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Certificate of Coverage and Summary Plan Description

2020

Good benefits. Good health.

VIVA HEALTH
CERTIFICATE OF COVERAGE

Your Certificate of Coverage is an extremely important document. It contains detailed information about Covered Services, services which are excluded or limited, your legal rights as a VIVA HEALTH, Inc. Member, and other important information about your health care Plan. **Please read this Certificate carefully and keep it with your Summary of Benefits. It is the Subscriber's responsibility to review all plan materials with his/her Covered Dependents, if any. Additional copies of this Certificate are available upon request.**

Members of this Plan may see any VIVA HEALTH Participating Physician. Referrals from the PCP are not required for visits to Participating specialists to be covered. Some services require prior-authorization to be covered. These are listed in Part VIII. Please see the provider directory for a list of the Plan's Participating Providers. The current provider directory is available by calling Customer Service and on the web at www.vivahealth.com. Emergency Services are covered only for treatment of Emergency Medical Conditions. Always call VIVA HEALTH as soon as possible after receiving Emergency Services. If you are unsure if your condition is an Emergency Medical Condition, contact your PCP or the physician on-call if after hours. Members may use contracted urgent care facilities for Urgently Needed Services.

This Certificate contains information about how VIVA HEALTH operates its care delivery system and an explanation of the benefits to which Members are entitled under the terms of the Plan.

Contact the Customer Service Department at 1-800-294-7780 or 205-558-7474 (in Birmingham) if you have any questions.

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GENERAL INFORMATION

A. Introduction

Enrollee coverage is subject to the terms of this Certificate of Coverage and the Group Policy between the Program Manager and the Trustee acting on behalf of the Employer and to the payment of required premiums. You may examine the Group Policy at the office of the Employer. For Covered Services received on or after January 1, 2020, or the Employer Group Policy renewal date, whichever is later, this Certificate replaces and supersedes any Certificate previously issued to you by VIVA HEALTH. Members should read this Certificate in its entirety as many of its provisions are interrelated. The Trustee reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Group Policy as permitted by law without the approval of Enrollees. This Certificate may be modified by the attachment of riders and/or amendments. VIVA HEALTH has an agreement with the Trustee and Program Manager to serve as the contract administrator of this Plan and reserves the right to terminate the contract administration agreement as permitted by law without the approval of Enrollees. VIVA HEALTH provides administrative claims payment services only and does not assume any responsibilities of the Plan other than those specified in the contract administration agreement.

In order for medical services to be considered Covered Services, services must be obtained directly from Participating Providers, with the exception of Emergency Services and, with Prior Authorization, Urgently Needed Services outside the Service Area. Please see Part IX.D. for more information on coverage for Emergency Services and Part VIII.E. for more information on coverage for Urgently Needed Services. **Always call VIVA HEALTH within 24 hours or as soon as reasonably possible after Emergency Services are received.** Follow-up care in an emergency room is not a covered service. Participating Providers may change from time to time, so you should always verify the status of a provider on the web at www.vivahealth.com or by calling VIVA HEALTH.

To be Covered Services, services must be Medically Necessary, included in the Schedule of Benefits, and not excluded in the listing of Plan exclusions. Some services also require prior-authorization from VIVA HEALTH to be Covered Services. The fact that a medical provider performs or prescribes a service or that a service is the only available treatment for a particular medical condition does not mean the service is a Covered Service.

VIVA HEALTH, Trustee, and Program Manager have sole and exclusive discretion in interpreting the benefits covered under this Certificate and the Group Policy. VIVA HEALTH may periodically delegate discretionary authority to other persons or organizations providing services.

B. VIVA HEALTH's Role in Delivering Service

VIVA HEALTH enters contracts with medical providers to provide Covered Services to Enrollees. Participating Providers are independent contractors, not employees of VIVA HEALTH. Contractual arrangements with Participating Providers vary. Some contracts require VIVA HEALTH to pay Participating Providers based on an agreed upon number of Enrollees rather than the amount of Covered Services provided. Contracts may contain incentives for Participating Providers to assist VIVA HEALTH in providing cost-effective care.

Members are responsible for choosing a doctor from among VIVA HEALTH's Participating Providers. Members must decide if the relationship with the selected doctor meets expectations and change doctors if it does not. Members must work with the doctor to decide the types of care or treatment that are appropriate. VIVA HEALTH does not under any circumstances make treatment decisions. VIVA HEALTH only makes administrative decisions about the benefits covered under the Plan for payment purposes. Your financial or family situation, the distance you live from a hospital or other facility or any other non-medical factor is not considered. The Participating Provider is responsible for the quality of care a Member receives and VIVA HEALTH is not liable for any act or omission of a Participating Provider.

MEMBER RIGHTS AND RESPONSIBILITIES

A. Member Rights

1. A Member has the right to timely and effective redress of complaints through a complaint process.

2. A Member has the right to obtain current information concerning a diagnosis, treatment, and prognosis from a physician or other provider in terms the Member can reasonably be expected to understand. When it is not advisable to give such information to the Member, the information shall be made available to an appropriate person on the Member's behalf.

3. A Member has the right to information about VIVA HEALTH and its services and to be given the name, professional status, and function of any personnel providing health services to him/her.

4. A Member has the right to give his/her informed consent before the start of any surgical procedure or treatment.

5. A Member has the right to refuse any drugs, treatment, or other procedure offered to him/her by the health maintenance organization or its providers to the extent provided by law and to be informed by a Physician of the medical consequences of the Member's refusal of drugs, treatment, or procedure.

6. When Emergency Services are necessary, a Member has the right to obtain such services without unnecessary delay.

7. A Member has the right to see all records pertaining to his/her medical care unless access is specifically restricted by the attending Physician for medical reasons.

8. A Member has the right to be advised if a health care facility or any of the providers participating in his/her care propose to engage in or perform human experimentation or research affecting his/her care or treatment. A Member or legally responsible party on his/her behalf may, at any time, refuse to participate in or continue in any experimentation or research program to which he/she has previously given informed consent.

9. A Member has the right to be treated with dignity. VIVA HEALTH recognizes the Member's right to privacy. Personally identifiable health information shall not be released except when proper authorization to release medical records is obtained or when release is allowed or required by law.

10. A Member may obtain the names, qualifications and titles of Participating Providers by contacting VIVA HEALTH's Customer Service Department.

11. A Member has the right to be informed of the rights listed in this subsection.

12. A Member has the right to participate in decision-making regarding his or her health care.

13. A Member has the right to a candid discussion of appropriate or Medically Necessary treatment options for his/her conditions, regardless of cost or benefit coverage.

B. Member Responsibilities

1. A Member is responsible for providing, to the extent possible, information needed by professional staff to care for the Member and for following instructions and guidelines given by those providing health care services.

2. To be Covered Services, all medical care, except Emergency Services, must be obtained through Participating Providers. The only exceptions are Urgently Needed Services outside the Service Area and services determined not to be available through Participating Providers both of which require authorization in advance by VIVA HEALTH. A Member must notify VIVA HEALTH within 24 hours or as soon as reasonably possible after Emergency Services are initially provided by Participating and non-Participating Providers.

3. Emergency room services may be used only for Emergency Medical Conditions as defined in Part I. It is the Member's responsibility to establish a relationship with a Personal Care Provider in order for the Personal Care Provider to assist the Member in accessing appropriate care when the Member requires treatment for an illness or injury that is not an Emergency Medical Condition.

4. A Member must always carry his/her Membership ID card, show it to the provider each time Covered Services are received, and never permit its use by another person.

5. A Member must notify VIVA HEALTH and the Program Manager of any changes in address, eligible family Members, and marital status or if secondary health insurance coverage is acquired.

6. A Member must pay all applicable Coinsurance, Copayments, and Deductibles directly to the Participating Provider who renders care. Dissatisfaction with the care or service received does not relieve the Member of this financial responsibility.

7. A Member must cooperate in the administration of the Double Coverage, Coordination of Benefits or Subrogation provisions set forth in Parts V, VI and VII, respectively. Failure to do so may result in VIVA HEALTH denying payment for affected claims.

C. No health maintenance organization may, in any event, cancel or refuse to renew a Member solely on the basis of the health of a Member.

PART I. DEFINITIONS

Capitalized terms in this Certificate have the following meanings:

"Accidental Injury" means an injury happening unexpectedly and taking place not according to the usual course of events (for example, a motor vehicle accident). Accidental Injury does not include any damage caused by chewing or biting on any object.

"Calendar Year" means the period of time from January 1 through December 31 of any year. Benefits subject to a Calendar Year limit do not reset when a person enrolls in this Plan from another plan offered by VIVA HEALTH at any time during the Calendar Year.

"Certificate" means this document and any riders, attachments, or amendments hereto.

"Chronic Condition" means any diagnosed condition for which a Member receives ongoing care, treatment or medication.

"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.

"Common-Law Spouse" means a spouse by a non-ceremonial marriage that is recognized as a common law marriage under the laws of the state where the marriage was entered into. Under Alabama law, new common law marriages cannot be entered into after January 1, 2017.

"Complaint Procedure" means the process for resolving problems and disputes set forth in Part XI of this Certificate.

"Copayment" means the amount of payment indicated in the Summary of Benefits (Attachment A hereto) which is due and payable by the Member to a provider of care at the time services are received.

"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 or Former Subscriber's family who meets the eligibility requirements of Part II of this Certificate, and has been enrolled by the Subscriber in accordance with Part III.

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

"Covered Transplant Procedure" means any human to human Medically Necessary organ or tissue transplant specified in Part IX.H. of this Certificate, subject to the limitations stated in Part X. of this Certificate.

"Crisis Intervention" means Medically Necessary care rendered during that period of time in which an individual exhibits extreme symptoms that could result in harm to that individual or to others in his environment.

"Deductible" when a Deductible applies, the Deductible is the amount a Member must pay for health services received in a Calendar Year before the Plan will pay any amount for health services received in that year. The Deductible applies based on the Calendar Year in which a Member receives the services, even if the services were requested or approved in the previous Calendar Year. The Deductible may change during the course of a Calendar Year for Members in non-Calendar Year plans. If the Deductible increases with a new plan year, the Member may owe Cost Sharing again up to the amount of the increase, even if the Deductible was reached earlier in the Calendar Year. Health services for which Coverage is subject to satisfaction of the annual Deductible are identified in Attachment A, Summary of Benefits.

"Durable Medical Equipment" means equipment which:

1. can withstand repeated use;
2. is primarily and customarily used to serve a medical purpose;
3. generally is not useful to a person in the absence of illness or injury; and
4. is appropriate for use in the home.

"Eligible Employee" means an employee of Employer who is not temporary or non-permanent and who satisfies the requirements specified in Part II and Attachment A of this Certificate and in the Group Policy, including being scheduled to work the minimum number of hours per week specified and completing the new hire waiting period, if any.

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. Care for Emergency Medical Conditions is available in and out of the Service Area and includes ambulance services for Emergency Medical Conditions dispatched by 911, if available, or by the local government authority. Air ambulance transportation outside the United States or back to the United States is not a Covered Service.

"Emergency Services" means services to treat Emergency Medical Conditions available 24 hours a day, 7 days a week as described more fully in Part IX.D. of this Certificate.

"Employer" means the employer or party acting on behalf of the employer (the Trustee) that has entered into a Group Policy 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.)

"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 Food & Drug Administration ("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.

"Former Subscriber" means any Eligible Employee for whom coverage was provided by this Plan and who elected to drop coverage of this plan upon attaining the age of 65 in accordance with Section V. B of this plan.

"Group Policy" means the agreement and any riders and amendments thereto which constitute the agreement regarding the Plan's health benefits, exclusions, and other conditions between the Trustee (acting on behalf of the Employer) and the Program Manager.

"Habilitative Services" or "Habilitation Services" means physical therapy, speech therapy, occupational therapy, and/or applied behavior analysis services prescribed by a Participating Provider for a Member to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to autism, autism spectrum disorder, or pervasive developmental delay as set forth in Part IX.A.8.

"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.

"Hospice Care" means non-curative care provided to a terminally ill Member by a properly licensed or accredited hospice agency as set forth in Part IX.A.22.

"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 in Part IX.B.

"Initial Acquisition" means the first purchase whether obtained while a Member or prior to coverage under the Plan.

"Initial Plan Open Enrollment" means the <u>first</u> Plan Open Enrollment Period held by the Employer for enrollment of Eligible Employees in the Plan.

"Inpatient" means a Physician has written orders for admission and the Hospital, Skilled Nursing Facility, or Inpatient rehabilitation facility has formally admitted you to a room.

"Intermittent" means non-continuous care delivered at intervals.

"Lifetime" means the lifetime of the Member.

"Long-Term Acute Care Hospital (LTCH)" means a legally operated facility defined as an acute care hospital that focuses on patients who need care for an extended period and is licensed by the State as such and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or the federal Medicare program.

"Manual Manipulative Treatment" means the therapeutic application of chiropractic manipulative treatment rendered to restore/improve motion, reduce pain, and improve function in the management of an identifiable neuromusculoskeletal condition.

"Medical Director" means an Alabama licensed Physician designated by VIVA HEALTH or his/her designee to monitor and review the provision of Covered Services to Members. The Medical Director also supervises the quality improvement and utilization management programs established by VIVA HEALTH.

"Medically Necessary" or "Medical Necessity" means services or supplies provided by a Hospital, Skilled Nursing Facility, Home Health Agency, Physician or other health care provider which are determined by the Medical Director or its utilization review committee to be:

1. evidence-based, generally accepted standards of medical practice;
2. necessary to meet the basic health care needs of the Member;
3. rendered in the most cost-efficient manner, setting, supply or level appropriate for the delivery of the Covered Service;
4. of demonstrated medical value and consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury;
5. appropriate in type, frequency, and duration of treatment with regard to recognized standards of good medical practice; and
6. not solely for the convenience of the Member, his or her Physician, Hospital, or other health care provider.

Only your medical condition is considered in deciding which setting is Medically Necessary. Your financial or family situation, the distance you live from a hospital or other facility or any other non-medical factor is not considered. For inpatient services and supplies, Medically Necessary further means that the Member's medical symptoms or conditions require that the diagnosis or treatment cannot be safely provided to the Member as an outpatient.

"Medicare" means Title XVIII of the Social Security Act and all amendments thereto.

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

"Open Enrollment Period" means those periods of time, not less than that required by applicable law, established by the Employer from time to time but no less frequently than once in any 12 consecutive months during which Eligible Employees who have not previously enrolled in the Plan may do so.

"Out of Area Services" means those services provided outside the Service Area. Covered Out of Area Services are more fully described in Part VIII.E.

"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 as provided in Part VIII.L. 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.

"Outpatient" means a Physician has not written orders to admit you to the hospital as an inpatient. Even if you are receiving medical treatment and/or stay the night you might still be considered an "outpatient". If you are not sure if you are an outpatient, you should ask the hospital staff. Observation is considered Outpatient.

"Participating Hospital for Transplant Benefits" means Hospital facilities designated by VIVA HEALTH to provide Covered Transplant Procedures to Members. Not all Participating Hospitals are approved by VIVA HEALTH as Participating Hospitals for Transplant Benefits.

"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 Physician for Transplant Benefits" means physicians designated by VIVA HEALTH to provide Covered Transplant Procedures to Eligible Members. Not all Participating Physicians are approved by VIVA HEALTH as Participating Physicians for Transplant Benefits.

"Participating Provider" or "Participating" means a Participating Physician, a Participating Specialist, a Hospital, Skilled Nursing Facility, 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. A list of Participating Providers is available to each Subscriber upon enrollment. Such list shall be revised by VIVA HEALTH from time to time as VIVA HEALTH deems necessary. A current list is available by calling VIVA HEALTH Customer Service and on the VIVA HEALTH website at www.vivahealth.com.

"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.

"Personal Care Provider" means a Participating Physician under contract by VIVA HEALTH to provide primary care services. A Personal Care Provider is generally an Internist, Family Practitioner, General Practitioner, Pediatrician, or, sometimes, an Obstetrician/Gynecologist and is often referred to as a Primary Care Physician, PCP, or Personal Care Physician.

"Physician" means a person who holds a degree of doctor of medicine or doctor of osteopathy, and who is licensed to practice as such in the state in which services are provided. Physician also means a chiropractor, a podiatrist, an optometrist, and a dentist or a dental hygienist when licensed to practice as such in the state in which services are provided and when performing services within the scope of his or her license.

"Plan" means the group medical benefits plan which has been established by the Employer and through which benefits are provided, in whole or in part, through the Group Policy and this Certificate.

"Plan Year" means the period of time specified in Exhibit A of the Group Policy.

"Prior Authorization" means VIVA HEALTH has given approval in advance for payment for certain Covered Services to be performed. Prior Authorization may include place of service. Authorization does not guarantee payment. For information on services requiring Prior Authorization, see Part VIII.D of this Certificate.

"Professional Services" means services performed by Physicians and health professionals which are Medically Necessary, generally recognized as appropriate care within the Service Area, which are set forth in Part IX hereof, and which are performed, prescribed, directed, or authorized by a Participating Physician.

"Program Manager" means the entity charged by the Trustee with overseeing the benefits administration of the Plan as specified in the Group Policy.

"Prosthesis" means an artificial device that replaces a missing part of the body.

"Qualifying Previous Coverage" means benefits or coverage provided under Medicare, Medicaid, CHAMPUS, TRICARE, Indian Health Services program, any similar publicly sponsored program, or a group or individual health insurance policy or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the Plan.

"Rehabilitative Services" or "Rehabilitation Services" means physical therapy, speech therapy, and/or occupational therapy services prescribed by a Participating Provider for a Member to regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition as set forth in Part IX.A.7.a-b.

"Service Area" means those counties in Alabama in which VIVA HEALTH is licensed to operate.

"Significant Improvement" means substantial ongoing positive changes in the condition of the patient as determined by the Medical Director.

"Skilled Nursing Care" means care provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) under the supervision of an R.N. if all of the following conditions are met:

1. The services are required on an Intermittent or part-time basis.
2. The services must require the skills of an R.N. or L.P.N. under the supervision of an R.N.
3. The services must be reasonable and necessary for the treatment of an illness or injury.

"Skilled Nursing Facility" means an institution which is licensed by the state in which it is situated to provide skilled nursing services and which has been approved as a participating Skilled Nursing Facility under the Medicare program.

"Sound Natural Teeth" means teeth free from active or chronic clinical decay, having at least fifty percent (50%) bony support and having not been weakened by multiple dental procedures.

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

"Transplant Benefit Period" means the period beginning with the date the Member receives Prior Authorization for a Covered Transplant Procedure and ending 365 days after the date of the transplant, or until such time as the Member is no longer covered under this Certificate, whichever is earlier.

"Trustee" means the individual legally acting on behalf of the Employer groups funded through Iron Reinsurance Member Master Plan Trust.

"Urgently Needed Services" means services needed immediately as a result of an unforeseen illness, injury, or condition to prevent a serious deterioration of health when you are outside of the Service Area or when you are

within the Service Area and care cannot be reasonably delayed until you can be treated by your Personal Care Provider.

"VIVA HEALTH" means VIVA HEALTH, Inc. an Alabama corporation licensed as a health maintenance organization or VIVA HEALTH Administration, L.LC. a corporation licensed to perform utilization review in the State of Alabama in accordance with the Group Policy. VIVA HEALTH may subcontract with other companies as it deems necessary to carry out the terms of this Certificate.

PART II. ELIGIBILITY

A. Who is Eligible for Coverage?

1. Eligible Employee. To be eligible to enroll as a Subscriber, a person must work or reside in the Service Area, meet the definition of Eligible Employee in Part I, complete and return to VIVA HEALTH the enrollment application and authorization for release required by VIVA HEALTH, and meet all requirements of an Eligible Employee set forth in the Group Policy and Attachment A, which are made part of this Certificate.

2. Eligible Dependents. To be eligible to enroll as a Covered Dependent, a person must be listed on the enrollment application completed by Subscriber or Former Subscriber, reside in the Service Area or with the Subscriber or Former Subscriber (except as noted below), and meet the criteria in one of (a) through (f) below:

a. The Subscriber's or Former Subscriber's present lawful spouse. If the marriage is by common law (instead of a legal ceremonial marriage), a signed affidavit satisfactory to VIVA HEALTH or Program Manager must be submitted by the Subscriber or Former Subscriber as proof of eligibility for coverage of the spouse as a Common Law spouse. Under Alabama law, new common law marriages cannot be entered into after January 1, 2017;

b. Any child, including biological, stepchild or legally adopted child (including a child placed for adoption) of either the Subscriber or Former Subscriber or the Subscriber's or Former Subscriber's spouse, who is under the age of twenty-six (26). For dependents subject to a qualified medical child support court order that requires the Subscriber or Former Subscriber or the Subscriber's or Former Subscriber's spouse to be financially responsible for medical or other health care, residency in the Service Area is not required but coverage for services delivered outside the Service Area is limited to **Emergency Services and, with Prior Authorization, Urgently Needed Services.** A description of the procedures governing a determination as to whether a particular court decree is qualified may be obtained, without charge, from VIVA HEALTH;

c. Any child who is under the age of twenty-six (26) if the Subscriber or Former Subscriber or the Subscriber's or Former Subscriber's spouse is a court-appointed legal guardian with permanent legal custody (not temporary legal custody) of the child, provided (i) proof of such guardianship is submitted with the enrollment form (a power of attorney does not satisfy this requirement) and (ii) the child is a dependent (qualifying child or qualifying relative) of the Subscriber or Former Subscriber or the Subscriber's or Former Subscriber's spouse under Internal Revenue Code Section 152;

d. For dependent children eligible under subsection (b) or (c) who are full-time students at an accredited educational institution, residency in the Service Area is not required, but coverage for services delivered outside the Service Area is limited to **Emergency and, with Prior Authorization, Urgently Needed Services.** A dependent child who is not enrolled in an accredited educational institution for one semester per Calendar Year continues to qualify as a

full-time student if the child was enrolled the previous semester and intends to be enrolled the following semester. For purposes of this section, an accredited educational institution is a postsecondary educational institution including an institution of higher education (as defined in Section 102 of the Higher Education Act of 1965). Upon the request of VIVA HEALTH or Program Manager, the Subscriber agrees to provide proof of full-time student status;

e. Any unmarried child as described in subsection (b) or (c) above but without regard to age, who (1) is and continues to be incapable of self-sustaining employment by reasons of mental or physical disability, (2) is chiefly dependent (greater than 50%) upon the Subscriber or Former Subscriber for economic support and maintenance, and (3) has been deemed disabled by the Social Security Administration, provided acceptable proof of such incapacity and dependency is furnished to VIVA HEALTH by the Subscriber or Former Subscriber no later than thirty (30) days of the child's attainment of age twenty-six (26) and subsequently as may be required by VIVA HEALTH, but not more frequently than annually. In addition, such unmarried child's disability must have commenced prior to the child's reaching age 26 and the child must have been enrolled hereunder as a Covered Dependent immediately prior to attaining age 26; or

f. The newborn child of a Subscriber or Former Subscriber will be covered at birth and for subsequent care only if the Subscriber or Former Subscriber formally enrolls the newborn within thirty (30) days after his/her birth. The newborn who is not enrolled within thirty (30) days must wait until the next Plan Open Enrollment Period.

A foster child or a child who has been placed in the Subscriber's or Former Subscriber's home (other than for adoption) is not an eligible dependent for purposes of the Plan. A grandchild of Subscriber or Former Subscriber or Subscriber's or Former Subscriber's spouse shall not be eligible for enrollment under the Plan unless the grandparent is the child's court-appointed legal guardian.

B. **Proof of Eligibility.** VIVA HEALTH or Program Manager reserves the right to require acceptable proof of eligibility at any time. Such proof must be legible and in a format and language that can be easily understood by VIVA HEALTH or Program Manager. In all cases, VIVA HEALTH's or Program Manager's determination of eligibility shall be conclusive.

PART III. ENROLLMENT AND EFFECTIVE DATE

A. **Initial Enrollment.** During the Initial Plan Open Enrollment, each Eligible Employee of the Employer shall be entitled to apply for coverage as a Subscriber for himself/herself and for the employee's eligible dependents, who must be listed on the enrollment application provided by VIVA HEALTH. For Eligible Employees who apply during Initial Plan Open Enrollment, the effective date is the first day of the first Plan Year.

B. **Newly Eligible Employee.** Each new employee of the Employer entering employment subsequent to the Employer's initial enrollment effective date shall be permitted to apply for coverage for himself/herself and eligible dependents, within thirty (30) days of becoming an Eligible Employee. For Eligible Employees who apply within thirty (30) days of becoming an Eligible Employee, the effective date is the day the new employee became an Eligible Employee when there is no new hire waiting period. When the Employer imposes a new hire waiting period, the effective date is the first day of the month after the new hire waiting period is satisfied.

C. **Newly Eligible Dependents.** Each Eligible Employee has a thirty (30) day special enrollment period upon marriage, birth, adoption, or placement for adoption. The Eligible Employee and eligible dependents may be enrolled by completing and submitting to VIVA HEALTH a signed enrollment request form within thirty (30) days of the date such person first becomes an eligible dependent. The effective date is the day he/she became an eligible dependent (the date of birth for a newborn or the date of adoption or placement for adoption for a newly adopted child).

D. **Open Enrollment.** Persons who do not enroll during Initial Plan Open Enrollment or within thirty (30) days of becoming a newly Eligible Employee or a newly eligible dependent may only enroll during an Open Enrollment Period. An Open Enrollment Period shall be held at least annually at which time Eligible Employees and their eligible dependents may enroll as Members under the Plan. The effective date for Eligible Employees and eligible dependents who apply during an Open Enrollment Period will be the first day of the next Plan Year.

E. **Special Enrollment.** A special enrollment period may be available for an Eligible Employee or eligible dependent who does not enroll under A, B, or C above, had Qualifying Previous Coverage, and lost that other coverage. For the special enrollment period to be available, the loss of other coverage must be because the other coverage was COBRA coverage that was exhausted, the other coverage ended due to loss of eligibility (other than loss due to failure to pay premiums or termination of coverage for cause such as fraud), or the other coverage ended due to an Employer's ending contributions toward the other coverage. The Eligible Employee must request enrollment within thirty (30) days of the exhaustion of COBRA continuation coverage, other loss of eligibility, or the Employer's ending contributions. However, if the Eligible Employee or eligible dependent is covered under Medicaid or a State child health plan and coverage of the Eligible Employee or eligible dependent under such plan is terminated as a result of the loss of eligibility for such coverage, the Eligible Employee may request coverage under the Plan no later than 60 days after termination of coverage. Also, if the Eligible Employee or eligible dependent becomes eligible for assistance with respect to coverage under the Plan under Medicaid or a State child health plan, the Eligible Employee may request coverage under the Plan no later than 60 days after the date the Eligible Employee or eligible dependent is determined to be eligible for such assistance. For Eligible Employees and eligible dependents applying during the special enrollment period, the effective date is the day following the date of loss of the other coverage.

F. **Limitations.** Persons initially or newly eligible for enrollment must complete the proper application and submit it to VIVA HEALTH or Program Manager within thirty (30) days of becoming eligible. Persons who do not enroll within thirty (30) days of becoming eligible may be enrolled only during a subsequent Open Enrollment Period. If coverage is terminated, re-enrollment is necessary. Any new coverage shall be effective as if the Member were a new enrollee under Part III.

G. **Notice of Ineligibility**. It shall be the Subscriber's responsibility to notify VIVA HEALTH or Program Manager of any changes that will affect his/her eligibility or the eligibility of Covered Dependents for Covered Services. If a Member loses eligibility, VIVA HEALTH or Program Manager has the right to retroactively terminate coverage to the date the Member ceased to be eligible and to recover any costs incurred by the Plan during that period.

H. **Rules of Eligibility.** No eligible person will be refused enrollment or re-enrollment in the Plan because of his/her health status, his/her age (except as provided in Part II.A.2), or his/her requirements for health services. However, no person is eligible to re-enroll hereunder who has had coverage terminated under Part IV.B. or IV.C.

I. **Leaves of Absence.** If the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA) and the Employer determines a Subscriber's leave qualifies as FMLA leave, the Subscriber remains eligible for coverage under this Certificate during the FMLA leave. A Subscriber on military leave that is covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) should contact the Employer's Plan Administrator regarding the Subscriber's rights to continue Plan coverage and the Subscriber will remain eligible for coverage under this Certificate to the extent required by USERRA.

PART IV. TERMINATION OF MEMBER'S COVERAGE

Coverage under the Plan will terminate as follows:

A. The date the Group Policy is terminated by the Trustee or the Employer or Program Manager as specified in the Group Policy. If the Group Policy is terminated for Employer's failure to pay premiums as required by the Group Policy, Program Manager is not liable to the Member for anything resulting from the termination. This includes, but is not limited to, liability for the refunding of any employee premium contributions and payment for health services received by the Member during any resulting break in coverage.

B. If the Member permits the use of his/her or any other Member's Plan identification card by any other person, or uses another person's card, the card shall be surrendered to VIVA HEALTH at VIVA HEALTH's request and coverage of the Member may be terminated effective upon written notice by VIVA HEALTH. Both the Subscriber and any Covered Dependents shall be liable to Program Manager for all costs incurred by the Plan as a result of the misuse of the identification card.

C. If a Member, on behalf of himself or another Member, or a person seeking coverage on behalf of the Member, performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact, 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 Program Manager. This includes but is not limited to material information relating to residence and/or employment within the Service Area and 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 intentional misrepresentation of material fact or Program Manager may rescind coverage under the Plan retroactively to the date specified by Program Manager. If the fraudulent activity relates to Plan eligibility, the termination may, at Program Manager's sole option, be retroactive to the date of enrollment (if the Member was never eligible) or the date the Member ceased to be eligible. VIVA HEALTH or Program Manager 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 Program Manager to cancel or discontinue coverage prospectively or to cancel or discontinue coverage retroactively to the extent such cancellation is attributable to a failure to timely pay the required premiums or contributions toward the cost of coverage. Program Manager reserves the right to pursue other available remedies in addition to coverage termination.

D. Subject to the continuation privileges of Part XII hereof, the coverage of any Member who ceases to be eligible shall terminate as of the date on which eligibility ceased; if the coverage of a Subscriber or Former Subscriber terminates due to the termination of their employment, then the Covered Dependents enrolled by the Subscriber or former Subscriber will cease to be eligible as of the date of the Subscriber's or Former Subscriber's coverage termination.

E. If a Subscriber's or Former Subscriber's employment or residence is no longer in the Service Area or a Covered Dependent's residence is no longer with the Subscriber or in the Service Area (except in accordance with Part II.A.(2).b and Part II.A.(2).d), termination is the date of such move. The Employer or Subscriber is responsible for notifying VIVA HEALTH or Program Manager of the Subscriber's or Covered Dependent's

move from the Service Area. Coverage will terminate on the date of the move, even if the required notice is not provided.

F. If the Employer or Program Manager instructs VIVA HEALTH to terminate coverage of a Member, the termination date will be that requested in such notice. Neither VIVA HEALTH nor the Program Manager is responsible for any delay in notification of coverage termination from the Employer to VIVA HEALTH or Program Manager. Services received between the date a Member's coverage is terminated by the Employer and the date VIVA HEALTH or Program Manager is notified by the Employer of the termination are not Covered Services even when such services have been authorized by VIVA HEALTH or a Participating Provider. When employment is terminated, most Employers terminate a Subscriber's coverage and the coverage of any Covered Dependents under the Certificate 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 Certificate ends. In no case will coverage extend beyond the last day of the month following the month of employment termination. If the Subscriber or Former Subcriber moves outside the Service Area between the date of employment termination and the date coverage ends, coverage for services delivered outside the Service Area is limited to **Emergency Services and, with Prior Authorization, Urgently Needed Services.**

G. If the Employer or Program Manager terminates coverage for any reason, the Employer or Program Manager is responsible for notifying Members of the termination.

The Subscriber is responsible for immediately notifying any Covered Dependents of a coverage termination.

PART V. DOUBLE COVERAGE

A. **Workers' Compensation.** The benefits under the Plan for Members eligible for Workers' Compensation or similar coverage for on-the-job injuries are not designed to duplicate any benefit for which such Members are eligible under the applicable Workers' Compensation Law, and do not affect any requirements for Workers' Compensation Insurance. The Plan shall not cover services denied by Workers' Compensation Insurance with respect to a Member due to the Member's failure to elect such coverage or to comply with its terms and conditions. The Plan shall not cover services required to be covered under the applicable Workers' Compensation Law whether or not the Employer has insurance coverage.

B. **Medicare.** Subscribers must notify their Employer and VIVA HEALTH and Program Manager when they or their dependents become eligible for Medicare. However, if an Eligible Employee chooses to drop coverage under this plan for himself or herself and enroll in Medicare, the Eligible Employee will become a Former Subscriber and the eligible Covered Dependent(s) of that Former Subscriber may remain covered under this Plan until the earlier of the date the Eligible Dependent(s) no longer meets the definition of eligible Dependent under the Plan or the date the Former Subscriber's employment with the Employer terminates for any reason.

Except as otherwise provided by applicable federal law that would require the Plan to be the primary payor, the benefits under the Plan for Members aged sixty-five (65) and older, or Members otherwise eligible for Medicare, do not duplicate any benefit to which such Members are eligible under the Medicare Act, including Part B of such Act. Services or expenses that a Member is, or would be, entitled to under Medicare, regardless of whether the Member properly and timely applied for or submitted claims to Medicare, are covered assuming the expenses normally payable by Medicare Parts A and B were covered. The Plan will not pay expenses normally payable by Medicare Parts A and B.

If the Plan is the secondary payor to Medicare, for primary coverage Members must enroll and maintain coverage under both Medicare Part A and Part B, even if the Member continues to be actively employed.

When the Plan is secondary and a Member is eligible for primary benefits under Medicare, VIVA HEALTH will process Member claims assuming all benefits offered under the primary coverage have been covered, regardless of whether the Member has elected primary coverage. If the Member is not enrolled in both parts of Medicare or does not follow the rules of Medicare or the Medicare Advantage or similar Medicare plan, the Member could be responsible for large out-of-pocket costs.

Members age 65 and older who have coverage due to a Subscriber's active employment will be covered for the same benefits available to Members under age 65. However, the Plan is the secondary payor for Medicare-eligible Members 65 and older in group health plans sponsored by Employers with fewer than 20 employees. The Plan is the secondary payor for Members eligible for Medicare due to disability in group health plans sponsored by Employers with fewer than 100 employees.

To the extent permitted by law, where the Plan has paid for benefits but Medicare is the responsible payor, acceptance of such services shall be deemed to constitute the Member's consent and agreement that all sums payable pursuant to the Medicare program for services provided hereunder to such Member shall be payable to and retained by the Plan.

PART VI. COORDINATION OF BENEFITS

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 Certificate 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 Certificate. All requirements in Part VIII. Access to Care, including but not limited to requirements related to use of Participating Providers 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 Certificate 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, the Plan 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, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan 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 the Plan 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 the Plan to enforce the Plan's rights under this Part.

PART VII. THIRD PARTY RECOVERY, SUBROGATION AND RIGHT OF REIMBURSEMENT

A. **Payment Condition.** The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of members, and/or their Eligible Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Member(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Member shall be a trustee over those Plan assets.

In the event a Member(s) settles, recovers, or is reimbursed by any Coverage, the Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Member(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Member(s) for charges incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Member(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

B. **Subrogation.** As a condition to participating in and receiving benefits under this Plan, the Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Member(s) fails to so pursue said rights and/or action.

If a Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Member(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Member is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Member's/Members' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. <u>Right of Reimbursement</u>. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Member(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Member(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Member's/Members' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Member are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Member's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which

attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

D. **Member is a Trustee Over Plan Assets.** Any Member who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Member understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Member is not represented by an attorney, instruct the insurance company or any third party from whom the Member obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Member disputes this obligation to the Plan under this section, the Member or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Member, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

E. **Release of Liability.** The Plan's right to reimbursement extends to any incident related care that is received by the Member(s) (Incurred) prior to the liable party being released from liability. The Member's/Members' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Member has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

F. **Excess Insurance.** If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

G. **Separation of Funds.** Benefits paid by the Plan, funds recovered by the Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Member(s), such that the death of the Member(s), or filing of bankruptcy by the Member(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

H. **Wrongful Death**. In the event that the Member(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Member(s) and all others that benefit from such payment.

I. **Obligations.** It is the Member's/Members' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Member may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Member is not represented by an attorney, instruct the insurance company or any third party from whom the Member obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Member over settlement funds is resolved.

If the Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Member's/Members' cooperation or adherence to these terms.

J. **Offset.** If timely repayment is not made, or the Member and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Member(s) in an amount equivalent to any outstanding amounts owed by the Member to the Plan. This provision applies even if the Member has disbursed settlement funds.

K. **Minor Status.** In the event the Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

L. **Language Interpretation.** The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

M. **Severability.** In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

PART VIII. ACCESS TO CARE

A. **Entitlement to Covered Services.** Subject to all terms, conditions, and definitions in this Certificate, each Member shall be entitled to receive Medically Necessary Covered Services set forth in Part IX and the applicable Attachments to this Certificate, which are made a part hereof. Certain Covered Services are subject to payment of Cost Sharing, which is the financial responsibility of the Member and is set forth in Attachment A, Summary of Benefits. Cost Sharing applies based on the Plan benefits on the date the Covered Services were received, regardless of when the Covered Services were requested or approved. If tests or other Covered Services are necessary to determine Medical Necessity, the Member is responsible for the applicable Coinsurance, Copayment or Deductible. If a service that is not a Covered Service was authorized or covered by exception or an error in the past, the Plan is not required to authorize or cover that service going forward.

B. **Participating Providers.** Enrolling for Coverage under the Group Policy does not guarantee Covered Services will be provided by a particular Participating Provider. The directory of Participating Providers is subject to change. Members may call VIVA HEALTH's Customer Service Department or visit the website at www.vivahealth.com to verify that a particular provider is a Participating Provider.

C. Provision of Care.

1. By Participating Providers: Except for Emergency Services as set forth in Part IX.D. or as otherwise prior-approved by VIVA HEALTH, all services must be provided by a Participating Provider, subject to the limitations set forth in Part IX and X and the limitations, Coinsurances, Copayments, Deductibles, and any Lifetime maximum set forth in Attachment A. If a Participating Provider's agreement with VIVA HEALTH terminates, a Member shall be required to utilize another Participating Provider. Before accepting services, a Member should verify and is responsible for verifying that the Participating Provider's agreement with VIVA HEALTH has not terminated.

2. By non-Participating Providers:

   a. Under this Certificate, **no charges will be covered** by the Plan for services received by the Member from non-Participating Providers, unless:

      i. the services are Emergency Services or are Urgently Needed Services delivered outside the Service Area for which the Member has received prior approval from VIVA HEALTH. The Member must notify VIVA HEALTH within 24 hours or as soon as reasonably possible after Emergency Services are initially provided by Participating or non-Participating Providers; or

      ii. the services are determined NOT to be available in the Service Area through Participating Providers (see paragraph (c) below). If Medically Necessary services are not available in the Service Area through Participating Providers, a prior approval from VIVA HEALTH is required before a Member can receive Covered Services from an appropriate non-Participating Provider. The Plan will cover up to 100% of the actual charges, subject to applicable Coinsurances, Copayments, and Deductibles **if, and only if, VIVA HEALTH's Medical Director has made the determination referred to in paragraph (c) below.**

   b. If a Member obtains care from a non-Participating Provider without prior-authorization by VIVA HEALTH, **no charges for services will be covered by the Plan, except for Emergency Services.**

   c. The determination of whether Medically Necessary Covered Services are available through Participating Providers in the Service Area is made by the Medical Director upon request from a Participating Provider or a Member. Members may make the request through VIVA HEALTH Customer Service.

   d. A non-Participating Provider must furnish proof that the Member actually paid the applicable Copayment or Coinsurance. Without such proof, benefits may not be paid to a non-Participating Provider.

D. Prior Authorizations. Certain services and places of service require authorization from VIVA HEALTH prior to receiving a service. If such authorization is not obtained, no charges for those services will be covered by the Plan. The list of Covered Services requiring Prior Authorization is subject to change, and the most recent version is available on www.vivahealth.com or by calling Customer Service. The list of services requiring Prior Authorization includes but is not limited to the following:

1. Hospital admissions and transfers **(if you are admitted to the Hospital for an Emergency Medical Condition, you must call VIVA HEALTH within 24 hours or as soon as reasonably possible for the admission to be a Covered Service)**
2. Hospital observation unit
3. Hospital Outpatient services

4. Outpatient surgery
5. Skilled Nursing Facility admissions
6. Inpatient rehabilitation or day treatment
7. Heart catheterization
8. Pain clinic care
9. Physical, speech, and occupational therapy and applied behavior analysis
10. Home Health Agency services
11. Durable Medical Equipment, Orthotics, and Prosthetics
12. Sleep studies
13. Transplant services
14. Non-emergency Care by non-Participating Providers (only when care is not available through Participating Providers within the Service Area)
15. Imaging services [including, but not limited to, MRIs, MRAs, CT scans, myelograms, nuclear medicine, discograms, PET scans, and 3D and 4D imaging (including ultrasound)]
16. All scopes performed outside the physician's office excluding colonoscopy and EGD
17. All plastic surgery (see Part X.H.)
18. All sinus or nasal surgery
19. Arteriograms
20. Cardiac and pulmonary rehabilitation
21. Holter monitors if worn longer than 24 hours
22. Genetic testing
23. Genomic testing
24. Testosterone pellets
25. Intensive Outpatient Programs (IOPs)
26. Partial Hospitalization Programs (PHPs)

E. **Services Provided Outside the Service Area.** Out-of-Area Services are limited to Emergency Services (as set forth in Part IX.D) and Urgently Needed Services (services that are required immediately and unexpectedly), subject to the limitations contained in this Certificate and its Attachments. Services that are not Emergency Services must be authorized in advance by VIVA HEALTH. Elective or specialized care required as a result of circumstances that could reasonably have been foreseen prior to departure from the Service Area is not a Covered Service. **Always call VIVA HEALTH within 24 hours or as soon as reasonably possible after Emergency Services are received.**

F. **Review.** The medical care provided to you by your Personal Care Provider, specialists or other health care professionals will be reviewed by VIVA HEALTH for eligibility, coverage and Medical Necessity. This review can occur after the service has been provided and/or paid for. The review of care for lengthy Outpatient treatment plans and Inpatient Hospital stays will be conducted during the treatment period.

G. **New Medical Technologies.** VIVA HEALTH will review new, non-experimental, medical technologies from time to time as deemed appropriate by VIVA HEALTH to determine if the service should be added or deleted as a Covered Service in the Schedule of Benefits in Part IX. This review will include consideration of information available from medical literature, experts in the field, and state and/or federal regulatory agencies.

H. **Authorization Does Not Guarantee Payment.** If the Member has other coverage as described in Parts V. and VI., and such other coverage is responsible for payment or would have been responsible if the Member had complied with its terms and conditions, the Plan is not responsible for payment even if services were authorized.

Coverage of certain benefits is limited in quantity (such as number of visits or days) and/or in maximum dollars of coverage. These limitations are specified in Attachment A to this Certificate. Authorizations do not extend such limitations. For example, if a benefit is limited to 10 visits per year, the 11th visit will not be a Covered Service even if the 11th visit is authorized by VIVA HEALTH. Likewise, if benefit coverage is limited to a specified dollar amount, services received for the benefit after the specified dollar amount is reached are not Covered Services even if the services are authorized by VIVA HEALTH. Members may contact VIVA HEALTH's Customer Service Department to determine the quantity or dollars of services that have been used. However, VIVA HEALTH records will only reflect the claims submitted by providers and paid by VIVA HEALTH as of the current date. Services the Member recently received may not be reflected. Therefore, it is the Member's responsibility to monitor usage of limited benefits.

In order for authorized services to be Covered Services, you must be a Member at the time services are received. Authorizations are not valid for services received after the date coverage terminates. For coverage terminations initiated by the Employer or Program Manager, there may be a delay between the date a Member's coverage is terminated by the Employer or Program Manager and the date VIVA HEALTH is notified by the Employer or Program Manager of the termination. In the event employment ends, please consult with the Employer or Program Manager to determine when your coverage under this Certificate ends. VIVA HEALTH is not responsible for any delay in notification of coverage termination from the Employer or Program Manager to VIVA HEALTH. Services received between the date a Member's coverage is terminated by the Employer or Program Manager and the date VIVA HEALTH is notified by the Employer or Program Manager of the termination are not Covered Services even when such services have been authorized by VIVA HEALTH or a Participating Provider. If the Program Manager terminates the Group Policy due to Employer's non-payment of premium, any services received during the period for which no premium was paid are not Covered Services even if authorized by VIVA HEALTH.

An authorization given for a Member who was ineligible for the Plan on the date the authorized service was received will not be honored. The Member and/or Subscriber will be held financially responsible for the cost of such service.

I. **Care After Hours and on Weekends.** If you have an urgent need for care that is not an Emergency Medical Condition when your Personal Care Provider's office is closed, call your Personal Care Provider. The answering service will connect you to your Personal Care Provider or the physician on-call for him/her who will assist you in determining the best course of action. If you need to be seen right away, you also have the option of visiting a Participating urgent care facility or another Participating Provider. Participating Providers are listed on the VIVA HEALTH website at www.vivahealth.com. You may also call VIVA HEALTH at the number on your Member identification card and speak with the nurse on-call.

J. **Lifetime or Annual Maximum Benefit Limits**. Subject to all terms, conditions and definitions in this Certificate, each Member is entitled, when a Lifetime or Annual Maximum applies, to Covered Services up to an amount not to exceed the Lifetime or Annual Maximum. Health care services deemed "essential health benefits" by the Affordable Care Act and its implementing regulations are not subject to lifetime or annual maximum dollar limits.

K. **Reaching the Lifetime or Annual Maximum Benefit Limit.** Whether a Member has reached the benefit limit is determined by adding the amounts of benefits used for Covered Services provided a Member under this Plan and under any other VIVA HEALTH plan. When dollar limits apply, the amount for each Covered Service is based on VIVA HEALTH's fee schedule for Covered Services. This fee schedule is to be used for all amounts regardless of VIVA HEALTH's arrangements with any Participating Providers.

L. **Out-of-Pocket Maximum**. The Out-of-Pocket Maximum consists of Deductibles, Coinsurance and Copayments for qualified Covered Services incurred by a Member during a Calendar Year. Qualified

Covered Services are health care services for Emergency and Urgently Needed Services and for other health care services deemed "essential health benefits" by the Affordable Care Act and its implementing regulations when such services are received by Participating Providers. The Out-of-Pocket Maximum for medical services does not include costs for premiums, health care this plan does not cover, health care services not deemed essential health benefits or services received from non-Participating Providers, except Emergency and Urgently Needed Services. The Plan's specific Out-of-Pocket Maximum(s), if applicable, is (are) described in Attachment A, Summary of Benefits.

PART IX. SCHEDULE OF BENEFITS

Health services described in this Part IX are Covered Services when provided in accordance with the requirements for accessing care described in Part VIII. Covered Services are **subject to exclusions described in Part X** and to the limitations and payment of applicable Copayments, Coinsurance, and/or Deductibles as described in Attachment A, Summary of Benefits. When coverage of a service is limited, such as to a particular number of visits, number of days or a certain dollar amount, the Member is responsible for the cost of the service after the coverage limit is met even when the service is Medically Necessary.

A. Professional Services Performed Within the Plan Service Area.

1. Physician Services. The following are Covered Services when provided by a Participating Physician. Services are furnished at the Physician's office, Hospital, Skilled Nursing Facility, or at the Member's home (when the Member's health so requires and as authorized by the Medical Director):

    a. diagnosis and treatment of illness or injury;
    b. routine physical examinations when provided by a Personal Care Provider;
    c. usual and customary pediatric and adult immunizations in accordance with accepted medical practice when provided by a Personal Care Provider except for work-required immunizations and immunizations for travel abroad;
    d. pre- and post-operative care;
    e. prenatal care, delivery, and post-natal care of mother;
    f. consultant and referral services from Participating Specialists;
    g. pediatric care, including newborn care and intensive care nursery (subject to prior-authorization) for Covered Dependents;
    h. family planning services including voluntary sterilization (tubal sterilization and vasectomy) and the provision of intrauterine devices and subcutaneous implants for contraception;
    i. examinations to determine the need for hearing correction.

2. Preventive Services. Certain preventive items and services are covered at 100% with no copayment, coinsurance or deductible from the Member when provided by a Participating Provider. These items and services generally include those recommended by the U.S. Preventive Services Task Force with a grade of A or B; immunizations for routine use recommended by the Advisory Committee on Immunization Practices; and, with respect to infants, children, adolescents and women, preventive care and screenings 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.

    If a preventive item or service described in this Part is billed separately, in addition to an office visit charge, the Member may be responsible for a copayment, coinsurance and/or deductible for the office visit. In that case, the Member would not pay an additional copayment, coinsurance and/or deductible for the separately billed preventive service or item. A copayment, deductible or coinsurance also may apply if the primary purpose of the Member's visit is not routine, preventive care.

All preventive services must be received by Participating providers in order to be covered at 100%. In some cases, the services must be received as part of an annual physical, well-child or well-baby checkup in order to be covered at 100% with no copayment, coinsurance or deductible.

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% and the applicable limitations and guidelines. The document is available on the website at www.vivahealth.com or by calling Customer Service. Members who do not receive prescription drugs through VIVA HEALTH's pharmacy benefit manager are not entitled under this Certificate to preventive services that require a prescription. Please consult the "VIVA HEALTH Wellness Benefits" guide to determine which services require a prescription.

3. Surgery and Anesthesia. These services include surgical services performed at Inpatient and Outpatient surgical facilities that are Participating Providers and anesthesia administered in conjunction with such surgery. All surgical services must have authorization from VIVA HEALTH prior to the surgical procedure.

4. Laboratory Procedures and X-ray Examinations. Diagnostic and therapeutic radiology services; diagnostic laboratory services performed by a Participating laboratory in support of other basic services prescribed by a Participating Physician. **All such procedures, even when requested by a Participating Provider, must be performed by a Participating facility, laboratory, or provider with the exception of Emergency Services and, with Prior Authorization, Urgently Needed Services outside the Service Area.**

5. Vision Care. Medically Necessary visits for the treatment of illness or injury only.

6. Home Health Care. Medically Necessary short-term Skilled Nursing Care, provided at a Member's home through a Home Health Agency by a Registered Nurse or Licensed Practical Nurse duly licensed by the applicable state. Coverage is limited to the number of days specified in Attachment A; Prior Authorization must be obtained from VIVA HEALTH's Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable period of time. During the course of treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided for the full number of days allowed per Attachment A.

7. Rehabilitative Services for Physical, Occupational and Speech Therapy.

   a. Outpatient Rehabilitative Services. Medically Necessary Outpatient short-term Rehabilitative Services upon referral from a Participating Physician and with prior approval of the Medical Director. Therapy is covered only when required as a result of or in preparation for Medically Necessary surgery or other Medically Necessary procedure or as a result of Accidental Injury, stroke, or congenital anomaly present at birth. Coverage of Outpatient Rehabilitative Services is limited to the number of visits specified in Attachment A; Prior Authorization must be obtained from the Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable period of time (within 2 months in most cases). During the course of treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided.

   b. Inpatient Rehabilitative Services. Medically Necessary Inpatient short-term Rehabilitative Services upon referral from a Participating Physician and with prior approval of the Medical Director. Coverage of Inpatient Rehabilitative Services is limited to the number of days specified

in the Attachment A. Prior Authorization must be obtained from the Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable period of time. During the course of treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided for the full number of days allowed per the Attachment A. An Inpatient rehabilitation Copayment will apply, even if the Member has paid a Hospital Copayment for a Hospital stay immediately prior to the rehabilitation admission.

8. Outpatient Habilitative Services for Physical, Occupational and Speech Therapy and Applied Behavior Analysis. Medically Necessary Outpatient Habilitative Services upon prescription from a Participating Provider and with prior approval of the Medical Director. Therapy is covered only in conjunction with an approved treatment plan designed to attain, maintain, or prevent deterioration of a function never learned or acquired as a result of autism, autism spectrum disorder, or pervasive developmental delay. A service that does not help the Member to meet functional goals in an approved treatment plan within a prescribed time frame is not a Habilitative Service. When a Member does not demonstrate continued progress toward the goals of an approved treatment plan, a service that was previously Habilitative is no longer Habilitative.

9. Outpatient services for cardiac and pulmonary rehabilitation. Medically Necessary Outpatient short-term rehabilitation services upon referral from the Personal Care Provider or a Participating Physician and with prior approval of the Medical Director. Coverage is limited to thirty-six (36) total visits per Calendar Year; Prior Authorization must be obtained from a Participating Physician and the Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable period of time (within 6 months in most cases). During the course of treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided for the full thirty-six (36) visits.

10. Services for Infertility. Coverage for infertility services is limited to initial consultation, one counseling session, Medically Necessary office visits, and tests only for Subscriber or Subscriber's covered spouse. Testing for semen analysis, HSG, and endometrial biopsy is limited to once during the Member's Lifetime. Intrauterine insemination, assisted reproductive technology and other treatments are not Covered Services.

11. Mental Health Services. Mental health services required by a court order are specifically excluded from coverage as indicated in Part X.J. Mental health services for the following conditions are also excluded except for purposes of making the initial diagnosis: eating disorders, learning disorders, motor skills disorders, communication disorders, mental retardation, sexual, paraphilia, truancy, disciplinary, or other behavioral problems. Please see Part X. for additional exclusions.

    Inpatient mental health services must be authorized prior to treatment and meet established Medical Necessity guidelines. If you are admitted to the Hospital from the emergency room for Inpatient mental health services, authorization does not have to be obtained prior to treatment but always call VIVA HEALTH within 24 hours or as soon as reasonably possible. Outpatient mental health services may be authorized prior to treatment if desired to verify coverage. Certain services and diagnoses may not be covered and all services must meet Medical Necessity guidelines. Mental Health Services may include assessment, diagnosis, treatment planning, medication management, and psychotherapy (e.g. individual, family and group). Mental Health Services may be provided by licensed Participating Providers including psychiatrists, nurse practitioners, psychologists, professional counselors, and clinical social workers.

    If covered, Mental Health Services include:

a. Outpatient Mental Health Services. When care is Medically Necessary:

i. Psychotherapy provided by a licensed mental health Provider in order to treat a mental health disorder. Brief, goal-directed talk therapy is provided for individuals, groups, and families.

ii. Pharmacotherapy provided by psychiatrists who are medical doctors and specialize in treating mental disorders using the biomedical approach, which includes psychotherapy. Pharmacotherapy may also be provided by licensed nurse practitioners working alongside psychiatrists.

iii. Psychological testing administered and interpreted by a licensed Clinical Psychologist. The testing must have sound psychometric properties and be conducted for purposes of aiding in diagnosis of a Mental Health Disorder or in the process of reassessing a failed treatment.

iv. Crisis Assessment provided in an ambulatory or facility-based program designed to help the Member cope with a crisis and gain access to the next appropriate level of care. Crisis Assessment is usually indicated when there is evidence of an impending or current psychiatric emergency without clear indication for Inpatient treatment.

v. Dual Diagnosis programs when a Member has a severe or complex Mental Health Disorder(s) and a comorbid Substance-Related Disorder(s).

vi. Electroconvulsive therapy (ECT), also known as electroshock, is a psychiatric treatment in which seizures are electrically induced in patients who are under anesthesia for a therapeutic effect. Electroconvulsive therapy administered by a specially trained psychiatrist may differ in its application. The frequency and total number of treatments will vary depending on the condition being treated, the individual response to treatment and the Medical Necessity of the treatment. ECTs are provided in an Outpatient facility or when necessary during an acute Inpatient stay.

vii. Intensive Outpatient Program (IOP) services, which include individual therapy, group therapy, family and/or multi-family therapy and psycho-education to decrease symptoms and improve Member's level of functioning

viii. Partial Hospitalization Program (PHP) services, which include nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, substance abuse evaluation, and counseling. Partial hospitalization is covered for Members meeting Prior Authorization criteria when the partial hospitalization program is in lieu of inpatient treatment.

b. Inpatient Mental Health Services. The same services covered under section a. Outpatient Mental Health Services above are covered Inpatient Mental Health Services when care is Medically Necessary and authorized by VIVA HEALTH or its designee. Acute inpatient treatment represents the most intensive level of care and is provided in a secure and protected hospital setting. Inpatient treatment is indicated for stabilization of individuals who display acute conditions or are at a risk of harming themselves or others.

Treatment in other levels of care such as Residential treatment and care in a Sanatorium, State, or Government Facility are specifically excluded from coverage.

12. Substance Abuse Services. Substance abuse services required by a court order are specifically excluded from coverage as indicated in Part X.J. Please see Part X. for additional exclusions.

    Inpatient substance abuse services must be authorized prior to treatment and meet established Medical Necessity guidelines. If you are admitted to the Hospital from the emergency room for Inpatient substance abuse services, authorization does not have to be obtained prior to treatment but always call VIVA HEALTH within 24 hours or as soon as reasonably possible. Outpatient substance abuse services may be authorized prior to treatment if desired to verify coverage. Certain services and diagnoses may not be covered and all services must meet Medical Necessity guidelines. Substance Abuse Services may be provided by licensed Participating Providers including Psychiatrists, Addictionologists, Nurse Practitioners, Psychologists, Professional Counselors, and Clinical Social Workers.

    If covered, Substance Abuse Services include:

    a. Outpatient Substance Abuse Health Services. When care is Medically Necessary:

        i. Psychotherapy provided by a licensed mental health Participating Provider in order to treat a chemical dependency. Brief, goal-directed talk therapy is provided for individuals, groups, and families.

        ii. Pharmacotherapy provided by Psychiatrists, Addictionologists, or Nurse Practitioners specializing in treating chemical dependency using the biomedical approach, which includes psychotherapy.

        iii. Psychological testing administered and interpreted by a licensed Clinical Psychologist. The testing must have sound psychometric properties and be conducted for purposes of aiding in diagnosis of a Substance-Related Disorder or in the process of reassessing a failed treatment.

        iv. Crisis Assessment provided in an ambulatory or facility-based program designed to help the Member cope with a crisis and gain access to the next appropriate level of care. Crisis Assessment is usually indicated when there is evidence of an impending or current substance-related emergency without clear indication for Inpatient treatment.

        v. Dual Diagnosis programs when a Member has a severe or complex Mental Health Disorder(s) and a comorbid Substance-Related Disorder(s) that make it unlikely he or she would benefit from a program focusing solely on the Substance-Related Disorder(s).

        vi. Ambulatory detoxification (also known as Outpatient detoxification) to safely detoxify patients from drugs and alcohol without an admission to a hospital. Ambulatory detoxification can be undertaken by patients who show mild symptoms of withdrawal. Appropriate candidates should have transportation, a support system and the ability to monitor progress while at the same time showing no signs of medical complications or severe withdrawal risk.

        vii. Intensive Outpatient Program (IOP) services, which include individual therapy, group therapy, family and/or multi-family therapy and psycho-education to decrease symptoms and improve Member's level of functioning.

        viii. Partial Hospitalization Program (PHP) services, which include nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, substance abuse evaluation, and counseling. Partial hospitalization is covered for Members

meeting Prior Authorization criteria when the partial hospitalization program is in lieu of Inpatient treatment.

b. Inpatient Substance Abuse Services. The same services covered under section a. Outpatient Substance Abuse Services above are covered Inpatient Substance Abuse Services when care is Medically Necessary and authorized by VIVA HEALTH or its designee. Acute Inpatient treatment represents the most intensive level of care and is provided in a secure and protected hospital setting. Inpatient treatment is indicated for stabilization of individuals who display acute conditions or are at a risk of harming themselves or others. Inpatient Substance Abuse services also include:

   i. Acute Inpatient Medical Detoxification provided in a Substance Abuse Treatment Facility or in a general Hospital that provides Substance Abuse Treatment Services for the purpose of completing a medically safe withdrawal from a substance(s). This treatment is usually indicated when there is a risk of severe withdrawal symptoms or seizures and/or comorbid psychiatric or medical conditions that cannot be safely treated in a less intensive setting.

   ii. Inpatient Rehabilitation provided in a Hospital licensed and credentialed to treat Substance-Related Disorders. Inpatient Rehabilitation provides structured treatment services with 24-hour on-site nursing care and monitoring. Daily and active treatment by a psychiatrist supervising the plan of care is required. All general services relevant to a Member's comorbid medical condition(s) should be available as needed.

Treatment in other levels of care such as Residential treatment and care in a halfway house or other sober living arrangement are specifically excluded from coverage.

13. Maternity Care. Maternity Care includes risk-appropriate prenatal care, intrapartum and postpartum care for the Subscriber or a Covered Dependent. For medically high-risk pregnant women, maternity care includes transportation when Medically Necessary. **Please see Part X. K. for excluded maternity services outside the Service Area.**

14. Newborn Care. Newborn Care includes preventive health care services and services for or related to injury or sickness of a Covered Dependent, including the Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. **Please see Part X. K. for excluded newborn care services outside the Service Area.**

15. Oral Surgery. Only the following procedures are covered:

    a. removal of tumors;
    b. cysts of the jaws, cheeks, lip, tongue and roof of the mouth;
    c. treatment of fractured facial bones;
    d. external and internal incision and drainage;
    e. cutting of salivary glands or ducts;
    f. frenectomy;
    g. orthognathic surgery and
    h. treatment of non-dental birth defects (such as cleft lip or cleft palate) which have resulted in a severe functional impairment.

16. Extraction and Replacement of Teeth. Extraction and replacement of Sound Natural Teeth are covered if due to Accidental Injury. "Accidental Injury" is defined in Part I of this Certificate and does not

include any damage caused by chewing or biting on an object. VIVA HEALTH may require proof of Accidental Injury (for example, a copy of the accident report).

17. Temporomandibular Joint Disorders. Non-surgical and surgical management of temporomandibular joint (TMJ) disorders, including office visits, and adjustments to the orthopedic appliance, physical therapy, joint splint, and hospital related services (including but not limited to room and board, general anesthesia and Outpatient surgery services). All surgical services must have authorization from VIVA HEALTH prior to the surgical procedure.

18. Chiropractic Services. Manual Manipulative Treatment to correct subluxation by a Participating chiropractor is limited to the number of visits per Calendar Year indicated in Attachment A, Summary of Benefits. Related x-ray services are Covered Services at the initial visit when Medically Necessary. See Attachment A, Summary of Benefits for specific coverage.

19. Allergy Services. Allergy Services and supplies ordered by or under the direction of a Participating Physician. See Attachment A, Summary of Benefits for specific coverage.

20. Sleep Disorders. Coverage for evaluations and treatment of severe or life-threatening sleep disorders. All sleep studies and surgical procedures must be approved in advance by VIVA HEALTH and meet VIVA HEALTH's guidelines. Coverage for sleep studies is subject to the Cost Sharing specified in Attachment A, Summary of Benefits.

21. Post-Mastectomy Reconstructive Surgery. In connection with a mastectomy and in consultation with the attending physician and the patient, all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

22. Hospice Care. Non-curative medical care, supplies and drugs included in the daily fee for hospice care provided by a properly licensed or accredited Participating hospice agency are covered for a terminally ill Member when a Participating Provider certifies the Member's life expectancy is less than six months and the Member is no longer pursuing curative treatment. Coverage is limited to 180 days per Lifetime. Hospice Care must have authorization from VIVA HEALTH before services are rendered.

23. Genetic/Genomic Testing. Genetic/genomic testing coverage is limited to comprehensive testing of the BRCA1 and BRCA2 genes and Oncotype Dx testing and limited additional testing when Medically Necessary and required to diagnose and treat a Member's existing Medical condition. Testing is subject to Member Cost Sharing as described in Attachment A. Genetic tests considered preventive services as described in Part IX.A.2 are not subject to Cost Sharing. Testing must be approved in advance by VIVA HEALTH and meet VIVA HEALTH'S guidelines. Lifetime testing limits may apply.

24. Testosterone Pellets. Covered as a second-line replacement therapy for males with congenital or acquired endogenous androgen absence or deficiency associated with primary or secondary hypogonadism or for the treatment of delayed male puberty. Must be approved in advance by VIVA HEALTH and meet VIVA HEALTH's guidelines. Not covered for females.

25. Telephonic and/or virtual visits ("telemedicine" or "telehealth"). Telephonic and/or virtual visits ("telemedicine" or "telehealth"), including outside of a medical facility, for Covered Services that include the diagnosis and treatment of certain medical conditions for Members through the use of interactive audio and/or video telecommunication technology. Benefits are available only when Covered Services are delivered through a designated Participating telemedicine provider. Call VIVA

HEALTH Customer Service or visit www.vivahealth.com for a list of the Plan's Participating Provider(s) designated as telemedicine providers. Depending on a Member's medical condition, telemedicine may not be appropriate to diagnose and treat the condition. The designated, Participating telemedicine provider may decline to provide a service and direct Members to seek treatment instead from in-person Providers when appropriate.

B. Hospital Services. All Hospital Services, except in the case of Emergency Services, must be provided in a Hospital that is a Participating Provider, must be Medically Necessary, and authorization from VIVA HEALTH prior to the admission is required. If the Member is in the Hospital on the effective date of coverage, the Member must notify VIVA HEALTH of such confinement within twenty-four (24) hours of the Member's effective date or as soon as reasonably possible in order for the benefits provided in this Certificate to be Covered Services on the Member's effective date. If the Member is admitted to the Hospital due to an Emergency Medical Condition, the Member must notify VIVA HEALTH of such confinement within twenty-four (24) hours or as soon as reasonably possible. In either case, if the Member fails to notify VIVA HEALTH of the confinement as required, coverage of Hospital services will not begin until VIVA HEALTH receives such notification.

If a Member is admitted to a non-Participating Hospital due to an Emergency Medical Condition, the Member must notify VIVA HEALTH as stated above and VIVA HEALTH may arrange for the Member's care to be transferred to a Participating Provider as soon as the Member's medical condition is stable. If the Member refuses such transfer to a Participating Provider, the Member will be financially responsible for the cost of care after the Member's condition was stable. Professional Services rendered in a Hospital must be Covered Services under Part IX.A. for the Hospital Services to be Covered Services.

1. Inpatient Services.

   a. semi-private room, if available (private room only if Medically Necessary and authorized by a Participating Provider and VIVA HEALTH's Medical Director);
   b. general nursing care (special duty nursing when Medically Necessary);
   c. meals (special diets when Medically Necessary);
   d. use of operating room and related facilities;
   e. use of intensive care unit or cardiac care unit and related services;
   f. diagnostic and therapeutic x-ray;
   g. laboratory;
   h. other diagnostic testing;
   i. drugs, medications, biologicals, anesthesia, and oxygen services;
   j. physical therapy;
   k. speech therapy;
   l. radiation therapy;
   m. occupational therapy;
   n. chemotherapy;
   o. inhalation therapy;
   p. administration of whole blood and blood derivatives (but not the whole blood itself);
   q. hospital social services;
   r. rehabilitation services during a Hospital stay in an acute facility with the prior approval of VIVA HEALTH's Medical Director; if a Member has a separate admission into a rehabilitation unit as part of a Hospital stay or is transferred to another facility for rehabilitation services, the Inpatient rehabilitation Copayment will apply in addition to the Hospital Copayment;
   s. post-partum care;
   t. newborn care for Covered Dependents. If a newborn is discharged from the Hospital with the mother following delivery, the Inpatient Hospital Copayment will not apply to the newborn's stay

unless the newborn has a separate admission. If the newborn has a separate admission to a special unit such as the neonatal intensive care unit or is transferred to a higher level of care, the Hospital Copayment will apply even if the newborn is discharged from the Hospital with the mother. If the newborn remains in the Hospital after the mother is discharged, the Hospital stay must be prior-authorized and the Hospital Inpatient Copayment will apply. No charges for the newborn will be covered by the Plan if the newborn is not added as a Covered Dependent within 30 days of birth or adoption; and

u. long-term acute care services during or following a Hospital stay in an acute facility, with the prior approval of VIVA HEALTH's Medical Director; if a Member has a separate admission into a long-term acute care hospital (LTCH) as part of a Hospital stay or is transferred to an LTCH following a Hospital stay, a separate Inpatient Hospital Copayment will apply for the long-term acute care services in addition to the initial Hospital Copayment.

2. Outpatient Services. Outpatient services shall include diagnostic services, radiotherapy and chemotherapy, and x-ray services which can be provided in a non-Hospital based health care facility or at a Hospital outpatient department for Members who are ambulatory. These services require Prior Authorization by VIVA HEALTH.

C. Extended Care and Skilled Nursing Facility Services. Skilled Nursing Facility services are covered up to the number of days specified in Attachment A (including semi-private room, board and general Skilled Nursing Care) at a Skilled Nursing Facility approved by VIVA HEALTH if the primary purpose of such institutionalization is care by health professionals for the medical condition(s) requiring such Skilled Nursing Facility care. In all instances, care must be Medically Necessary, ordered by a Participating Physician, and have prior approval by the Medical Director. If the Member is in a Skilled Nursing Facility on the effective date of coverage, the Member must notify VIVA HEALTH of such confinement within twenty-four (24) hours of the Member's effective date or as soon as reasonably possible in order for the benefits provided in this Certificate to be Covered Services on the Member's effective date. Otherwise, coverage of Skilled Nursing Facility services will not begin until VIVA HEALTH receives such notification.

D. Emergency Services.

1. Emergency Services. Emergency medical care, including Hospital emergency room services and emergency ambulance services will be covered twenty-four (24) hours per day, seven (7) days per week, if provided by an appropriate health professional whether in or out of the Service Area if the following conditions exist:

   a. the Member has an Emergency Medical Condition;
   b. treatment is Medically Necessary; and
   c. treatment is sought immediately after the onset of symptoms or referral to a Hospital emergency room is made by a Participating Physician.

   No Prior Authorization of Emergency Services from VIVA HEALTH is required. VIVA HEALTH will retrospectively review claims for Emergency Services to determine if each of the above criteria is met. In determining whether an Emergency Medical Condition existed, VIVA HEALTH will consider whether a prudent layperson with an average knowledge of health and medicine would reasonably have considered the condition to be an Emergency Medical Condition.

   There is a Copayment for each emergency room visit as specified in Attachment A. The Copayment will be waived if the Member is admitted to a Hospital through that Hospital's emergency room as an inpatient for the same condition within 24 hours from the time of initial treatment by emergency room

staff. **If you are admitted to the Hospital from the emergency room, always call VIVA HEALTH within 24 hours or as soon as reasonably possible.**

2. Payment to Non-Participating Providers. Payment for services of non-Participating Providers shall be limited to expenses for such care required before the Member can, without medically harmful or injurious consequences, utilize the services of a Participating Provider. VIVA HEALTH may elect to transfer the Member to a Participating Provider as soon as it is medically appropriate to do so. Services rendered by non-Participating Providers are not Covered Services if the Member refuses to be transferred after VIVA HEALTH notifies the Member of the intent to transfer services to a Participating Provider.

   To be eligible for payment, Emergency Services from Participating and non-Participating Providers must meet the following criteria:

   a. Treatment must be for an Emergency Medical Condition as defined in Part I; and
   b. The Member must notify VIVA HEALTH within 24 hours or as soon as reasonably possible after Emergency Services are initially provided.

3. Follow-up Care. Follow-up care in an emergency room is not a Covered Service. Follow-up care must be provided by a Participating Physician, unless otherwise authorized by VIVA HEALTH's Medical Director. Benefits for continuing or follow-up treatment are otherwise provided only in the Service Area, subject to all provisions of this Certificate.

E. Ambulance Services. Emergency ambulance transportation by a licensed ambulance service to a Hospital for treatment of an Emergency Medical Condition. Transportation must be to the nearest facility that can provide the appropriate level of care, or as dispatched by 911, if available, or the local government authority. Air ambulance transportation outside the United States or back to the United States is not a Covered Service.

F. Durable Medical Equipment and Prosthetics. The following benefits are provided if Medically Necessary and approved by a Participating Provider and the Medical Director before acquisition **and subject to the Coinsurance and/or limitations defined in Attachment A.**

Coverage is provided for Durable Medical Equipment and Prosthetics described below that meets the minimum specifications that are Medically Necessary. Additional features or upgrades are the Member's responsibility. Except as specified, all maintenance, inspections, replacements and repairs of Durable Medical Equipment and Prostheses are the responsibility of the Member, regardless of whether the Plan purchased the original Durable Medical Equipment or Prostheses. Replacement of a Prosthesis or Durable Medical Equipment is a Covered Service when the normal growth and development of a child or a change in medical condition necessitates the replacement. Replacement for the purpose of technical modification or enhancement is excluded. Replacement due to loss, breakage, theft or malfunction is excluded except due to normal wear and tear over a reasonable period of time as determined by VIVA HEALTH.

1. The cost of Initial Acquisition or rental (whichever is the most cost-effective as determined by the Medical Director) from approved providers of the following Durable Medical Equipment for use outside a Hospital or Skilled Nursing Facility:

   a. Standard hospital type beds
   b. Wheelchairs
   c. Crutches, Walkers, Canes
   d. Braces (limb or spine only)

e. Traction devices
f. Infant apnea monitors
g. Oral appliance, BiPAP, and C-PAP (if documented obstructive sleep apnea)
h. Nebulizers
i. Oxygen
j. Bedside commodes
k. Insulin pumps
l. Delivery pumps for tube feedings (included tubing and connectors)
m. Wound vacuum up to a maximum of 28 calendar days
n. Continuous passive motion (CPM) machine up to a maximum of 21 calendar days as required following a joint surgery or procedure
o. Bone growth stimulator (coverage is limited to a maximum of three months)
p. Ostomy supplies and catheters (does not include diapers or incontinent undergarments, rubber bands, rubber gloves, scissors or other products not directly related to Medically Necessary ostomy and urological care)
q. Breast pumps (one every four years)
r. Continuous glucose monitors
s. Cardioverter defibrillators
t. Pneumatic compression devices
u. INR monitors
v. Speech-generating devices
w. High-frequency chest wall oscillation devices

2. Initial Acquisition of Prostheses after Accidental Injury or surgical removal.

G. **Diabetic Supplies**. Standard blood glucose monitors, syringes, needles, lancets, and chem-strips for diabetics. VIVA HEALTH may limit coverage of such supplies to a particular type or brand. Pens for use in administering insulin injections are not covered unless Medically Necessary and prior authorized by VIVA HEALTH.

H. **Transplant Services.** Services and supplies for transplants when ordered by a Participating Physician at a Participating Hospital for Transplant Benefits and authorized in advance by VIVA HEALTH. Coverage is provided for kidney, cornea, kidney/pancreas, liver, lung, heart, bone marrow, intestinal/multivisceral, and peripheral stem cell transplants when such transplants are Medically Necessary and not excluded by the terms of Part X. Donor search fees are covered only for bone marrow transplants and are limited to $10,000 per Member per Lifetime. Organ donor treatment or services only covered when the transplant service recipient is a Member under the Plan and only covered to the extent these services are not covered by another plan or program.

I. **Statement of Rights under the Newborns' and Mothers' Health Protection Act.** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., the Member's physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours, as applicable). Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours). Pre-certification is still required for the delivery and for newborn placement in an intensive care nursery. Pre-certification is also required for any length of stay period in excess of the minimum (48 or 96 hours), even though not required for the minimum length of stay period. For information on precertification, contact VIVA HEALTH.

PART X. EXCLUSIONS

Like other health plans, SOME SERVICES ARE NOT COVERED under this Plan. Some of these excluded items may be Covered Services if the Employer has chosen to cover them, as specified in riders to this Certificate. The following services are not Covered Services:

A. Care that is not Medically Necessary or that is not a Covered Service as determined by VIVA HEALTH. Care that would be a Covered Service but that is not Medically Necessary is excluded. Care that is Medically Necessary but that is not a Covered Service is likewise excluded. This includes payment for benefits after a benefit limit described in Attachment A has been reached.

B. Care that is rendered before the date a person becomes a Member or after the date a person ceases to be a Member, including care for medical conditions arising prior to the date the Member's coverage terminates, even if such services were authorized by VIVA HEALTH. If a Member is in a Hospital or Skilled Nursing Facility, coverage of the stay begins on the effective date of coverage, regardless of the date of admission, and coverage ends on the date coverage under the Plan terminates, regardless of the date of discharge.

C. Care that requires authorization from VIVA HEALTH for which no authorization was given.

D. Provision for personal hygiene, convenience, safety or comfort items, training, or services (e.g., air conditioners, humidifiers, whirlpool baths, exercise equipment, classes, apparel, telephone or TV charged to your Hospital bill, or housekeeping services charged as part of home health care).

E. Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations, investigations, or treatments that are not otherwise Covered Services. Examples of such excluded services include when such services relate to career, education, sports, camp, travel, employment, insurance, marriage, adoption, medical research, or are to obtain or maintain a license of any type.

F. Expenses for medical report preparation and presentation when not required by Participating Physicians.

G. Travel and transportation to receive consultation or treatment even though prescribed by a Physician, except for emergency ambulance services described in Part IX.E. Air ambulance transportation outside the United States or back to the United States.

H. Plastic or cosmetic medical or surgical treatment or other health services or supplies except reconstructive surgery necessary to repair a significant functional disorder resulting from disease, injury, or congenital anomaly present and apparent at birth. Services for cosmetic purposes including but not limited to reformation of sagging skin, changes in appearance of any portion of the body, removal of keloids, scar revision, hair transplants or removal, and chemical peels or abrasion of the skin, are not Covered Services. The presence of a psychological condition will not entitle a Member to coverage. Complications or later surgery related in any way to cosmetic surgery is not covered even if Medically Necessary.

I. The removal or replacement of breast implants except when required by post-mastectomy reconstruction. Breast reduction unless VIVA HEALTH's criteria for determining Medical Necessity are met. If covered, breast reduction surgery is limited to one surgery per Member per Lifetime.

J. Care for conditions that federal, state or local law or government authorities require to be treated in a public facility or a facility designated by a governmental entity or require coverage to be purchased or provided through other arrangements such as workers' compensation, no-fault automobile insurance or similar legislation; Inpatient care following court-ordered commitment, regardless of location, until the commitment is released; Other health services required by a court order unless such services are otherwise Covered Services; Care that is or can be provided in a school; Health services received while on active military duty or as a result of war, terrorism, or any act of war, whether declared or undeclared; Care for military service connected disabilities for which the Member is entitled to service and for which facilities are reasonably available to the Member; Care for medical conditions resulting from travel to a country outside of the United States for which a U.S. governmental entity has issued a travel warning or alert when the medical condition is a result of the reason for the warning or alert.

K. Except for Urgently Needed and Emergency Services, charges for pregnancy and newborn care outside the Service Area.

L. Maternity-related 3D and 4D imaging (including ultrasounds) and non-Medically Necessary Amniocentesis. Surrogate parenting/pregnancy. If a surrogate or adoption delivery occurs outside the Service Area, care for the newborn provided outside the Service Area is not a Covered Service.

M. All charges associated with non-Covered Services including charges for services related to complications caused by non-Covered Services, supplies, or treatment.

N. Any other services and/or supplies that are not specifically included as Covered Services in this Certificate or otherwise required to be Covered Services by state or federal statute or regulation.

O. Custodial, domiciliary, private duty nursing, or convalescent care, rest cures and respite care.

P. Substance abuse treatment programs or clinics that are not abstinence-based.

Q. Substance abuse treatment that is related to narcotic maintenance therapy or caffeine addiction; treatment provided in a halfway house or other sober living arrangement; or treatment that is not otherwise a Covered Service when recommended or required to maintain a professional license.

R. Any admission to an Inpatient facility, outpatient facility, or emergency room resulting in Member's being discharged against medical advice. The Member will be responsible for all charges associated with the admission.

S. Organ donor treatment or services when the recipient is not a Member under the Plan. Services and associated expenses for or related to organ, tissue, or cell transplantation except as described in Part IX.H. Transplants involving mechanical or animal organs and solid organ transplants performed as a treatment for cancer are excluded.

T. Dental examination and treatment and orthodontic treatment, including the care, treatment, filling, or removal or replacement of teeth or structures or tissue directly supporting teeth, implants, braces, and other related services; dental or oral surgery, except as specified in Part IX.A.15, 16, and 17. Any hospitalization related to any form of dentistry.

U. Fees charged for missed appointments and similar fees or penalties. Members who do not keep their appointments are responsible to the provider for any charges incurred as a result. Convenience surcharges or fees related to scheduling appointments.

V. Special-duty nursing except Medically Necessary special-duty nursing in the Hospital.

W. All therapy or counseling and any associated testing other than those services expressly covered under Part IX. Examples of excluded services include therapies that do not meet national standards for mental health professional practice, counseling for personal, family or marriage problems, therapy that is not short-term or crisis oriented, therapy for treatment of learning disorders, eating disorders, communication disorders, mental retardation, developmental delays (including speech) and perceptual disorders, therapy or counseling for behavioral treatment, psychoanalysis, sex therapy or treatment for sex offenders, confrontation therapy, sleep therapy, megavitamin therapy, alternative therapy, cult deprogramming, expressive therapy (e.g. psychodrama), insight-oriented therapy, guided imagery, animal assisted therapy, aversion therapy, carbon dioxide therapy, hyperbaric therapy or other oxygen therapy for psychological treatment, marathon therapy, massage therapy, aroma therapy, primal therapy, sedative action electrostimulation therapy, tryptophan therapy, orthomolecular therapy, nutritional-based therapy, and stress and co-dependency treatment except in association with services provided for a treatable mental or substance abuse disorder. Examples of excluded testing include intelligence quotient (IQ) and achievement testing. All mental health services other than those expressly covered under Part IX.

X. All services or expenses of any kind related to infertility services for Subscriber's Covered Dependent child. All infertility treatment, such as artificial insemination, reversal of surgical sterilization procedures, tuboplasty, in-vitro fertilization, gamete intra fallopian transfer (GIFT) programs, zygote intra fallopian transfer (ZIFT) programs, embryo transport, and any other treatments or procedures, except as provided in Part IX.A.10 and under the prescription drug benefit.

Y. All other mental health and substance abuse services except as specifically set forth in Part IX.A.11 and 12.

Z. Services and associated expenses for non-surgical and surgical treatment of obesity (including morbid obesity) or weight control including but not limited to gastric bypass surgery, stomach staples, balloon insertion and removal, lap banding and similar procedures, reversal of surgical treatment for obesity, weight control programs and weight control medications, except for counseling by a Participating Provider. Such services are excluded regardless of the cause of the obesity or the need for weight control and whether or not such services are Medically Necessary to treat or prevent illness. Counseling and behavioral intervention by a PCP may be covered under the Plan's preventive services benefit. See Part IX.A.2 for eligibility and limits.

AA. Hypnotherapy, crystal healing, transcendental meditation, holistic medicine, acupressure, acupuncture, biofeedback, bio-energetic therapy, sensitivity training, Rolfing and other forms of alternative treatment and self-help or motivational training or training for personal or professional growth and development.

BB. Subcutaneous implants and/or removal of subcutaneous implants except for implants used as provided in Part IX.A.1(h) and Part IX.A.24.

CC. Expenses associated with Clinical Trials with the exception of routine care provided by Participating Providers for what would otherwise be Covered Services. Experimental or Investigational drugs, products, or treatments including medical, surgical or psychiatric procedures, and pharmaceutical

regimes (this includes any drugs or other products which have not been approved as safe and effective for their intended use by the U.S. Food and Drug Administration).

DD. The following rehabilitation programs, regardless of duration or the setting in which the services are provided: mitral valve prolapse programs, PMS programs, work hardening programs, vocational rehabilitation, educational rehabilitation, and rehabilitation related to learning disabilities.

EE. Vision therapy, eye exercises, visual training orthoptics, shaping of the cornea with contact lenses, Lasik/Lasek surgery, PRK, CK, radial keratotomy and any other surgical procedure for the improvement of vision when vision care can be made adequate through the use of glasses or contact lens and charges associated with the purchase or fitting of eyeglasses or contact lenses.

FF. Except for preventive medications as described in Part IX.A.2, all over-the-counter medications, biologicals, biotechnicals, and prescription medications, including self-administered injectable drugs, vitamins (with the exception of B-12 for select indications), and nutritional supplements for Outpatient treatment. Non-injectable medications provided in a Physician's office except as required to treat an Emergency Medical Condition.

GG. Services or expenses for routine foot care including but not limited to trimming of corns, calluses, and nails except Medically Necessary diabetic foot care.

HH. Abortion.

II. Wigs or prosthetic hair.

JJ. Corrective shoes, shoe lifts, and shoe inserts except for diabetic Members when Medically Necessary to prevent ulceration of the foot. Qualifying diabetic Members may have up to three pairs of shoes and inserts per Lifetime, and no more than one pair of shoes and inserts per year, when Medically Necessary and approved by VIVA HEALTH in advance.

KK. Supplies, equipment and appliances considered disposable and/or non-durable or convenient for use in the home, such as dressings, elastic stockings, ace bandages, gauze, disposable cervical collars, diapers, and other urological supplies except as provided in Part IX.F.1(p).

LL. All Durable Medical Equipment not listed as covered in Part IX.F hereof even if prescribed by a Participating Provider.

MM. Services required as a result of participation on a scholastic sports team where coverage is or is required to be provided through the school.

NN. Services required as a result of the Member's committing an illegal act, participating in a riot, or participating in the commission of any assault or felony or services provided to the Member while the Member is incarcerated in a prison, jail, or other penal institution.

OO. Services ordered or rendered 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.

PP. Enteral feedings and nutritional and electrolyte supplements.

QQ. Hearing therapy and charges incurred in connection with the purchase or fitting of hearing aids, with the exception of cochlear implants.

RR. Penile implants or other devices or treatments related to or used to correct impotence or other sexual dysfunction or inadequacy.

SS. Diagnosis and treatment of snoring.

TT. Sublingual and subcutaneous provocative and neutralization testing and cytotoxic testing for food allergies.

UU. Health-related education, except diabetes self-management.

VV. Genetic and genomic testing, except as provided in Part IX.A.23, including pre-implantation genetic diagnosis. Genetic testing primarily for the benefit of someone other than the Member. Gene therapy, including the use of drugs, procedures, ad/or health care services to replace or correct faulty or missing genetic material.

WW. Tele-consultation and computer/on-line consultation and services and all virtual testing and screening except as provided in Part IX.A.25.

XX. Services for which the Member has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of coverage under this Certificate.

PART XI. CLAIMS AND COMPLAINT PROCEDURES

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 him or her in connection with the Member's rights under these claims procedures.

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 Medical Management 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) 933-1232. Urgent pre-service claims may be filed by calling our Medical Management Department at (205) 558-7475 or 1-800-294-7780.
    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 Medical Management 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 XIII.I. Notice of Claim of this Certificate. 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 Attachment A 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 is neither an individual who was 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, the Member should call Customer Service at the number indicated on the back of this Certificate or on the Member identification card. Any problem or dispute between a Member and VIVA HEALTH or between a Member and a Participating Provider must be dealt with through VIVA HEALTH's Complaint Procedure. Complaints may concern non-medical or medical aspects of care as well as the terms of this Certificate, including its breach or termination. Complaints are processed according to the Complaint Procedure set forth herein. The Complaint Procedure may be revised by VIVA HEALTH 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. **Inquiry.** Most problems can be handled simply by discussing the situation with a representative of VIVA HEALTH's Customer Service Department. 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 that can be resolved by telephone to the Member's satisfaction are not classified as complaints. Members with Inquiries that 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 by the Customer Service Representative 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 VIVA HEALTH's review of the Informal Complaint. In the case of an adverse outcome, a Member will be provided the additional rationale, if any, upon which the decision was based. Upon written request, a Member has the right to review or request copies of any new or additional evidence considered by VIVA HEALTH. 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 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. The Formal Complaint should be mailed 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 information 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 will receive written notification regarding the Formal Complaint Committee's decision postmarked 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 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 after the day the request was received or, if additional information is necessary, within 48 hours after receipt of all information necessary to complete the review. 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 both the provider and the Member within three days after the day the decision is made. 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, as described below. A determination that the Member fails to meet the eligibility requirements of the Plan is not subject to external review

If the Expedited Formal Complaint Committee does not grant the 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 denied claims for benefits. This external review process applies to an adverse benefit determination or final internal adverse benefit determination on appeal. The decision to be reviewed usually will be the denial of an appeal as part of the Formal Complaint process described above. 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.

   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.

6. **Member's Rights after Exhausting Complaint Procedure**. A Member whose Plan is subject to ERISA has the right to bring a lawsuit with respect to an adverse benefit determination only after the internal Complaint Procedure described herein has been completely exhausted or waived. Any such suit must be brought within 180 days after issuance of the final decision on appeal at the Formal Complaint level of the Complaint Procedure.

PART XII. CONTINUATION COVERAGE

A Federal law known as "COBRA" requires most Employers sponsoring group health plans to offer participating employees and their families the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates in certain instances where coverage under the Employer's plan would otherwise end.

A. Continuation Coverage Under COBRA. As provided in Part XII.B through XII.E below, Continuation Coverage under COBRA generally applies only to Employers that are subject to the provisions of COBRA. Generally, COBRA applies if the Employer has 20 or more employees. Members should contact the Employer's Plan Administrator to determine if he or she is eligible to continue coverage under COBRA. VIVA HEALTH is not responsible for notifying Members of any right to Continuation Coverage.

Continuation Coverage for Members who selected continuation coverage under a prior plan that was replaced by coverage under the Policy shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth in Part XII.D below, whichever is earlier.

In no event shall the Plan be obligated to provide Continuation Coverage under the Plan to a Member if the Employer or its designated Plan Administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Member in a timely manner of the right to elect Continuation Coverage and notifying the Plan in a timely manner of the Member's election of Continuation Coverage.

VIVA HEALTH is not the Employer's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

B. Events Giving Rise to Continuation Coverage Option.

1. Subscriber. A Subscriber has a right to purchase this Continuation Coverage when the Subscriber loses coverage under the Plan for either of the following Qualifying Events:
   a. a reduction in the Subscriber's hours of employment below 30 hours per week; or
   b. the termination of a Subscriber's employment unless the employment is terminated because of the Subscriber's gross misconduct.

2. Subscriber's Spouse. A Subscriber's or Former Subscriber's spouse who is a Member has the right to purchase Continuation Coverage when the Subscriber loses coverage under the Plan for any of the following Qualifying Events:

   a. the death of the Subscriber or Former subscriber;
   b. a termination of the Subscriber's or Former Subscriber's employment unless termination is due to gross misconduct;

c. a reduction in the Subscriber's or Former Subscriber's hours of employment with Employer below 30 hours per week;
d. divorce or legal separation from the Subscriber or Former Subscriber; or
e. the Subscriber becomes entitled to Medicare (Part A, Part B, or both).

3. Dependent Child. A dependent child who is a Member has the right to purchase Continuation Coverage if coverage is lost under the Plan for any of the following Qualifying Events:

a. the death of the Subscriber or Former Subscriber;
b. a termination of the Subscriber's or Former Subscriber's employment unless termination is due to gross misconduct;
c. a reduction in the Subscriber's or Former subscriber's hours of employment with Employer below 30 hours per week;
d. the Subscriber's or Former Subscriber's divorce or legal separation;
e. the Subscriber becomes entitled to Medicare (Part A, Part B, or both); or
f. the dependent ceases to be a "dependent child" under the Plan.

4. New Child during Continuation Coverage. A child who is born to or placed for adoption with the Subscriber or Former Subscriber during a period of COBRA coverage will be eligible to become a Member. Adding the child requires proper notice to the Plan Administrator and enrollment under Part II.

5. Retired Subscribers and their Covered Dependents. Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Employer, and that bankruptcy results in loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's Covered Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

C. Period of Continuation Coverage.

1. 18 Months Coverage Rule. COBRA requires that a Member be afforded the opportunity to purchase Continuation Coverage for up to 18 months if either of the following Qualifying Events occur:

a. termination of the covered Subscriber's employment, unless termination is due to gross misconduct; or
b. reduction in the covered Subscriber's hours of employment below 30 hours per week.

2. 36 Months Coverage Rule. COBRA requires that a Member be afforded the opportunity to purchase Continuation Coverage for up to 36 months if any of the following Qualifying Events occur:

a. Death of the Subscriber;
b. Divorce or legal separation from the Subscriber;
c. Subscriber becomes entitled to Medicare (Part A, Part B, or both); and
d. Child ceases to be a dependent under the Plan.

3. Special Rule for Multiple Qualifying Events other than Entitlement to Medicare. If during an 18-month period of Continuation Coverage a Member experiences an event giving rise to 36 months of Continuation Coverage, the Member may elect to extend the Continuation Coverage to 36 months beginning on the date the original 18-month period began. (Special rules involving entitlement to Medicare are discussed below.) Member must contact the Plan Administrator within 60 days of the

date the second qualifying event occurs in order to extend continuation coverage under this rule. Failure to contact the Plan Administrator will lead to termination of Continuation Coverage.

4. Dependents Upon Subscriber's Entitlement to Medicare. COBRA requires that if a Subscriber becomes entitled to Medicare (regardless of whether such Qualifying Event causes a loss of coverage under the Plan), the period of coverage eligibility for the spouse of such Subscriber or the dependent child of such Subscriber shall not terminate before the end of the 36- month period following the earlier of the date of the first Qualifying Event or the date the Subscriber becomes entitled to Medicare. Entitlement to Medicare means the Subscriber is eligible to receive and signs up for Medicare insurance. Under the terms of this plan, a Subscriber who is eligible to receive and signs up for Medicare insurance is known as a Former Subscriber. This plan exceeds the COBRA requirements by allowing Dependents of Former Subscribers to remain on the Plan for as long as the Former Subscriber remains an employee.

   This coverage is available only to the spouse and dependent children of Subscriber and only if such individuals themselves are Members at the time the Subscriber becomes entitled to Medicare. To receive this coverage, a Member must notify the Plan Administrator that the Subscriber becomes entitled to Medicare. Failure to notify the Plan Administrator of the Subscriber's entitlement may lead to termination of Continuation Coverage.

5. Special Rule for Disabled Qualified Beneficiaries. If the Subscriber, the spouse of a Subscriber, or the dependent child of a Subscriber is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage, the qualified beneficiaries, if then covered under the Plan, would be eligible for extended Continuation Coverage beyond the normal period of 18 months. Under this special rule, qualifying beneficiaries may extend Continuation Coverage for up to 29 months from the time they are first eligible to elect Continuation Coverage due to a termination or reduction in hours of employment.

   In order to be entitled to this extended coverage, the disabled person must provide the Plan Administrator a copy of the Social Security Administration determination of his or her disability within the earlier of 60 days after the Administration makes a disability determination, or the last day of the initial 18-month period of Continuation Coverage. Such individual must notify the Plan Administrator within 30 days of the date the Social Security Administration makes a final determination that he or she is no longer disabled.

D. **Termination of Continuation Coverage.** A Member's Continuation Coverage will end for any of the reasons listed in Part IV of this Certificate and for the following reasons:

1. The Employer no longer provides group health coverage to any of its employees (special rules may apply if a health plan is terminated or coverage is reduced on account of bankruptcy proceedings);

2. The premium for Continuation Coverage is not paid in full on time;

3. A Member becomes covered under another group health plan as an employee, spouse or dependent, after COBRA coverage is elected, so long as the new group health plan does not exclude or limit coverage for a pre-existing condition for which the Member was covered under the Plan;

4. A Member becomes entitled to Medicare (under Part A, Part B, or both) after the date COBRA coverage is elected; or

5. A Subscriber's spouse ends a legal separation from a Subscriber and once again becomes covered under the Plan as a spouse.

In addition, if Continuation Coverage was extended to 29 months due to disability, the extended coverage will end with the month that begins more than 30 days after a final determination under the Social Security Administration that the disabled person is no longer disabled even if the total period of coverage is less than 29 months. In no event, however, will the period of coverage be less than 18 months unless one of the above events occurs.

COBRA coverage will be terminated retroactively if a Member is determined to have been ineligible. A Member's Continuation Coverage with the Plan will also end on the date coverage ends under the Group Policy for any reason. The Member must look to a subsequent group health plan, if any, of the Employer for Continuation Coverage after the Group Policy ends.

E. Notice Procedures.

1. Notice to be Provided by Member. Under COBRA, the Member must inform the Plan Administrator of a divorce, legal separation, or a child losing Covered Dependent status under the Plan within 60 days of the event. A Member must also notify the Plan Administrator in accordance with the special rules regarding disability determination, if applicable. If the Plan Administrator is not informed within 60 days after one of these events has occurred, the right to purchase Continuation Coverage under the Benefits Plan will be lost.

   In addition, there are also special rules for Continuation Coverage that apply when the Subscriber becomes entitled to Medicare as determined by the Social Security Administration. The Medicare rules are described in more detail above. To receive the maximum amount of coverage in the event the Subscriber becomes entitled to Medicare, the Member should notify the Plan Administrator as soon as possible after such Medicare entitlement occurs.

2. Notice to be Provided by Employer. The Employer has the responsibility to notify the Plan Administrator of a Subscriber's death, termination of employment or reduction in hours worked below 30 hours per week, commencement of a proceeding in bankruptcy with respect to the Employer if the Plan provides retiree coverage, or Medicare entitlement (Part A, Part B, or both).

3. Notice to be Provided by Plan Administrator. When the Plan Administrator is notified of a divorce, legal separation, child losing dependent status, employee's death, termination of employment, reduction in hours worked below 30 hours per week, or Medicare entitlement, the Plan Administrator will in turn notify the Members of the right to purchase Continuation Coverage by providing a COBRA Notice.

4. Election Period and Premium Payment. To elect Continuation Coverage, a Member has 60 days from the date that is the later of (1) the date the Member was provided with COBRA Notice, or (2) the date the Member would lose coverage because of one of the events described above. The Member must inform the Plan Administrator by sending the Plan Administrator written notice of electing no later than the end of the 60-day period described in the previous sentence. The Plan Administrator must then notify VIVA HEALTH of the Member's election within 14 days. Subscribers may elect Continuation Coverage on behalf of their spouses and parents may elect Continuation Coverage on behalf of their children. Continuation Coverage is optional. If a Member does not elect Continuation Coverage within the 60-day period, the Member's coverage under the Plan will end without any Continuation Coverage.

Members must pay all premiums for coverage due retroactive to the day the Member lost coverage under the Plan no later than the forty-sixth (46th) day following the initial election to purchase Continuation Coverage. For each premium payment thereafter, payment is due on the first of the month for which the premium applies (for example, the premium for the month of June is due June 1). If premiums are not paid on or before the first of each month, a grace period of 30 days will be allowed for payment of any delinquent premium. A failure to pay premiums before the expiration of the grace period will result in a loss of all Continuation Coverage that has not been paid for.

5. Employer as Plan Administrator. In no event shall the Plan be obligated to provide Continuation Coverage under the Plan to a Member if the Employer or the Employer's designated Plan Administrator fails to perform its responsibilities under this Part or under COBRA. VIVA HEALTH is not the Employer's designated Plan Administrator and does not assume any of a Plan Administrator's responsibilities under COBRA.

6. Other Options. There may be other coverage options for you and your family beside COBRA. You can buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

F. **Questions**. Questions concerning your COBRA continuation coverage rights should be addressed to the Employer's Plan Administrator.

PART XIII. GENERAL PROVISIONS

A. **Identification Card.** Cards issued by VIVA HEALTH to Members pursuant to this Certificate are for identification only. **Members must show the identification card every time Covered Services are received. Failure to show the identification card or otherwise clearly identify himself/herself as a VIVA HEALTH Member prior to receiving care will result in the Member being financially responsible for services that require prior-approval in order to be Covered Services.** You will automatically receive a new Identification Card when certain card information changes. Please destroy the old card to prevent confusion. Possession of a Plan identification card confers no right to services or other benefits under the Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Member. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this Certificate will be liable for the actual cost of such services or benefits.

B. **Notice.** Any notice under the Plan to VIVA HEALTH may be given by United States Mail, first class, postage prepaid, addressed as follows:

VIVA HEALTH
Post Office Box 55926
Birmingham, Alabama 35255-5926

Or if notice is to a Member, at the last address known to VIVA HEALTH.

C. **Interpretation of Certificate.** To the extent not governed by The Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et. seq. (ERISA), the laws of the State of Alabama shall be applied to interpretations of this Certificate.

D. **Gender.** The use of any gender herein shall be deemed to include the other gender and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

E. **Clerical Error.** Clerical error, whether of the Employer, Program Manager, or VIVA HEALTH in keeping any record pertaining to the coverage hereunder, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

F. **Policies and Procedures.** VIVA HEALTH may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which Members shall comply.

G. **Waiver.** No agent or other person, except an authorized officer of VIVA HEALTH, has the apparent or express authority to waive any conditions, provisions or restrictions of this Certificate, to extend the time for making a payment, or to bind the Plan by any promise or representation made by giving or receiving any information. The waiver of any condition, provision or restriction of this Certificate or of the waiver of a breach of any provision hereof shall not be deemed a waiver of any other condition, provision, restriction or breach hereof.

H. **Authorization To Examine Health Records.** Each Member consents to and authorizes a Physician, Hospital, Skilled Nursing Facility or any other provider of care to disclose to VIVA HEALTH information pertaining to the care, treatment, or condition of the Member. This includes permitting the examination and copying of any portion of the Member's hospital or medical records, as needed and when requested by VIVA HEALTH or persons or organizations providing services on VIVA HEALTH's behalf. This applies to both Subscribers and Covered Dependents whether or not such Covered Dependents have signed the Subscriber's enrollment form. Information from medical records of Members and information received from Physicians, Hospitals, Skilled Nursing Facilities or other providers of care incident to the relationship shall be kept confidential and may not be disclosed without the consent of the Member except for use reasonably necessary in connection with government requirements established by law, the administration of this Agreement (including, but not limited to, utilization review, quality improvement, and claims management), or as otherwise permitted by law.

I. **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 as described in Part VIII.C.2. 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.**

J. **Assignment.** The coverage and any benefits under the Plan are personal to Members and may not be assigned unless consent of VIVA HEALTH is obtained in writing.

K. **Amendments.** The Employer specifically reserves the right to amend, modify or terminate the Plan without the consent or concurrence of any Member, and shall notify Members of any material change in the Plan.

L. **Circumstances Beyond VIVA HEALTH's Control.** Provision of Covered Services could be delayed or made impractical by circumstances not reasonably within the control of VIVA HEALTH, such as complete or partial destruction of facilities; war; riot; civil insurrection; labor disputes; disability of a significant part of Hospital or medical group personnel; or similar causes. If so, Participating Physicians and Providers will make a good faith effort to provide Covered Services. Neither VIVA HEALTH nor any Participating Provider shall have any other liability or obligation on account of such delay or such failure to provide Covered Services.

M. **Certification Procedures.** VIVA HEALTH provides Creditable Coverage Certifications to Plan Members if requested. It ordinarily will specify the period of time for which a Member was covered under the Plan and under COBRA, as applicable, and any waiting period.

N. **Administrative Information.** The Plan is a group health plan providing Covered Services. The Plan is funded through the Group Policy, which is the Employer's contract with the Program Manager and includes this Certificate. Under the Group Policy, VIVA HEALTH performs certain administrative services. VIVA HEALTH is also given discretionary authority to determine eligibility for Covered Services, to interpret the Plan, and to make any and all factual findings appropriate to apply the Plan or to decide any disputes related to the Plan as permitted by its contract administration agreement with the Trustee and Program Manager.

O. **Acceptance of Premium not a Guarantee of Coverage.** Program Manager's acceptance of premium payment does not guarantee coverage hereunder and does not constitute a waiver of any of the terms of this Certificate.

PART XIV. FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to loss of insurance coverage, restitution, fines, confinement in prison, or any combination thereof.

PART XV. NONDISCRIMINATION AND LANGUAGE ACCESSIBILITY NOTICE

Nondiscrimination Notice:

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. VIVA HEALTH does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

VIVA HEALTH:

- Provides free aids and services to people with disabilities 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 these services, contact VIVA HEALTH'S Civil Rights 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 Civil Rights Coordinator:

Address: 417 20th Street North, Suite 1100
Birmingham, AL, 35203
Phone: 1-800-294-7780 (TTY: 711)
Fax: 205-449-7626
Email: VIVACivilRightsCoord@uabmc.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, VIVA HEALTH'S Civil Rights 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
1-800-368-1019 (TDD: 1-800-537-7697)

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

Section 1557 of the Affordable Care Act Grievance Procedure:

It is the policy of VIVA HEALTH not to discriminate on the basis of race, color, national origin, sex, age or disability. VIVA HEALTH has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of VIVA HEALTH's Civil Rights Coordinator:

Address: 417 20th Street North, Suite 1100
Birmingham, AL, 35203
Phone: 1-800-294-7780 (TTY: 711)
Fax: 205-449-7626
Email: VIVACivilRightsCoord@uabmc.edu

VIVA HEALTH's Civil Rights Coordinator has been designated to coordinate the efforts of VIVA HEALTH to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for VIVA HEALTH to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Civil Rights Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Civil Rights Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records of VIVA HEALTH relating to such grievances. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Civil Rights Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Civil Rights Coordinator by writing to the Chief Administrative Officer within 15 days of receiving the Civil Rights Coordinator's decision. The Chief Administrative Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or 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
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.

VIVA HEALTH will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided 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 qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Civil Rights Coordinator will be responsible for such arrangements.

Language Assistance Services:

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務．請致電 1-800-294-7780 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-294-7780 (TTY: 711)번으로 전화해 주십시오

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-294-7780 (TTY: 711).

Arabic
انتباه : إذا كنت تتكلم العربية ، وخدمات المساعدة اللغوية ، مجانا ، تتوفر لك. دعوة 1-800-294-7780 (TTY : 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-294-7780 (TTY: 711).

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-294-7780 (ATS: 711).

Gujarati
ધ્યાન: તમેગજુ રાતી બોલેછે, ભાષા સહાય સેવાઓ વવના મલ્ૂયેતમારા માટેઉપલબ્ધ છે. કોલ 1-800- 294-7780 (TTY : 711) .

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-294-7780 (TTY: 711).

Hindi
ध्यान दें: आप हिंदी बोलते हैं, तो भाषा सहायता सेवाओं के प्रभार से मुक्त आप के लिए उपलब्ध हैं। कॉल 1-800-294-7780 (TTY : 711)।

Laotian
ໂປດຊາບ: ຖ້າວ່າ ທ່ານ ອ້ າພາສາ ລາວ, ການບ ິລການຊ ່ ວຍເຫ ຼ ອດ ້ ານພາສາ, ໂດຍ ່ ບເສ ັ ຽ ງ ຄ ່ າ, ແມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທ 1-800-294-7780 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-294-7780 (телетайп: 711).

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-294-7780 (TTY: 711).

Turkish
DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-800-294-7780 (TTY: 711) irtibat numaralarını arayın.

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 1-800-294-7780（TTY: 711）まで、お電話にてご連絡ください.

IRON REHEALTH an Arsenal company

WELLNESS 5000

Effective Dates: Coverage Beginning On or After January 1, 2020

Attachment A to Certificate of Coverage

The Plan's services and benefits, with their copayments, coinsurance, and some of the limitations, are listed below. **Services received in a primary, specialty, or urgent care office may be subject to a copay or coinsurance in addition to the office visit cost-sharing depending on the type of service received.** Please remember that this is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage.

Please keep this Attachment A for your records.

MEDICAL BENEFITS	COVERAGE
CALENDAR YEAR DEDUCTIBLE: Applies ONLY to those benefits with coinsurance coverage when the Member pays a set percentage of the cost. Does not apply to benefits with a copayment. Does not apply to Biological, Biotechnical and Specialty Pharmaceuticals ordered through Express Scripts but will apply to such drugs when provided directly by a physician or hospital.	$5,000 per individual; $10,000 per family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, prescription, mental, and substance abuse services, prescription drugs, and specialty drugs. The maximum includes deductibles, copayments, and coinsurance paid by the Member for qualified services but does not include premiums, ancillary charges, or out-of-network charges over the maximum payment allowance. 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. See the Certificate of Coverage for details.	$7,900 per individual; $15,800 per family
PREVENTIVE CARE: • Well Baby Care (Children under age 3) • Routine Physicals (One per Calendar Year for ages 3+) • Covered Immunizations • OB/GYN Preventive Visit (One per Calendar Year) • Preventive Prenatal Care (As defined in the Certificate of Coverage) • Other preventive items and services. See Certificate of Coverage for more information	100% Coverage
OTHER PRIMARY CARE SERVICES: • Medical Physician Services • Hearing Exams • Illness and Injury • X-Ray and Laboratory Procedures ○ Covered Genetic Testing	 $35 Copayment per visit 80% Coverage
SPECIALTY CARE: *(No PCP Referral Required)* • Medical Physician Services • OB/GYN Services • Illness and Injury • X-Ray and Laboratory Procedures ○ Covered Genetic Testing	 $50 Copayment per visit 80% Coverage
URGENT CARE CENTER SERVICES: • Medical Physician Services • Illness and Injury	 $50 Copayment per visit
TELEHEALTH SERVICES:	$0 Copayment per consultation
VISION CARE: *(No PCP Referral Required)* • Illness and Injury	 $50 Copayment per visit
ALLERGY SERVICES: *(No PCP Referral Required)* • Physician Services • Testing and treatment	 $50 Copayment per visit 80% Coverage
CHRONIC CARE MAINTENANCE: *(Including, but not limited to, dialysis, radiation therapy, wound care, wound therapy)*	80% Coverage
DIAGNOSTIC SERVICES: *(Including, but not limited to, CT Scan, MRI, PET/SPECT, ERCP)*	80% Coverage
OUTPATIENT SERVICES: • Surgery and Other Outpatient Services	80% Coverage
HOSPITAL INPATIENT SERVICES: • Physician Services • Facility Services	 80% Coverage
MATERNITY SERVICES: • Physician Prenatal and Postnatal Services • Physician Delivery Services • Maternity Hospitalization	 $50 Copayment per delivery 80% Coverage 80% Coverage
Newborn care and other services covered <u>only</u> for enrolled child of employee or employee's spouse. Eligible baby must be enrolled in plan within 30 days of birth or adoption for care to be covered. No coverage for children of employee's dependent child.	
EMERGENCY ROOM SERVICES: *(Cost sharing waived if admitted within 24 hours)*	80% Coverage
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	80% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	80% Coverage
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	80% Coverage
DIABETES SELF-MANAGEMENT EDUCATION:	$50 Copayment per visit

IRON REHEALTH an Arsenal company

WELLNESS 5000

Effective Dates: Coverage Beginning On or After January 1, 2020

Attachment A to Certificate of Coverage

MEDICAL BENEFITS	COVERAGE
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	80% Coverage
REHABILITIATION SERVICES: Physical, Speech, and Occupational Therapy *(Limited to 60 total inpatient days and 25 total outpatient visits per Calendar Year)*	80% Coverage
HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis *(Limited to a diagnosis of Autism, Autism Spectrum Disorder, or Pervasive Developmental Delay)*	80% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	80% Coverage
CHIROPRACTIC SERVICES: *(No PCP Referral Required. Covered up to 25 visits per Calendar Year)*	$50 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	$50 Copayment per visit
SLEEP DISORDERS:	$50 Copayment per visit
• Sleep Study	80% Coverage per sleep study
TRANSPLANT SERVICES:	80% Coverage
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES[1]:	
• Inpatient Services	80% Coverage
• Outpatient Services	$50 Copayment per visit

[1]Treatment at a residential facility is not a covered service. Certain diagnoses are excluded from coverage. See your Certificate of Coverage for details.

PHARMACEUTICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[2]:	
• **Tier 1 (Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$5 Copayment per 31-day supply
○ Mail-order	$12 Copayment per 90-day supply
○ Participating Pharmacy	$15 Copayment per 90-day supply
• **Tier 2 (Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$20 Copayment per 31-day supply
○ Mail-order	$43 Copayment per 90-day supply
○ Participating Pharmacy	$60 Copayment per 90-day supply
• **Tier 3 (Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$60 Copayment per 31-day supply
○ Mail-order	$150 Copayment per 90-day supply
○ Participating Pharmacy	$180 Copayment per 90-day supply
• **Tier 4 (Non-Preferred Brand and Non-Preferred Generic Drugs)**	
○ From a Participating Pharmacy	$80 Copayment per 31-day supply
○ Mail-order	$200 Copayment per 90-day supply
○ Participating Pharmacy	$240 Copayment per 90-day supply
• **Tier 5 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals[3] and Non-Preferred Drugs)**	60% Coverage
• **Select Generic Oral Contraceptives**	100% Coverage[4]
• **Diabetic Testing Supplies** (OneTouch glucose meters, OneTouch glucose test strips, and any brand of lancets/lancet devices)	100% Coverage

[2]Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. [3]May be administered in the home, physician's office or on an outpatient basis. When these medications are received from Express Scripts, they must be ordered by calling 1-800-803-2523. For a list of medications in this category, please refer to www.vivaemployer.com/Members/Default.aspx. [4]Applicable Copayment for other generic oral contraceptive drugs and all brand oral contraceptive drugs.

When generic is available, Member pays difference between generic and brand price ("ancillary charge"), plus Copayment. Ancillary charges do not count toward the out-of-pocket maximum. Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780 | Visit our Website at www.vivahealth.com

Pre-Existing Condition Policy: No pre-existing condition exclusions or waiting period.

Eligible Dependent: Eligible Employee's lawful spouse and children of Eligible Employee under age 26 or disabled dependents who meet eligibility criteria. Dependents with a last name different from employee's must be verified as eligible through submission of a marriage or birth certificate with the enrollment application.

Nondiscrimination Notice: 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.

Language Assistance Services: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-294-7780 (TTY: 711).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-294-7780 (TTY：711).

VIVA HEALTH®

ATTACHMENT B
OUTPATIENT PRESCRIPTION DRUG RIDER

The benefits in this Rider supplement the benefits set forth in the Certificate, of which this Rider is a part. Nothing contained herein shall be held to vary, alter, waive or extend any of the terms, conditions, provisions or limitations of the Certificate, except as expressly stated below. Capitalized terms have the meaning ascribed to them in the Certificate unless specifically defined in Section I below.

I. Defined Terms. For purposes of this Rider, 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. Ancillary Charges do not count toward the Out-of-Pocket Maximum.

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 that is manufactured and marketed under a trademark or name by a specific drug manufacturer.

E. **"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.

F. **"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 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.

G. **"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.

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

I. **"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.

J. **"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 than for Preferred Prescription Drugs, regardless of the reason the Non-Preferred medication is selected.

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

L. **"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.

M. **"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.

N. **"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.

O. **"Prior Approval"** means the process of obtaining authorization from VIVA HEALTH prior to dispensing certain Prescription Drugs. The Participating 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.

P. **"Specialty Pharmaceuticals"** refers to a category of drugs that are often high cost and/or require customized management that may include coordination of care, adherence management, medication utilization review, frequent patient monitoring and training, and/or restricted handling or distribution. Specialty pharmaceuticals typically target chronic, rare or complex disease states; however, this category also includes medications for common conditions that require a healthcare provider to administer.

Q. **"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.

II. Benefits. Subject to the limitations set forth below and payment of the applicable Copayments and Coinsurance (if applicable), up to a 31-day supply (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 and prescribed by a Participating Physician (or by a non-Participating Physician upon authorization by the Plan for Covered Services). To be covered, a Prescription Drug must be listed on the VIVA HEALTH Formulary and 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. The tier in which a drug is classified determines the Copayment or Coinsurance a Member will owe. Generic drugs may be classified at any tier. Tiers are generally determined by the cost of the drug to the Plan with Tier 1 being the lowest cost drugs.

For Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals, a Coinsurance may apply. Please see Attachment A for a description of Coinsurance levels (if applicable) and the 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.

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% 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 Attachment A for 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. 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 except for preventive medication as described in Section III of this Outpatient Prescription Drug Rider, when use of the Brand-Name product instead of the generic equivalent is Medically Necessary for the provision of the preventive service. 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 the Plan. Reimbursement is not guaranteed. Reimbursement is only available for Prescription Drugs that qualify for benefits as described in Section II.

VI. **Limitations:**

A. Prescription Drugs will be dispensed in a quantity not to exceed a 31-day supply of medication or 90-day supply for eligible drugs by mail order (or at retail if the Participating Pharmacy offers a 90-day supply at retail). Some Prescription Drugs may be subject to additional supply limits based on coverage criteria developed by VIVA HEALTH. 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. 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 Participating 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 a Participating Provider.

C. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals, as defined by VIVA HEALTH, require Prior Approval. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals generally must be obtained from VIVA HEALTH'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. 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. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals are subject to the Coinsurance (if applicable) specified in Attachment A. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals 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 and 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.

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.

VII. Exclusions. The following exclusions from coverage apply to this rider in addition to the exclusions listed in the Certificate.

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 VIVA HEALTH for all costs associated with any payment made by VIVA HEALTH for such prescriptions.

E. Drugs prescribed by a provider with the same legal residence as the Member or who is a member of the Member's family, including self, 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. Drugs prescribed for the purpose of terminating pregnancy.

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

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

K. 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.

L. Inspirease and other respiratory assistance apparatus.

M. Any drug dispensed prior to the effective date of this Rider or after this Rider 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 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 the Plan to be experimental.

P. Prescription Drug therapy necessitated by medical or surgical procedures, treatment, or care that are not Covered Services pursuant to the Certificate.

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, vitamins with fluoride, and B-12 injections. The exceptions are 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.

W. Unit dose packaging of Prescription Drugs.

X. 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.

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

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

AA. Prescription Drugs for any condition, Accidental 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.

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

CC. Prescription food products and nutritional supplements.

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

VIII. 90-Day Supply 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 (if covered by this Plan) are available in up to a 90-day supply. Refer to Attachment A for coverage specific to this Plan.

C. Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals and over-the-counter tobacco cessation products are not eligible for a 90-day supply.

IX. Coordination of Benefits. The coordination of benefits provisions in the Certificate do not apply to Covered Services under this Outpatient Prescription Drug Rider. Prescription Drug benefits are not eligible for coordination of benefits with any other benefit plan.

X. Miscellaneous Provisions:

VIVA HEALTH 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.

NOTICE OF HEALTH INFORMATION PRACTICES

Effective Date: *April 14, 2003*

Date Amended: *10/12/07; 10/13/08; 3/4/09; 11/2/09; 12/8/10; 9/1/13; 9/1/14; 1/1/19; 1/1/20*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE.

This Notice describes the health information practices of VIVA HEALTH, Inc., VIVA HEALTH Administration L.L.C. and Triton Health Systems, L.L.C. (collectively referred to hereafter as "VIVA HEALTH") , as well as the group health plan(s) in the Organized Health Care Arrangement (OHCA) in which VIVA HEALTH participates with your group health plan (GHP), if applicable. All entities, sites and locations of VIVA HEALTH (and the group health plan(s) in the OHCA, if applicable) follow the terms of this Notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this Notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a membership record of your enrollment in our plan. We also maintain records of payments we have made for health care services you have received and medical information we have used to make decisions about your care. We need these records to provide the benefits and services you are entitled to receive as a member of our plan and to comply with certain legal and regulatory requirements. This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this Notice of our legal duties and privacy practices with respect to medical information about you;
- notify you in the case of a breach of your unsecured identifiable medical information; and
- follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose your information will fall within one of the categories.

- **For Treatment and Treatment Alternatives.** We may use or disclose medical information about you to help your doctors and other health care providers coordinate or arrange your medical treatment or care. For example, VIVA HEALTH may notify a doctor that you have not received a covered preventive health screening that is recommended by a national institute or authoritative agency, or we may alert your doctor that you are taking prescription drugs that could cause adverse reactions or interactions with other drugs. In addition, VIVA HEALTH may help your health care provider coordinate or arrange medical services that you need, or help your health care provider find a safer prescription drug alternative. We may also disclose medical information about you to people outside VIVA HEALTH, and the OHCA (if applicable) who may be involved in your medical care, such as your family members or close friends. We may use and disclose your medical information to tell you about health-related benefits or services that may be of interest to you.

- **For Payment.** We may use and disclose medical information about you for payment purposes. Examples of payment include, but are not limited to:

- obtaining plan premiums;
- determining or fulfilling our responsibility for coverage of benefits (or the provision of benefits);
- processing claims filed by providers who have treated you;
- reviewing health care services to determine medical necessity, provision of coverage, or justification of charges;
- coordinating benefits with other health plans (payers), both within and outside of the OHCA (if applicable), that provide coverage for you;
- pursuing recoveries from third parties (subrogation); and
- providing eligibility information to health care providers.

➢ **For Health Care Operations.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary for VIVA HEALTH, and the group health plan(s) in the OHCA (if applicable), to operate and make sure that all our members receive quality care. We may also combine medical information about many of our members to decide what additional services or benefits we should offer and what services or benefits are not needed. Examples of health care operations include, but are not limited to:

- conducting quality assessment and improvement activities;
- conducting population-based activities relating to improving health or reducing health care costs;
- engaging in care coordination or case management;
- detecting fraud, waste or abuse;
- providing customer service;
- business management and general administrative activities related to our organization and the services we provide, or to the group health plan(s) in the OHCA (if applicable); and
- underwriting, premium rating, or other activities relating to the issuing, renewal or replacement of a Group Health Policy. ***Note: We will not use or disclose genetic information about you for underwriting purposes.***

We may also disclose your medical information for certain health care operations of another covered entity. For example, if you receive benefits through a group health plan, we may disclose medical information about you to other health plans or their business associates that are involved in administering your group health plan benefits.

➢ **Organized Health Care Arrangements.** VIVA HEALTH participates in Organized Health Care Arrangements, referred to as "OHCAs," with some of our network providers and group health plans (GHPs). In the OHCAs with our network providers, VIVA HEALTH and the network providers work jointly to help coordinate the medically necessary care you need in the most appropriate care setting. In the OHCAs with our underwritten GHPs, sharing your eligibility and protected health information with a GHP, or the GHP's Business Associate, allows the GHP, or its Business Associate, to administer benefits that are offered to you through an employer-sponsored plan or GHP. An OHCA enables the entities of the OHCA to better address your health care needs. The entities of the OHCA may also share in the cost of your medical care and work together to assess the quality of the medical care you receive. Medical information about you will be shared among the entities participating in the OHCA for treatment, payment or health care operation purposes (described above) relating to the OHCA. Whenever we disclose protected health information to GHPs, they must follow applicable laws governing the use and disclosure of your protected health information, including, but not limited to, the applicable privacy and security rules under the Health Insurance Portability and Accountability Act (HIPAA). For purposes of OHCAs between VIVA HEALTH and GHPs, this Notice constitutes a joint notice of privacy practices, issued in accordance with 45 C.F.R. §164.520(d).

- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to the Subscriber, a friend or family member who is involved in your medical care or payment for your medical care, and to your personal representative(s) appointed by you or designated by applicable law. State and federal law may require us to secure permission from a child age 14 or older prior to making certain disclosures of medical information to a parent. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your status and location.

- **Health-Related Benefit and Service Reminders.** We may use and disclose medical information to contact you and remind you to talk to your doctor about certain covered medical screenings or preventive services. We may also use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Research**. Under certain circumstances, we may use and disclose medical information about you to researchers when their clinical research study has been approved by a facility's Institutional Review Board. Some clinical research studies require specific patient consent, while others do not require patient authorization. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. This would be done through a retrospective record review with no patient contact. The Institutional Review Board reviews the research proposal to make certain that the proposal has established protocols to protect the privacy of your health information.

- **Certain Marketing Activities.** We may use medical information about you to forward promotional gifts of nominal value, to communicate with you about services offered by VIVA HEALTH, to communicate with you about case management and care coordination, and to communicate with you about treatment alternatives. We do not sell your health information to any third party for their marketing activities unless you sign an authorization allowing us to do this.

- **Business Associates.** There are some benefits and services VIVA HEALTH provides through contracts with Business Associates. Examples include a copy service we use when making copies of your health information, consultants, accountants, lawyers, and subrogation companies. When these services are contracted, we may disclose your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

- **Plan Sponsor of Group Health Plan (GHP).** We may disclose, in summary form, your claim history and other similar information to your Plan Sponsor if your Plan Sponsor has a Group Health Policy with VIVA HEALTH. Such summary information does not contain your name or other distinguishing characteristics. We may also disclose to the Plan Sponsor the fact that you are enrolled in, or disenrolled from, VIVA HEALTH. We may disclose your medical information to the Plan Sponsor for administrative functions that the Plan Sponsor provides to VIVA HEALTH (for example, if the Plan Sponsor assists its members in resolving complaints) if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your protected health information. The Plan Sponsor must also agree not to use or disclose your protected health information for employment-related activities.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

- **Public Health Activities.** We may disclose medical information about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- **Food and Drug Administration (FDA).** We may disclose to the FDA and to manufacturers health information relative to adverse events with respect to food, supplements, products, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose to a government authority authorized by law to receive reports of child, elder, and domestic abuse or neglect.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, licensure, and inspections. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made by the seeking party to tell you about the request or to obtain an order protecting the information requested. We may disclose medical information for judicial or administrative proceedings, as required by law.

- **Law Enforcement.** We may release medical information for law enforcement purposes as required by law, in response to a valid subpoena, for identification and location of fugitives, witnesses or missing persons, for suspected victims of crime, for deaths that may have resulted from criminal conduct and for suspected crimes on the premises.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Organ and Tissue Donation.** If you are an organ donor, we may use or release medical information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organ, eye or tissue to facilitate organ, eye or tissue donation and transplantation.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

- **Other uses and disclosures.** We will obtain your authorization to use or disclose your psychotherapy notes (other than for uses permitted by law without your authorization); to use or disclose your health information for marketing activities not described above; and prior to selling your health information to any third party. Any uses and disclosures not described in this Notice will be made only with your written authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you. For information on the application of these rights to medical information maintained by your GHP (if applicable), please contact your GHP's Privacy Officer.

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes enrollment, payment, claims processing, and case or medical management records held by VIVA HEALTH.

  To inspect and copy medical information held by VIVA HEALTH that may be used to make decisions about you, you must submit your request in writing to VIVA HEALTH'S Privacy Officer (see contact information later in this Notice). If you request a copy (paper or electronic) of the information, we will charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by VIVA HEALTH will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information kept by VIVA HEALTH.

  To request an amendment, your request must be made in writing on the required form and submitted to VIVA HEALTH's Privacy Officer (see contact information later in this Notice). In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - is not part of the medical information we keep;
  - is not part of the information which you would be permitted to inspect and copy; or
  - is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you for reasons other than treatment, payment or health care operations.

  To request this list or accounting of disclosures, you must submit your request in writing on the required form to VIVA HEALTH's Privacy Officer (see contact information later in this Notice). Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be

free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  ***We are not required to agree to your request*.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing on the required form to VIVA HEALTH's Privacy Officer (see contact information later in this Notice). In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing on the required form to VIVA HEALTH's Privacy Officer (see contact information later in this Notice). We will not ask you the reason for your request, but your request must clearly state that the disclosure of all or part of the information could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Revoke Authorization.** You have the right to revoke your authorization to use or disclose your medical information except to the extent that action has already been taken in reliance on your authorization. Revocations must be made in writing to VIVA HEALTH's Privacy Officer (see contact information later in this Notice).

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

  You may obtain a copy of this Notice at our website, www.vivahealth.com. To obtain a paper copy of this Notice, call VIVA HEALTH's Customer/Member Service Department (phone numbers are listed on your health plan ID card).

YOUR RESPONSIBILITIES FOR PROTECTING MEDICAL INFORMATION.

As a member of VIVA HEALTH, you are expected to help us safeguard your medical information. For example, you are responsible for letting us know if you have a change in your address, email or phone number. You are also responsible for keeping your health plan ID card safe. If you have on-line access to Plan information, you are responsible for establishing a password and protecting it. If you suspect someone has tried to access your records or those of another member without approval, you are responsible for letting us know as soon as possible so we can work with you to determine if additional precautions are needed.

CHANGES TO THIS NOTICE.

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. If we make a material change to this Notice, we will include the new Notice in our annual mailing to all

Subscribers covered by VIVA HEALTH. We will also post the new Notice on our website at www.vivahealth.com. The Notice will contain the effective date on the first page.

FOR MORE INFORMATION OR TO REPORT A PROBLEM.

If you have questions and would like additional information, you may contact VIVA HEALTH's Privacy Officer (see contact information below). If you believe your privacy rights have been violated, you may file a complaint with VIVA HEALTH , with your GHP (if applicable) or with the Secretary of the Department of Health and Human Services. To file a complaint with VIVA HEALTH, contact VIVA HEALTH's Privacy Officer (see contact information below). All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

NOTICE EFFECTIVE DATE: The effective date of the Notice is April 14, 2003, amended on October 12, 2007, October 13, 2008, March 4, 2009, November 2, 2009, December 8, 2010, September 1, 2013, September 1, 2014, January 1, 2019, and January 1, 2020.

VIVA HEALTH PRIVACY OFFICER – CONTACT INFORMATION.

Address: VIVA HEALTH
Attention: Privacy Officer
417 20th Street North
Suite 1100
Birmingham, AL 35203

Email: vivamemberhelp@uabmc.edu

Phone: 1-800-294-7780 (TTY users, please call the Alabama Relay Service at 711)

VIVA HEALTH's normal business hours are from 8 a.m. to 5 p.m., Monday through Friday.

VIVA HEALTH NOTICE OF FINANCIAL INFORMATION PRACTICES

VIVA HEALTH is committed to maintaining the confidentiality of your personal financial information. We may collect and disclose non-public financial information about you to assist in providing your health care coverage or to help you apply for financial assistance from federal and state programs. Examples of personal financial information may include your:

- Name, address, phone number (if not available from a public source)
- Date of birth
- Social security number
- Income and assets
- Premium payment history
- Bank routing/draft information (for the collection of premiums)
- Credit/debit card information (for the collection of premiums)

We do not disclose personal financial information about you (or former members) to any third party unless required or permitted by law.

We maintain physical, technical and administrative safeguards that comply with federal standards to guard your personal financial information.