percentage of the cost of Covered Services. The Member is responsible for the payment of Coinsurance directly to the provider of the Covered Service. The total amount the Member pays in Coinsurance may be subject to Calendar Year maximum limits if specified in Attachment A, Summary of Benefits.

"Complaint" means a problem or dispute between a Member and VIVA HEALTH or between a Member and a Participating Provider. Complaints may involve non-medical or medical aspects of care as well as terms of this Certificate, including its breach or termination.

1. **"Informal Complaint"** means those issues that are not resolved to the Member's satisfaction at the Inquiry level or for which the Member requests a written response.
2. **"Formal Complaint"** means a subsequent written expression following an Informal Complaint by the Member or on the Member's behalf regarding the resolution of an Informal Complaint.
3. **"Expedited Formal Complaint"** means a verbal or written request by the Member or the provider on the Member's behalf regarding an adverse medical necessity decision when the standard response time could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.

"Complaint Procedure" means the process for resolving problems and disputes set forth in Part XI of this Outpatient Prescription Drug Rider.

"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.

"Cosmetic" refers to prescription drugs and supplies that are non-Medically Necessary and change or improve appearance or self-esteem without significantly improving physiological function. Prescription drugs and supplies that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered Cosmetic.

"Cost Sharing" means the share of costs for Covered Services covered by your Plan that you pay out of your own pocket. This term generally includes Deductibles, Coinsurance, and Copayments, or similar charges, but it does not include premiums, balance billed amounts for non-Participating Providers, or the cost of non-Covered Services.

"Covered Dependent" means a member of the Subscriber's family who meets the eligibility requirements of the Plan and has been enrolled by the Subscriber in accordance with the Plan's terms.

"Covered Service(s)" means those Medically Necessary health services and supplies to which Members are entitled under the terms of this Outpatient Prescription Drug Rider.

"Deductible" when a Deductible applies, the Deductible is the amount a Member must pay for covered Prescription Drugs received in a calendar year before VIVA HEALTH will pay any amount for covered Prescription Drugs received in that year.

"Eligible Employee" means an employee of Employer who is not temporary or non-permanent and who satisfies the Plan's eligibility requirements , including being scheduled to work the minimum number of hours per week specified and completing the new hire waiting period, if any.

"Employer" means the employer or party that has entered into a Group Policy with VIVA HEALTH under which VIVA HEALTH will provide or arrange Covered Services for Eligible Employees.

"Enrollee" means any Subscriber or Covered Dependent. (Also referred to as Member.)

"Excluded" means a Prescription Drug that is not covered by VIVA HEALTH. Members will be responsible for the full cost of Excluded drugs. The most commonly prescribed Excluded drugs appear on the published Formulary designated by VIVA HEALTH as Excluded. Drugs newly approved by the Food & Drug Administration ("FDA") are Excluded but are not yet listed on the Formulary as Excluded. Such newly approved drugs remain Excluded unless and until reviewed and approved by VIVA HEALTH and its designee.

"Experimental" or **"Investigational"** means medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, supplies, treatments, procedures, drugs, or devices that VIVA HEALTH makes a determination are Experimental or Investigational. Determinations of whether a service, supply, treatment, procedure, or device is Experimental or Investigational are made if:

1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
2. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes;
3. it is not of proven benefit for the specific diagnosis or treatment of a Member's particular condition;
4. is not approved for the proposed use by the FDA;
5. it is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of a Member's particular condition; or
6. it is provided or performed in special settings for research purposes.

"Formulary" means the Prescription Drugs that this plan will cover. All Prescription Drugs must be Medically Necessary to be Covered Services and some require Prior Approval. The Formulary is subject to periodic review and modification by VIVA HEALTH or its designee. Members may obtain a copy of the most commonly prescribed drugs on the Formulary by contacting VIVA HEALTH and on the VIVA HEALTH website at www.vivahealth.com. The pharmacy Formulary covered by this prescription drug rider is different from a medical Formulary, which describes the medical coverage that your Employer may have purchased through the medical benefit.

"Generic" means a Prescription Drug which is chemically equivalent to a Brand-Name drug whose patent has expired.

"Group Policy" means the Group Policy and any riders and amendments thereto which constitute the agreement regarding health benefits, exclusions and other conditions between VIVA HEALTH and the Employer.

"Home Health Agency" means an organization licensed by the State which is under contract to render home health services to Members and has been approved as a participating Home Health Agency under the federal Medicare program.

"Hospital" means a legally operated facility defined as an acute care hospital and licensed by the State as such and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or the federal Medicare program.

"Hospital Services" means those acute care services furnished and billed by a Hospital which are authorized by a Participating Physician and set forth as Covered Services.

"Inquiry" means normal business operations conducted verbally or in writing between a Member and VIVA HEALTH. Examples of inquires include requests for ID cards, clarification of benefits and address changes.

"Maintenance Drugs" means those covered Prescription Drugs taken on a regular basis prescribed for a chronic disease state lasting 90 or more days.

"Medically Necessary" means outpatient prescription drugs determined by VIVA HEALTH 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.

"Member" means any Subscriber or Covered Dependent. (Also referred to as Enrollee.)

"Non-Preferred" means a Brand-Name or Generic Prescription Drug that is not designated by VIVA HEALTH's Formulary as Preferred. The Formulary is subject to periodic review and modification by VIVA HEALTH or its designee. Members pay a higher Copayment or more cost-sharing for Non-Preferred Prescription Drugs, regardless of the reason the Non-Preferred medication is selected.

"Out-of-Pocket Maximum" when an Out-of-Pocket Maximum applies, the Out-of-Pocket Maximum is the most a Member will pay in a Calendar Year for Deductibles, Copayments and Coinsurance for qualified Covered Services. If you have a non-calendar plan year, the maximum limit may change during the course of a calendar year. If the limit increases with a new plan year, you may owe Cost Sharing again up to the amount of the increase even if you reached the limit earlier in the Calendar Year.

"Participating Pharmacy" means a pharmacy which, at the time of dispensing Prescription Drugs under this rider, is in your Plan network and under contract to provide Prescription Drugs to Members. A Participating Pharmacy can either be a retail pharmacy or a mail-order pharmacy service.

"Participating Physician" means a Physician who, at the time of providing or authorizing services to a Member, is under contract to provide Professional Services to Members.

"Participating Specialist" means a Participating Physician who, at the time of providing or authorizing services to a Member, practices in a particular medical specialty and is under contract to provide services to Members as a Participating Specialist.

"Participating Provider" or **"Participating"** means a Participating Physician, a Participating Specialist, a Hospital, laboratory, Home Health Agency, or any other duly licensed institution or health professional under contract to provide Professional Services, Hospital Services, or other Covered Services to Members.

"Plan" means the group medical and prescription drug benefit plan which has been established by the Employer and through which benefits are provided.

"Preferred" means a Brand-Name or Generic Prescription Drug that is designated by VIVA HEALTH's Formulary as Preferred. The Formulary is subject to periodic review and modification by VIVA HEALTH or its designee. Members pay a lower Copayment or less cost-sharing for Preferred Prescription Drugs than for Non-Preferred Prescription Drugs.

"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. Injectable insulin is considered a Prescription Drug.

"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.

"Prior Approval" or **"Pre-Service Claim"** means the process of obtaining authorization from VIVA HEALTH or its designee prior to dispensing certain Prescription Drugs. The prescribing physician obtains Prior Approval from VIVA HEALTH or its designee for any Prescription Drug which appears on the list of Prescription Drugs requiring Prior Approval. Prior Approval includes approving the place of service as well as the Prescription Drug. The list of Prescription Drugs requiring Prior Approval and approval criteria are subject to periodic review and modification.

"Specialty Drugs" refers to a category of drugs that are often high cost, require special handling for storage or administration which necessitates dispensing through a specialty pharmacy or administration by a healthcare provider, and treat complex conditions such as cancer or multiple sclerosis that may require specialized clinical management and monitoring. Specialty Drugs include Biological Drugs, also known as biotechnical drugs, and Biosimilars.

"Step-Therapy" means in order to receive benefits for a covered Prescription Drug, the Member may first be required to use and clinically fail the preferred formulary alternatives before progressing ("stepping up") to the potentially higher cost or higher risk prescribed therapy.

"Subscriber" means any Eligible Employee for whom coverage provided by this Plan is in effect.

II. Benefits. Subject to the limitations set forth below and payment of the applicable Copayments and Deductibles specified in the schedule of benefits, up to a 30-day supply (up to a 90-day supply for eligible drugs by mail order or at retail if the Participating Pharmacy offers a 90-day supply) of Prescription Drugs will be covered when dispensed by a Participating Pharmacy. To be covered, a Prescription Drug must be listed on the VIVA HEALTH Formulary and be Medically Necessary. Certain Prescription Drugs require Prior Approval from VIVA HEALTH or its designee to be covered. Members are responsible for the payment of Copayments, Coinsurance (if applicable), Deductibles (if applicable), and any Ancillary Charges before VIVA HEALTH makes payment.

III. Coinsurance, Copayments, Ancillary Charges, and Out-of-Pocket Maximums.

For Specialty Drugs, a Coinsurance may apply. Please see the 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 30-day supply per prescription.

Certain preventive, over-the-counter drugs and Prescription Drugs are covered at 100% with no Copayment, Coinsurance or Deductible from the Member when the Member has a Prescription

Order for the drug, and it is provided by a Participating Provider. These items generally are those recommended by the U.S. Preventive Services Task Force with a grade of A or B; and, with respect to infants, children, adolescents and women, preventive care provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Such item or service may not be covered until the plan year that begins one year after the date the recommendation or guideline is issued. Guidelines and limitations apply. Often only the generic form of the preventive drug is covered at 100%. Recommendations and guidelines for preventive care change from time to time. See "VIVA HEALTH Wellness Benefits" for a detailed list of preventive benefits covered at 100% under this Prescription Drug Rider and the applicable limitations and guidelines. The document is available on the website at www.vivahealth.com or by calling Customer Service.

For other outpatient Prescription Drugs, the Member must pay the applicable Copayment amounts per Prescription Order or Refill. The Member must also pay the Ancillary Charge if applicable. The Ancillary Charge applies regardless of the reason the Brand-Name medication is selected over the Generic except for preventive medication as described in this section, when use of the Brand-Name product instead of the Generic equivalent is Medically Necessary for the provision of the preventive service. If the Prescription Drug cost is less than the Copayment, the Member pays the Prescription Drug cost. Refer to the summary of benefits for Deductible, Coinsurance (if applicable) and Copayment amounts.

If you purchase a drug without authorization and pay out-of-pocket, 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 not guaranteed. 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 Plan may receive rebates for certain Brand-Name Prescription Drugs. Rebates are not considered in the calculation of any Coinsurance or Copayment. 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. If the Brand-Name drug is Excluded, the Member will be responsible for the full cost of the drug.

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 or if you purchase a drug without authorization and pay out-of- pocket, you will be required to pay the full cost of the Prescription Drug and may then seek reimbursement from VIVA HEALTH or its designee for the amount that would have been paid under VIVA HEALTH. Reimbursement is not guaranteed. 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. In the event pharmacy insurance is retroactively implemented, first contact VIVA HEALTH to assist in the adjudication of retroactive pharmacy

claims.

VI. Termination of Member's Coverage. Coverage under VIVA HEALTH will terminate as follows:

A. The date VIVA HEALTH 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 VIVA HEALTH.

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 VIVA HEALTH.

E. If a Member, on behalf of oneself or another Member, or a person seeking coverage on behalf of the Member, knowingly causes or allows incorrect or incomplete information to be furnished to VIVA HEALTH 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 material 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 fraud or material misrepresentation or VIVA HEALTH may rescind coverage under the Plan back to the Member's effective date. VIVA HEALTH will provide the Member with at least 30 days' advance written notice before coverage may be rescinded. The foregoing shall not affect the ability of VIVA HEALTH to cancel or discontinue coverage prospectively or to cancel or discontinue coverage retroactively to the extent it is attributable to a failure to timely pay the required premiums or contributions toward the cost of coverage.

F. If a Member fails to pay a required Copayment, Coinsurance, or Deductible, coverage may be terminated upon thirty (30) days written notice by VIVA HEALTH.

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 VIVA HEALTH 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 VIVA HEALTH is notified by the Employer of the termination are not Covered Services even when such services have been authorized by VIVA HEALTH. 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 30-day supply of medication or not to exceed a 90-day supply for eligible drugs by mail order (or at retail if the Participating Pharmacy offers up to a 90-day supply). A month's supply is as written by the provider, up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Some Prescription Drugs may be subject to additional supply limits based on coverage criteria developed by VIVA HEALTH 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 VIVA HEALTH or its designee. This list is subject to periodic review and modification by VIVA HEALTH 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 VIVA HEALTH's established procedures. A complete listing of such Prior Approval drugs can be obtained from VIVA HEALTH or its designee.

C. Specialty Drugs, as defined by VIVA HEALTH, may require Prior Approval. Specialty Drugs generally must be obtained from Plan's specialized pharmacy provider. These drugs treat complex conditions such as cancer or multiple sclerosis that may require specialized clinical management and monitoring. A current list of Specialty Drugs 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. Select specialty infusion drugs that can be provided in the home or physician's office will only be approved in those settings unless another care setting (e.g., an outpatient facility) is medically necessary and approved by VIVA HEALTH in advance. Specialty Drugs are subject to the Cost Sharing (if applicable) specified in the schedule of benefits. Most Specialty Drugs are not covered without Prior Approval.

D. VIVA HEALTH 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. VIVA HEALTH's Formulary is subject to periodic review and modification by VIVA HEALTH or its designee. For example, a Brand-Name drug for which a Generic becomes available may change designations to Non-Preferred or Excluded. Prescription Drugs newly approved by the FDA are subject to exclusion but are not yet listed on the Formulary as Excluded. Such newly approved drugs remain Excluded unless and until reviewed and approved by VIVA HEALTH or its designee.

F. VIVA HEALTH 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). VIVA HEALTH reserves the right to deny coverage of dosages exceeding the FDA-approved maximum daily dosage for the condition being treated.

G. VIVA HEALTH will coordinate with the pharmacy to obtain information about cost-sharing assistance the Member may have received whenever possible. If we are unable to get the necessary information from the pharmacy, the Member may be asked to provide proof of the amounts paid. Adjustments to your Deductible or Out-of-Pocket Maximum for portions of the Member Cost Sharing paid by manufacturer coupons or similar assistance programs may be made at the time the Prescription Drug is dispensed or after the Prescription Drug is dispensed. Any claims affected by the adjustment may be reprocessed and subject to additional Member Cost Sharing. In no event may an amount applied to your Copayment or Coinsurance by the coupon issuer be eligible to be applied to the Deductible or Out of Pocket Maximum. Members have a responsibility to inform VIVA HEALTH about the use of Cost Sharing assistance, manufacturer coupons, or similar assistance programs to cover their Cost Sharing for Covered Prescription Drugs.

H. Once a drug is dispensed, the Member will not be refunded any out-of-pocket costs under the Plan if all or a portion of the prescription cannot be used for any reason including changes in treatment plans or other medical reasons.

I. Clinical edits may apply to certain Formulary drugs (e.g., Prior Approval, Step Therapy, Exclusions, or quantity limits to amount and/or duration) even when a Participating Provider has written a prescription for that drug. An Ancillary Charge may apply in addition to a Copayment or Coinsurance (if applicable) to Prescription Drugs approved with clinical edits.

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 and over-the-counter preventive medication as described in Section III of this Outpatient Prescription Drug Rider).

B. Prescription Drugs listed on the VIVA HEALTH Formulary as Excluded. Prescription Drugs newly approved by the FDA but not yet reviewed by VIVA HEALTH or its designee for inclusion on the Formulary.

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 self, spouse, brother, sister, parent, or child.

F. Drugs prescribed for Cosmetic purposes.

G. Drugs prescribed to treat hair loss or hair growth, regardless of the underlying reason or need for the hair loss or hair growth.

H. Drugs prescribed for the purpose of weight reduction or for the treatment of any condition which is based upon weight reduction (including, but not limited to, appetite suppressants, amphetamines, and glucagon-like peptide-1 receptor agonists).

I. After costs have reached $5,000 per family per Lifetime, drugs prescribed for the purpose of treating infertility including, but not limited, to Clomid, Serophene, Metrodin, and Yocon.

J. Drugs prescribed for the purpose of treating infertility for any Members other than the Subscriber or Subscriber's spouse.

K. Drugs prescribed for the purpose of terminating pregnancy.

L. Drugs prescribed for the purpose of improving sexual function.

M. Therapeutic or testing devices (including, but not limited to, glucometers), appliances, medical supplies, support garments or non-medical substances, regardless of their intended use.

N. All smoking cessation drugs and aids except for certain preventive drugs covered at 100% as described in Section III of this Outpatient Prescription Drug Rider.

O. Inspirease and other respiratory assistance apparatus.

P. Any drug dispensed prior to the effective date of this Plan or after this Plan has been terminated.

Q. 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.

R. Drugs used for non-FDA approved indications or in dosages exceeding the FDA-approved maximum daily dosage for the condition being treated, drugs labeled "Caution, limited by federal law to investigational use" or otherwise designated as Experimental drugs, medications used for Clinical Trials or Experimental indications unless such drugs would have otherwise been covered for routine patient care services, and/or dosage regimens determined by VIVA HEALTH or its designee to be Experimental.

S. 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.

T. Drugs covered under the Member's plan for medical benefits.

U. Prescriptions dispensed by a non-Participating Pharmacy.

V. Prescriptions prescribed by non-Participating Physicians, unless authorized by VIVA HEALTH.

W. Replacement Prescription Drugs resulting from lost, stolen, broken, or otherwise destroyed Prescription Order or Refill.

X. 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.

Y. Vitamins and minerals, except for select formulations for specific diagnoses as part of a Member's plan of care defined by a Participating Provider for select indications and except for prenatal vitamins and certain preventive vitamins covered at 100% as described in Section III of this Outpatient Prescription Drug Rider, which are Covered Services when prescribed by a Participating Provider.

Z. Unit dose packaging of Prescription Drugs.

AA. Compound drugs except when used for medically accepted indications that are supported by citations in standard reference compendia for the specific route of administration being prescribed. Only National Drug Codes (NDCs) for FDA approved prescription drug products are covered. Traditional compounding bulk powders, chemicals, creams, and similar products are not FDA-approved drug products and are not covered. Compounded products that are copies of commercially available FDA-approved drug products and drugs coded as OTC (over the counter) are not covered. All compounded prescriptions are subject to review and those with a total cost exceeding $200 are subject to Prior Approval.

BB. Growth hormone except for a documented hormone deficiency, Turner's Syndrome, growth delay due to cranial radiation, or chronic renal disease.

CC. Prescription Drugs prescribed for the purpose of preventing disease or illness related to international travel.

DD. 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.

EE. Drugs when the Member is participating in a Clinical Trial unless such drugs would otherwise be covered.

FF. Prescription food products and nutritional supplements.

IX. 90-Day Supply for Maintenance Drugs and Oral Contraceptives:

A. Maintenance Drugs and oral contraceptives are available in up to a 90-day supply. Refer to the schedule of benefits for coverage specific to this Plan.

B. Specialty Drugs and over-the-counter tobacco cessation products are not eligible for a 90-day supply.

X. Coordination of Benefits. Prescription Drug coverage under this Prescription Drug Rider is considered a separate policy and will only be coordinated with other eligible Prescription Drug coverage as determined by VIVA HEALTH.

A. **Duplicate Coverage Not Intended.** It is not intended that payments made for services rendered to Members shall exceed one hundred percent (100%) of the cost of the services provided. Therefore, in the case of duplicate coverage, the Plan may recover from the Member or from any other plan under which the Member is covered proceeds consisting of benefits payable to, or on behalf of, the Member up to the amount of the Plan's cost obligation for Covered Services.

B. **Benefit Determinations.** The Plan and the other plan(s) providing benefits shall determine which plan is primarily responsible for payment of covered benefits (i.e., the primary plan). If the Plan is primary, only those services outlined in this Prescription Drug Rider are Covered Services. If Member's other plan is primary, the Plan is secondary. The other plan must, therefore, pay up to its maximum benefit level after which the Plan shall pay for any remaining expenses subject to the following provisions:

1. The total combined payment by the Plan and any other plan to or on behalf of a Member shall not exceed the maximum amount that the Plan would pay if it were primary.

2. The Plan shall not cover services denied by the primary plan with respect to a Member due to the Member's failure to comply with its terms and conditions, except when such services were provided by or under the care of a Participating Provider.

3. The Plan shall not be liable for payments for any services or supplies that are not Covered Services under this Plan. All requirements in Part VII. Limitations, including but not limited to requirements related to use of Participating Pharmacies, Formulary drugs and prior-authorizations, must be met in order for services to be Covered Services even when the Plan is secondary.

4. Benefits will only be paid for when Covered Services are provided by Participating Providers, except for treatment of Emergency Medical Conditions and, with Prior Authorization, Urgently Needed Services outside the Service Area. The Member must notify VIVA HEALTH within 24 hours or as soon as reasonably possible after Emergency Services are provided by Participating and non-Participating Providers.

C. **Order of Benefit Determination Rules.** The rules determining whether the Plan or another plan is primary will be applied in the following order:

1. The plan having no coordination of benefits provision or non-duplication coverage exclusion shall always be primary.

2. The plan covering a Member as a Subscriber will be primary for care rendered to that Member. In addition, the benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this provision is ignored.

3. The plan of the parent whose birthday comes first in the Calendar Year shall be primary with respect to dependent coverage. This rule is subject to the following rules for divorced or separated parents:

a. If parents are divorced or separated and there is a court decree that establishes financial responsibility for medical, dental, or other health care expenses for the child, the plan covering the child as a dependent of the parent who has the responsibility will be primary.

b. In the absence of a court decree, the plan of the parent with legal custody will be primary.

c. If the parent with custody has remarried, the order of benefits will be:

i. The plan of the parent with custody.
ii. The plan of the stepparent with custody.
iii. The plan of the parent without custody.

4. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, Member, or Subscriber longer are determined before those of a plan which covered that person for the shorter time.

D. **Right to Receive and Release Necessary Information.** For the purposes of determining the applicability and implementation of the terms of this provision of this Prescription Drug Rider or any provision of similar purpose of any other plan, VIVA HEALTH may, without consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, that VIVA HEALTH deems to be necessary for such purposes. Any person claiming benefits hereunder shall furnish VIVA HEALTH such information as may be necessary to implement this provision.

E. **Facility of Payment.** Whenever benefits that should have been provided hereunder in accordance with this Part have been covered under any other plan, VIVA HEALTH shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid hereunder and, to the extent of such payments, the Plan shall be fully discharged from liability hereunder.

F. **Right of Recovery**. Whenever payments have been made under the Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, VIVA HEALTH shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as VIVA HEALTH shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations. Recovery of amounts of payments made on a Member's behalf shall include the reasonable cash value of any benefits provided in the form of services. Nothing in this Part shall be interpreted to require VIVA HEALTH to reimburse a Member in cash for the value of services provided by a plan which provides benefits in the form of services.

G. **Member's Cooperation**. Any Member who fails to cooperate in VIVA HEALTH's administration of this Part will be responsible for the amounts expended by the Plan for services subject to this Part and any legal expenses incurred by VIVA HEALTH to enforce the Plan's rights under this Part.

XI. Claims and Complaint Procedure.

A. Claims For Benefits

VIVA HEALTH has established and maintains claims procedures under which benefits can be requested by Members and disputes about benefit entitlement can be addressed. These claims procedures govern the filing of benefit claims, notification of benefit determinations, and Appeal of Adverse Benefit Determinations. Such claims procedures are available for use by the Member or the Member's authorized representative. Normally, an authorized representative must be appointed in writing on a specified form signed by the Member. If a person is not properly designated as the Member's authorized representative, VIVA HEALTH will not be able to deal with them in connection with the Member's rights under these claims procedures, unless the person is legally authorized to act on the behalf of a Member under the age of 14.

1. **Pre-Service Claims**. Pre-service claims are claims for services not yet received that require an authorization or referral under the terms of the Plan. Pre-service claims are typically filed by a Participating Provider. If the Member wishes to file a pre-service claim directly, the Member must meet the following requirements:

    a. Address the claim to VIVA HEALTH Pharmacy Department. Non-urgent pre-service claims must be in writing mailed to the following address: 417 20th Street North, Suite 1100, Birmingham, Alabama 35203 or by fax at (205) 872-0458 or by fax at 1-888-773-7386 for specialty drugs. Urgent pre-service claims may be filed by calling our Pharmacy Department at 1-800-294-7780 or calling Accredo Specialty Authorization Center at 1-800-753-2851 if the pre-service claim is related to a specialty drug.
    b. Provide at least the following information: Member name, date of birth, Member identification number, Member telephone number, a description of the service requested, and the name, address, and telephone number of the provider who will perform the service. If other than the Member, provide the name and telephone number of a contact person.
    c. A statement regarding any medical circumstances or exigencies that would assist in determining a reasonable timeframe for processing the claim.
    d. In order for the claim to be considered for processing as an urgent claim, the Member must request the claim be processed as such at the time the claim is filed. A claim qualifies as urgent if delaying a claim determination (*i.e.*, having the non-urgent 15 days to make a determination) could seriously jeopardize the member's life or health or the member's ability to regain maximum function or – in the opinion of a physician with knowledge of the member's medical condition – would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

    VIVA HEALTH will provide the Member with an oral notice of an incomplete pre-service claim if the claim fails to meet the requirements stated above. If the Member specifically requests written notice of an incomplete pre-service claim, such notice will be provided only if the Member's request is received by the VIVA HEALTH Claims Coordinator or the Pharmacy Department as described in 1.a. above.

    VIVA HEALTH has up to 72 hours to process urgent pre-service claims and up to 15 days to process standard (non-urgent) pre-service claims. If additional information is required for an urgent care claim, VIVA HEALTH will notify the Member of information needed not later than 24 hours after receipt of the claim. We will have 48 hours

following receipt of such additional information to make a determination. The notice of determination on urgent pre-service claims may be made orally with written notification provided within three days. If additional information is required on a standard pre-service claim, VIVA HEALTH will notify the Member of information needed within 15 days. We will have 15 days following receipt of such additional information to make a determination and issue a written notice of the determination. To facilitate receipt of additional information, VIVA HEALTH may request it directly from the provider. However, the Member is still responsible for ensuring VIVA HEALTH receives the information in a timely manner. If no response is received on an incomplete pre-service claim within 45 days, the claim will be considered withdrawn.

2. **Post-Service Claims**. Post-service claims are claims for services already received. Post-service claims are typically filed by a Participating Provider. If the Member wishes to file a post-service claim directly, the Member must provide the information and meet the filing time frames described in Part XII. Notice of Claim . Please contact Customer Service for assistance filing a claim. VIVA HEALTH has up to 30 days to process post-service claims. If additional information is required on a post-service claim, VIVA HEALTH will notify the Member or Member's provider what additional information is needed within 30 days. We will have 15 days following receipt of such additional information to make a determination. Although we may have all the information required to treat a submission as a post-service claim, from time to time VIVA HEALTH might need additional information such as medical records to determine whether the claim should be paid. In this case, VIVA HEALTH will ask the Member to furnish such additional information and will suspend processing of the claim until the information is received. To facilitate receipt of additional information, VIVA HEALTH may request it directly from the provider. However, the Member is still responsible for ensuring that we get the information on time. If no response is received on an incomplete claim within 45 days, the claim will be considered withdrawn. Sometimes VIVA HEALTH may ask for additional time to process the claim. If the Member decides not to give additional time, VIVA HEALTH will process the claim based on the information we have. This may result in the denial of the claim.

3. **Concurrent Care Decisions**. When an approved course of treatment is coming to an end, the Member may file a claim to extend such treatment. Benefit limits described in the schedule of benefits still apply. The amount of time VIVA HEALTH has to decide a claim to extend an approved course of treatment depends on whether it is an urgent claim or a standard claim. The same timeframes discussed above for pre-service claims apply to concurrent care decisions.

4. **Appeals**. Appeals are Complaints regarding an Adverse Benefit Determination. An Adverse Benefit Determination is a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit or is a rescission of coverage. After an Adverse Benefit Determination, a Member will be given written notice that includes information as to the Member's right to appeal. Upon written request, a Member will also be given reasonable access to and copies of all documents, records, and other information in VIVA HEALTH's possession relevant to the Member's claim for benefits.

   Appeals are processed as Complaints in accordance with the Complaint Procedure described below, except that the processing timeframes may be different. Specifically, standard pre-service appeals will be processed within 15 days at the Informal Complaint

level and within 15 days at the Formal Complaint level. Post-service Appeals will be processed within 30 days at the Informal Complaint level and within 30 days at the Formal Complaint level. An Expedited Formal Complaint that meets the definition of an urgent Appeal will be processed within 72 hours. Examples of claims subject to Appeals include denied services and payments (in whole or in part) and the reduction or termination of a previously approved course of treatment.

On Appeal, the Member has the right to submit written comments, documents, records, and other information relating to the claim for benefits regardless of whether the information was considered in the initial benefit determination. When an Adverse Benefit Determination was made based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment will be consulted in processing an Appeal. The health care professional retained for consultation will be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of any such individual. The Member will be provided a written notice of the benefit determination on review.

B. **Complaint Procedure**

If a Member has a question about the services provided, the Member may call VIVA HEALTH or its designee. Any problem or dispute related to VIVA HEALTH 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:

1. **Inquiries.** Most problems can be handled simply by discussing the situation with a representative of VIVA HEALTH or its designee. This can be done by phone or in person and will often avoid the need for written Complaints and formal meetings. VIVA HEALTH asks Members to try this process first to resolve any problems. Issues which can be resolved by telephone to the Member's satisfaction are not classified as Complaints. Members with Inquiries which are not resolved to their satisfaction will be informed of the Informal Complaint Procedure available to them or their authorized representative.

2. **Informal Complaint.** If the Member's problem cannot be resolved to the Member's satisfaction at the Inquiry level or the Member requires a written response, 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 from the receipt date of the Informal Complaint within 15 days for pre-service Appeals, within 30 days for post-service Appeals and within 45 days for other Complaints. 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.

3. **Formal Complaint.** If the Member is dissatisfied with the Informal Complaint decision, a Formal Complaint may be filed. 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 VIVA HEALTH's receipt of the original Informal Complaint. VIVA HEALTH may allow an extension of the 12-month limit due to extenuating circumstances. Formal Complaints must be submitted by written letter sent to:

VIVA HEALTH
Attention: Complaint Coordinator
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

A provider may act on behalf of the Member in the Formal Complaint process if the provider certifies in writing to VIVA HEALTH that the Member is unable to act on his or her own behalf due to illness or disability. A family member, friend, provider, or any other person may act on behalf of the Member after written notification of authorization is received by VIVA HEALTH from the Member. Members also have the right to request that a VIVA HEALTH Staff Member assist them with the Formal Complaint.

All 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 from the receipt date of the Formal Complaint within 15 days for pre-service Appeals and 30 days for post-service Appeals and other Complaints. The Member is given written notification regarding the Formal Complaint Committee's decision within five working days of the decision being made. In the case of a final internal Adverse Benefit Determination at the Formal Complaint level (in whole or in part), the Member may have a right to an external review process, as described below. A determination that the Member fails to meet the eligibility requirements of the Plan is not subject to external review.

4. **Expedited Formal Complaints**. Any Complaint related to an adverse Medical Necessity decision may be considered for expedited review. This includes complaints related to service denials or reductions. Expedited review allows the Member to bypass the Informal and Formal Complaint steps of the Complaint Procedure. The Member or provider may request an expedited review. Both the decision to grant an expedited review and the expedited review itself are conducted by the Expedited Formal Complaint Committee. An expedited review is granted if the standard response time could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.

   If the Expedited Formal Complaint Committee grants the expedited review, the Expedited Formal Complaint Committee will review the Complaint and render a decision within a time period that accommodates the clinical urgency of the situation, but not later than 72 hours from the time the request was received. The Expedited Formal Complaint Committee notifies the provider of its decision by phone or fax the day the decision is made or the next business day if the provider's office is closed. Written notification of the decision is mailed to the Member within three days after the day the decision is made and to the provider within the same timeframe if the provider filed the expedited review request on behalf of the Member. In the case of a final internal Adverse Benefit Determination at the Expedited Formal Complaint level, the Member has a right to an external review process, except after a determination that the Member fails to meet eligibility requirements of the Plan.

If the Expedited Formal Complaint Committee does not grant Member's request for an expedited review, the Member will receive written notification postmarked within three working days after receipt of the request. The notification will verify that the request will be automatically transferred to the informal level of the Complaint Procedure as described above.

5. **External Review**. VIVA HEALTH has available an independent external review process for certain denied claims for benefits. This external review process applies to an Adverse Benefit Determination or final internal Adverse Benefit Determination on Appeal that involves medical judgment or compliance with the Cost Sharing and surprise billing protections in the No Surprises Act and its implementing regulations or a rescission of coverage. A determination that a person is not a Member under the terms of this Certificate, however, is not eligible for the external review process unless it involves a rescission. The decision to be reviewed through the external review process usually will be the denial of an Appeal as part of the Formal Complaint process described above.

   An Expedited external review process is available for (i) an Adverse Benefit Determination, if the Adverse Benefit Determination involves a medical condition of the Member for which the timeframe for completion of an expedited internal Appeal under paragraph XI.B.4 above would seriously jeopardize the life or health of the Member, or would jeopardize the Member's ability to regain maximum function and the Member has filed a request for an expedited internal Appeal under paragraph XI.B.4 above; or (ii) a final internal Adverse Benefit Determination, if the Member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which the Member received emergency services, but has not been discharged from a facility.

   For a Complaint to be considered for external review, a Member must file a request for an external review with VIVA HEALTH within four months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. The external review process is handled by an Independent Review Organization (IRO). An IRO's external review decision is binding on VIVA HEALTH, as well as the Member, except to the extent other remedies are available under State or Federal law.

   A Member must request an external review by writing the VIVA HEALTH Complaint Coordinator at the address above. Request for an expedited external review for urgent cases may be made by calling VIVA HEALTH. VIVA HEALTH will notify a Member whether the Member's request is eligible for external review. If eligible, the Independent Review Organization will notify the Member of an opportunity to submit additional written information for the IRO to consider. The assigned IRO will provide written notice of the final external review decision within 45 days after receiving the request for external review, or within 72 hours for an expedited external review.

XII. Notice of Claim. Participating Providers are responsible for submitting a request for payment of Covered Services directly to VIVA HEALTH. The Plan will reimburse a Member for Covered

Services from non-Participating Providers only for Emergency Services or services authorized by the Plan. The Member is responsible for sending a request for reimbursement to VIVA HEALTH in a language and on a form provided by or acceptable to VIVA HEALTH. The request must include the Member's name, address, telephone number, and Member identification number (found on the Member identification card), the provider's name, address, and telephone number, the date(s) of service, and an itemized bill including the CPT codes or a description of each charge. If the Member is enrolled in any other health plan, the Member must also include the name(s) of the other carrier(s). **Such claim shall be allowed only if notice of claim is made to VIVA HEALTH or its designee within one hundred and eighty (180) days from the date on which covered expenses were first incurred.**

XIII. Miscellaneous Provisions. Neither VIVA HEALTH nor the Plan shall 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.

XIV. Non-Discrimination and Language Accessibility Notice.

Nondiscrimination Notice:

Discrimination is Against the Law

VIVA HEALTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). VIVA HEALTH does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

VIVA HEALTH:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact VIVA HEALTH'S Section 1557 Coordinator.

If you believe that VIVA HEALTH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with VIVA HEALTH'S Section 1557 Coordinator, 417 20th Street North, Suite 1100, Birmingham, AL, 35203, 1-800-294-7780, TTY: 711, VIVACivilRightsCoord@uabmc.edu. You can file a grievance by mail, fax, or email. If you need help filing a grievance, VIVA HEALTH'S Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Toll-free at: 1-800-368-1019 - TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language access, effective communication, reasonable modification, and non-discrimination policies and procedures are available at all VIVA HEALTH offices and at vivahealth.com.

Discrimination Grievance Procedure (under Section 1557 of the Affordable Care Act):

In accordance with Section 1557 of the Affordable Care Act (Section 1557), it is the policy of VIVA HEALTH to not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

This is the grievance procedure for providing prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 and its implementing regulations at 45 C.F.R. Part 92, issued by the U.S. Department of Health and Human Services. Section 1557 and its implementing regulations may be examined at https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities.

Any person who believes that VIVA HEALTH subjected someone to discrimination prohibited by Section 1557 may file a grievance under this procedure.

It is against the law for VIVA HEALTH to intimidate, threaten, coerce, retaliate, or otherwise discriminate against anyone who files a grievance, or participates in the investigation of a grievance for the purpose of interfering with any right or privilege secured by Section 1557. Section 1557 and its implementing regulations may be examined in the office of VIVA HEALTH's Section 1557 Coordinator at 417 20th Street North, Suite 1100, Birmingham, AL, 35203.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- Grievances must be submitted in writing to:

  ATTN: VIVA HEALTH Section 1557 Coordinator
  417 20th Street North, Suite 1100
  Birmingham, AL 35203, or

  (by fax or email): 205-449-7626, or VIVACivilRightsCoord@uabmc.edu

- A grievance should contain the name and contact information of the person filing it as well as the alleged discriminatory action and alleged basis (or bases) of discrimination, the date the grievance was filed, and any other pertinent information.
- When a grievance includes allegations that would violate Section 1557, the Section 1557 Coordinator (or their designee, if applicable) shall investigate the grievance. This investigation

may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the grievance.

- VIVA HEALTH shall inform an individual that they have a right to reasonable modifications in the grievance procedure if needed.
- The Section 1557 Coordinator must keep confidential the identity of an individual who has filed a grievance under this part except as required by law or to carry out the purposes of this part, including the conduct on any investigation, including to investigate the grievance.
- VIVA HEALTH will issue to the person who filed the grievance a written decision on the grievance no later than 30 days after the date VIVA HEALTH receives the grievance. The decision shall include the resolution date and a notice to the complainant of their right to pursue further administrative or legal remedies.
- VIVA HEALTH will maintain the files and records relating to such grievances for at least three years from the date VIVA HEALTH resolves the grievance.

The person filing the grievance may appeal the written decision by writing to the Chief Administrative Officer within 15 days of the date of the notification of the decision. The Chief Administrative Officer shall issue a written decision in response to the appeal no later than 30 days after VIVA HEALTH receives the appeal.

VIVA HEALTH, through the Section 1557 Coordinator, will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided reasonable modifications, appropriate auxiliary aids and services, or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include but are not limited to providing these services in a timely manner and without cost to individuals being served to ensure that individuals have an equal opportunity to participate in the grievance process.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal and administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Toll-free at: 1-800-368-1019 - TDD: 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Availability of Language Assistance Services and Auxiliary Aids and Services:

English (English)
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-294-7780 (TTY: 711) or speak to your provider.

Español (Spanish)
ATENCIÓN: Si habla español (Spanish), tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-294-7780 (TTY: 711) o hable con su proveedor.

中文 (Traditional Chinese)
注意：如果您說中文 (Chinese)，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-294-7780（TTY：711）或與您的提供者討論。

中文 (Simplified Chinese)
注意：如果您說中文 (Chinese)，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-294-7780（文本电话：711）或咨询您的服务提供商。

한국어 (Korean)
주의: 한국어 (Korean) 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-294-7780(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Việt (Vietnamese)
LƯU Ý: Nếu bạn nói tiếng Việt (Vietnamese), chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-294-7780 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية)Arabic(، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-294-7780 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch (German) sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-294-7780 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Français (French)
ATTENTION : Si vous parlez Français (French), des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-294-7780 (TTY : 711) ou parlez à votre fournisseur.

ગુજરાતી (Gujarati)
ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ

છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-294-7780 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Tagalog (Tagalog)
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-294-7780 (TTY: 711) o makipag-usap sa iyong provider.

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-294-7780 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ລາວ (Lao)
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ (Lao), ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-294-7780 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

РУССКИЙ (Russian)
ВНИМАНИЕ: Если вы говорите на русский (Russian), вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-294-7780 (TTY: 711) или обратитесь к своему поставщику услуг.

Português (Portuguese)
ATENÇÃO: Se você fala **português** (Portuguese), serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-294-7780 (TTY: 711) ou fale com seu provedor.

Türkçe (Turkish)
DİKKAT: Türkçe (Turkish) konuşuyorsanız, ücretsiz dil yardım hizmetleri sizin için mevcuttur. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak mevcuttur. 1-800-294-7780 (TTY: 711) numarasını arayın veya sağlayıcınızla görüşün.

日本語 (Japanese)
注：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-294-7780（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。