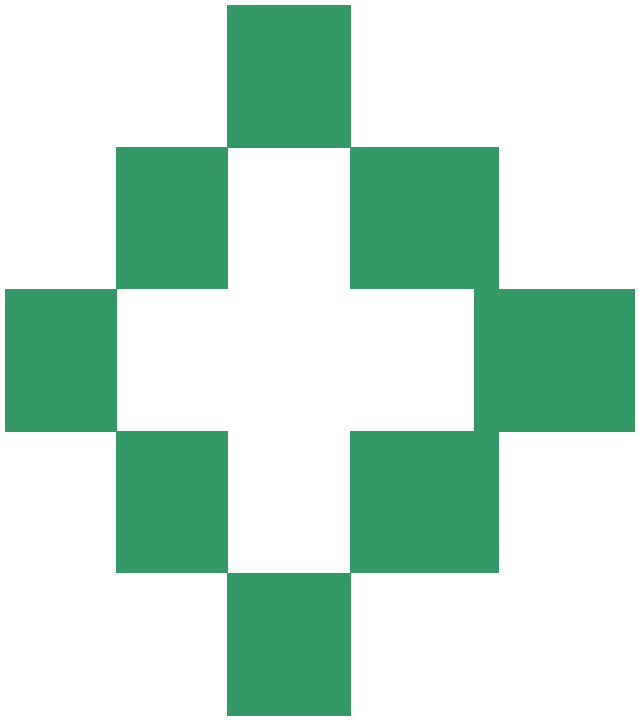
VIVA HEALTH



BENEFIT MANAGER'S ADMINISTRATION GUIDE

VIVA HEALTH

BENEFIT MANAGER'S ADMINISTRATIVE MANUAL

THIS GUIDE PROVIDES A BROAD OVERVIEW OF ISSUES RELATED TO YOUR VIVA HEALTH POLICY. IF THERE ARE ANY DISCREPANCIES BETWEEN THIS GUIDE AND THE GROUP POLICY OR THE CERTIFICATE OF COVERAGE, THE GROUP POLICY AND CERTIFICATE OF COVERAGE ARE THE GOVERNING DOCUMENTS.

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Dear Administrator:

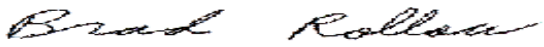
I know choosing the right health plan for your employees and their families is a tremendous responsibility, and we are grateful you have entrusted VIVA HEALTH with your company's health care needs. The employees at VIVA HEALTH understand the sensitive issues surrounding the administration of health care benefits, so they strive to provide exceptional customer service. At VIVA HEALTH we are committed to setting the standard in health care excellence -- promoting and maintaining a high quality and outstanding health care product for all of our customers. VIVA HEALTH stands for:

- Serving local communities through commitment and dedication to our customers and providers;
- Leading the health care industry in the efficient delivery of quality medical care; and
- Promoting good health through coverage of preventive care and quality improvement activities aimed at helping members stay well.

VIVA HEALTH realizes superior service starts by creating strong relationships with our plan administrators. This is why we created this manual -- to act as a guide to VIVA HEALTH and its resources. We hope it will answer your questions and concerns regarding our company and your coverage. If you or your employees have any questions or concerns not covered in this manual, please call our Customer Service Department at (205) 558-7474 in Birmingham or 1-800-294-7780. We will be glad to assist you.

Thank you for selecting VIVA HEALTH. We look forward to fulfilling your health care needs in the years to come.

Sincerely,



Brad Rollow
President/CEO
VIVA HEALTH, Inc.

Marketing/Sales: 1-800-294-7780 (in Birmingham)

American Behavioral Health (ABH): (205) 879-7957 or .1-800-925-5327

For TTY services, please call the Alabama Relay Service at 1-800-548-2546 and have them place the call for you.

Normal office hours are Monday through Friday from 8:00 a.m. until 5:00 p.m.

At VIVA HEALTH, we want a strong relationship with you, the Benefits Manager, that anticipates and eliminates potential problems before they occur. For your benefit, some important telephone numbers and addresses are listed on this page. Please do not hesitate to call us regarding claims, enrollment, providers, benefits or other concerns you or your employees may have.

ADDRESSES

Enrollment:
VIVA HEALTH, INC.
Attn: Enrollment Department
1222 14th Avenue South
Birmingham, Alabama 35205

Billing:
VIVA HEALTH, INC.
Attn: Billing Department
PO Box 934530
Atlanta, Georgia 31193-4530

Claims:
VIVA HEALTH, INC.
Attn: Claims Department
P.O. Box 55926
Birmingham, Alabama 35255

Please visit our website at **www.vivahealth.com**

TELEPHONE NUMBERS

VIVA HEALTH Office:
(205) 939-1718 (in Birmingham)

Customer Service:
(205) 558-7474 (in Birmingham)
or 1-800-294-7780

PRODUCT LINES

VIVA HEALTH for Small Businesses (2-50 employees)

VIVA HEALTH offers one product line for small businesses – These are known as our VIVA Access plans.

VIVA *ACCESS*

VIVA *ACCESS* allows members to seek care from any participating specialist in the network without first obtaining a PCP referral. **VIVA *ACCESS* members are not required to select a Personal Care Physician. VIVA *ACCESS*** offers a simple co-payment or co-insurance system to members when visiting a VIVA HEALTH participating provider but also allows members to self-refer to participating specialists. As a managed care product, VIVA *ACCESS* is designed to involve members in controlling healthcare costs through the use of financial incentives to encourage members to make cost-effective choices.

PLAN COMPARISON OF COMMONLY USED SERVICES

Limitations and Coverage Maximums Apply. Please see Attachment A and the Certificate of Coverage for each plan for more detail.

BENEFITS	VIVA Gold	VIVA Silver	VIVA 90	VIVA 80
Calendar Year Deductible:	$0	$0	$300 single $900 family	$500 single $1,500 family
Calendar Year Coinsurance Limit:	N/A	N/A	$1,500 single $4,500 family	$2,000 single $6,000 family
Preventive Services: • **Well Baby Care (Children up to age 3)** • **Routine Physicals (One per Calendar Year for ages 3+)** • **Covered Immunizations** • **OB/GYN Preventive Visit (One per Calendar Year)** • **Other preventive items and services. See Certificate of Coverage for recommendations and guidelines.**	100% Coverage	100% Coverage	100% Coverage	100% Coverage
Other Primary Care Services: • **Surgical and Medical Physician Services** • **Hearing Exams** • **Illness and Injury** • **X-Rays and Laboratory Procedures**	$25	$30	$25	$30
Specialty Care: • **Surgical & Medical Physician Services** • **X-Ray and Laboratory Procedures** • **OB/GYN Services**	$40	$45	$40	$45
Vision Care: • **One routine vision exam every 12 months** • **Other eye care office visits**	$40	$45	$40	$45
Chiropractic Services:	$40	$45	$40	$45
Allergy Services: • **Physician Visits** • **Testing**	$40 80%	$45 80%	$40 90%*	$45 80%*
Diagnostic Services: *(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)*	$175	$250	90%*	80%*

BENEFITS	VIVA Gold	VIVA Silver	VIVA 90	VIVA 80
Outpatient Services: **Surgery & Other Outpatient Services**	$175	$250	90%*	80%*
Hospital Inpatient Services: • **Physician Services** • **Semi-private Room**	 100% $500	 100% $750	 90%* 90%*	 80%* 80%*
Hospital Inpatient Services: • **Physician Services** • **Semi-private Room**	100% $500	100% $750	90%* 90%*	80%* 80%*
Maternity Services: • **Physician Copayment** *Prenatal, delivery, and postnatal care* • **Maternity Hospitalization**	$40 $500	$45 $750	$40 90%*	$45 80%*
Emergency Room Services: *(Copayment waived if admitted through ER)*	$125	$150	$175	$200
Emergency Ambulance Services	80%	80%	90%*	80%*
Durable Medical Equipment & Prosthetic Devices	80%	80%	90%*	80%*
Skilled Nursing Facility Services	80%	80%	90%*	80%*
Rehabilitation Services	80%	80%	90%*	80%*
Home Health Care Services	80%	80%	90%*	80%*
Mental Health • ***Inpatient*** • ***Outpatient*** ** Partial or day hospitalization, intensive outpatient treatment and treatment at a residential facility are not covered services. Certain diagnoses are excluded from coverage. See the Certificate of Coverage for details.*	 $500 $40	 $750 $45	 90% ** $40	 80%** $45

Prescription Drug Rider
• ***Retail*** *(30 Day Supply)*
  • Preferred Generic
  • Generic
  • Preferred
  • Non-Preferred
 	
• ***Mail Order*** *(90 day supply)*
  • Preferred Generic
  • Generic
  • Preferred
  • Non-Preferred
	
	$5
	$20
	$40
	$65
	
	$12
	$43
	$86
	$162
		
		$5
		$20
		$40
		$65
		
		$12
		$43
		$86
		$162
			
			$5
			$20
			$40
			$65
			
			$12
			$43
			$86
			$162
				
				$5
				$20
				$40
				$65
				
				$12
				$43
				$86
				$162

Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals *There is a separate member out-of-pocket maximum of $10,000 per member per Calendar Year for this benefit.	90%	90%	90%	90%
Diabetic Supplies: Insulin covered under prescription drug rider	100%	100%	90%*	80%*

- * Subject to Calendar Year deductible (Deductible does not count toward the Coinsurance Limit)
- ** Subject to Coinsurance Limit (Please see separate limit for Biological, Biotechnical & Specialty Pharmaceuticals)

ELIGIBILITY REQUIREMENTS

INITIAL PLAN OPEN ENROLLMENT: Each employee of your company will make an election to cover himself/herself and any eligible dependents. Unless a Qualifying Event has occurred *(see Section 3-3)*, employees will not be permitted to change coverage until the anniversary date of the policy.

OPEN ENROLLMENT PERIOD: Beginning thirty (30) days prior to the anniversary date of the policy, employees and their dependents that may have waived coverage during the initial enrollment period may enroll. VIVA HEALTH must receive the enrollment documents within thirty (30) days of the policy renewal date.

Eligible Employees are as follows:

- All full-time employees who work a minimum of 30 hours per week. At the employer's discretion, this may be reduced to a minimum of 17.5 hours as long as the reduced eligibility criteria are stated in the Employer's Group Policy with VIVA HEALTH and uniformly applied to all employees.
- Partners, sole proprietors and corporate officers or owners who devote a minimum of 30 hours per week to the business.

Non-eligible Employees include:

- Consultants;
- Non-permanent employees;
- Independent contractors.

ELIGIBLE DEPENDENTS: Typically, dependents are eligible for coverage at the same time as the employee. However, any person who becomes a newly eligible dependent may be enrolled by the employee by completing and submitting a signed Health/Enrollment Form within thirty-one (31) days of the date such a person first becomes an eligible dependent.

Eligible dependents are as follows:

- The employee's present lawful spouse. If the marriage is by common law (instead of a ceremonial marriage), a signed affidavit satisfactory to VIVA HEALTH must be submitted by the employee as proof of eligibility for coverage of the spouse as a Common Law Spouse.

ELIGIBILITY REQUIREMENTS CONTINUED

- 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.

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

- For dependent children eligible above 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 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;

- Any unmarried child as defined 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 within thirty-one (31) days of the child's attainment of age twenty-six 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

- 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.

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.

ELIGIBILITY REQUIREMENTS CONTINUED

Non-eligible dependents include:

- Dependents who are employed full-time;
- Dependents who do not meet the requirements on the prior page and the certificate of coverage;
- Grandchildren or foster children (unless required by state law or legal guardianship has been established).

Note: *Employees or dependents who have not encountered a qualifying event (see below) and apply for coverage beyond the thirty-one (31) day eligibility period are classified as late entrants. Late entrants will become eligible at the next open enrollment period.*

QUALIFYING EVENT: A qualifying event is a situation allowing an employee/dependent to enroll during the policy year. The following are some examples of qualifying events:

Employee qualifying events include:

- Return from layoff or leave of absence;
- Divorce/Separation (when previously covered under spouse)
- Loss of other coverage (due to loss of employment, layoff or death of a spouse under whose policy the employee was previously covered).

Dependent qualifying events include:

- Birth/Adoption
- Marriage to the Subscriber
- Loss of other coverage (involuntary loss of employment, layoff, or divorce);
- Newly attained dependent status (i.e., such as when a child over age 19 becomes eligible under student guidelines).

Note: *In order to qualify an enrollment form must be completed and received within 30 days of the qualifying event. Verification of the qualifying event such as a copy of the marriage certificate, adoption papers, or court orders and letter of explanation must accompany the enrollment application.*

ELIGIBILITY REQUIREMENTS CONTINUED

LATE ENTRANTS An eligible employee or dependent who does not elect coverage during the 30-day period in which he/she is initially eligible is considered a late entrant and subject to a pre-existing condition exclusion period *(see Sections 3-5).* An eligible employee or dependent is not considered a late entrant in the following instances:

1. The individual meets each of the following:
   - The individual was covered under qualifying previous coverage at the time of the initial plan enrollment.
   - The individual lost the qualifying previous coverage as a result of cessation of employer contribution, termination of employment or eligibility, involuntary termination of the coverage, death of a spouse or divorce.
   - The individual requests enrollment within 30 days after termination of the qualifying previous coverage or the change in conditions which gave rise to the termination of coverage.
2. The individual enrolls during the annual open enrollment period.
3. A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order (only when the dependent resides in the service area).
4. The individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within 30 days after the change in status.

Note: *Qualifying previous coverage is defined as Medicare, Medicaid, CHAMPUS, TRICARE, Indian Health Service program, or a group or individual health insurance policy or health benefit arrangement which provides benefits similar to or exceeding benefits offered by VIVA HEALTH.*

NEW HIRE WAITING PERIOD: The new hire waiting period is the period of time agreed upon by the employer and VIVA HEALTH that the employee must satisfy before becoming eligible for coverage. When a group is first submitted, applications are required on all full-time employees including those currently in their waiting period. The Employer can decide to waive the waiting period at initial group enrollment to allow all Eligible Employees to become effective on the first day of coverage. However, the waiting period must be waived for all employees. Please see Exhibit B of the Group Policy for the agreed upon New Hire Waiting Period. This waiting period may only be changed at the annual renewal period for the group.

ELIGIBILITY REQUIREMENTS CONTINUED

EMPLOYER CONTRIBUTION: The employer is required to contribute at least 50% of the single contract premium. The contribution of premium should be based on the composite rate as listed on Exhibit B.

EMPLOYEE PARTICIPATION: Minimum participation requirements are as follows:

- For groups of 2-3 employees, 100% of eligible employees.
- For groups of 4 or more employees, 75% of eligible employees.

Note: *For purposes of calculating minimum participation, employees covered by group health insurance provided by a spouse's employer and employees covered by the health benefit plan pursuant to COBRA will not be included in the calculation.*

PRE-EXISTING CONDITION EXCLUSIONARY PERIOD: A 12-month pre-existing condition exclusionary period is imposed on all new members. A Certificate of Credible Coverage indicating the length of time a member has been continuously covered under qualifying previous coverage allows for some or all of this period to be waived. New members fall into one of four categories and are subject to the pre-existing condition period indicated in the chart below:

Enrollee Type	Pre-Existing Condition Period
Initial Enrollee	Provide a Certificate of Credible Coverage in order to reduce the pre-existing period for the time period 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 this coverage. This time period does not include a new hire waiting period.
New Hires	Provide a Certificate of Credible Coverage in order to reduce the pre-existing period for the time period 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 this coverage. This time period does not include a new hire waiting period.
Late Enrollees	Eligible employees or dependents who did not elect coverage when initially eligible may join the plan during the annual open enrollment period of 30 days. A 12 month pre-existing condition period may be imposed.
Loss of prior Qualifying Coverage	An eligible employee or dependent may join the plan within 30 days following a qualifying event. A Certificate of Credible Coverage will be used to reduce the pre-existing condition period if the member joins when initially eligible.

A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage. Pregnancy is not considered a pre-existing condition and no pre-existing condition shall apply to a dependent newborn or adopted child if covered within thirty (30) days of birth or adoption.

In all cases, VIVA HEALTH's determination of eligibility is final.

ENROLLMENT PROCESS

ENROLLMENT FORMS: As with any health insurance or benefit plan, VIVA HEALTH requires applicants to complete an enrollment application. This enrollment application is used to enroll members and dependents in VIVA HEALTH's plan. Careful completion of this form by your employees will result in better customer service from VIVA HEALTH. To ensure promptness in processing the enrollment application, employees should provide all information requested on the Health/Enrollment Form *(copies of this form are located in the front of your administrator binder).* An incomplete application will not be processed and will, if necessary, be returned to the employee for the missing information. Please instruct your employees to use a pen, print clearly and return the form to you for authorization and mailing. All enrollment applications should be sent to:

VIVA HEALTH, INC.
Attn: Enrollment Department
1222 14th Avenue South
Birmingham, Alabama 35205

To obtain additional enrollment applications, call VIVA HEALTH's Customer Service Department at (205) 558-7474 (in Birmingham) or 1-800-294-7780 or visit our website at www.vivahealth.com

ENROLLMENT PROCESS CONTINUED

STATUS CHANGES: Below are the steps to follow to make status changes on a member or group.

- To add dependents to an employee's policy, an Enrollment form must be completed. Please be sure the employee completes the form in its entirety.
- To change the name or address of the business or a member's address or name, please fax or mail a letter explaining the changes to fax # (205) 939-1748 or 1222 14th Avenue South Birmingham, AL 35205.

IDENTIFICATION CARDS: After your employees enroll in VIVA HEALTH, the employee will receive two identical identification cards with the employee and each covered dependent listed on both cards along with corresponding copayment amounts. The identification card is the basic document used by your employees to obtain services from VIVA HEALTH providers and should be carried by the member at all times.

SUBSEQUENT RENEWALS: Approximately one month prior to your contract anniversary date, your VIVA HEALTH representative will contact you to discuss coverage and premiums for the coming year. Some companies opt to make changes at renewal such as contractual waiting periods or different benefit plans. **This can only be done at the time of contract renewal.**

The purpose of these discussions is to elect a VIVA HEALTH benefit plan that is compatible with your company's overall objectives. At this point, discussions about your renewal premiums take place, the final design of your benefits program is decided and plans for the upcoming enrollment period are set in motion.

COVERAGE TERMINATION

EMPLOYEE DISENROLLMENT PROCESS: Employees can be terminated by the employer as follows:

- **Via the Billing Invoice:**
  Line out the employee information on your Billing Detail page; note the **date of termination** and submit the detail page with your payment. If the member's disenrollment occurs on or before the 15th day of the month, you can be reimbursed the full premium amount for that particular month. If the member's disenrollment occurs after the 15th day of the month, premiums will not be reimbursed or prorated. Any premium credit should appear on the following month's invoice.

- **Via Written Confirmation:**

Mail or fax a written statement to terminate a particular employee and the date to terminate his/her coverage to the VIVA HEALTH Enrollment Department at fax # (205) 558-7546.

It is very important for you to notify the VIVA HEALTH of coverage terminations as soon as possible via your billing statement or written confirmation. Retroactive terminations can be administered no farther back than 60 days.

GROUP PLAN TERMINATION:

Reasons by VIVA HEALTH, INC.:

- Non-payment of premiums when due (you remain liable for payment of premiums for the time the policy was in force);
- When contribution requirements are not met (31 day advance notice will be given);
- Inadequate group participation;
- No longer a business;
- Not meeting eligibility requirements (must withhold FICA taxes from at least 2 eligible employees); or
- Any other breach of contract.

Reasons by you, the Employer:

- Written request for cancellation as of a specified future date faxed or mailed to VIVA HEALTH.

EMPLOYER'S RESPONSIBILITIES: As the Employer, you must inform employees of conversion and continuation rights on a timely basis, when applicable.

CONTINUATION OF COVERAGE

Applicable only to Employers consisting of 20 or more employees on 50% of it's typical business days during the preceding Calendar Year.

The member and/or dependent's coverage under this plan will terminate according to the provisions stated below. However, in many cases the member and/or dependent will have the option to choose continuation of group benefits as provided by the **Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)**.

***** IMPORTANT NOTE *****

Employers are responsible for notifying eligible Members in a timely manner of the right to elect Continuation Coverage under COBRA and notifying VIVA HEALTH, Inc. in a timely manner of the Member's election of Continuation Coverage. VIVA HEALTH, Inc. agrees to provide coverage under the Group Policy for those covered persons who are eligible to continue coverage under federal or state law. VIVA HEALTH, Inc. **will not** perform any administrative duties with respect to the Employer's compliance with federal or state law. All duties of the Plan administrator, including but not limited to notification of COBRA and state law continuation rights, and billing and collection of premiums, remain the sole responsibility of the Employer. In no event shall VIVA HEALTH, Inc. be obligated to provide Continuation Coverage to a Member if the Employer or its Plan administrator fails to perform its responsibilities.

The member's coverage under this plan will terminate:

- At the employer's discretion, the day the employment ends or the last day of the month in which employment ends. For coverage purposes, the member's employment is deemed terminated when he/she ceases work;
- When the plan is discontinued;
- In addition to the above, coverage terminates for a dependent on the last day of the month in which such person ceased to be an eligible dependent. Coverage as a dependent also terminates if the person becomes insured as an employee.

If the Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), continuation of group benefits as provided by COBRA will be available for employees, spouses and dependents after certain "qualifying events" occur, such as termination of the employee's employment, the eligibility of the employee for Medicare, death of the employee, divorce, legal separation or when a child no longer qualifies as a dependent under the plan.

CONTINUATION OF COVERAGE CONTINUED

EMPLOYEES ELIGIBLE FOR CONTINUATION OF GROUP BENEFITS: Coverage under the group policy will be available (subject to appropriate premium payments) for up to eighteen months for employees (including their spouses and dependent children) who have terminated employment or who have lost their coverage due to reduced work hours. No continuation coverage is available for employees or their dependents when employment has been terminated for gross misconduct.

DEPENDENTS ELIGIBLE FOR CONTINUATION OF GROUP BENEFITS: Coverage under the group policy will be available (subject to appropriate premium payments) for three years from the date that coverage would otherwise end for the following persons previously covered as dependents:

- Widowed spouse and dependent children;

- Divorced or legally separated spouse and dependent children;
- Dependent children who no longer qualify as dependents under the group health plan;
- Spouse who is no longer entitled to health care coverage because a retired employee has become eligible for Medicare.

SPECIAL RULE FOR DISABLED QUALIFIED BENEFICIARIES: If the employee or the employee's spouse or dependent child 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 disabled individual, if then covered under the Plan, is eligible for extended Continuation Coverage beyond the normal period of 18 months. Under this special rule, qualifying disabled individuals 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 employer's Plan Administrator a copy of the Social Security Administration's determination of 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.

COVERAGE AVAILABLE UNDER THE CONTINUATION OPTION: The coverage that is available under "Continuation of Coverage" will be the same that is available to other members of the group plan. The contract benefits and premiums may change if the benefits and premiums for the group change.

CONTINUATION OF COVERAGE CONTINUED

PREMIUM PAYMENT: If a member or dependent qualifies for continued group coverage, he/she will be required to pay the premium directly to your office. The coverage will be canceled if the member or dependent fails to pay the entire amount each time it is due or if the member's check is returned as insufficient.

NOTICE AND ELECTION PERIOD: The member or dependent must notify VIVA HEALTH, INC. of divorce or that a dependent is no longer eligible for coverage. A member should obtain a "Continuation of Coverage" application from your office when he/she becomes divorced, terminated, eligible for Medicare, or his/her spouse dies or a dependent is no longer eligible for coverage. A member or dependent has sixty (60) days after any of these events or the date he/she receives the notice form from the company, whichever is later, to elect coverage. However, premiums will be due from the day the regular group coverage ends.

CANCELLATION OF CONTINUATION COVERAGE: If the member does not pay all of his/her premiums for "Continuation of Coverage" on time or if the member's check is returned as insufficient, the coverage will automatically end. A member or dependent's coverage will also end if he/she becomes covered by other group coverage upon enrollment, marriage or if he/she becomes

eligible for Medicare. It will also end if the employer discontinues the entire group health care benefit plan.

PENALTIES FOR NON-COMPLIANCE: Employer plans must satisfy applicable COBRA requirements; if they do not, the employer will be denied a tax deduction for contribution to all group health plans it sponsors and an amount contributed on behalf of highly paid employees will be taxable to them. Employees may also bring suit against the employer under the Employee Retirement Income Security Act (ERISA). State and local government employers not offering continued coverage will be subject to suit for equitable relief.

PLAN REQUIREMENTS : The law applies to coverage under all plans, including standard group plans (both insured and self-insured), health maintenance organizations, and cafeteria plans. Coverage offered must be identical to that offered to comparable active employees covered under the plan's provisions. For example, if coverage for vision benefits is available to active employees, it must be made available for continuation coverage. If coverage is modified for comparable active employees, the same modifications must also be offered for continuation coverage. A qualified beneficiary would have the same rights as an active employee during an open enrollment period. If the qualified beneficiary becomes covered by another plan, no coverage needs to be made available, even if the new plan does not provide the coverage that could be available under the COBRA administration rules.

CONTINUATION OF COVERAGE CONTINUED

PAYMENT AMOUNTS: A qualified beneficiary may decide whether to elect continuation coverage within 60 days from the date the group coverage terminates, based on the qualifying event, or the date the qualified beneficiary was notified of the right to elect continuation coverage. If the employee elects continuation coverage, the qualified beneficiary has 45 days from the date of election to pay for the coverage. In total, the employee has 105 days from the date of the qualifying event to pay the premium for coverage during the election period. Premium payments cannot exceed 102% of the cost of coverage for a comparable active beneficiary.

TERMINATION: If the employer discontinues group health coverage for all employees, coverage for qualified COBRA beneficiaries can be discontinued as well. Extended coverage can also be terminated if the qualified beneficiary does not make timely premium payments. When a qualified beneficiary becomes covered by another group health plan, or becomes entitled to Medicare, continuation coverage can be terminated.

NOTIFICATION: You are responsible for notifying employees and their spouses of their rights under COBRA. In addition, the summary plan description must contain the continuation coverage rights.

PROVIDER NETWORK & BENEFITS

VIVA ACCESS: With the VIVA *Access* health plan, the employee **DOES NOT** select a PCP. The employee has the ability to visit any physician within the network without a referral. As with the HMO product, certain services still require prior authorization by VIVA HEALTH (as described in page 4-2). The VIVA HEALTH participating provider should request prior authorization from VIVA HEALTH prior to delivering the service or supply.

HOSPITALIZATION AND ANCILLARY SERVICES: Many services require prior authorization from VIVA HEALTH. Prior authorization is generally requested by the PCP or referred specialist. Failure to obtain prior authorization will result in a non-covered service. The following is a list of services which require prior authorization. This list is subject to change.

- Hospital Admissions (for emergency admissions, the member must contact VIVA Health within 48 hours)
- Durable Medical Equipment, Orthotics, and Prosthetics
- Home Health
- IV Therapy, hospice, non-emergency ambulance
- Pain Clinics
- Major Diagnostic Services (such as colonoscopies, EGDs, etc.)
- Inpatient rehabilitation or day treatment
- CT scans, MRA's and MRI's
- Arteriograms, Cardiac Caths, Cardiac Rehab, Pulmonary Rehab
- Holter monitors (if worn longer than 24 hours)
- Gastrointestinal contrast studies, GI endoscopy
- Myelograms, discograms, DEXA scans
- Physical, Speech and Occupational Therapy
- Hospital Observation Unit
- Sleep Studies, C-PAP, MSLT, PSNG
- Hospital Outpatient Services
- Prescription drugs on VIVA HEALTH's Prior Approval List
- Outpatient Surgery
- All Plastic, Sinus or Nasal Surgery
- SPECT scans and all scopes
- Allergy Testing
- Dialysis
- Transplant Services
- Extended Care and Skilled Nursing Facilities

The following is a list of services that can be obtained from participating providers without a referral from your PCP:

- OB/GYN office care
- Mammograms
- Ultrasounds
- Routine X-rays
- Optometry and Ophthalmology office care

PROVIDER NETWORK & BENEFITS CONTINUED

MEDICAL EMERGENCIES:

> **Emergency Medical Condition:** a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. Care for Emergency Medical Conditions is available in and out of the Service Area and includes ambulance services for Emergency Medical Conditions dispatched by 911, if available, or by the local government authority.

If a member has an Emergency Medical Condition, he or she should seek help immediately at the nearest emergency facility. **If a member is admitted to the hospital, the member should contact VIVA HEALTH at 1-800-294-7780 within 48 hours or as soon as possible. Failure to notify VIVA HEALTH could result in a denial of benefits.** We are available 24 hours a day, year-round. If the member is not admitted, the member should still notify VIVA HEALTH of the emergency room visit within the following 48 hours or as soon as possible. Notification does not guarantee payment. Payment is based on a PCP referral or medical necessity (i.e. whether the condition met the definition of an Emergency Medical Condition).

Should members have an illness or injury after regular office hours or on weekends that is not an emergency, they should contact their PCP. VIVA HEALTH has a nurse on call 24 hours a day 7 days a week if the member cannot reach the PCP or requires further assistance. After hours, Members may call the regular Customer Service number of 1-800-294-7780. The answering service will page the After Hours Nurse as needed.

CARE OUTSIDE THE SERVICE AREA: VIVA HEALTH covers members worldwide for emergency care, 24 hours a day, seven days a week. Members should simply follow the instructions described under "Emergency Care" on their member identification card. If the situation is an emergency medical condition, the member should seek help immediately. Members should notify VIVA HEALTH within *48*

hours of an emergency hospital admission so follow-up care can be arranged with their PCP, if applicable, upon return to the service area.

In non-emergency situations, at the onset of an illness or injury, members should call their PCP for authorization. Remember, care that can safely be postponed until the member's return to the service area is not a covered benefit. Also care required as result of circumstances that could have reasonably been foreseen prior to departure from the service area is not a covered service.

PROVIDER NETWORK & BENEFITS CONTINUED

MENTAL HEALTH SERVICES: For most members (including all children under 18 and all VIVA ACCESS members), mental health services are provided by American Behavioral Health (ABH). ABH is a nationally recognized leader in mental health and substance abuse management. Members may contact MHNet directly to arrange services. ABH will assess the member's needs and then refer them to the appropriate inpatient or outpatient provider in the service area.

ABH: (205) 879-7957 (in Birmingham) or 1-800-925-5327

If an adult VIVA HEALTH member (over 18) member selects a PCP that is member of the Health Services Foundation (part of the UAB Health System), mental health services are provided by UAB and the member's PCP will make the referral. Please call (205) 801-8000 for appointments.

PHARMACY BENEFITS: All participating pharmacies utilize our on-line claims adjudication system. This system automatically tells the pharmacist the level of co-payment to collect from the member, thereby eliminating the need to file a claim form. Members must use participating physicians and participating pharmacies to receive their prescription drug benefit.

VISION CARE: Members may visit a VIVA HEALTH participating optometrist or ophthalmologist without a referral from their PCP. Routine eye exams are covered once every twelve (12) months.

MEMBERSHIP ISSUES

CUSTOMER SERVICE DEPARTMENT: Your employees and their dependents may occasionally have questions regarding whether certain services are covered. While VIVA HEALTH includes substantial detailed information on these issues in the enrollment materials provided to your employees, we recognize that questions regarding certain exclusions or limitations will inevitably arise. For questions regarding coverage, please have your employees call the Customer Service Department.

Members may also contact a Customer Service Representative to:

- Obtain assistance in changing a Primary Care Physician;
- Obtain identification cards;
- Inquire about eligibility;
- Discuss concerns; and
- Inquire about bills or claims.

Customer Service: (205) 558-7474 (in Birmingham) or 1-800-294-7780.
Office hours are from 8:00 am – 5:00 pm Monday through Friday. Please visit our website at www.vivahealth.com for additional customer service information.

PROVIDER CONCERNS: Any concerns that members may have, including those related to providers, should be addressed to our Customer Service Department. Here are a few examples of areas where members may require assistance:

- **Appointments and Service:** Sometimes members may have difficulty obtaining appointments with providers, and occasionally, members want to express concerns about services rendered by providers. While these situations are rare, our Customer Service Department will assist with these problems.

- **Provider Sends Bill to Member:** In all VIVA HEALTH provider contracts, providers are expressly prohibited from billing VIVA HEALTH members for covered services (except co-payments, coinsurance or deductibles). Therefore, by contract, our providers have no legally enforceable claim against your employees or their dependents for covered services. Encourage your employees to simply remind the provider of their VIVA HEALTH membership and ask that the claim be filed with VIVA HEALTH. Your employees can notify us they continue to be billed for covered services so that we can correct the situation directly with the provider's office.

  Provider Status Questions: VIVA HEALTH updates its provider listing on a regular basis. We often add new providers who may not have been listed in your enrollment materials and sometimes a provider leaves our network. If you or your employees have questions regarding the current status of a particular provider or need an updated list , the Customer Service Department will be happy to assist you. A current provider directory is also available on the VIVA HEALTH website at www.vivahealth.com.

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MEMBERSHIP ISSUES CONTINUED

DEPENDENTS IN COLLEGE: Dependent, full-time college students in an accredited educational institution will be covered for urgent and emergency care while away at school. Routine care is not covered outside of VIVA HEALTH's service area. However, routine care appointments can be scheduled with a participating provider for the dependent while the dependent is at home on holiday leave.

COORDINATION OF BENEFITS (COB): The VIVA HEALTH Enrollment Application requests specific information regarding coverage by other insurance carriers. When members have additional coverage and claims are received, VIVA HEALTH contacts the other carrier and determines if VIVA HEALTH or the other carrier is the primary payer. If VIVA HEALTH is primary, only those services outlined in the Certificate of Coverage are covered benefits. If the member's other insurance plan is primary, the carrier must pay up to its maximum benefit level. After the maximum is met VIVA HEALTH will pay for any remaining expenses subject to the provisions in the Certificate of Coverage.

COMPLAINT PROCEDURE: VIVA HEALTH has established a complaint procedure to resolve problems or disagreements members may have regarding claim payment and other membership issues. We want your employees to be satisfied with the medical care and services they receive as members of VIVA HEALTH. If they have a question about the services VIVA HEALTH provides or the member complaint procedure, please have them call the Customer Service Department. The Complaint Procedure must be initiated by the Member no later than twelve (12) months after the incident or matter in question occurred.

The Complaint Procedure consists of the following levels for review:

A. **Inquiries.** Most problems can be handled simply by discussing the situation with a representative of 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. Members with Inquiries which are not resolved to their satisfaction will be informed of the Informal Complaint Procedure available to them or their authorized representative.

MEMBERSHIP ISSUES CONTINUED

B. **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 within 45 days of the receipt date of the Informal

Complaint. The written notice includes the outcome of VIVA HEALTH's review of the Informal Complaint. In the case of an adverse outcome (in whole or in part), the Member has a right to a second review by filing a Formal Complaint.

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

VIVA HEALTH, Inc.
Attention: Complaint Coordinator
Post Office Box 55926
Birmingham, Alabama 35255-5926

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 VIVA HEALTH's Formal Complaint Committee. The Member or any other party of interest may provide pertinent data to the Formal Complaint Committee in person or in writing. The Formal Complaint Committee issues its decision within 30 days of the receipt date of the Formal Complaint. The Member is given written notification regarding the Formal Complaint Committee's decision within 5 working days of the decision being made. In the case of an adverse outcome (in whole or in part), the Member has a right to a Third Level Review by the State Health Officer or the Alabama Insurance Commissioner.

MEMBERSHIP ISSUES CONTINUED

D. **Expedited Formal Complaints**. Any Complaint related to an adverse medical necessity decision may be considered for expedited review. This includes complaints related to service denials or reductions. Expedited review allows the Member to bypass the Informal and Formal Complaint steps of the Complaint Procedure. The Member or provider may request an expedited review. Both the decision to grant an expedited review and the expedited review itself are conducted by the 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 determines the complaint justifies an 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 three working days 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. The Member has a right to a Third Level Review by the State Health Officer or the Alabama Insurance Commissioner.

E. **Third Level Review**. If the Member believes the Complaint Procedure has not been carried out in accordance with the Certificate of Coverage, the Member may register a complaint with the State Health Officer or the Commissioner of the Alabama Department of Insurance.

BILLING PROCESS

BILLING INVOICE: Invoices are mailed out on or around the 15th of each month. VIVA HEALTH is a prepaid health plan, meaning the bill you receive toward the end of the month is the bill for next month's premiums. Payments are due by the first day of each month. A grace period of ten (10) days will be allowed. If payment is not received by the 10th of the month, it is considered late and subject to late penalty fees. If you have not made payment by the end of the month, VIVA HEALTH will initiate termination procedures *(see Section 3-8 through 3-9)*. The VIVA HEALTH Finance Department will send you a 10-Day Letter of notification of imminent termination.

The Billing Invoice includes the following:

- **detail listing of current month premiums for each subscriber**
- **detail listing of any prior month adjustments due for each subscriber**
- **any unpaid balance**

REMITTANCE PROCEDURES: Include the billing invoice with your check and send it to the address printed on the bill. This is critical to assure proper verification of your premium payments.

PLEASE PAY THE AMOUNT BILLED AND DO NOT ADJUST YOUR BILL.

If we do not receive your enrollment form or change application form in time to be reflected on your current bill, your additions or terminations will be reflected on your next bill. Terminations cannot be made further back than 60 days. It is very important that you notify the employee of their termination date. VIVA HEALTH is not responsible for any claims incurred or service authorized during the period between the date of termination and the date you notify VIVA HEALTH of the termination.

REFERENCE

ORDERING FORMS: Should you or your employees need additional materials or forms, such as those listed below, please contact the Customer Service Department or your Account Service Representative *(see Section 1-2)*. These forms may also be downloaded from our website on the Internet at www.vivahealth.com.

- Health/Enrollment Application
- Continuation Enrollment Forms
- Medical Claim Forms
- Certificate of Coverage

NEWSLETTERS: VIVA HEALTH, INC. has developed various communication tools to keep our clients and members up-to-date, ranging from trends in the managed care industry to suggested preventive measures to maintain a healthy lifestyle. We generally communicate this information through special mailings and the following newsletters:

- **VIVA VOICE** is a periodic newsletter sent to all members and Benefit Managers. The newsletter furnishes our members and their Benefit Managers with articles on subjects ranging from diet and exercise to reminders they can use to maximize their health care benefits.
- **VIVA PROVIDERS** is a periodic newsletter sent to all providers in VIVA HEALTH's network. In this newsletter, we take time to update providers on VIVA HEALTH's benefits and services and to provide helpful information on various health-related topics.

FREQUENTLY ASKED QUESTIONS

1. **How do I add new employees to my group coverage?**
   Upon eligibility, employees can be added to your policy simply by having them complete the Health/Enrollment Application. Your authorization signature and verification of hire is required. This must be done within 30 days following the new hire waiting period.

2. **How do I delete an employee off my group contract/policy?**
   You can mark them off your billing and write in the termination date or fax a written statement to fax # (205) 558-7546. Please notify us promptly of terminations. Terminations can not be made further back than 60 days. It is very important that you communicate the termination date to the employee. VIVA HEALTH is not responsible for any claims incurred or service authorized during the period between the date you terminate the employee's coverage and the date you notify VIVA HEALTH of the termination.

3. **How much will adding an employee to my group cost?**
   Rate information can be found attached to your Group Policy as listed on the Exhibit B.

4. **When should I receive my invoice?**
   VIVA HEALTH mails or e-mails billing invoices on or around the 15th of the month for the next month's premium.

5. **When is my bill due?**
   Payments are due by the first day of each month for that month's premium.

6. **What if an employee does not receive a member ID card?**
   The member may call Customer Services at (800) 294-7780 to request a new card and verify his/her address or e-mail customer service by visiting our website at www.vivahealth.com. Allow 2 weeks from the time an enrollment application is received for an ID card to be mailed.

7. **What if an employee does not receive their member ID card and a doctor/pharmacist refuses to provide services without verification?**
   The member or provider may call Customer Service and a representative can contact the provider to verify membership status and eligibility.

8. **What if an employee receives a bill from a doctor or hospital or other provider?**
   The bill may be for their portion – such as a deductible, copayment, or coinsurance. However, if an employee has any questions regarding how a claim was paid by VIVA HEALTH they should call the Customer Service Department. A Customer Service Representative will explain how the claim was processed and what portion of the bill will be the member's responsibility.

9. **How does an employee add a new dependent after the initial enrollment?**
   New dependents are eligible upon the date of birth, marriage, adoption and must be enrolled within thirty (31) days of the qualifying event (see Section 3-3). This can be done by completing an enrollment application.

10. **How does an employee change incorrect information on a member ID card?**
    If a member receives an ID card with a misspelled name, incorrect date of birth or other error the member may call the Customer Service Department and have the information corrected. A new card can be issued.