ADDENDUM TO THE VIVA HEALTH CERTIFICATE OF COVERAGE FOR EMPLOYERS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Please keep this Addendum with your Certificate of Coverage for future reference. Section I.E. of this Addendum includes rules for filing claims and appeals.

I. STATEMENT OF ERISA RIGHTS

Except for governmental plans and certain church plans, Plans with VIVA HEALTH are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). As a participant in a Plan governed by ERISA, Members are entitled to certain rights and protections under ERISA. If your employer is required to comply with ERISA, this Addendum is applicable to you. ERISA provides that Members shall be entitled to:

A. Receive Information About Your Plan and Benefits.

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if required to be filed by the plan administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series, if required to be filed) and updated summary plan description. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report, if one is required to be filed. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage.

1. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Members or Member's Covered Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan, including Part XII of the Certificate of Coverage, governing COBRA continuation coverage rights.

2. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if a Member has creditable coverage from another plan. One should be provided a certificate of creditable coverage, free of charge, from a group health plan or health insurance issuer when one loses coverage under a plan, when one becomes entitled to elect COBRA continuation coverage, when one's COBRA continuation coverage ceases, if one requests it before losing coverage, or if one requests it up to 24 months after losing coverage. Without evidence of creditable coverage, a Member may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after the enrollment date in one's coverage.

C. Prudent Actions by Plan Fiduciaries.

1. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Members and other plan participants and beneficiaries. No one, including the Employer, a union, or any other person, may fire

a Member or otherwise discriminate against a Member in any way to prevent the Member from obtaining a welfare benefit or exercising rights under ERISA.

2. If a Member's claim for a welfare benefit is denied or ignored, in whole or in part, a Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial all within certain time schedules. Under ERISA, there are steps a Member can take to enforce the above rights. For instance, if a Member requests a copy of Plan documents or the latest annual report from the plan administrator and does not receive them within 30 days, a Member may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to $110 a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If a Member has a claim for benefits which is denied or ignored, in whole or in part, a Member may file suit in a state or Federal court. In addition, if a Member disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, a Member may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if a Member is discriminated against for asserting rights, the Member may seek assistance from the U.S. Department of Labor, or the Member may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Member is successful the court may order the person the Member sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees, for example, if it finds the Member's claim is frivolous.

D. Assistance with Your Questions.

If a Member has any questions about the Plan, a Member should contact the plan administrator. Contact information for the plan administrator is available from the Employer. If a Member has any questions about this statement or about a Member's rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, a Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

E. Have Your Claims and Appeals Processed in Accordance with ERISA Standards.

ERISA requires plans to establish and maintain claims procedures under which benefits can be requested by participants and beneficiaries and disputes about benefit entitlement can be addressed. This includes procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. Such procedures are available for use by the Member or his/her authorized representative. In most cases, an authorized representative must be appointed in writing on a specified form signed by the Member. If someone 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 procedures.

1. Pre-Service Claims. Pre-services claims are claims for services you have 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 the VIVA HEALTH Medical Management Department, attention: ERISA Claims Coordinator. Non-urgent pre-service claims must be in writing mailed to the following address:

VIVA HEALTH, Inc.
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

or by fax at (205) 933-1232. Urgent pre-service claims may be filed by calling our Medical Management Department at (205) 558-7475 or 1-800-294-7780.

b. Provide at least the following information: Member name, date of birth, Member identification number, Member telephone number, a description of the service requested, and the name, address, and telephone number of the provider who will perform the service. If other than the Member, we also need the name and telephone number of a person we can call back.

c. A statement regarding any medical circumstances or exigencies that would assist the plan 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 deciding a claim (i.e., using the non-urgent 15 day allowance) 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 an oral notice of an incorrectly filed pre-service claim if the claim fails to meet the requirements stated above unless a written notice is specifically requested. Such notice will be provided only if the Member request is received by the ERISA Claims Coordinator or the Medical Management Department as described in 1.a. above and includes the Member name, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is being requested.

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 on an urgent care claim, VIVA HEALTH will tell you what information is needed within 24 hours. We will have 48 hours following receipt of such additional information to make a determination. The notice of our 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 tell you what information is 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 such. In order to facilitate our receipt of additional information that may be required, we may request it directly from your provider. If we do this, you are 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.

2. Post-Service Claims. Post-service claims are claims for services you have 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 meet the requirements and filing time frames described in Section XIII.I., Notice of Claim, of the Certificate of Coverage. If we get a submission that does not qualify as a claim, we will notify you or your provider of what is needed in order for us to process the submission as a claim. Please contact Customer Service at 1-800-294-7780 if you need 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 tell you or your provider what 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 we might need additional information such as medical records to determine whether the claim should be paid. In this case, we will ask you to furnish such additional information and will suspend processing of your claim until the information is received. In order to facilitate our receipt of additional information that may be required, we may request it directly from your provider. If we do this, you are 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 your claim. If you decide not to give us additional time, we will process your claim based on the information we have. This may result in the denial of your claim.

3. Concurrent Care Decisions. When an approved course of treatment comes to an end, the Member may file a claim to extend such treatment. The amount of time VIVA HEALTH has to decide a claim to extend an approved course of treatment that is ending varies as follows:

   a. Urgent and request made more than 24 hours prior to the end of the approved course: 24 hours

   b. Urgent and request made less than 24 hours prior to the end of the approved course: 72 hours

   c. Non-urgent: standard timeframes for pre- and post-service claims discussed above.

4. Appeals. Appeals are complaints regarding an adverse benefit determination. An adverse benefit determination is a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a benefit. A Member will be given written notice of an adverse benefit determination on a claim that includes 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 relevant to the Member's claim for benefits.

   Appeals on claims subject to the ERISA claims procedures are processed in accordance with the Complaint Procedure described in Part XI of the Certificate of Coverage except that processing timeframes are different for ERISA claims. Specifically, standard pre-service claims will be processed within 15 days at the informal complaint level and within 15 days at the formal complaint level. Post-service claims will be processed within 30 days at the informal complaint level and within 30 days at the formal complaint level. Expedited formal complaints will be processed within 72 hours. Examples of claims subject to appeals include denied services and claims (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. Where 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. In this case, 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 Member has the right to bring suit under ERISA Section 502(a) with respect to an adverse benefit determination only after the Complaint Procedure described herein and in Part XI has been

completely exhausted. 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.

II. ADMINISTRATIVE INFORMATION

The following information is provided as part of the requirements for making the Certificate of Coverage a Summary Plan Description as defined under ERISA.

A. The plan sponsor is the Employer. The plan administrator is also the Employer, unless the Employer in writing names another person or entity. The plan administrator is the agent for legal process, unless the Employer in writing names another person. The address for the plan sponsor, plan administrator and agent for legal process is the Employer's address, unless the Employer in writing provides Members with a different address. If a Member files a lawsuit seeking Covered Services, though, the Plan's agent for legal process is VIVA HEALTH and VIVA HEALTH is a necessary party to any such lawsuit for Covered Services funded by the Group Policy. VIVA HEALTH's address is

VIVA HEALTH, Inc.
417 20th Street North, Suite 1100
Birmingham, Alabama 35203

B. The Employer is responsible for providing to Members the Plan's official name, the Plan number assigned by the plan sponsor, and the plan sponsor's IRS Employer Identification Number (EIN). Plan records are kept on the basis of a Plan Year specified in Exhibit A of the Group Policy. The Plan Year is a Calendar Year unless Members are informed in writing otherwise.

C. 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 the Certificate of Coverage. 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.

D. The Employer currently intends to continue the Plan, but reserves its rights to amend or terminate the Plan. VIVA HEALTH also reserves its rights to amend or terminate the Plan as provided under the Group Policy.

E. The Plan requires contributions to be paid to VIVA HEALTH. Generally, the Employer and Subscriber contribute in relative amounts as the Employer requires. The Employer may change the levels of contribution. VIVA HEALTH may, when permitted under the Group Policy, change the amounts required to be contributed. Deductibles, Coinsurance and Copayments are described in the Schedule of Copayments, which is Attachment A to the Certificate of Coverage.

F. A list of Participating Providers is a separate document. The list is provided automatically, without charge, to Members requesting it.