VIVA HEALTH®

UAB

UAB Post Doctoral

Certificate of Coverage

and Summary Plan Description

2025

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 that are excluded or limited, your rights as a VIVA HEALTH 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 material with their Covered Dependents, if any. Additional copies of this Certificate are available upon request.**

Members of this Plan select a VIVA HEALTH Participating Physician to be the Member's Personal Care Provider (PCP). Referrals from the PCP are required for visits to Participating Specialists to be covered. Visits to Participating vision and OB/GYN providers do not require PCP referrals. 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 participants are entitled under the terms of the Plan. Contact the Customer Service Department at 1-800-294-7780 or 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 VIVA HEALTH and 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, 2025, 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. VIVA HEALTH 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.

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.F. 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.** 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 a referral from the Personal Care Provider or 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 has 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 them.

4. A Member has the right to give their 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 them 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 their 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 their care propose to engage in or perform human experimentation or research affecting their care or treatment. A Member or legally responsible party on their behalf may, at any time, refuse to participate in or continue in any experimentation or research program to which they have 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 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 their health care.

13. A Member has the right to a candid discussion of appropriate or Medically Necessary treatment options for their 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 the 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 their 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 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 Cost Sharing 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.

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

"Appeal" means a Complaint regarding an Adverse Benefit Determination.

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

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

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

"Cosmetic" means non-Medically Necessary procedures or services that primarily serve to change or improve appearance or self-esteem without significantly improving physiological function. Procedures and services that correct an anatomical or congenital anomaly without significantly improving or restoring physiologic function are considered Cosmetic. Cosmetic procedures and services include, but are not limited to, drug treatment, plastic surgery, and nutritional procedures and treatments.

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

"Covered Dependent" means a member of the Subscriber's family who meets the eligibility requirements of 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 that has entered into a Group Policy with VIVA HEALTH under which VIVA HEALTH will provide or arrange Covered Services for Eligible Employees.

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

"Experimental" or "Investigational" means medical, surgical, diagnostic, psychiatric, substance use disorder, 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.

"Formulary" means the Prescription Drugs or Provider-Administered Drugs that this plan will cover. All drugs must be Medically Necessary to be Covered Services and some require Prior Authorization. The Formulary is subject to periodic review and modification by VIVA HEALTH or its designee. The medical Formulary covered by this Certificate is different from a pharmacy Formulary, which describes the prescription drug coverage that your Employer may have purchased under an optional prescription drug rider.

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

"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 a skill or function never learned or acquired 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 first 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.

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

"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 their 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, their 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.F.

"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 Cost Sharing 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 or Nurse Practitioner under contract by VIVA HEALTH to provide primary care services and chosen by a Member to provide Professional Services and coordinate health care services for the Member. A Personal Care Provider is generally an Internist, Family Practitioner, General Practitioner, Pediatrician, Nurse Practitioner, 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 their 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 Sponsor" means an Employer or organization that offers a group health Plan to its eligible employees.

"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.E. 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.

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

"Provider System" means a grouping of Participating Providers generally based on the Hospital with which they are affiliated. When a Member selects a Personal Care Provider in a Provider System, the Personal Care Provider only refers the Member to the Participating Physicians and Participating Hospital(s) within that Provider System. If a Covered Service is not available within the Provider System, the Personal Care Provider will work with VIVA HEALTH to identify another Participating Provider who can perform the service.

"Provider-Administered Drug(s)" means drugs or medications usually administered in a provider's office, outpatient infusion center, outpatient facility, inpatient hospital, or home health setting that require either administration or close monitoring by a provider or licensed health professional.

"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.

"Residential Treatment" means 24 hour per day skilled care provided under the supervision of an R.N. at a Residential Treatment Center if all of the following conditions are met:

1. Can be safely treated in a Residential Treatment Center level of care.
2. The services are required on an Intermittent or part-time basis and cannot reasonably be provided through intensive outpatient treatment or partial hospitalization.
3. The services must require the skills of a licensed therapist, psychiatric nursing staff, or L.P.N. under the supervision of an R.N. and treatment overseen by a Participating Ph.D. psychologist or psychiatrist.
4. The services must be reasonable and necessary for the treatment of a mental health or substance use disorder.
5. The services provide structured activities throughout the day, for a minimum of 5 days per week.

"Residential Treatment Center" means a live-in facility for mental health or substance use disorders properly licensed by the state in which it is situated to operate as a sub-acute or immediate care facility.

"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 Facility Care" means 24 hour per day skilled care provided under the supervision of an R.N. at a Skilled Nursing Facility if all of the following conditions are met:

1. Can be safely treated in a Skilled Nursing Facility level of care.
2. The services are required on an Intermittent or part-time basis and cannot reasonably be provided through outpatient rehabilitation.
3. The services must require the skills of a licensed physical therapist, occupational therapist, speech therapist, R.N., or L.P.N. under the supervision of an R.N. and treatment overseen by a Participating Physician.
4. The services must be reasonable and necessary for the treatment of an illness or injury.
5. The services provide structured activities throughout the day for a minimum of 5 days per week.

"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.

"Skilled Services" means care overseen by a Participating Provider and provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) under the supervision of an R.N. or provided by a physical therapist, occupational therapist, or speech therapist. Care must be required on an Intermittent or part-time basis and be reasonable and necessary for the treatment of an illness or injury.

"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.

"Specialty Pharmaceutical(s)" means a drug that typically targets chronic, rare or complex disease states, including plasma-derived pharmaceuticals (biological) and protein-based therapeutics (biotechnical). The drugs are used for specialized therapy that requires customized care management that may include frequent dosing adjustments and intensive clinical monitoring and intensive patient training and compliance assistance. Specialty Pharmaceuticals often require specialized product handling and/or administration requirements and are usually only available through limited specialty pharmacy distribution, not retail pharmacies. Specialty Pharmaceuticals may also include medications for common conditions that require a health care provider to administer or drugs only available through limited specialty pharmacy distribution, even if they don't have other specialty drug characteristics, as determined by VIVA HEALTH.

"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.

"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.L.C. 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 Dependent. To be eligible to enroll as a Covered Dependent, a person must be listed on the enrollment application completed by Subscriber, reside in the Service Area and/or with the Subscriber (except as noted below), and meet the criteria in one of (a) through (e) below:

    a. The 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 must be submitted by the 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 the Subscriber's spouse, who is under the age of twenty-six (26). For dependent children under the age of twenty-six (26), residency in the Service Area is not required. However, coverage for services delivered outside the Service

Area is limited to **Emergency Services and, with Prior Authorization, Urgently Needed Services**;

c. Any child who is under the age of twenty-six (26) if the Subscriber or the 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 the Subscriber's spouse under Internal Revenue Code Section 152. For dependent children under the age of twenty-six (26), residency in the Service Area is not required. However, coverage for services delivered outside the Service Area is limited to **Emergency Services and, with Prior Authorization, Urgently Needed Services**;

d. 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 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 no later than thirty (30) days of the child's attainment of age 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

e. The newborn child of a Subscriber will be covered at birth and for subsequent care only if the Subscriber formally enrolls the newborn within thirty (30) days after their 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 home (other than for adoption) is not an eligible dependent for purposes of the Plan. A grandchild of Subscriber or 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 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. In all cases, VIVA HEALTH'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 oneself 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 oneself 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 they 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 for 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 sixty (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 sixty (60) days after the date the Eligible Employee or eligible dependent is determined not 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 the 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 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 of any changes that will affect their eligibility or the eligibility of Covered Dependents for Covered Services. If a Member loses eligibility, VIVA HEALTH 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 their health status, their age (except as provided in Part II.A.2), or their 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 determines a Subscriber's leave qualified as Family and Medical Leave Act 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 VIVA HEALTH or the Employer as specified in the Group Policy. If the Group Policy is terminated for Employer's failure to pay premiums to VIVA HEALTH as required by the Group Policy, VIVA HEALTH 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 their 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 VIVA HEALTH for all costs incurred by the Plan as a result of the misuse of the identification card.

C. If a Member, on behalf of oneself 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 on the date specified by VIVA HEALTH. 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 VIVA HEALTH may rescind coverage under the Plan retroactively to the date specified by VIVA HEALTH. If the fraudulent activity relates to Plan eligibility, the termination may, at VIVA HEALTH'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 will provide the Member with at least 30 days advance written notice before coverage may be rescinded. The foregoing shall not affect the ability of VIVA HEALTH to cancel or discontinue coverage prospectively or to cancel or discontinue coverage retroactively to the extent such cancellation is attributable to a failure to timely pay the required premiums or contributions toward the cost of coverage. VIVA HEALTH 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 terminates for any reason, then the Covered Dependents enrolled by the Subscriber will cease to be eligible as of the date of the Subscriber's coverage termination.

E. If a 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 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 instructs VIVA HEALTH to terminate coverage of a Member, the termination date will be that requested in such notice. VIVA HEALTH is not responsible for any delay in notification of coverage termination from the Employer to VIVA HEALTH. Services received between the date a Member's coverage is terminated by the Employer and the date VIVA HEALTH is notified by the Employer of the termination are not Covered Services even when such services have been authorized by VIVA HEALTH 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 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 terminates coverage for any reason, the Employer 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 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 when they or their dependents become eligible for Medicare. 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. VIVA HEALTH will not pay expenses normally payable by Medicare Parts A and B.

If VIVA HEALTH is the secondary payor to Medicare, for primary coverage Members must enroll and maintain coverage under both Medicare Part A and Part B. When VIVA HEALTH 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.

To the extent permitted by law, where VIVA HEALTH 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 VIVA HEALTH.

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 the Member's Personal Care 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, referrals, and 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, VIVA HEALTH shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid hereunder and, to the extent of such payments, the Plan shall be fully discharged from liability hereunder.

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

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

PART VII. SUBROGATION AND RIGHT OF REIMBURSEMENT

A Member's accepting Covered Services is consent to and confirms VIVA HEALTH's subrogation and reimbursement rights. As used in this Part, "Member" includes any person acting on a Member's behalf, as well as the Member. The requirements of this subrogation provision may operate only to the extent permitted under statutory law, case law, or other regulations of the State of Alabama, if not pre-empted by federal law.

VIVA HEALTH is subrogated to all rights to recover that a Member has or might have from any third party, in contract, tort or otherwise, for Covered Services that the Plan has provided. VIVA HEALTH also has the right to bring a lawsuit in its own or in the Member's name against any such third party. VIVA HEALTH may contract with another entity to perform subrogation related services on its behalf.

In addition, VIVA HEALTH has a separate reimbursement right that is to be paid by a Member out of any recovery from a third party for any injury or illness for which the Plan provided Covered Services. VIVA HEALTH is to be paid and VIVA HEALTH's reimbursement right satisfied first, even if the Member does not recover for all of the Member's claims (that is, the Member is not made whole) or if the Member's recovery is for, or is described as for, the Member's damages other than health care expenses, or the Member is a minor.

VIVA HEALTH has a lien on any amount recovered or to be recovered by a Member from a third party for any injury or illness for which the Plan provided Covered Services. VIVA HEALTH may give notice of its lien to any party that is or may become obligated to pay or that is or may become in possession of an amount that may be subject to the lien.

The amounts of VIVA HEALTH's subrogation rights, reimbursement rights and liens are based on the Covered Services provided for the Member under the Plan and on VIVA HEALTH's fee schedule for Covered Services. This fee schedule is to be used to calculate the amounts regardless of VIVA HEALTH's arrangements with any Participating Providers.

The Member is required to furnish to VIVA HEALTH all information that the Member has concerning any rights to recover from third parties for any injury or illness for which the Plan provided Covered Services. This includes notifying VIVA HEALTH before filing any lawsuit or settling any claim. The Member is required to execute such documents as VIVA HEALTH may request related to VIVA HEALTH's enforcing its subrogation rights, reimbursement rights or liens. The Member is required not to allow VIVA HEALTH's subrogation and reimbursement rights to be limited or reduced by any act or omission by the Member. If the Member does not cooperate as required, VIVA HEALTH may file a lawsuit in its own name against the Member to enforce its rights under this Part, and the Member is to pay VIVA HEALTH's legal expenses incurred to enforce its rights under this Part.

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. 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 Cost Sharing. 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 go to www.vivahealth.com to verify that a particular provider is a Participating Provider.

C. **Role of Personal Care Provider.** Each Member shall select or have selected on their behalf a Personal Care Provider through whom certain covered primary medical services shall be provided and who will coordinate the Covered Services to be received by the Member. Members are strongly encouraged to establish relationships with their Personal Care Providers. If you are a new patient, call the Personal Care Provider to set an appointment. It is important to have a physician who knows you and your medical history should you become ill or suffer an injury.

1. Prior Approval of Health Services by Personal Care Provider is Required. The Personal Care Provider will take care of most problems directly. They will determine if other services are Medically Necessary and will refer the Member to proper sources of care. If the Personal Care Provider is part of a Provider System, referrals will be made to Participating Physicians and other providers in the same Provider System as the Personal Care Provider. If a Covered Service is not available within the Provider System, the Personal Care Provider will work with VIVA HEALTH to identify another Participating Provider who can perform the service. **The Plan will not cover health services if a Member consults another Physician, Hospital, Skilled Nursing Facility or any other institutional or individual health care provider without a VIVA HEALTH approved referral from their Personal Care Provider. The only services not requiring a PCP referral are Emergency Services and office visits to an optometrist, ophthalmologist, or OB/GYN.** Vision and OB/GYN services still must be received from a Participating Provider within the Member's Provider System and some procedures may require Prior Authorization from VIVA HEALTH. Members do not need Prior Authorization or a referral from VIVA HEALTH or from any other person (including a Personal Care Provider) in order to obtain access to OB/GYN services from a professional in VIVA HEALTH's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating Providers who specialize in obstetrics or gynecology, contact VIVA HEALTH Customer Service or visit www.vivahealth.com. When a referral by a Personal Care Provider is required, such a referral is not a determination that services/procedures are Covered Services. Coverage determinations are made by VIVA HEALTH based upon the terms of this Certificate and not by the Personal Care Provider.

2. Choosing a Personal Care Provider. Members have the right to designate any Personal Care Provider who participates in VIVA HEALTH's Participating Provider network and who is available to accept the Members. New Members should select a Personal Care Provider at the time of enrollment. This can be accomplished by indicating their choice on the enrollment application or by calling the Customer Service Department within 30 days of enrollment. Children may select a pediatrician who is a Participating Provider as their Personal Care Provider. For information on how to select a Personal Care Provider and for a list of

participating Personal Care Providers, contact Customer Service or visit VIVA HEALTH's website. If a Member does not select a Personal Care Provider within 30 days of enrollment, one may be designated by VIVA HEALTH in proximity to the Member's home. If a Member is enrolled in more than one product offered by VIVA HEALTH, the Member must select the same Participating Physician as their Personal Care Provider for all VIVA HEALTH products in which they are enrolled.

3. Changing the Personal Care Provider. A Member may change their Personal Care Provider to another Participating Physician periodically by calling the Customer Service Department. The change will be effective immediately.

D. Referrals.

1. To Participating Providers: A Member's Personal Care Provider in conjunction with the Medical Director will determine if the Member requires the services of a specialist or hospitalization, home health care, Skilled Nursing Facility care or any other health services. Covered Services will be provided through Participating Providers, subject to the limitations set forth in Part IX and Part X and the limitations, Cost Sharing, and any Lifetime maximum set forth in Attachment A. If the Member's Personal Care Provider is part of a Provider System, the Personal Care Physician will only refer Members to Participating Providers in the same Provider System. 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 that the Participating Provider's agreement with VIVA HEALTH has not terminated.

2. To 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 Member's Personal Care Provider may ask VIVA HEALTH to approve a referral for the Member to an appropriate non-Participating Provider. The Plan will cover 100% of the actual charges, subject to applicable Cost Sharing **if, and only if, the Member has been referred by the Personal Care Provider, and 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 from 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 or the Personal Care Provider. 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 Cost Sharing. Without such proof, benefits may not be paid to a non-Participating Provider.

E. **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, including wound care
5. Skilled Nursing and Long-Term Acute Care 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. All ancillary services (home health, IV therapy, hospice care, Durable Medical Equipment, orthotics, and prosthetics)
12. Sleep studies: C-PAP, MSLT, PSNG
13. Transplant services
14. Non-emergency Care by non-Participating Providers (will only be authorized when care is not available through Participating Providers)
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, excluding in-office scopes
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)
27. Specialty Pharmaceuticals
28. Infertility Treatment
29. Obstetrical admissions if mother or baby stay longer than 48 or 96 hours after delivery
30. Non-emergent ambulance transport
31. Angiograms except when CT guided
32. Cardiac catheterizations

33. Photodynamic therapy
34. Psychological and neurological testing
35. Electroconvulsive therapy (ECT) & transcranial magnetic stimulation (TMS)
36. Proton beam radiotherapy
37. Residential Treatment

F. **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.**

G. **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.

H. **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 Summary 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.

I. **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 of Coverage. 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, there may be a delay between the date a Member's coverage is terminated by the Employer and the date VIVA HEALTH is notified by the Employer of the termination. In the event employment ends, please consult with the Employer 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 to VIVA HEALTH. Services

received between the date a Member's coverage is terminated by the Employer and the date VIVA HEALTH is notified by the Employer of the termination are not Covered Services even when such services have been authorized by VIVA HEALTH or a Participating Provider. If VIVA HEALTH 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.

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 with a Lifetime Maximum. 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 Cost Sharing 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 and infertility treatment and Skilled Nursing Facility services from Participating facilities. 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 (except for infertility treatment and Skilled Nursing Facility services from Participating facilities), or services received from non-Participating Providers, except Emergency and Urgently Needed Services. Portions of the Member Cost Sharing paid by manufacturer coupons or similar assistance programs, such as those offered by pharmaceutical manufacturers, may not be applied to your Deductible or Out-of-Pocket Maximum. Members have a responsibility to inform VIVA HEALTH about the use of Cost Sharing assistance, manufacturer coupons, or similar assistance programs to cover the Cost Sharing for covered drugs or Covered Services. The Plan's specific Out-of-Pocket Maximum(s), if applicable, is (are) described in Attachment A, Summary of Benefits.

M. **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 Physician's office is closed, call your Personal Care Physician. The answering service will connect you to your Personal Care Physician or the physician on-call for them to 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.

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 Cost Sharing 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 the Member's Personal Care Provider. These services are also covered when furnished by a Participating Specialist (upon proper referral by the Personal Care Provider). 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 Member's Personal Care Provider):

    a. diagnosis and treatment of illness or injury;
    b. routine physical examinations when provided by the Member's Personal Care Provider;
    c. usual and customary pediatric and adult immunizations in accordance with accepted medical practice when provided by the Member's 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 Cost Sharing 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 Cost Sharing for the office visit. In that case, the Member would not pay an additional Cost Sharing for the separately billed preventive service or item. Cost Sharing 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 Cost Sharing.

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 performed by a Participating laboratory services in support of other basic services prescribed by the Personal Care Provider or the 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. Some employers do not offer vision care through VIVA HEALTH. Please see Attachment A to determine if vision care is a Covered Service under this Certificate. If covered, services include routine eye exams including refractions by a Participating ophthalmologist or optometrist every 12 months. Other visits are covered when Medically Necessary for the treatment of illness or injury. Office visits to a Participating ophthalmologist or optometrist do not require a referral from the Personal Care Provider.

6. Home Health Care. Medically Necessary short-term Skilled Services, provided at a Member's home through a Home Health Agency by a licensed physical therapist, occupational therapist, speech therapist, 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 the Personal Care Provider and 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 the 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 the Personal Care Provider or 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 disabling illness, injury, or congenital anomaly. Coverage of Outpatient Rehabilitative Services is limited to the number of visits specified in Attachment A; Prior Authorization must be obtained from the Personal Care Provider and 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 the Personal Care Provider or 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 Personal Care Provider and 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. The Inpatient rehabilitation Cost Sharing will apply, even if the Member has paid the Hospital Cost Sharing 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 a skill or function never learned or acquired as a result of a diagnosed developmental disorder/disability, autism or autism spectrum disorder or a congenital, genetic, or early acquired disorder resulting from sickness, injury, trauma, or some other event or condition suffered by a Member prior to that Member developing functional life skills. Such functional life skills include, but are not limited to, walking, talking, or self-help skills. 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 the Personal Care Provider 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. Testing for infertility diagnosis is limited to semen analysis, HSG and endometrial biopsy (covered once during the Member's Lifetime). Treatment for infertility is subject to Prior Authorization, limited to ovulation induction, insemination procedures, and Assisted Reproductive Technology (ART), and only covered for Subscriber and/or Subscriber’s spouse. Insemination procedures include artificial insemination (AI), intrauterine insemination (IUI), and therapeutic donor insemination. ART includes in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cryopreserved embryo transfers (Frozen Embryo Transfers (FET)), intracytoplasmic sperm injection (ICSI) or ovum microsurgery, or other non-experimental pregnancy-producing procedures. Infertility services also include the retrieval and initial cryo-preservation of sperm, eggs, and embryos when Medically Necessary. Fees associated with storage are not covered after the first 12 months. See Part X. exclusion W. Coverage for infertility treatment is subject to the Cost Sharing and lifetime maximums specified in Attachment A, Summary of Benefits.

11. Mental Health Services. Covered Services are generally provided for conditions or disorders that fall under the diagnostic categories listed in the mental disorders section of the *International Classification of Diseases,* as periodically revised. Exclusions apply. Mental health services required by a court order are specifically excluded from coverage as indicated in Part X.J. Please see Part X. for additional exclusions.

    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. If the Plan includes an optional prescription drug rider, pharmacotherapy.

        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. ECT is a psychiatric treatment in which seizures are electrically induced in patients that 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. Transcranial magnetic stimulation (TMS). TMS is a non-invasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression. TMS is typically used when other treatments have not been effective.

        viii. 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.

ix. Partial Hospitalization Program (PHP) services, which include nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, substance use disorder evaluation, and counseling. Partial hospitalization is covered for Members meeting Prior Authorization criteria.

b. Inpatient Mental Health Services. 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. 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. Inpatient Mental Health services also include:

i. Residential Treatment for Mental Health Care. Residential Treatment services are covered at a Residential Treatment Center approved by VIVA HEALTH if the primary purpose of such institutionalization is care by health professionals for the mental health condition(s) requiring such Residential Treatment care. Must be provided in an appropriately licensed and Participating Residential Treatment Center. 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 Residential Treatment Center 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 Residential Treatment Center services will not begin until VIVA HEALTH receives such notification.

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

12. Substance Use Disorder Services. Substance use disorder services required by court order are specifically excluded from coverage as indicated in Part X.J. Please see Part X. for additional exclusions.

Substance Use Disorder Services may be provided by licensed Participating Providers including Psychiatrists, Addictionologists, Nurse Practitioners, Psychologists, Professional Counselors, and Clinical Social Workers.

If covered, Substance Use Disorder Services include:

a. Outpatient Substance Use Disorder 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. If the Plan includes an optional prescription drug rider, pharmacotherapy.

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 they 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 use disorder evaluation, and counseling. Partial hospitalization is covered for Members meeting Prior Authorization criteria.

b. Inpatient Substance Use Disorder Services. Inpatient substance use disorder 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 use disorder 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. The same services covered under section a. Outpatient Substance Use Disorder Services above are covered Inpatient Substance Use Disorder 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 individual who display acute conditions or are at a risk of harming themselves or others. Inpatient Substance Use Disorder Services also include:

i. Acute Inpatient Medical Detoxification provided in a Substance Use Disorder Treatment Facility or in a general Hospital that provides Substance Use Disorder 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.

iii. Residential Treatment Services for Substance Use Disorder. Residential Treatment services are covered at a Residential Treatment Center approved by VIVA HEALTH if the primary purpose of such institutionalization is care by health professionals for the substance use disorder condition(s) requiring such Residential Treatment care. Must be provided in an appropriately licensed and Participating Residential Treatment Center. 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 Residential Treatment Center 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 Residential Treatment Center services will not begin until VIVA HEALTH receives such notification.

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

13. Maternity Care. Maternity Care includes risk-appropriate prenatal care, intrapartum and postpartum care for the Subscriber or the Subscriber's 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 the 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. surgical removal of partial or bony impacted teeth;
    b. removal of tumors;
    c. cysts of the jaws, cheeks, lip, tongue and roof of the mouth;
    d. treatment of fractured facial bones;
    e. external and internal incision and drainage;
    f. cutting of salivary glands or ducts;
    g. frenectomy;
    h. orthognathic surgery; and
    i. 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, 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 and other limitations 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, 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 real-time, interactive audio and/or video telecommunication technology. Telemedicine provider must be a Participating Provider for services to be Covered Services. Cost Sharing will apply based on provider's specialty and the Plan's schedule of benefits as if Covered Services were provided in person. See Attachment A, Summary of Benefits for specific coverage. Certain specialties and Covered Services may not be available through telemedicine. Depending on a Member's medical condition, telemedicine may not be appropriate to diagnose and treat the condition and Participating Providers who offer telehealth services may decline to provide a telehealth service and direct Members to seek treatment instead from in-person providers when appropriate. In addition, Participating Providers are not required to offer any Covered Services via telehealth.

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.

1. Inpatient Services.

    a. semi-private room, if available (private room only if Medically Necessary and authorized by the Member's Personal Care 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 Cost Sharing will apply in addition to the Hospital Cost Sharing;
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 Cost Sharing 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 Cost Sharing will apply to the newborn in addition to the Cost Sharing for the mother, 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 newborn Hospital Inpatient Cost Sharing 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;
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 Cost Sharing will apply for the long-term acute care services in addition to the initial Hospital Cost Sharing;
v. mental health services; and
w. substance use disorder services.

2. Outpatient Services. When authorized by Member's Personal Care Provider, Outpatient services include diagnostic services, radiotherapy and chemotherapy, and x-ray services that 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 the Member's Personal Care Provider and VIVA HEALTH.

C. **Extended Care and Skilled Nursing Facility Care**. Skilled Nursing Facility Care is covered up to the number of days specified in Attachment A (including semi-private room, board and general Skilled Nursing Facility 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 the Member's Personal Care Provider, 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 Care 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 Member's Personal Care Provider.

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 Cost Sharing for each emergency room visit as specified in Attachment A. The Cost Sharing 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 Member's Personal Care Provider and the 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 the Member's Personal Care 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 and power-operated mobility devices
    c. Crutches, Walkers, Canes
    d. Braces (limb or spine only)
    e. Traction devices
    f. Infant apnea monitors
    g. Oral appliances, 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 (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. Lymphedema compression treatment items
    v. INR monitors
    w. Speech-generating devices
    x. 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. Insulin is not covered under this Certificate's medical benefit but is provided under the optional prescription drug rider (Attachment B) at the back of this Certificate.

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 a referral from the Personal Care Provider or authorization from VIVA HEALTH for which no referral or 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. 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 governmental 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.

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. Residential services that provide care for which the primary purpose is to attend to the Member's activities of daily living which do not include or require the continuing attendance of trained medical or licensed behavioral health or substance use disorder professionals.

P. Substance use disorder treatment that is related to 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.

Q. 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.

R. 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.

S. 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, except when the services cannot be performed in an office setting and coverage criteria are met.

T. 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.

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

V. All other mental health and substance use disorder treatment, therapy, or counseling and any associated testing other than those services expressly covered under Part IX.A.11 and 12. Excluded services include;

1. therapies that do not meet national standards for mental health professional practice;
2. services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* section on Mental and Behavioral Disorders;
3. alternative treatments, self-help or motivational training, and training for personal or professional growth and development;
4. services for the following conditions except for purposes of making the initial diagnosis: learning disorders, simple speech delay as described in Part X.UU., conduct and disruptive impulse control disorders, intellectual disabilities, gambling disorders, sexual, paraphilia, truancy, disciplinary, or other behavioral problems not deemed Medically Necessary;
5. counseling for personal, family, or marriage problems;
6. stress and co-dependency treatment except in association with services provided for a treatable mental or substance use disorder; and
7. intelligence quotient (IQ) and achievement testing.

W. Reversal of surgical sterilization procedures and any other infertility treatments or procedures, except as provided in Part IX.A.10. Non-medically necessary fertility preservation. Storage of reproductive materials, including covered cryopreserved materials, such as sperm, eggs, embryos,

ovarian tissue, and testicular tissue after the initial 12 months. 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.

X. 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 Participating Provider may be covered under the Plan's preventive services benefit. See Part IX.A.2. for eligibility and limits.

Y. 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.

Z. 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 regimens (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).

AA. 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.

BB. Vision therapy, eye exercises, visual training orthoptics, shaping 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 or eyeglasses or contact lenses.

CC. Except for preventive medications as described in Part IX.A.2 or as part of Covered Services during an Outpatient observation stay, emergency department admission, or Inpatient admission:

1. Over-the-counter medications;
2. Vitamins and minerals, except for select formulations for specific diagnoses as part of a Member's plan of care defined by a Participating Provider for select indications;
3. Retail pharmaceuticals;
4. Non-injectable medications provided in a Physician's office except as required to treat an Emergency Medical Condition; and
5. Specialty Pharmaceuticals except with Prior Authorization and when listed on VIVA HEALTH's medical Formulary and defined by VIVA HEALTH as a Provider-Administered Drug.

Additional prescription drug coverage is provided under the prescription drug rider (Attachment B) at the back of this Certificate.

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

EE. Elective abortion.

FF. Wigs or prosthetic hair.

GG. 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.

HH. 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).

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

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

KK. Services required as a result of the Member's committing an illegal act, participating in a riot, 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.

LL. 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.

MM. Nutritional and electrolyte supplements. Enteral nutrition not delivered via feeding tube.

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

OO. Devices or treatments related to or used to correct impotence or other sexual dysfunction or inadequacy, with the exception of penile implants.

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

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

RR. 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, except for a limited number of drugs and conditions approved by VIVA HEALTH or its designee with Prior Authorization from VIVA HEALTH.

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

TT. 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.

UU. Habilitative Services for self-correcting conditions (including, but not limited to, hoarseness or

developmental articulation errors) and simple speech delay, which includes:

1. Following typical speech patterns but at a slower rate than peers; Speech delay not caused by hearing loss, environmental factors, or developmental disorders/disabilities.

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 their 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 VIVA HEALTH Formal Complaint Committee. The Member or any other party of interest may provide pertinent information to the VIVA HEALTH Formal Complaint Committee in person or in writing. The VIVA HEALTH 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 VIVA HEALTH 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 VIVA HEALTH 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 VIVA HEALTH Expedited Formal Complaint Committee grants the expedited review, the VIVA HEALTH Expedited Formal Complaint Committee will review the complaint and render a decision within a time period that accommodates the clinical urgency of the situation, but not later than 72 hours from the time the request was received. The VIVA HEALTH 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, except after a determination that the Member fails to meet eligibility requirements of the Plan.

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

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

   A Member must file a request for an external review 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 MAXIMUS, an Independent Review Organization ("IRO"). The 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 can request an external review in writing by faxing the request to MAXIMUS at 1-888-866-6190 or by mail to MAXIMUS at:

   MAXIMUS Federal Services
   3750 Monroe Avenue Suite 708
   Pittsford, NY 14534

   A Member may also request a review online at externalappeal.cms.gov. For questions or concerns during the external review process, a Member can call the toll-free number 888-975-1080. A Member can submit additional written comments to the IRO at the address above. Any additional information submitted will be shared with VIVA HEALTH to give the Plan an opportunity to reconsider the denial. In urgent care situations, a Member can initiate a request for expedited review by calling the toll-free number 888-975-1080.

6. **Department of Insurance Review**. If a Member is dissatisfied with the Complaint Procedure, the Member has the right to Appeal to the Consumer Services Division of the Alabama Department of Insurance by calling 334-241-4141, visiting their website at www.aldoi.gov, or sending your Appeal to:

Alabama Department of Insurance
201 Monroe Street, Suite 502
Montgomery, AL 36104

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 they are 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 VIVA HEALTH 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 VIVA HEALTH 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 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;
    b. A termination of the Subscriber's employment unless termination is due to gross misconduct;
    c. A reduction in the Subscriber's hours of employment with Employer below 30 hours per week;
    d. Divorce or legal separation from the 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;
    b. A termination of the Subscriber's employment unless termination is due to gross misconduct;
    c. A reduction in the Subscriber's hours of employment with Employer below 30 hours per week;
    d. The 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 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. Special Rule for 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. The maximum aggregate period of Continuation Coverage for any or all Qualifying Events, including Medicare entitlement, is 36 months.

   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 their 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 they are 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 VIVA HEALTH 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 VIVA HEALTH 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 oneself as a VIVA HEALTH Member prior to receiving care will result in the Member being financially responsible for services that require prior-approval or referral in order to be Covered Services. You will automatically receive a new Identification Card when card information changes such as the Primary Care Physician or certain Cost Sharing. 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 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.D.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 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 VIVA HEALTH and includes this Certificate. Under the Group Policy, VIVA HEALTH performs certain administrative services. VIVA HEALTH is also given full and complete 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.

O. **Acceptance of Premium not a Guarantee of Coverage.** VIVA HEALTH'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. HEALTH INFORMATION PRIVACY

Disclosures of Protected Health Information to the Plan Sponsor:
In order for your benefits to be properly administered, the Plan needs to share your protected health information with the Plan Sponsor (your group). Following are circumstances under which the Plan may disclose your protected health information to the Plan Sponsor:

The Plan may inform the Plan Sponsor whether you are enrolled in the Plan.

- The Plan may disclose summary health information to the Plan Sponsor.
- The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The Plan may disclose your protected health information to the Plan Sponsor for Plan administrative purposes. This is because employees of the Plan Sponsor perform some of the administrative functions necessary for the management and operation of the Plan.

Following are the restrictions that apply to the Plan Sponsor's use and disclosure of your protected health information:

- The Plan Sponsor will only use or disclose your protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the Plan Sponsor discloses any of your protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The Plan Sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit Plan of the Plan Sponsor.
- The Plan Sponsor will promptly report to the Plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The Plan Sponsor will allow you or the Plan to inspect and copy any protected health information about you that is in the Plan Sponsor's custody and control. The HIPAA regulations set forth the rules that you and the Plan must follow in this regard. There are some exceptions.
- The Plan Sponsor will amend, or allow the Plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or healthcare operations.
- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the Plan and to the U.S. Department of Health and Human Services, or its designee.
- The Plan Sponsor will, if feasible, return or destroy all of your protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any business associate when the Plan Sponsor no longer needs your protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy your protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the Plan Sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- The University of Alabama System
- The UAB Health System
- The UAB Hospital Management, LLC
- The University of Alabama System (“UAS”) Office of Counsel
- The UAS Office of Internal Audit
- The UAB Privacy and Security Officers
- The UAB Human Resources department
- The UAB Employee Benefits department
- The UAB Employee Wellness
- The UAS and UAB Information Technology
- The UAS and UAB Compliance departments
- The UAB and UAS Risk Management

If any of the foregoing employees or workforce members of the Plan Sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions – which may include termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

Security of Your Personal Health Information:

Following are restrictions that will apply to the Plan Sponsor's storage and transmission of your electronic protected health information:

- The Plan Sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the Plan Sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations,
- If the Plan Sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

The Plan Sponsor will report to the Plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

For a detailed Notice of Health Information Practices for the Plan, visit vivahealth.com/privacy or refer to the benefit information provided by the Plan Sponsor for more information.

PART XV. 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 XVI. NONDISCRIMINATION AND LANGUAGE ACCESSIBILITY NOTICE

Nondiscrimination Notice:

Discrimination is Against the Law

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

VIVA HEALTH:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

If you believe that VIVA HEALTH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with VIVA HEALTH'S Section 1557 Coordinator:

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 by mail, fax, or email. If you need help filing a grievance, VIVA HEALTH'S Section 1557 Coordinator is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TDD: 1-800-537-7697)

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

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

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

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

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

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

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

Procedure:

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

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

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

- A grievance should contain the name and contact information of the person filing it as well as the alleged discriminatory action and alleged basis (or bases) of discrimination, the date the grievance was filed, and any other pertinent information.
- When a grievance includes allegations that would violate Section 1557, the Section 1557 Coordinator (or their designee, if applicable) shall investigate the grievance. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the grievance.
- VIVA HEALTH shall inform an individual that they have a right to reasonable modifications in the grievance procedure if they need them.
- The Section 1557 Coordinator must keep confidential the identity of an individual who has filed a grievance under this part except as required by law or to carry out the purposes of this part, including the conduct on any investigation, including to investigate the grievance.
- VIVA HEALTH will issue to the person who filed the grievance a written decision on the grievance no later than 30 days after its filing. The decision shall include the resolution date and a notice to the complainant of their right to pursue further administrative or legal remedies.
- VIVA HEALTH will maintain the files and records relating to such grievances for at least three years from the date VIVA HEALTH resolves the grievance.

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

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

The availability and use of this grievance procedure does not prevent a person from pursuing other legal and administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office

for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

Language Assistance Services:

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

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

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

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

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

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

العربية (Arabic)

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

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

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

ગુજરાતી (Gujarati)
ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-284-7780 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

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

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

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

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

Português (Portuguese)
ATENÇÃO: Se você fala **português** (Portuguese), serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos

acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-294-7780 (TTY: 711) ou fale com seu provedor.

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

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

UAB POST DOCTORAL

Effective Dates: January 1, 2025 – December 31, 2025

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 OUT-OF-POCKET MAXIMUM: The most a Member will pay per Calendar Year for qualified medical, mental, and substance use disorder services, prescription drugs, and specialty drugs. The maximum includes copayments, and coinsurance paid by the Member for qualified services but does not include premiums or out-of-network charges over the maximum payment allowance. See the Certificate of Coverage for details. Amounts from manufacturer coupons or similar assistance programs used to satisfy Member Copayments or Coinsurance do not count toward the Out-of-Pocket Maximum.	$7,350 per individual; $14,700 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** • **Nutritionist Preventive Visits** (Up to 3 per Calendar Year with a Registered Dietitian or Nutritionist) • **Other preventive items and services** (See Certificate of Coverage for details)	100% Coverage
OTHER PRIMARY CARE SERVICES:	
• **Medical Physician Services**	$20 Copayment per visit
• **Illness and Injury**	$20 Copayment per visit
• **Hearing Exams**	$20 Copayment per visit
• **X-Ray and Laboratory Procedures**	100% Coverage
○ Covered Genetic Testing	80% Coverage
SPECIALTY CARE: *(PCP Referral Required)*	
• **Medical Physician Services**	$30 Copayment per visit
• **Illness and Injury**	$30 Copayment per visit
• **X-Ray and Laboratory Procedures**	100% Coverage
○ Covered Genetic Testing	80% Coverage
• **OB/GYN Services** *(No PCP Referral Required)*	$30 Copayment per visit
URGENT CARE CENTER SERVICES:	
• **Medical Physician Services** • **Illness and Injury**	$20 Copayment per visit at UAB Urgent Care; $30 Copayment per visit at all other urgent care centers
VISION CARE: *(No PCP Referral Required)*	
• **One routine vision exam per Calendar Year** • **Other eye care office visits**	$30 Copayment per visit
ALLERGY SERVICES: *(PCP Referral Required)*	
• **Physician Services**	$30 Copayment per visit
• **Testing**	100% Coverage
DIAGNOSTIC SERVICES: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	100% Coverage
OUTPATIENT SERVICES: • **Surgery and Other Outpatient Services**	100% Coverage
HOSPITAL INPATIENT SERVICES:	
• **Physician and Facility Services**	$250 Copayment per admission (waived at UAB)
INFERTILITY SERVICES: *(Subject to a $5,000 maximum family medical lifetime benefit and a separate $5,000 maximum family prescription drug lifetime benefit. Eligibility limited to subscriber and/or subscriber's spouse.)*	
• **Initial consultation and counseling session**	$30 Copayment per visit; One per Lifetime
• **Semen analysis, HSG test, and endometrial biopsy**	$0 Copayment; One per Lifetime
• **Medically Necessary office visits and tests** (ultrasound, laboratory tests)	$30 Copayment per visit
• **Prescription drugs**	Cost varies by tier
• **Medical services to treat infertility** [assisted reproductive technology (ART), including intrauterine insemination (IUI) and in vitro fertilization (IVF)]	100% Coverage
MATERNITY SERVICES:	
• **Physician Services** *(Prenatal, delivery, and postnatal care)*	$30 Copayment per delivery
• **Maternity Hospitalization**	$250 Copayment per admission (waived at UAB)
Newborn care and other services covered only for enrolled child of employee or employee's spouse. Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered. No coverage for children of employee's dependent child.	
EMERGENCY ROOM SERVICES:	$50 Copay/visit (waived if admitted within 24 hours)
EMERGENCY AMBULANCE SERVICES: *(Must be Medically Necessary)*	100% Coverage
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	100% Coverage
MEDICAL NUTRITION SERVICES: *(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)*	$30 Copayment per visit

UAB POST DOCTORAL

Effective Dates: January 1, 2025 – December 31, 2025

Attachment A to Certificate of Coverage

MEDICAL BENEFITS	COVERAGE
DIABETES SELF MANAGEMENT EDUCATION:	$30 Copayment per visit
DIABETIC SUPPLIES: Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.	100% Coverage
SKILLED NURSING FACILITY SERVICES: *(100 days per Lifetime)*	100% Coverage
HOME HEALTH CARE SERVICES: *(Limited to 60 visits per Calendar Year)*	100% Coverage
REHABILITIATION AND HABILITATION SERVICES: Physical, Speech, and Occupational Therapy and Applied Behavior Analysis	$30 Copayment per visit; $250 Copayment per admission (waived at UAB)
CHIROPRACTIC SERVICES: *(PCP Referral Required)*	$30 Copayment per visit
TEMPOROMANDIBULAR JOINT DISORDER:	$30 Copayment per visit
SLEEP DISORDERS:	$30 Copayment per visit;
• **Sleep Study**	100% Coverage
TRANSPLANT SERVICES:	100% Coverage after $250 Hospital Copayment (waived at UAB)
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES:	
• **Inpatient Services**	100% Coverage after $250 Copay/admission (waived at UAB)
• **Outpatient Services**[1]	$30 Copayment per visit

[1]Outpatient office visits require a PCP referral.

MEDICAL BENEFITS	COVERAGE
COVERED PRESCRIPTION DRUGS[2]**:**	
• **Generic Drugs**	
○ From a Participating Pharmacy	$15 Copayment per 30-day supply
○ Mail-order	$30 Copayment per 90-day supply[3]
○ Participating Pharmacy	$45 Copayment per 90-day supply[3]
• **Preferred Brand Drugs**	
○ From a Participating Pharmacy	$45 Copayment per 30-day supply
○ Mail-order	$113 Copayment per 90-day supply[3]
○ Participating Pharmacy	$135 Copayment per 90-day supply[3]
• **Non-Preferred Brand Drugs**	
○ From a Participating Pharmacy	$70 Copayment per 30-day supply
○ Mail-order	$175 Copayment per 90-day supply[3]
○ Participating Pharmacy	$210 Copayment per 90-day supply[3]
• **Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals**[4,5]	80% Coverage
• **Oral Contraceptives**	$0 Copayment for generic and select brand drugs; Applicable Copayment for other brand drugs
• **Weight Loss Drugs (Contrave, Qsymia, Saxenda, and Wegovy)**[6]	70% Coverage after $200 weight loss drug deductible per member
• **Diabetic Testing Supplies**	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]A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. [4]May be administered in the home, physician's office or on an outpatient basis. There is a Member out-of-pocket maximum of $2,000 per Member per Calendar Year for biological drugs, biotechnical drugs, and specialty pharmaceuticals. 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 https://www.vivahealth.com/Group/Login/ [5]Cost Sharing for certain specialty drugs may vary and be set to the maximum of any available manufacturer-funded copay assistance programs and is not applied to the out-of-pocket maximum. [6]Cost Sharing for weight loss drugs (Contrave, Qsymia, Saxenda, and Wegovy) does not apply to drugs prescribed for diabetes. Cost Sharing for drugs prescribed for diabetes follows standard formulary tiering.

When generic is available, Member pays difference between generic and Brand price, plus Copayment.
Check with your participating pharmacy to learn if it is eligible to offer a 90-day supply at retail.

SMOKING CESSATION PRODUCTS:	
Two, 12-week treatment courses total per Calendar Year. Prescription required. [Generic nicotine replacement products (including the patch, lozenge, gum, inhaler, or nasal spray), or Nicotrol (inhaler), or Nicotrol NS (nasal spray), or Generic Zyban, or Varenicline tartrate (Chantix)].	$0 Copayment

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

Eligible Dependent: Eligible Employee's lawful spouse and children of Eligible Employees 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.

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

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 (including sex characteristics, including interstitial intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). VIVA HEALTH does not exclude people or treat them differently because 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).

UAB means University Hospital, UAB Women and Infants Center, UAB Highlands, UAB St. Vincent's, The Kirklin Clinic, Medical West, UAB Callahan Eye Hospital, Spain Rehabilitation Center, and all UAB satellite clinics.

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

G. **"Copayment"** means the amount of payment indicated in Section II that is due and payable by the Member to the Participating Pharmacy at the time a Prescription Drug is received.

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

I. **"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.

J. **"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.

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

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

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

N. **"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.

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

P. **"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.

Q. **"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.

R. **"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.

S. **"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.

T. **"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.

U. **"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.

V. **"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 30-day supply (up to 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.

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 30-day supply per prescription.

Certain preventive, over-the-counter drugs and Prescription Drugs are covered at 100% with no copayment, coinsurance or deductible from the Member when the Member has a Prescription Order for the drug, and it is provided by a Participating Provider. These items generally are those recommended by the U.S. Preventive Services Task Force with a grade of A or B; and, with respect to infants, children, adolescents and women, preventive care provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Such item or service

may not be covered until the plan year that begins one year after the date the recommendation or guideline is issued. Guidelines and limitations apply. Often only the generic form of the preventive drug is covered at 100%. Recommendations and guidelines for preventive care change from time to time. See this plan's Wellness Benefits flyer 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. In the event pharmacy insurance is retroactively implemented, first contact VIVA HEALTH to assist in the adjudication of retroactive pharmacy claims.

VI. Limitations:

A. Prescription Drugs will be dispensed in a quantity not to exceed a 30-day supply of

medication or not to exceed a 90-day supply for eligible drugs by mail order (or at retail if the Participating Pharmacy offers up to a 90-day supply). A month's supply is as written by the provider, up to a consecutive 30-day supply, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Some Prescription Drugs may be subject to additional supply limits based on coverage criteria developed by VIVA HEALTH. 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 (such as, for example, 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 and any claims affected by the adjustment may be reprocessed and subject to additional Member Cost Sharing. In no event may an amount applied to your Copayment or Coinsurance by the coupon issuer be eligible to be applied to the Deductible or Out of Pocket Maximum. Members have a responsibility to inform VIVA HEALTH about the use of Cost Sharing assistance, manufacturer coupons, or similar assistance programs to cover their Cost Sharing for Covered Prescription Drugs.

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

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

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.

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

H. Drugs prescribed for the purpose of weight reduction (including, but not limited to, appetite suppressants, amphetamines), except for the limited drugs on the Formulary when Prior Authorization is obtained by VIVA HEALTH's pharmacy department.

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

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

K. Drugs prescribed for the purpose of terminating pregnancy.

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

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

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

O. Inspirease and other respiratory assistance apparatus.

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

Q. Refills in excess of the amount specified by the prescribing Physician or any refill dispensed after one (1) year from the order of the prescribing Physician.

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

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

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

U. Prescriptions dispensed by a non-Participating Pharmacy

V. Prescriptions prescribed by non-Participating Physicians, unless authorized by the Plan.

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

X. Prescription Drugs furnished or otherwise covered by the local, state, or federal government to the extent of such coverage whether or not payment is actually received except as otherwise provided by law.

Y. Vitamins and minerals, except for select formulations for specific diagnoses as part of a Member's plan of care defined by a Participating Provider for select indications and except for prenatal vitamins and certain preventive vitamins covered at 100% as described in Section

III of this Outpatient Prescription Drug Rider, which are Covered Services when prescribed by a Participating Provider.

Z. Unit dose packaging of Prescription Drugs.

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

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

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

DD. Prescription Drugs for any condition, 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.

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

FF. Prescription food products and nutritional supplements.

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

A. Maintenance Drugs and Oral Contraceptives are available in up to a 90-day supply. Refer to Attachment A for coverage specific to this Plan.

B. 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 double coverage and coordination of benefits provisions in the Certificate apply to Covered Services under this Outpatient Prescription Drug Rider but only to the extent that is coordinated with other prescription drug coverage. Prescription Drug coverage under this Outpatient Prescription Drug Rider is considered a separate policy and will only be coordinated with other eligible prescription drug coverage as determined by VIVA HEALTH.

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

A. **Inquiries.** Most problems can be handled simply by discussing the situation with a representative of the Plan or its designee by phone or in person.

B. **Informal Complaint.** If the Member's problem cannot be resolved to the Member's satisfaction at the Inquiry level, the Member may file an Informal Complaint. Informal Complaints may be made verbally or in writing. A decision regarding an Informal Complaint and the mailing of a written notice to the Member is completed from the receipt date of the Informal Complaint within 15 days for pre-service Appeals, within 30 days for post-service Appeals, and within 45 days for other Complaints. The written notice includes the outcome of the review of the Informal Complaint. In the case of an adverse outcome (in whole or in part), the Member has a right to a second review by filing a Formal Complaint.

C. **Formal Complaint.** A Formal Complaint is the subsequent written expression of dissatisfaction by or on behalf of a Member regarding the resolution of an Informal Complaint. A Formal Complaint must be filed within 12 months of the Plan's receipt of the original Informal Complaint. The Plan may allow an extension of the 12-month limit due to extenuating circumstances. Formal Complaints may be submitted by written letter sent to:

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

A family member, friend, provider, or any other person may act on behalf of the Member after written notification of authorization is received by the Plan from the Member. Members also have the right to request that a VIVA HEALTH staff member assist them with the Formal Complaint. Formal Complaints are reviewed by the VIVA HEALTH Formal Complaint Committee. The Member or any other party of interest may provide pertinent data to the VIVA HEALTH Formal Complaint Committee in person or in writing. The VIVA HEALTH Formal Complaint Committee issues its decision from the receipt date of the Formal Complaint within 15 days for pre-service Appeals and 30 days for post-service Appeals and other Complaints. The Member is given written notification regarding the VIVA HEALTH Formal Complaint Committee's decision within five working days of the decision being made. In the case of a final internal Adverse Benefit Determination at the Formal Complaint level (in whole or in part), the Member may have a right to an external review process, as described below. A determination that the Member fails to meet the eligibility requirements of the Plan is not subject to external review.

D. **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 VIVA HEALTH 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 VIVA HEALTH Expedited Formal Complaint Committee grants the expedited review, the VIVA HEALTH Expedited Formal Complaint Committee will review the Complaint and render a decision within a time period that accommodates the clinical urgency of the situation, but not later than 72 hours from the time the request was received. The VIVA HEALTH

Expedited Formal Complaint Committee notifies the provider of its decision by phone or fax the day the decision is made or the next business day if the provider's office is closed. Written notification of the decision is mailed to the Member within three days after the day the decision is made and to the provider within the same timeframe if the provider filed the expedited review request on behalf of the Member. In the case of a final internal Adverse Benefit Determination at the Expedited Formal Complaint level, the Member 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.

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

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

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

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

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

external review decision within 45 days after receiving the request for external review, or within 72 hours for an expedited external review.

XI. 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

THIS NOTICE DESCRIBES HOW HEALTH 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 Triton Health Systems, L.L.C. and each of its covered subsidiaries including but not limited to VIVA HEALTH, Inc. and VIVA HEALTH Administration L.L.C. (collectively referred to hereafter as "VIVA HEALTH"). This Notice also describes the health information practices of group health plans (GHPs) that participate in an Organized Health Care Arrangement (OHCA) with VIVA HEALTH, 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 currently in effect. In addition, these entities, sites and locations may share health information with each other for the purposes of treatment, payment or health care operations described below.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you is personal and we are committed to protecting your information. We keep a membership record of your enrollment in our plan. We also maintain records of decisions and payments we've made related to health care services you or your treating providers have requested to be covered by the plan.

This Notice tells you about the ways in which we may use and disclose your health information. We also describe your rights and certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to your health information;
- Notify you in the case of a breach of your unsecured identifiable health information; and
- Follow the terms of the Notice currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe some of the ways that we will use and disclose your health 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.

- ***Treatment and Treatment Alternatives.*** We use or disclose your health information to help your doctors and other health care providers coordinate or arrange your health 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 health services that you need, or help your health care provider find a safer prescription drug alternative. We may disclose your health information to individuals outside VIVA HEALTH, and the OHCAs (if applicable), who may be involved in your health care, such as your family members or close friends. We may use and disclose your health information to tell you about health-related benefits or services that may be of interest to you.

- ***Health Information Exchanges (HIEs).*** We may participate in certain health information exchanges (HIEs) that allow us to exchange electronic health information with health care providers or entities who share in the HIE for treatment, payment, or health care operations purposes. Our participation in these exchanges helps improve the quality of care you receive. For a list of these exchanges, you may contact the VIVA HEALTH Privacy Officer for details (see contact information later in this Notice). You may choose not to have your

electronic health information included in these exchanges by submitting a written request on the required form to the Privacy Officer.

- ***Payment.*** We may use and disclose your health information 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.

- ***Health Care Operations.*** We may use and disclose your health information for our routine health care operations. These uses and disclosures are necessary for VIVA HEALTH, and the group health plan (GHP) in the OHCA (if applicable), to operate and make sure that all our members receive quality care. We may also combine health 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 (GHP) 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 health information for certain health care operations of another covered entity. For example, if you receive benefits through a GHP, we may disclose your health information to other health plans or their business associates that are involved in administering your GHP benefits.

- ***Organized Health Care Arrangements (OHCAs).*** We participate in OHCAs with some of our network providers and group health plans (GHPs). The entities of the OHCA may share in the cost of your health care and may work together to assess the quality of health care you receive. The entities of the OHCA may also use or disclose your health information for treatment, payment or health care operation purposes (described above) relating to the OHCA's joint activities. 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 and better address your health care needs.

  In the OHCAs with our GHPs, sharing your eligibility and 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. Whenever we disclose your health information to GHPs, they must follow applicable laws governing the use and disclosure of your 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 your health information to the eligible person who enrolled you on the plan ("Subscriber"), a friend or family member who is involved in your health care or payment for your health care, and to your personal representative(s)

appointed by you or designated by applicable law. We may also share a minor dependent's health information with the Subscriber or other parent/guardian on the same policy as the Subscriber, if applicable, unless such disclosure is prohibited by law or in certain situations where we are permitted by federal and state law to decide whether to disclose based on the minor's best interests. In addition, we may disclose your health information 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 health information to contact you and remind you to talk to your doctor about certain covered health screenings or preventive services or to tell you about health-related benefits or services that may be of interest to you. We may contact you by mail, telephone, text, or email or through the member portal or member application. For example, we may leave voice messages at the telephone number you provide to us or mail you a letter about health products that may be of interest to you.

- ***Research***. We may use and disclose your health information for medical research. All research studies must be approved by a special process required by law that protects patients involved in research, which includes their privacy board. While most research studies require specific patient consent, there are some instances where patient authorization is not required. For example, a research project may involve comparing the recovery of all patients who received one medication to those who received another for the same condition. This would be done with no patient contact.

- ***Certain Marketing Activities.*** We may use your health information 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 we provide 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. 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 that has a Group Health Policy with VIVA HEALTH, if applicable. 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 health 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 your health information when required to do so by federal, state or local law.

- ***Public Health Activities.*** We may disclose your health information 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 health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, licensure, and inspections. These activities allow 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 your health information in response to a court or administrative order. We may also disclose your health information 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 your health information for judicial or administrative proceedings, as required by law.

- ***Law Enforcement.*** We may release health 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 health 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, tissue or eye donor or recipient, we may use or release your health information to organizations that manage organ, tissue and eye procurement, banking, transportation, and transplantation.

- ***To Avert a Serious Threat to Health or Safety.*** We may use and disclose your health information 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 your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- ***National Security and Intelligence Activities.*** We may release your health information 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 your health information 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 your health information for workers' compensation or similar programs as authorized by law. 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 your health information to the correctional institution or law enforcement official for your health or for the health and safety of other individuals.

- ***Other uses and disclosures.*** We will obtain your written 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 HEALTH INFORMATION ABOUT YOU

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

- ***Right to Inspect and Obtain a Copy.*** You have the right to inspect and obtain a copy of your health records unless your doctor believes releasing that information to you could harm you. Enrollment, payment, claims processing, and case/care management or medical management records held by VIVA HEALTH are included in your right to inspect and obtain of a copy of your health records, but not psychotherapy notes, information gathered for a legal proceeding, or certain research records while the research is ongoing.

  Additionally, we are prohibited by law from knowingly engaging in Information Blocking. We will not engage in any practice that is likely to interfere with, prevent, or discourage your access, exchange, or use of your electronic health information.

  To inspect or obtain a copy of your health records held by VIVA HEALTH, 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 may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and obtain a copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed by following the instructions in the letter of denial you will receive.

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

  Your request for amendment must be made in writing on the required form, specify the records you wish to amend, give the reason for your request and must be submitted to VIVA HEALTH's Privacy Officer (see contact information later in this Notice).

  We may deny your request for amendment. If we do, we will tell you why and explain your options.

- ***Right to an Accounting of Disclosures.*** You have the right to request an "accounting of disclosures" which is a list of entities or persons (other than yourself) to whom we disclosed your health information without your authorization. The accounting would include disclosures made in response to a court order or subpoena or data submitted to a public health authority, but does not include disclosures that are exempted by law. For example, an accounting of disclosures does not include disclosures for treatment, payment or health care operations.

  To request an 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 more than the six years prior to the date of the request. Your request should indicate in what form you want the list (for example, on paper or 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 before any costs are incurred.

- ***Right to Request Restrictions.*** You have the right to request we restrict or limit how we use or disclose your health information for treatment, payment or health care operations. You also have the right to request a limit on your health information we disclose 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 in all circumstances. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If we deny your request, we will tell you why and explain your options.

  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 a family member.

- ***Right to Request Confidential Communications.*** You have the right to request that we communicate with you about health 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) and specify how or where you wish to be contacted. 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.

- ***Right to Revoke Authorization.*** You have the right to revoke your authorization to use or disclose your health 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.

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

YOUR RESPONSIBILITIES FOR PROTECTING HEALTH INFORMATION

As a member of VIVA HEALTH, you are expected to help us safeguard your health 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. Any change in the Notice could apply to health 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, the new Notice will be sent to all Subscribers covered by VIVA HEALTH by your Plan Sponsor (if applicable) or by VIVA HEALTH. We will also post the new Notice on our website at www.vivahealth.com.

FOR MORE INFORMATION OR TO REPORT A PROBLEM OR COMPLAINT

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, last amended January 1, 2025.

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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services**:**

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

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

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

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

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

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

العربية (Arabic)

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

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

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

ગુજરાતી (Gujarati)
ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑકિઝલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-284-7780 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

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

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

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

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

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

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

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