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Certificate of Coverage

2012

VIVA HEALTH
CERTIFICATE OF COVERAGE

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

Members of this Plan may see any VIVA HEALTH Participating Physician. Referrals from the PCP are not required for visits to Participating specialists to be covered. Some services require prior-authorization to be covered. These are listed in Part VIII. Access to Care. Mental health and substance abuse services are provided by American Behavioral Benefits Managers. 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 sought within 24 hours of the onset of symptoms. 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 205-558-7474 (in Birmingham) if you have any questions.

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TABLE OF CONTENTS

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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, 2012 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. Please see Part IX.D. for more information on coverage for Emergency Services. **Always call VIVA HEALTH within 24 hours or as soon as reasonably possible after Emergency Services are received.** Follow-up care in an emergency room is not a covered service. Participating Providers may change from time to time, so you should always verify the status of a provider on the web at www.vivahealth.com or by calling VIVA HEALTH.

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

VIVA HEALTH 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. 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

1. Member Rights

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

   B. 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.

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

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

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

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

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

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

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

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

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

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

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

2. Member Responsibilities

   A. 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.

   B. 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.

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

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

   E. 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.

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

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

PART I. DEFINITIONS

Capitalized terms in this Certificate have the following meanings:

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

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

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

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

"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 between a man and woman that is recognized as a common law marriage under the laws of the state where the Subscriber resides.

"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 Schedule of Copayments (Attachment A hereto) which is due and payable by the Member to a provider of care at the time services are received.

"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. Health services for which Coverage is subject to satisfaction of the annual Deductible are identified in Attachment A, Schedule of Copayments.

"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 (except as excluded in Part X.L. for pregnancy, delivery, or newborn care outside the Service Area) and includes ambulance services for Emergency Medical Conditions dispatched by 911, if available, or by the local government authority.

"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.)

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

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

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

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

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

"Lifetime" means the lifetime of the Member.

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

"Medically Necessary" 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) Necessary to meet the basic health care needs of the Member;
2) Rendered in the most cost-efficient manner, setting, supply or level appropriate for the delivery of the Covered Service;
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, his or her Physician, Hospital, or other health care provider.

For inpatient services and supplies, it further means that the Member's medical symptoms or conditions require that the diagnosis or treatment can not 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.

"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, Home Health Agency or any other duly licensed

institution or health professional under contract to provide Professional Services, Hospital Services or other Covered Services to Members. A list of Participating Providers is available to each Subscriber upon enrollment. Such list shall be revised by VIVA HEALTH from time to time as VIVA HEALTH deems necessary. A current list is available by calling VIVA HEALTH Customer Service and on the VIVA HEALTH website at www.vivahealth.com .

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

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

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

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

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

"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.

"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.

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

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

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

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

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

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

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

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

"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.

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

PART II. ELIGIBILITY

A. Who is Eligible for Coverage?

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

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

    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 dependents subject to a qualified medical child support order that requires the Subscriber or the Subscriber's spouse to be financially responsible for medical or other health care, residency in the Service Area is not required but coverage for services delivered outside the Service Area is limited to **Emergency Services only.** A description of the procedures governing a determination as to whether a particular court decree is qualified may be obtained, without charge, from VIVA HEALTH;

c. Any child who is under the age of twenty-six (26) if the Subscriber or 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;

d. For dependent children eligible under subsection (b) or (c) who are full-time students at an accredited educational institution, residency in the Service Area is not required, but coverage for services delivered outside the Service Area is limited to **Emergency Services only.** A dependent child who is not enrolled in an accredited educational institution for one semester per Calendar Year continues to qualify as a full-time student if the child was enrolled the previous semester and intends to be enrolled the following semester. For purposes of this section, an accredited educational institution is a postsecondary educational institution including an institution of higher education (as defined in Section 102 of the Higher Education Act of 1965). Upon the request of VIVA HEALTH, the Subscriber agrees to provide proof of full-time student status;

e. Any unmarried child as described in subsection (b) or (c) above but without regard to age, who (1) is and continues to be incapable of self-sustaining employment by reasons of mental or physical disability, (2) is chiefly dependent (greater than 50%) upon the Subscriber 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-one (31) days of the child's attainment of age twenty-six (26) and subsequently as may be required by VIVA HEALTH, but not more frequently than annually. In addition, such unmarried child's disability must have commenced prior to the child's reaching age 26 and the child must have been enrolled hereunder as a Covered Dependent immediately prior to attaining age 26; or

f. The newborn child of a Subscriber will be covered at birth and for subsequent care only if the Subscriber formally enrolls the newborn within thirty-one (31) days after his/her birth. The newborn who is not enrolled within thirty-one (31) 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 himself/herself and for the employee's eligible dependents, who must be listed on the enrollment application provided by VIVA HEALTH. For Eligible Employees who apply during Initial Plan Open Enrollment, the effective date is the first day of the first Plan Year.

B. Newly Eligible Employee. Each new employee of the Employer entering employment subsequent to the Employer's initial enrollment effective date shall be permitted to apply for coverage for himself/herself and eligible dependents, within thirty-one (31) days of becoming an Eligible Employee. For Eligible Employees who apply within thirty-one (31) 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-one (31) 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-one (31) days of the date such person first becomes an eligible dependent. The effective date is the day he/she became an eligible dependent (the date of birth for a newborn or the date of adoption or placement for adoption for a newly adopted child).

D. Open Enrollment. Persons who do not enroll during Initial Plan Open Enrollment or within thirty-one (31) days of becoming a newly Eligible Employee or a newly eligible dependent may only enroll during an Open Enrollment Period. An Open Enrollment Period shall be held at least annually at which time Eligible Employees and their eligible dependents may enroll as Members under the Plan. The effective date for Eligible Employees and eligible dependents who apply during an Open Enrollment Period will be the first day of the next Plan Year.

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

F. Limitations. Persons initially or newly eligible for enrollment must complete the proper application and submit it to VIVA HEALTH within thirty-one (31) days of becoming eligible. Persons who do not enroll within thirty-one (31) 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 his/her 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 his/her health status, his/her age (except as provided in Part II.A.2), his/her requirements for health services, or the existence on the effective date of coverage under the Plan of a pre-existing physical or mental condition, including pregnancy. However, no person is eligible to re-enroll hereunder who has had coverage terminated under Part IV.B. through IV.H.

I. Pre-Existing Conditions or Waiting Period Requirements. Except for a Member under age nineteen (19), coverage with respect to a Member's Pre-existing Conditions is excluded until after the time period specified in Attachment A hereto. Children under age 19 are not subject to pre-existing condition exclusions.
"Pre-existing Conditions" are a Member's medical conditions for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage or the first day of a new hire waiting period, if any. Pregnancy is not considered a pre-existing condition and no pre-existing condition limitations shall apply to a dependent newborn or adopted child (including a child placed for adoption) if covered within thirty-one (31) days of birth or adoption/placement for adoption. VIVA HEALTH will waive portions of the pre-existing waiting period to the extent of the period of time an individual was previously covered by Qualifying Previous Coverage provided that Qualifying Previous Coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of coverage under the Plan. Any new hire waiting period will not be included in the calculation of the sixty-three (63) days. The Member must provide acceptable proof of the Qualifying Previous Coverage. The Member has the right to request such proof (called a Certificate of Creditable Coverage) from the prior plan and the Plan will assist the Member in obtaining it as necessary.

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

PART IV. TERMINATION OF MEMBER'S COVERAGE

Coverage under the Plan will terminate as follows:

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

C. If, after reasonable efforts, a Participating Physician is unable to establish or maintain a satisfactory Physician-patient relationship with a Member, coverage of the Member may be terminated upon fifteen (15) days written notice by VIVA HEALTH. Examples of unsatisfactory physician-patient relationships include, but are not limited to, abusive or disruptive behavior in a physician's office, repeated refusals by the Member to accept procedures or treatment recommended by a Participating Physician, and a Member's securing services in a manner that impairs the ability of the Personal Care Provider to coordinate the Member's care.

D. If a Member materially violates the terms of the Group Policy or engages or attempts to engage in fraudulent or illegal activity related to coverage hereunder, coverage of the Member may be terminated upon thirty (30) days written notice 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. The Member (and Subscriber if Member was a Covered Dependent) shall be financially responsible for any claims incurred during the period the Member was fraudulently enrolled with no refund of premium. VIVA HEALTH reserves the right to pursue other available remedies in addition to coverage termination.

E. If a Member commits acts of physical or verbal abuse or harassment against VIVA HEALTH staff, a provider, or other Members, coverage of the Member may be terminated upon fifteen (15) days written notice by VIVA HEALTH.

F. If a Member, on behalf of himself or another Member, or a person seeking coverage on behalf of the Member, performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact, then the coverage of the Member who either furnished such information and/or on whose behalf such information was furnished, may be terminated from the Plan on the date specified by 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 material misrepresentation or VIVA HEALTH may rescind coverage under the Plan retroactively to the date specified by VIVA HEALTH. 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.

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

H. If a Member fails to cooperate in administration of the Double Coverage, Coordination of Benefits or Subrogation provisions set forth in Parts V, VI, and VII, respectively, then the coverage of such Member may be terminated upon fifteen (15) days written notice by VIVA HEALTH.

I. 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.

J. 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.

K. 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 between the date of employment termination and the date coverage ends, coverage for services delivered outside the Service Area is limited to **Emergency Services only.**

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

B. **Medicare.** 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 not Covered Services. If VIVA HEALTH is the secondary payor to Medicare, Members must enroll and maintain coverage under both Medicare Part A and Part B. When VIVA HEALTH is secondary to Medicare or to a Medicare Advantage or similar Medicare plan, VIVA HEALTH will process Member claims assuming all benefits offered under the primary coverage have been covered. 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 a Participating Provider.

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

4. Benefits will only be paid for when Covered Services are provided by Participating Providers, except for treatment of Emergency Medical Conditions. 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. The plan covering a Member as a spouse will be primary to a plan covering that Member as a child dependent.

5. 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,

any legal expenses incurred by VIVA HEALTH to enforce the Plan's rights under this Part, and may be terminated in accordance with Part IV.H.

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 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, the Member is to pay VIVA HEALTH's legal expenses incurred to enforce its rights under this Part, and the Member's coverage may be terminated under Part IV.H.

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 Coinsurance, Copayments, or Deductibles, which are the financial responsibility of the Member and are set forth in Attachment A.

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

C. **Provision of Care.**

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

2. By non-Participating Providers:

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

        i. the services are Emergency Services. 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.

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

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

    c. The determination of whether Medically Necessary Covered Services are available through Participating Providers in the Service Area is made by the Medical Director upon request from a Member.

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

D. **Prior Authorizations.** Certain services require authorization from VIVA HEALTH prior to receiving the service. If such authorization is not obtained, no charges for those services will be covered by the Plan. The services requiring prior authorization include:

1. Hospital admissions and transfers **(if you are admitted to the Hospital for an Emergency Medical Condition, you must call VIVA HEALTH within 24 hours or as soon as reasonably possible for the admission to be a Covered Service)**
2. Hospital observation unit
3. Hospital outpatient services
4. Outpatient surgery
5. Skilled Nursing Facility admissions
6. Inpatient rehabilitation or day treatment
7. Heart catheterization
8. Pain clinic care
9. Physical, speech and occupational therapy
10. Home Health Agency services
11. Durable Medical Equipment, Orthotics, and Prosthetics
12. Sleep studies
13. Transplant services
14. Non-emergency Care by non-Participating Providers (only when care is not available through Participating Providers within the Service Area)
15. Myelograms, discograms, and PET scans
16. All scopes performed outside the physician's office excluding colonoscopy and EGD
17. All plastic surgery (see Part X. exclusion I.)
18. All sinus or nasal surgery
19. Arteriograms
20. Cardiac and pulmonary rehabilitation.
21. Holter monitors if worn longer than 24 hours.

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

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

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

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

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

In order for authorized services to be Covered Services, you must be a Member at the time services are received. Authorizations are not valid for services received after the date coverage terminates. For coverage terminations initiated by the Employer, 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.

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

J. **Lifetime or Annual Maximum Benefit Limits**. Subject to all terms, conditions and definitions in this Certificate, each Member is entitled, when a Lifetime or Annual Maximum applies, to Covered Services up to an amount not to exceed the Lifetime or Annual Maximum.

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

PART IX. SCHEDULE OF BENEFITS

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

A. Professional Services Performed Within the Plan Service Area.

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

    a. diagnosis and treatment of illness or injury;
    b. routine physical examinations when provided by a Personal Care Provider;
    c. usual and customary pediatric and adult immunizations in accordance with accepted medical practice when provided by a Personal Care Provider except for work-required immunizations and immunizations for travel abroad;
    d. pre- and post-operative care;
    e. prenatal care, delivery and post-natal care of mother if the mother is the Subscriber or the Subscriber's spouse (Services or expenses of any kind, including complications, related to the pregnancy of any Covered Dependent other than the Subscriber's spouse are excluded);
    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 ligation and vasectomy) and the provision of intrauterine devices, except for subcutaneous implants for contraception;
    i. examinations to determine the need for hearing correction.

2. Preventive Services. Certain preventive items and services are covered at 100 % with no copayment, coinsurance or deductible from the Member when provided by a Participating Provider. These items and services generally include those recommended by the U.S. Preventive Services Task Force with a grade of A or B; immunizations for routine use recommended by the Advisory Committee on Immunization Practices; and, with respect to infants, children, adolescents and women, preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Such item or service may not be covered until the plan year that begins one year after the date the recommendation or guideline is issued.

    If a preventive item or service described in this Part, IX (2), is billed separately, in addition to an office visit charge, the Member may be responsible for a copayment, coinsurance and/or deductible for the office visit. In that case, the Member would not pay an additional copayment, coinsurance and/or deductible for the separately billed preventive service or item. A copayment, deductible or coinsurance also may apply if the primary purpose of the Member's visit is not routine, preventive care.

For children, preventive services (except for screenings for sexually transmitted diseases as described below) must be performed by their Personal Care Provider at their Well Baby or Well Child check-ups in order to be covered at 100 % with no copayment, coinsurance or deductible. For an adult Member, the following preventive services must be performed by the Member's PCP or OB/GYN during the annual physical examination in order to be covered with no copayment, coinsurance or deductible:

a. screening for high blood pressure
b. screening for counseling to reduce alcohol misuse
c. screening for cholesterol abnormalities
d. screening for depression
e. screening for diabetes
f. screening for obesity
g. counseling for tobacco use
h. screening for osteoporosis in females
i. screening for abdominal aortic aneurysm

In addition to the preventive services listed above, the following are other services that will be covered at 100 % for sexually active adolescents and high-risk adults with no copayment, coinsurance or deductible when performed by the Member's PCP or OB/GYN during an annual physical examination:

a. screening for cervical cancer
b. screening for HIV
c. screening for syphilis
d. screening for Chlamydia
e. counseling for sexually transmitted infection

The following medications or supplements are provided at 100 % with no copayment, coinsurance or deductible if prescribed by a Participating Provider:

a. aspirin to prevent myocardial infarctions or ischemic strokes
b. oral fluoride for children 6 years and younger whose water source is deficient in fluoride
c. iron supplementation for children 6 months to 12 months at increased risk for iron deficiency anemia
d. folic acid supplement for women of child-bearing age

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%. The document is available on the website at www.vivahealth.com or by calling Customer Service. Members who do not receive prescriptions through VIVA HEALTH's pharmacy benefit manager may call Customer Service for information on how to obtain the above medications at 100 % coverage.

Obesity. Obese Members, as defined by a body mass index (BMI) of 30 or greater, may receive at 100 % coverage counseling and behavioral interventions from a PCP or a Participating nutritionist twice a month for three months to promote sustained weight loss. The benefit is limited to once per Lifetime, or six total counseling visits with a PCP or Participating nutritionist to promote sustained weight loss.

Tobacco cessation. A Member may have one visit per year covered at 100 % for tobacco

cessation counseling by a Participating Physician. Pharmacy benefits are not covered under this Certificate but may be provided if the Plan includes an optional prescription drug rider. If so, such rider will be found at the back of this Certificate.

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

4. Laboratory Procedures and X-ray Examinations. Diagnostic and therapeutic radiology services; diagnostic laboratory services in support of other basic services prescribed by a Participating Physician.

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.

6. Home Health Care. Medically Necessary short-term Skilled Nursing Care, provided at a Member's home through a Home Health Agency by a Registered Nurse or Licensed Practical Nurse duly licensed by the applicable state. Coverage is limited to sixty (60) visits per Calendar Year; prior authorization must be obtained from VIVA HEALTH's Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable period of time. During the course of treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided for the full sixty (60) visits.

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

    a. Outpatient Rehabilitation Services. Medically Necessary outpatient short-term rehabilitation services upon referral from a Participating Physician and with prior approval of the Medical Director. Therapy is covered only when required as a result of Accidental Injury, stroke or congenital anomaly present at birth and identified within the first 12 months of birth. Coverage of outpatient rehabilitation is limited to the number of visits specified in Attachment A; prior authorization must be obtained from the Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable period of time (within 2 months in most cases). During the course of treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided.

    b. Inpatient Rehabilitation Services. Medically Necessary inpatient short-term rehabilitation services upon referral from a Participating Physician and with prior approval of the Medical Director. Coverage of inpatient rehabilitation is limited to sixty (60) days per Calendar Year; prior authorization must be obtained from the Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable period of time. During the course of treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided for the full sixty (60) days.

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

9. Services for Infertility. Coverage for infertility services is limited to initial consultation and one counseling session only. Testing is limited to semen analysis, HSG and endometrial biopsy (covered once during the Member's Lifetime). Treatment for infertility is not a Covered Service.

10. Mental Health Services. Some employers do not offer mental health services through VIVA HEALTH. Please see Attachment A to determine if mental health services are Covered Services under this Certificate. Mental health services required by a court order are specifically excluded from coverage. Mental health services for the following conditions are also excluded except for purposes of making the initial diagnosis: eating disorders, learning disorders, motor skills disorders, communication disorders, mental retardation, personality disorders, pervasive developmental disorders, sexual, paraphilia, and gender identity disorders, and truancy, disciplinary or other behavioral problems. Please see Section X. for additional exclusions.

    Inpatient mental health services must be authorized prior to treatment and meet established medical necessity guidelines. If you are admitted to the Hospital from the emergency room for inpatient mental health services, authorization does not have to be obtained prior to treatment but always call American Behavioral within 24 hours or as soon as reasonably possible. Outpatient mental health services may be authorized prior to treatment if desired to verify coverage. Certain services and diagnoses may not be covered and all services must meet medical necessity guidelines. American Behavioral is available during normal business hours, Monday through Friday 7 a.m. to 6 p.m. for information on benefits, covered services, eligibility and appointment scheduling, and 24 hours a day, seven days a week for emergencies. The toll free number is 800-677-4544. If the Member is not satisfied with his or her Participating Provider, he or she may call American Behavioral and ask for a referral to another Participating Provider. Mental Health Services may include assessment, diagnosis, treatment planning, medication management, and psychotherapy (e.g. individual, family and group). Mental Health Services may be provided by licensed Participating Providers including psychiatrists, nurse practitioners, psychologists, professional counselors, and clinical social workers.

    If covered, Mental Health Services include:

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

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

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

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

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

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

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

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

Treatment in other levels of care such as Residential treatment, Intensive Outpatient Programs (IOPs), Partial Hospitalization Programs (PHPs), and care in a Sanatorium, State or Government Facility are specifically excluded from coverage.

11. Substance Abuse Services. Some employers do not offer services related to substance abuse through VIVA HEALTH. Please see Attachment A to determine if services for substance abuse are Covered Services under this Certificate. Substance abuse services required by a court order are specifically excluded from coverage. Please see Section X. for additional exclusions.

    Inpatient substance abuse services must be authorized prior to treatment and meet established medical necessity guidelines. If you are admitted to the Hospital from the emergency room for inpatient substance abuse services, authorization does not have to be

obtained prior to treatment but always call American Behavioral within 24 hours or as soon as reasonably possible. Outpatient substance abuse services may be authorized prior to treatment if desired to verify coverage. Certain services and diagnoses may not be covered and all services must meet medical necessity guidelines. American Behavioral is available during normal business hours, Monday through Friday 7 a.m. to 6 p.m. for information on benefits, covered services, eligibility and appointment scheduling, and 24 hours a day, seven days a week for emergencies. The toll free number is 800-677-4544. If the Member is not satisfied with his or her Participating Provider, he or she may call American Behavioral and ask for a referral to another Participating Provider. Substance Abuse Services may be provided by licensed Participating Providers including Psychiatrists, Addictionologists, Nurse Practitioners, Psychologists, Professional Counselors, and Clinical Social Workers.

If covered, Substance Abuse Services include:

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

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

ii. Pharmacotherapy provided by psychiatrists, addictionologists, or nurse practitioners specializing in treating chemical dependency using the biomedical approach, which includes psychotherapy.

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

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

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

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

b. Inpatient Substance Abuse Services. The same services covered under section a. Outpatient Substance Abuse Services above are covered Inpatient Substance Abuse Services when care is Medically Necessary and authorized by VIVA HEALTH or its

designee. Acute inpatient treatment represents the most intensive level of care and is provided in a secure and protected hospital setting. Inpatient treatment is indicated for stabilization of individuals who display acute conditions or are at a risk of harming themselves or others. Inpatient Substance Abuse services also include:

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

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

Treatment in other levels of care such as Residential treatment, Intensive Outpatient Programs (IOPs), Partial Hospitalization Programs (PHPs), and care in a halfway house or other sober living arrangement are specifically excluded from coverage.

12. Maternity Care. Maternity Care includes risk-appropriate prenatal care, intrapartum and postpartum care for the Subscriber or the Subscriber's spouse. For medically high-risk pregnant women, maternity care includes transportation when Medically Necessary. **Please see Part X. L. for excluded maternity services outside the Service Area.**

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

14. 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; and
    h. treatment of non-dental birth defects (such as cleft lip or cleft palate) which have resulted in a severe functional impairment. Such treatment must be completed prior to the Member's 10th birthday.

15. 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). In order to be covered, treatment must begin within ninety (90) days after the accident and must be completed within six (6) months of the date of injury.

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

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

18. Allergy Services. Allergy Services and supplies ordered by or under the direction of a Participating Physician. See Attachment A, Schedule of Copayments for specific coverage.

19. Sleep Disorders. Coverage for evaluations and treatment of severe or life-threatening sleep disorders, limited to the maximum coverage amount specified in Attachment A. 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 Copayment and other limitations specified in Attachment A.

20. 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.

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

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

1. Inpatient Services.

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

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

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

D. Emergency Services.

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

   a. the Member has an Emergency Medical Condition; and
   b. treatment is Medically Necessary; and
   c. treatment is sought immediately after the onset of symptoms (within twenty-four (24) hours of occurrence) or referral to a Hospital emergency room is made by a Participating Physician.

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

   There is a Copayment for each emergency room visit as specified in Attachment A. The Copayment will be waived if the Member is admitted to a Hospital through that Hospital's emergency room as an inpatient for the same condition within 24 hours from the time of initial treatment by emergency room staff. **If you are admitted to the Hospital from the emergency room, always call VIVA HEALTH within 24 hours or as soon as reasonably possible.**

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

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

   a. Treatment must be for an Emergency Medical Condition as defined in Part I; and

   b. The Member must notify VIVA HEALTH within 24 hours or as soon as reasonably possible after Emergency Services are initially provided.

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

E. Ambulance Services. Emergency ambulance transportation by a licensed ambulance service to a Hospital for treatment of an Emergency Medical Condition.

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

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. Manual Wheelchairs
   c. Crutches, Walkers, Canes
   d. Pre-fabricated braces (limb or back only)
   e. Traction devices
   f. Infant apnea monitors
   g. 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 care)

2. Initial Acquisition of Prostheses after Accidental Injury or surgical removal that occurred while a Member under the Plan.

   Coverage is provided for Durable Medical Equipment and Prosthetics described above 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.

G. <u>Diabetic Supplies</u>. 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, but may be provided if the Plan includes an optional prescription drug rider. If so, such rider will be found at the back of this Certificate.

H. Transplant Services. Services and supplies for transplants when ordered by a Participating Physician for transplant benefits 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 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.

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).

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. This also includes payment for benefits subject to the pre-existing condition exclusion described in Part III.I. Children under age 19 are not subject to the pre-existing condition exclusion.

B. Care that is rendered 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 ends on the date coverage under the Plan terminates and does not extend until discharge.

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

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

E. Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations, investigations, or treatments that are not otherwise Covered Services. Examples of such excluded

services include when such services relate to career, education, sports, camp, travel, employment, insurance, marriage, adoption, medical research, or are to obtain or maintain a license of any type.

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

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

H. Transsexual related services, supplies, surgery or therapy.

I. Plastic or cosmetic medical or surgical treatment or other health services or supplies except reconstructive surgery necessary to repair a functional disorder resulting from disease, injury, or congenital anomaly present and apparent at birth. Services for cosmetic purposes including but not limited to reformation of sagging skin, changes in appearance of any portion of the body, removal of keloids, scar revision, hair transplants or removal, and chemical face 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.

J. 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, medical complications are present, all non-surgical alternatives have been exhausted, and the Member is within a specified percentage of recommended body weight. If covered, breast reduction surgery is limited to one surgery per Member per Lifetime.

K. Care for conditions that federal, state or local law require to be treated in a public facility or require coverage to be purchased or provided through other arrangements such as workers' compensation, no-fault automobile insurance or similar legislation; 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.

L. All services, including Emergency Services, for pregnancy, delivery, and newborn care outside the Service Area after the earlier of the date a physician has advised you not to travel, the 35th week of pregnancy for a single fetus, or the 30th week of pregnancy for two or more fetuses.

M. All services or expenses of any kind, including complications, related to infertility services for and the pregnancy of any Covered Dependent other than the Subscriber's spouse.

N. Surrogate parenting/pregnancy and non-Medically Necessary Amniocentesis. If a surrogate delivery occurs outside the Service Area, care for the newborn provided outside the Service Area is not a Covered Service.

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

P. 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.

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

R. Substance abuse treatment that is not abstinence-based.

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

T. 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.

U. Organ donor treatment or services where a Member serves as the organ donor but 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.

V. Dental examination and 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.13, 14, and 15. Any hospitalization related to any form of dentistry. Orthodontic treatment and orthognathic surgery.

W. 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.

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

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

Z. All infertility treatment, such as fertility drugs and substances, artificial insemination, reversal of surgical sterilization procedures, tuboplasty, in-vitro fertilization, gamete intra fallopian transfer (GIFT) programs, zygote intra fallopian transfer (ZIFT) programs, embryo transport, and any other treatments or procedures.

AA. Mental health services required by a court order, and all other mental health services except as specifically set forth in Part IX.A.10.

BB. 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, weight control programs and weight control medications, except for counseling by a Personal Care Provider. Such services are excluded regardless of the cause of the obesity or the need for weight control and whether or not such services are Medically Necessary to treat or prevent illness. Counseling and behavioral intervention by a PCP or Participating nutritionist may be covered under the Plan's preventive services benefit. See Section IX(A)(2) for eligibility and limits.

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

DD. Subcutaneous implants and/or removal of subcutaneous implants.

EE. Experimental or investigational drugs, products, or treatments including medical, surgical or psychiatric procedures, and pharmaceutical regimes (this includes any drugs or other products which have not been approved as safe and effective for their intended use by the U.S. Food and Drug Administration).

FF. 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.

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

HH. Except for preventive medications as described in Section IX(A)(2), all over-the-counter medications, biologicals, biotechnicals, and prescription medications, including self-administered injectable drugs, for outpatient treatment. Non-injectable medications provided in a Physician's office except as required to treat an Emergency Medical Condition. Additional prescription drug coverage may be provided by an optional rider if purchased by the Employer. If so, such rider will be found at the back of this Certificate.

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

JJ. Abortion.

KK. Wigs or prosthetic hair.

LL. 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 or inserts per Lifetime, and no more than one pair of shoes or inserts per year, when Medically Necessary and approved by VIVA HEALTH in advance.

MM. 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, ostomy supplies, disposable cervical collars, diapers, and other urological supplies.

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

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

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

QQ. Services required as a result of an intentionally self-inflicted illness or injury except when resulting from a physical or mental health condition and except for treatment of an injury resulting from an act of domestic violence.

RR. Services rendered by a provider with the same legal residence as the Member or who is a member of Member's family, including spouse, brother, sister, parent, or child.

SS. All enteral feedings and nutritional and electrolyte supplements.

TT. Hearing therapy and charges incurred in connection with the purchase or fitting of hearing aids.

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

VV. Diagnosis and treatment of snoring.

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

XX. Health-related education including prenatal classes except from a Participating Provider in the course of treatment.

YY. Genetic testing and gene therapy, including pre-implantation genetic diagnosis.

ZZ. Tele-consultation and computer/on-line consultation and services and all virtual testing and screening.

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

PART XI. CLAIMS AND COMPLAINT PROCEDURES

A. CLAIMS FOR BENEFITS.

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

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

    a. Address the claim to VIVA HEALTH Medical Management Department. Non-urgent pre-service claims must be in writing mailed to the following address: 1222 14th Avenue South, Birmingham, Alabama 35205 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 Section 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.

A. **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 according to the timeframes listed under Appeals in XI.A.4 if applicable, or within 45 days of receipt for other informal 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 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
1222 14th Avenue South
Birmingham, Alabama 35205

A provider may act on behalf of the Member in the Formal Complaint process if the provider certifies in writing to VIVA HEALTH that the Member is unable to act on his or her own behalf due to illness or disability. A family member, friend, provider, or any other person may act on behalf of the Member

after written notification of authorization is received by VIVA HEALTH from the Member. Members also have the right to request that a VIVA HEALTH staff member assist them with the Formal Complaint.

All Formal Complaints are reviewed by the Formal Complaint Committee. The Member or any other party of interest may provide pertinent information to the Formal Complaint Committee in person or in writing. The Formal Complaint Committee issues its decision within 30 days of the receipt date of the Formal Complaint. The Member will receive written notification regarding the Formal Complaint Committee's decision postmarked within five working days of the decision being made. In the case of a final internal adverse benefit determination at the Formal Complaint level (in whole or in part), the Member has a right to an external review process, except after a determination that the Member fails to meet eligibility requirements of the Plan.

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

   If the Expedited Formal Complaint Committee grants the expedited review, the Expedited Formal Complaint Committee will review the complaint and render a decision within a time period that accommodates the clinical urgency of the situation, but not later than 72 hours after the day the request was received. The Expedited Formal Complaint Committee notifies the provider of its decision by phone or fax the day the decision is made or the next business day if the provider's office is closed. Written notification of the decision is mailed to both the provider and the Member within three working 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 Expedited Formal Complaint Committee does not grant the Member's request for an expedited review, the Member will receive written notification postmarked within three working days after receipt of the request. The notification will verify that the request will be automatically transferred to the informal level of the complaint procedure as described above.

5. **External Review**. VIVA HEALTH has available an independent external review process for denied claims for benefits. This external review process applies to an adverse benefit determination or final internal adverse benefit determination on appeal. The decision to be reviewed usually will be the denial of an appeal as part of the Formal Complaint process described above. A determination that a person is not a Member under the terms of this Certificate, however, is not eligible for the external review process unless it involves a rescission.

   An expedited external review process is available for (i) an adverse benefit determination, if the adverse benefit determination involves a medical condition of the Member for which the timeframe for completion of an expedited internal appeal under paragraph XI.B.4 above would seriously jeopardize the life or health of the Member, or would jeopardize the Member's ability to regain maximum function and the Member has filed a request for an expedited internal appeal under paragraph XI.B.4 above; or (ii) a final internal adverse benefit determination, if the Member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life

or health of the Member or would jeopardize the Member's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Member received emergency services, but has not been discharged from a facility.

A Member must file a request for an external review with the Office of Personnel Management ("OPM") of the federal government 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") selected by OPM. 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 can request an external review in writing by sending the request electronically to OPM at DisputedClaim@opm.gov, by faxing it to OPM at 202-606-0036, or by mail to OPM at P.O. Box 791, Washington, D.C. 20044. For questions or concerns during the external review process, a Member can call the toll-free number 877-549-8152. 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 us 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 877-549-8152.

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

PART XII. CONTINUATION COVERAGE

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

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

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

In no event shall 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's spouse 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 Subscribers and only if such individuals themselves are Members at the time the Subscriber becomes entitled to Medicare. To receive this coverage, a Member must notify the Plan Administrator that the Subscriber becomes entitled to Medicare. Failure to notify the Plan Administrator of the Subscriber's entitlement may lead to termination of Continuation Coverage.

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

   In order to be entitled to this extended coverage, the disabled person must provide the Plan Administrator a copy of the Social Security Administration determination of his or her disability

within the earlier of 60 days after the Administration makes a disability determination, or the last day of the initial 18-month period of Continuation Coverage. Such individual must notify the Plan Administrator within 30 days of the date the Social Security Administration makes a final determination that he or she is no longer disabled.

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

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

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

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

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

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

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

COBRA coverage will be terminated retroactively if a Member is determined to have been ineligible. A Member's Continuation Coverage with 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.

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

PART XIII. GENERAL PROVISIONS

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

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

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

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

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

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

E. **Clerical Error.** Clerical error, whether of the Employer 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 Section VIII.C.2. The Member is responsible for sending a request for reimbursement to VIVA HEALTH in a language and on a form provided by or acceptable to VIVA HEALTH. The request must include the Member's name, address, telephone number, and Member identification number

(found on the Member identification card), the provider's name, address, and telephone number, the date(s) of service, and an itemized bill including the CPT codes or a description of each charge. If the Member is enrolled in any other health plan, the Member must also include the name(s) of the other carrier(s). **Such claim shall be allowed only if notice of claim is made to VIVA HEALTH or its designee within one hundred and eighty (180) days from the date on which covered expenses were first incurred.**

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

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

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

M. **Certification Procedures.** VIVA HEALTH provides Creditable Coverage Certifications to Plan participants in accordance with the Health Insurance Portability and Accountability Act of 1996. The certification is provided when regular coverage is lost, when COBRA coverage is lost, and again within 24 months after losing coverage 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. This certification may be used to reduce or eliminate a pre-existing condition waiting period if one becomes covered under a new group health plan within 63 days of the date coverage ends under the Plan.

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. 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.

Our Pledge Regarding Protected Health Information: This notice describes the health information practices of VIVA HEALTH, Inc. and VIVA HEALTH Administration, L.L.C. (VIVA HEALTH). We understand that your health information is personal and we are committed to protecting this information

as required by law. This notice will summarize the ways in which we may use and disclose protected health information about you. It will also describe your rights and certain obligations we have regarding the use and disclosure of such information. We are generally required by law to: (1) make sure that such information that identifies you is kept private, (2) give you notice of our privacy practices with respect to such information about you, and (3) follow the terms of the notice that is currently in effect.

How We May Use And Disclose Protected Health Information About You. The categories below describe different ways that we use and disclose protected health information. Not every use or disclosure in a category will be listed. We have provided a few examples of the types of uses and disclosures we are permitted to make without your authorization. Any other uses and disclosures will be made only with your written authorization.

- **For Treatment and Treatment Alternatives.** For example, we may disclose your protected health information to health care providers involved in your treatment or care. Such disclosures may include information about health services you received or should receive based on clinical recommendations and your prescription drugs. We may also use your protected health information to tell you about health-related benefits or services that may be of interest to you.
- **For Payment**. For example, we may use and disclose protected health information about you to process claims for covered health care services, to coordinate benefits with other benefit plans, to pursue recoveries from third parties (subrogation), or to provide eligibility information to a health care provider.
- **For Health Care Operations**. For example, we may use and disclose protected health information about you to conduct quality assessment and improvement activities, for underwriting, premium rating, or other activities relating to the issuing, renewal or replacement of a Group Policy, to engage in care coordination or case management, and for business management and general administrative activities related to our organization and the services we provide such as customer service and other activities that help us run our business.
- **Individuals Involved in Your Care or Payment for Your Care**. For example, we may disclose protected health information about you to the Subscriber, to a friend or family member who is involved in your medical care or payment for your health care, and to your personal representative(s) appointed by you or designated by applicable law. State and federal law may require us to secure permission from a child age 14 or older prior to making certain disclosures of protected health information to a parent.
- **Business Associates.** There are some services provided by VIVA HEALTH through contracts with business associates. Examples include subrogation companies, consultants, accountants, and lawyers. When services are contracted, we may disclose your protected 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 health information.
- **Employers**. VIVA HEALTH may disclose to the Employer (if any), in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. VIVA HEALTH may also disclose to the Employer the fact that you are enrolled in, or disenrolled from, VIVA HEALTH. VIVA HEALTH may disclose your protected health information to the Employer for administrative functions that the Employer provides to VIVA HEALTH (for example, if the Employer assists its employees in resolving complaints) if the Employer agrees in writing to ensure the continuing confidentiality and security of your protected health information. The Employer must also agree not to use or disclose your protected health information for employment-related activities.
- **As Required By Law**. We will disclose protected health information about you when required to do so by federal, state or local law.

- **Certain Marketing Activities.** We may use protected health information about you to forward promotional gifts of nominal value, to communicate with you about services offered by VIVA HEALTH, to communicate with you about case management and care coordination and to communicate with you about treatment alternatives.

- **Other Permitted Uses and Disclosures:**

- To public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- To a governmental agency authorized to oversee the health care system or government programs.
- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for law enforcement purposes as required by law.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- For research purposes in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To appropriate military authorities, if you are a member of the armed forces.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes and so they may provide protection of the President or other authorized persons or foreign heads of state or conduct special investigations.
- To workers' compensation or similar programs providing benefits for work-related injuries or illness.
- To the correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of a law enforcement official.

Your Rights Regarding Protected Health Information About You. You may make a written request to the Privacy Officer at the address at the end of this notice to do one or more of the following concerning your protected health information we maintain:

- **Right to Inspect and Copy** protected health information that may be used to make decisions about your care. In limited cases VIVA HEALTH does not have to agree to your request. We may charge a fee for the costs of copying, mailing or other supplies.

- **Right to Amend** if you feel that protected health information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by VIVA HEALTH. You must provide a reason that supports your written request. We may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the protected health information we keep; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

- **Right to an Accounting of Disclosures**. This is a list of the disclosures we made of protected health information about you for reasons other than treatment, payment, or health care operations. Your written request must state a time period not longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions** or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. In your written request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications** with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate reasonable requests to the extent possible. Your request must specify how or where you wish to be contacted. Even though you requested that we communicate with you in confidence, VIVA HEALTH may give the Subscriber cost and payment information.
- **Right to Revoke Authorization** to use or disclose your protected health information except to the extent that action has already been taken in reliance on your authorization.
- **Right to a Paper Copy of This Notice**. You may ask us to give you a paper copy of this notice at any time.

Your Responsibilities Regarding Protected Health Information. As a member you are expected to help us safeguard your protected health information. For example, you are responsible for letting us know if you have a change of address and for keeping your member 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 is trying to access your records or those of another member without approval, let 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 the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for protected 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, VIVA HEALTH will send a new notice to all Subscribers covered by VIVA HEALTH at that time. **The currently effective notice will be posted on VIVA HEALTH's web site at www.vivahealth.com at all times.**

For More Information or To Report A Problem. If you have questions or would like additional information, you may contact VIVA HEALTH's Privacy Officer at 1222 14th Avenue South, Birmingham, AL 35205 or by e-mail at vivamemberhelp@uabmc.edu or by telephone at 1-800-294-7780. For TTY services, please call the Alabama Relay Service at 1-800-548-2546. Office hours are Monday-Friday, 8:00 a.m.– 5:00 p.m. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer in writing at the address above or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

PART XV. 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 us 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 via a public source)
- date of birth
- social security number
- income and assets
- premium payment history
- bank routing/draft 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.

VIVA HEALTH
1222 14th Avenue South
Birmingham, Alabama 35205

Customer Service
1-800-294-7780
(205) 558-7474
www.vivahealth.com