

SERFF Tracking Number: MCHX-125933550 State: Arkansas  
 Filing Company: AIG Life Insurance Company State Tracking Number: 41029  
 Company Tracking Number: OT-2008  
 TOI: H09G Group Health - Organ & Tissue Sub-TOI: H09G.000 Health - Organ & Tissue Transplant -  
 Transplant - Limited Benefit Limited Benefit  
 Product Name: OT-2008 AIG Life Insurance Co Organ & Tissue Trans  
 Project Name/Number: OT-2008 AIG Life Insurance Co Organ & Tissue Transplant Policy/OT-2008 AIG Life Insurance Co Organ & Tissue Transplant  
 Policy

## Filing at a Glance

Company: AIG Life Insurance Company

Product Name: OT-2008 AIG Life Insurance Co SERFF Tr Num: MCHX-125933550 State: ArkansasLH

Organ & Tissue Trans

TOI: H09G Group Health - Organ & Tissue SERFF Status: Closed State Tr Num: 41029

Transplant - Limited Benefit

Sub-TOI: H09G.000 Health - Organ & Tissue Co Tr Num: OT-2008 State Status: Approved-Closed

Transplant - Limited Benefit

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting

Disposition Date: 12/12/2008

Date Submitted: 12/05/2008

Disposition Status: Approved-Closed

Implementation Date Requested: 01/04/2009

Implementation Date:

State Filing Description:

## General Information

Project Name: OT-2008 AIG Life Insurance Co Organ & Tissue  
Transplant Policy

Status of Filing in Domicile: Authorized

Project Number: OT-2008 AIG Life Insurance Co Organ & Tissue  
Transplant Policy

Date Approved in Domicile: 11/24/2008

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Association, Employer,  
Trust

Filing Status Changed: 12/12/2008

Deemer Date:

State Status Changed: 12/12/2008

Corresponding Filing Tracking Number:

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**Filing Description:**

AIG LIFE INSURANCE COMPANY (NAIC #: 66842)

OT-2008 Organ & Tissue Transplant Policy

OT-2008-CERT Organ & Tissue Transplant Certificate

OT-2008-APP Policyholder Application

OT-2008-RENEWAL Renewal Endorsement

OT-2008-AMD Policy/Certificate Amendment

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of AIG Life Insurance Company. We have provided an authorization letter for your files.

The referenced forms are submitted on behalf of AIG Life Insurance Company for your review and approval. These are new forms that will replace our Organ & Tissue Transplant Policy (M20001, et al.) that is currently available in your state. However, we do not wish to withdraw the current approved forms. These forms were approved by Delaware, our domicile state, on November 24, 2008.

Although these forms are being filed using the Uniform Coding Matrix identifier H09G.000, we would like to point out that our product provides benefits on an expense incurred basis (not a daily scheduled amount). These forms will only be marketed to self-funded plan sponsors that are categorized as large groups in your state (including Associations, Single Employer Trusts, and Multi-Employer Trusts, if allowed in your state). The product is a non-contributory product designed to relieve the plan sponsor of catastrophic medical expenses related to transplant procedures. The forms contain variable text that has been indicated with brackets. In order to assist your review of the bracketed text, we have enclosed a Statement of Variable Language.

Amendment OT-2008-AMD is an administrative amendment designed to accommodate language changes due to: a) subsequent state requirements; and/or b) Policyholder requirements. It may also be used to specify administrative information related to the Policy and/or Certificate.

This product will be marketed through licensed brokers/agents.

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If allowed in your state, it is our intent to deem these forms approved if we have not received a disposition upon the expiration of the initial review period.

Enclosed, please find any required certifications and/or transmittal forms. If you have any questions or concerns regarding this submission, please do not hesitate to contact us. We thank you in advance for your time and consideration.

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - McHughConsulting)

Jane Neal, Compliance Assistant mcr@mchughconsulting.com  
 McHugh Consulting Resources (215) 230-7960 [Phone]  
 Doylestown, PA 18901 (215) 230-7961[FAX]

### Filing Company Information

AIG Life Insurance Company CoCode: 66842 State of Domicile: Delaware  
 One Alico Plaza Group Code: 12 Company Type:  
 Wilmington, DE 19801 Group Name: State ID Number:  
 (302) 594-2000 ext. [Phone] FEIN Number: 25-1118523  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$250.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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AIG Life Insurance Company \$250.00 12/05/2008 24353149



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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/12/2008	12/12/2008

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	12/11/2008	12/11/2008	SPI McHughConsulting	12/12/2008	12/12/2008

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## **Disposition**

Disposition Date: 12/12/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	Form Listing	Approved-Closed	Yes
Supporting Document	AR Readability	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	12.12.08 Resubmission letter	Approved-Closed	Yes
Supporting Document	Revised Form Listing	Approved-Closed	Yes
Supporting Document	Revised Readability	Approved-Closed	Yes
Form (revised)	Organ & Tissue Transplant Policy	Approved-Closed	Yes
Form	Organ & Tissue Transplant Policy	Replaced	Yes
Form (revised)	Organ & Tissue Transplant Certificate	Approved-Closed	Yes
Form	Organ & Tissue Transplant Certificate	Replaced	Yes
Form	Policyholder Application	Approved-Closed	Yes
Form	Renewal Endorsement	Approved-Closed	Yes
Form	Policy/Certificate Amendment	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 12/11/2008  
Submitted Date 12/11/2008  
Respond By Date  
Dear Jane Neal,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Organ & Tissue Transplant Certificate (Form)

Comment:

Under the Subrogation and Right of Reimbursement portion of the policy and certificate, it is stated that..."We may reduce future benefits payable under the Policy for any Covered Charges by the payment that the Participant or his or her legal representative has received from any other party. It is further stated that..."We will not pay for future Covered Charges until such Covered Charges have exceeded all amounts that were recovered or are to be recovered by or on behalf of a Participant...".

Our statutes allow carriers the right to subrogation under ACA 23-79-146. There is no mention of an offset.

Our Legal Department has reviewed case law on this topic. It appears that the subrogation rights of the insurer are limited to the funds recovered by the insured from the third party. In *Sereboff v. Mid-Atlantic Medical Services, Inc.*, the US Supreme Court in 2006 stated that the funds must be specifically identifiable and only considered the funds recovered in the settlement. This would exclude possible future claims.

Our Legal Department outlines a problem on how recovery from future covered charges will work. If the insurer is owed \$10,000 from a subrogation claim, how will this be identified on their EOB? How will they notify providers of this possible offset? When a provider calls in to verify benefits, they are informed of the basic benefits, deductible amounts and out of pocket amounts. They are also informed if the patient has met his deductible and if the out of pocket amounts have been met. In this case, the provider has been assigned the benefits and is expecting payment from the insurer only to find out later that the insured owed the insurer money and no payments on the claim will be paid.

It is the opinion of our Legal Department that we should follow the Supreme Court ruling and limit subrogation rights to the actual funds paid by the third party tortfeasor

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Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/12/2008
Submitted Date	12/12/2008

Dear Rosalind Minor,

### Comments:

Please find attached a response to your December 11, 2008, objection letter.

### Response 1

Comments: Please find attached:

#### Related Objection 1

Applies To:

- Organ & Tissue Transplant Certificate (Form)

Comment:

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**Changed Items:**

**Supporting Document Schedule Item Changes**

- Satisfied -Name: 12.12.08 Resubmission letter  
Comment:
- Satisfied -Name: Revised Form Listing  
Comment:
- Satisfied -Name: Revised Readability  
Comment:

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Organ & Tissue Transplant Policy	OT-2008-AR		Policy/Contract/Fraternal Certificate	Revised		45	OT-2008-AR.PDF
<b>Previous Version</b>							
Organ & Tissue Transplant Policy	OT-2008		Policy/Contract/Fraternal Certificate	Initial		45	OT-2008.PDF
Organ & Tissue Transplant Certificate	OT-2008-CERT-AR		Certificate	Revised		45	OT-2008-CERT-AR.PDF
<b>Previous Version</b>							





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## Form Schedule

### Lead Form Number: OT-2008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	OT-2008-AR	Policy/Cont	Organ & Tissue Transplant Policy Certificate	Revised	Replaced Form #: Previous Filing #:	45	OT-2008-AR.PDF
Approved-Closed	OT-2008-CERT-AR	Certificate	Organ & Tissue Transplant Certificate	Revised	Replaced Form #: Previous Filing #:	45	OT-2008-CERT-AR.PDF
Approved-Closed	OT-2008-APP	Application/Policyholder Enrollment Form	Application	Initial		53	OT-2008-APP.PDF
Approved-Closed	OT-2008-RENEWAL	Certificate Renewal Amendmen	Renewal Endorsement	Initial		63	OT-2008-RENEWAL.PDF
Approved-Closed	OT-2008-AMD	Certificate Amendmen	Policy/Certificate Amendment	Initial		49	OT-2008-AMD.PDF



**AIG LIFE INSURANCE COMPANY**  
ONE ALICO PLAZA  
WILMINGTON, DELAWARE 19801

[ **Administrative Office:**  
Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, Indiana 46268  
(888) 449-2377]

### Organ & Tissue Transplant Policy

**POLICYHOLDER:** [Policyholder Name]  
**POLICYHOLDER ADDRESS:** [Policyholder Address]  
**POLICY NUMBER:** [Policy Number]  
**POLICY EFFECTIVE DATE:** [January 1, 2009]  
**POLICY ANNIVERSARY DATE:** [January 1] of each succeeding year  
**PREMIUM DUE DATE:** First premium payment is due on the **Policy Effective Date** above. Thereafter, each premium payment is due on the first day of the month.  
**INITIAL ENROLLMENT:** [ ]  
**MINIMUM ENROLLMENT:** [50]  
**PREMIUMS PER MONTH:**

**AIG Life Insurance Company** will provide the Policy benefits to each **Participant** in consideration and acceptance of the **Policyholder's** signed **Application** and premium, and subject to all Policy provisions.

This Policy becomes effective at 12:01 a.m. Standard Time on the **Policy Effective Date** shown above, and replaces any previous agreement relating to transplant services between the **Policyholder** and the **Company**. The first premium payment and all subsequent premium payments are due on the **Premium Due Date** shown above.

***THIS IS A LIMITED BENEFIT POLICY AND IS NOT INTENDED TO BE A MAJOR MEDICAL HEALTH PLAN.***

***PLEASE READ THIS POLICY AND CERTIFICATE CAREFULLY FOR A FULL DESCRIPTION OF THE BENEFITS, EXCLUSIONS, AND LIMITATIONS.***

This Policy is signed for the **Company** by its Secretary and President.

**AIG Life Insurance Company**

*Elizabeth M. Tuck*  
Secretary

*Matthew E. Winters*  
President

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## POLICYHOLDER PROVISIONS

- A. Defined Terms.** Boldfaced terms have special meaning. Please refer to the Definitions section or Benefit Provision section of this Policy for a complete description of such terms.
- B. Coverage.** **Participants** are entitled to coverage for **Covered Transplant Services**, subject to the terms, conditions, limitations, and exclusions set forth in this Policy as further described in Paragraph M below of this Provision.
- C. Payment of Premiums.** All premiums must be paid by the **Premium Due Date** shown in the Policy Face Page. Premiums shall be remitted to **us** at the following address:

[ Medical Excess LLC  
Dept. 2173  
Los Angeles, CA 90084-2173 ]

- D. Grace Period.** Unless **we** or the **Policyholder** have given written notice of cancellation, a grace period of 31 days shall apply for the payment of any premiums due (except the first premium payment which is due on the **Policy Effective Date**). At the end of the 31-day grace period, **we** may cancel this Policy without further notice. During the grace period, the contract will remain in force, provided that, **we** receive the entire premium payment prior the end of the grace period. Failure to pay the entire premium prior to the end of the grace period will result in cancellation back to the applicable **Premium Due Date**.

**We** are not obligated to pay any claims incurred by a **Participant** during the grace period, until the premium due is received. It is possible that **we** may inadvertently accept premium payment from the **Policyholder** after the grace period has expired. This acceptance does not obligate **us** to reinstate this Policy. Unless this Policy is reinstated, the payment will be refunded within a reasonable time after the error is discovered.

- E. Right To Amend Rates And Policy Terms.** **We** may revise the premium rates or any other terms of this Policy on:
1. [The date the **Policyholder** amends the **Medical Plan**.
  2. The date a benefit change is made to this **Policy** at the **Policyholder's** request.
  3. The date the **Policyholder** adds or deletes a subsidiary or affiliate.
  4. The date an increase or decrease in the number of **Participants** exceeds [25%] in any [one] month or [XX,25%] over any period of [XXX,three] consecutive months. The number of **Participants** will be derived from the **Policyholder's** monthly premium statements or any other reports obtained from the **Policyholder** or the **Medical Plan's Administrator**.
  5. The date **we** are notified by the state in which the **Policyholder** is located of any state imposed tax or assessment for which **we** are obligated to pay.
  6. The date of any change in the **Policyholder's** business that materially affects **our** risk.
  7. The date it is discovered that there has been a material misrepresentation or nondisclosure of information that **we** could reasonably have expected to have been disclosed to **us** by the **Policyholder** or the **Policyholder's Medical Plan Administrator**.]
- F. Incontestability.** **We** may declare this **Policy** void back to the inception date of the **Policy Year** or cancel this Policy, if the **Application** contains a material misrepresentation. However, this provision will not apply once this Policy has been continuously in effective for two years.
- G. Representations Not Warranties.** A copy of the **Application** is attached to this Policy. All statements made by the **Policyholder** or by **Participants** applying for coverage will be considered representations and not warranties. No statement appearing on the **Application** will be used to contest the validity of the **Policyholder's** right to the benefits of this Policy, unless the **Policyholder** has been furnished a copy of the **Application**.
- H. Evidence of Insurability.** **We** may ask the **Policyholder** for verification that a **Participant** is covered under the **Policyholder's Medical Plan**.

## POLICYHOLDER PROVISIONS

(Continued)

- I. **Policy Termination.** This Policy may be cancelled by the **Policyholder** or **us**, for any reason, on the date specified in writing by either party, provided that the other party is notified not less than [31] calendar days in advance of the date of termination. If the **Policyholder** provides notice without a specified termination date, termination will be effective the first **Premium Due Date** following **our** receipt of the written notice of termination.

***If the Policy terminates during a Policy Year (other than a Policy Anniversary Date), coverage provided to Participants will be terminated immediately, regardless of whether a Participant is in the middle of an established Transplant Benefit Period.***

**We** may cancel this Policy if the **Policyholder's** enrollment drops below the Minimum Enrollment shown on the Policy Face Page. However, **we** must provide written notification to the **Policyholder** of such cancellation not less than [ten (10) days] in advance of the termination date.

This Policy may be cancelled without notification, upon the earliest of the following dates:

1. [The date the **Medical Plan** is discontinued.
  2. The date the **Policyholder's Medical Plan Administrator** listed in the Schedule of Benefits is changed to an administrator that **we** have not authorized.
  3. The date it is determined that the **Policyholder's Medical Plan Administrator** is not properly licensed as required by state law.
  4. The date the **Medical Plan** is found to be in violation of federal or state law. **We** reserve the right to allow the **Medical Plan** [90] calendar days within which to achieve compliance. Failure to comply by such date will result in termination of this Policy.
  5. Upon the **Policy Effective Date**, if the **Policyholder** fails to provide **us** (within the first [90] days of the **Policy Effective Period**) with requested materials or information necessary for **our** final review and approval of the premium rates. If this Policy is terminated under this provision, **we** will return the premium paid by the applicant for the current **Policy Year**, and **we** will have no liability under the terms of this Policy for the current **Policy Year**.
  6. Upon the **Premium Due Date** if **we** do not receive premiums within the specified Grace Period.
  7. The date the **Policyholder** becomes insolvent or files for bankruptcy, unless **we** and an appointed Trustee in Bankruptcy agree to continue the coverage during a period of reorganization.]
- J. **Notice.** When **we** provide written notice to the **Policyholder's** last known address regarding the administration of this Policy, it is deemed to be notice to all affected parties including all **Participants**. The **Policyholder** is responsible for giving notice to **Participants**, if applicable.
- K. **Legal Action.** No legal action may be brought under this Policy within 60 days after **we** receive a claim. No action may be brought after 3 years from the date the claim is required to be furnished to **us**.
- L. **Information Release and Data Confidentiality.** The **Policyholder** and all **Participants** that need **Covered Transplant Services** must allow **us** access to medical information from all appropriate **Providers**. Such information is necessary in order for **us** to make proper benefit determinations. The information will not be used, disclosed, furnished, or made accessible to anyone other than **our** authorized employees and vendors contracted by **us** to carry out **our** obligations under this Policy. In accordance with the applicable law, **we** and the **Policyholder** agree to establish and maintain administrative, technical and physical safeguards to protect the security, confidentiality and integrity of the medical information.
- M. **Entire Contract.** This Policy (along with the Certificate) and the signed **Application** form the entire contract between the **Policyholder** and **us**. No amendment to this Policy shall be effective unless confirmed by a written Endorsement agreed to and issued by **us**. No agent or representative of the **Company**, other than an executive officer, may change this Policy or waive any of its provisions. No verbal statement by any executive officer or other employee of the **Company** is binding on **us**.

## POLICYHOLDER PROVISIONS

(Continued)

- N. Audit.** We shall have the right to inspect and audit all records and procedures of the: 1) **Policyholder**; 2) its **Medical Plan Administrator**; or 3) any other organization involved in the administration or adjudication of claims. In addition, we shall have the right to require premium records, proof of eligibility, and claim payment information in a manner that meets our requirements.
- O. Clerical Error.** A clerical error made by the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or us will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated. Any clerical error in data provided to us must be corrected and promptly reported to us. We will make appropriate adjustments to premiums due and/or benefit determinations. Any refund in premium due to **Policyholder** error is limited to the [12-month period prior to the date of the request for refund].
- P. Conformity with Statutes.** Any provision of this Policy that, on the **Policy Effective Date**, is in conflict with the requirements of state or federal statutes or regulations (in the applicable jurisdiction) is hereby amended to conform to the minimum requirements of such statutes and regulations.
- Q. Subrogation and Right of Reimbursement.** Another party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to **Covered Transplant Services**. Such party may include, but is not limited to, any of the following: a) the party or parties who caused the need for the **Covered Transplant Procedure**; b) the insurer or other indemnifier of the party or parties who caused the **Covered Transplant Procedure**; c) a guarantor of the party or parties who caused the **Covered Transplant Procedure**; d) a worker's compensation insurer; or e) any other person, entity, policy or plan that is liable or legally responsible in relation to the **Covered Transplant Procedure**. When this happens, we may, at our option: a) subrogate, that is, take over the **Participant's** right to receive payments from such party (the **Participant** or his or her legal representative must transfer to us any rights he or she may have to take legal action arising from the **Covered Transplant Procedure** to recover any sums paid under this Policy on behalf of the **Participant**); or b) recover from the **Participant** or his or her legal representative any benefits paid under this Policy from any payment the **Participant** is entitled to receive from the other party. The **Participant** or his or her legal representative must cooperate fully with us in asserting its subrogation and recovery rights. The **Participant** or his or her legal representative will, within 5 days of receiving our request, provide all information and sign and return all documents necessary to exercise our rights under this provision.

We will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration that the **Participant** receives or is entitled to receive from any of the sources listed above. This lien will not exceed the greater of: a) the amount recovered from any other party; or b) the amount of benefits paid by this Policy for **Covered Charges** plus the amount of all future benefits which may become payable under this Policy which result from the **Covered Transplant Services**. The **Company** will have the right to offset or recover such benefits from the amount received from any other party.

If the **Participant** or his or her legal representative makes any recovery from any other party and fails to reimburse us for any **Covered Charges**, then the **Participant** or his or her legal representative will be personally liable to us for the **Covered Charges** paid under this Policy.

Our first lien rights will not be reduced due to the **Participant's** own negligence; or due to the **Participant** not being made whole; or due to attorney's fees and costs. We are secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. We have the right to recover interest at the rate of [1/2% per month] commencing on the date the **Participant** or his or her legal representative recovers any funds from any other party. We are not subject to any state law doctrines, including, but not limited to, the common fund doctrine, which would purport to require us to reduce our recovery by any portion of a **Participant's** attorney's fees and costs.

This provision also applies to any funds recovered from any other party by or on behalf of any dependent, the estate of any **Participant**; or on behalf of any incapacitated person.

## POLICYHOLDER PROVISIONS

(Continued)

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The following pages comprise the Certificate of Coverage delivered to the **Policyholder** for delivery to each **Member**.

The Certificate of Coverage is part of this Policy.

## SCHEDULE OF BENEFITS

**POLICY YEAR:** [January 1, 2008 through December 31, 2008]

### COVERED TRANSPLANTS:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart                             | <input type="checkbox"/> Heart/ Lung              | <input type="checkbox"/> Autologous Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo              |
| <input type="checkbox"/> Lung/Double Lung                  | <input type="checkbox"/> Kidney/ Pancreas         | <input type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (related)    |
| <input type="checkbox"/> Kidney (living or deceased donor) | <input type="checkbox"/> Kidney/Liver             | <input type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (unrelated)] |
| <input type="checkbox"/> Pancreas                          | <input type="checkbox"/> Liver/Intestine          |   |
| <input type="checkbox"/> Liver (living or deceased donor)  | <input type="checkbox"/> Pancreas/Intestine       |   |
| <input type="checkbox"/> Intestine                         | <input type="checkbox"/> Liver/Pancreas/Intestine |   |
| <input type="checkbox"/> Ventricular Assist Device         | <input type="checkbox"/> Other (specify):         |   |

### TRANSPLANT BENEFIT PERIOD:

The Transplant Benefit Period begins [on the date of **Transplant Evaluation** for][ten (10) days before] a **Covered Transplant Procedure**.

The Transplant Benefit Period ends on the earliest of the following dates:

1. [The end of the 365th day following the **Covered Transplant Procedure**;
2. The date the **Participant's** Lifetime Limit has been reached under the Policy or under the **Medical Plan**;
3. The date the Policy terminates, but only if:
  - a. The **Policyholder** cancels the Policy prior to the last day of the current **Policy Year**; or
  - b. The **Participant's** Transplant Benefit Period has begun, but such **Participant** has not received a **Covered Transplant Procedure** as of the date of termination of the Policy; or
4. The date the **Participant's** COBRA benefits terminate, if applicable.
5. The date established by the Non-Performance of Covered Transplant Procedures provision.]

[If there is no **Transplant Evaluation**, the Transplant Benefit Period begins on the date of a **Covered Transplant Procedure**.]

[If a **Transplant Evaluation** occurs while the Policy is in force and results in a **Covered Transplant Procedure** that takes place during this **Policy Year**, the expenses for the **Transplant Evaluation** will be eligible for reimbursement even if it occurred prior to the Transplant Benefit Period. This benefit does not apply to individuals with a **Pre-existing Condition** unless the **Transplant Evaluation** occurs after the **Pre-existing Condition Waiting Period** has expired.]

For a Bone Marrow/Peripheral Stem Cell Tissue Transplant, the date the tissue is re-infused is deemed to be the date of the **Covered Transplant Procedure**.

All benefits provided during a Transplant Benefit Period that extend beyond the **Policy Year** will be based on the Policy terms in effect at the start of the Transplant Benefit Period.

A Transplant Benefit Period cannot begin prior to the date the **Participant** first becomes covered under the Policy.

**LIFETIME LIMIT:** [\$            for each **Participant**]

The following charges are included within and reduce each **Participant's** Lifetime Limit:

1. All benefits paid on behalf of the **Participant** (including covered donor charges) under the Policy and any preceding or succeeding Organ & Tissue Transplant Policy between **us** and the **Policyholder**; and
2. All benefits paid by **us** under the "Travel, Lodging, and Meals Benefit" provision.

## SCHEDULE OF BENEFITS

(Continued)

**[DEDUCTIBLE AMOUNT (APPLICABLE TO HIGH DEDUCTIBLE HEALTH PLANS ONLY):**

Although the Policy does not impose a **Deductible Amount**, if a **Participant** selects a high deductible health plan sponsored by the **Policyholder**, then the **Deductible Amount** set forth in such **Policyholder's** high deductible health plan must be paid by the **Participant** before benefits are payable under the Policy. This requirement is necessary in order for the **Participant** to remain eligible for the tax benefits afforded by the health savings account associated with the **Policyholder's** high deductible health plan.]

**REIMBURSEMENT AMOUNTS:**

- A. PARTICIPATING PROVIDER: ..... [100%] of **Covered Charges** for **Covered Transplant Services** provided through a **Participating Transplant Facility**. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.)
- B. NONPARTICIPATING PROVIDER: ..... [80%] of **Covered Charges** for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** with respect to the type of **Covered Transplant Procedure** performed. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.) Benefits for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** will not exceed the Maximum Amounts stated below:

COVERED TRANSPLANT PROCEDURE	MAXIMUM BENEFIT FOR ALL COVERED TRANSPLANT SERVICES PROVIDED BY A NONPARTICIPATING TRANSPLANT FACILITY
Heart	\$437,000
Lung (Single)	\$261,000
Lung (Double)	\$363,000
Kidney (living or deceased donor)	\$156,000
Pancreas	\$163,000
Liver (living or deceased donor)	\$196,000
Intestine	\$626,000
Heart/Lung	\$495,000
Kidney/Pancreas	\$200,000
Kidney/Liver	\$419,000
Liver/Intestine	\$700,000
Pancreas/Intestine	\$668,000
Liver/Pancreas/Intestine	\$716,000
Autologous Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b>	\$175,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - related	\$297,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - unrelated	\$380,000

- C. SECONDARY PAYOR: ..... When benefits under the Policy are considered secondary, as determined by the Coordination of Benefits provisions, benefit payments will be based on the lesser of: a) **Covered Charges**; or b) the negotiated amount established between the primary payor and the **Provider**.

**SCHEDULE OF BENEFITS**  
(Continued)

**ENDORSEMENTS:** Yes  No

If yes, please specify:  
[ ]

**POLICYHOLDER'S MEDICAL PLAN ADMINISTRATOR:**

[Administrator Name]

## BENEFIT PROVISIONS

Boldfaced terms have special meaning. Please refer to the Definitions section or Benefit Provision section for a complete description of such terms.

### INSURING AGREEMENT:

Subject to all terms, conditions, limitations, and exclusions, **we** will pay **Covered Charges** incurred by **you** for **Covered Transplant Services** performed in a **Transplant Facility** that are directly related to a **Covered Transplant Procedure**.

### NOTIFICATION REQUIREMENTS:

**We** must be notified as soon as possible by **you**, the **Policyholder**, or **your Physician** that a **Covered Transplant Procedure** is being considered. Notification must occur before the referral is made and services are rendered for any **Transplant Consultation** and/or **Transplant Evaluation**. Failure to provide this notification may result in a decrease or denial of benefits. Notifications must be submitted to:

[Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, IN 46268  
Attention: Transplant Nurse Advisor  
(888) 449-2377]

### COVERED TRANSPLANT SERVICES:

*The following services require our prior approval and are eligible for coverage if they are provided to **you**, performed within a **Transplant Facility**, and directly related to a **Covered Transplant Procedure**. [Complications of donation experienced by the living donor are not covered.]*

1. Transplant Consultation. **Transplant Consultation** means a consultation with a transplant **Physician** to determine if **your** condition is such that **you** qualify for further evaluation according to the **Transplant Facility's** established **Transplant Evaluation** protocol.
2. Transplant Evaluation. **Transplant Evaluation** means tests, labs, x-rays, scans, procedures (including dental evaluations, x-rays, and examinations), and consultations for **you** (and any applicable living donor) that are in compliance with the **Transplant Facility's** established transplant program protocol.
3. Solid Organ Procurement. **Solid Organ Procurement** means compatibility testing and procurement expenses for living and deceased donors; donor's surgical procedure to remove the organ or tissue; and inpatient and outpatient services for living donor.
4. Bone Marrow or Stem Cell Procurement. **Bone Marrow or Stem Cell Procurement** means expenses for:
  - a. Procurement from **you** for autologous bone marrow/stem cell transplant;
  - b. Procurement from a living donor for allogeneic bone marrow/stem cell transplant, including compatibility testing of relatives;
  - c. Testing/typing of potential unrelated donors;
  - d. Tests related to the procurement of bone marrow/stem cells, including human leukocyte antigen typing;
  - e. Collection and storage [(for up to 6 months)] of bone marrow/stem cells (autologous or allogeneic) for future use, as long as a bone marrow/stem cell transplant has been scheduled to occur [within the same 6 months]; and
  - f. Bone marrow/stem cell registry search expenses such as from the National Marrow Donor program (NMDP).

## BENEFIT PROVISIONS

(Continued)

5. Covered Transplant Procedure. **Covered Transplant Procedure** means a **Medically Necessary** adult or pediatric human organ and tissue transplants listed as a Covered Transplant in the Schedule of Benefits that is not **Experimental and/or Investigational Treatment**.
6. Transplant Hospitalization. **Transplant Hospitalization** means the hospitalization for the **Covered Transplant Procedure** including inpatient **Hospital** services, **Physician** services and ancillary services. For solid organ transplantation, coverage begins twenty-four (24) hours prior to the transplant procedure. Hospitalization of living solid organ donors is covered. Such services must be provided according to the **Transplant Facility's** established transplant program protocol. For bone marrow/stem cell transplants, coverage begins with the workup immediately prior to beginning **High Dose Chemotherapy** to include subsequent infusion of autologous or allogeneic bone marrow/stem cells. Bone marrow/stem cell transplantation may be performed as an inpatient or outpatient.
7. Follow-Up. **Follow-Up** means **Hospital** services (inpatient and outpatient), **Physician** services, labs, x-rays, procedures, and other diagnostic tests rendered by or at the **Transplant Facility** to determine the status of the transplanted organ or tissue after discharge from a **Transplant Hospitalization**. Such services must be provided according to the **Transplant Facility's** established transplant program follow-up guidelines or protocol.
8. Complications after Transplant for Recipient. **Complications after Transplant for Recipient** means services to treat complications experienced by the transplant recipient after transplant, such as:
  - a. Rejection of a solid organ;
  - b. Surgical complications; and
  - c. Graft versus host disease of transplanted bone marrow or stem cells.

Services may be rendered during the **Transplant Hospitalization** or after discharge from **Transplant Hospitalization**.

9. Acute Rehabilitation or Non-Acute Rehabilitation after Discharge from Transplant Hospitalization. **We** will pay for up to [a total of 15 days/visits] for home rehabilitation and physical therapy (inpatient or outpatient).
10. Home Health Care after Discharge from Transplant Hospitalization. **We** will pay for up to [a total 15 home health care visits] by a registered nurse to administer intravenous drugs, train the patient (and/or family) for self-administration of drugs, wound care, or similar procedures.
11. Durable Medical Equipment after Discharge from Transplant Hospitalization. **We** will pay for rental of durable medical equipment after discharge from the **Transplant Hospitalization**. This benefit is limited to the lesser of [a total 15 days of rental] or the purchase price of such equipment.
12. Prescription Drugs. **We** will pay for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals that are **Medically Necessary** after discharge from the **Transplant Hospitalization** for up to 365 days after the date of transplantation. Drugs used to treat conditions not directly related to the **Covered Transplant Procedure** are not covered.
13. Ventricular Assist Device (VAD). **We** will pay for expenses for the VAD and any related **Provider** expenses from the date of insertion up to [a total 5 days] following the date of insertion, provided that:
  - a. The VAD is approved by the Food and Drug Administration (FDA);
  - b. **You** are simultaneously listed as an acceptable transplant candidate and approved for transplant by **us**; and
  - c. **You** receive the VAD at a **Transplant Facility**.

[VAD related benefits are limited to a maximum of \$100,000 for each Transplant Benefit Period.]  
**Complications as a result of the insertion of a VAD are not covered under the Policy.**]

## BENEFIT PROVISIONS

(Continued)

### [PRE-EXISTING CONDITION WAITING PERIOD:

If **you** have a **Pre-existing Condition** on the **Policy Effective Date** (referred to in the Renewal Endorsement as the Original Policy Effective Date), **you** are required to fulfill a [12 month] waiting period before benefits are provided under the Policy. The waiting period does not apply if **you** become eligible for coverage after the **Policy Effective Date** (or Original Policy Effective Date, if applicable), unless **you** are added to the **Medical Plan** as a result of the **Policyholder** acquiring a new group, affiliate, division, and/or subsidiary.

If **you** receive a transplant during a **Pre-Existing Condition Waiting Period**, that transplant and all related charges are excluded from coverage under the Policy and subsequent renewals.]

### MULTIPLE TRANSPLANTS:

If **you** require more than one **Covered Transplant Procedure**, benefits are determined as follows:

1. **Covered Transplant Procedures** that are due to related causes are subject to the same Transplant Benefit Period established by the first **Covered Transplant Procedure**. However, if the related **Covered Transplant Procedures** are separate by at least 90 days, a separate Transplant Benefit Period will be established for each procedure.
2. **Covered Transplant Procedures** that are due to unrelated causes will each have their own Transplant Benefit Period.
3. In no event will benefits provided under the Policy exceed the **Participant's** Lifetime Limit shown in the Schedule of Benefits, regardless of the number of **Covered Transplant Procedures** performed.

### NON-PERFORMANCE OF COVERED TRANSPLANT PROCEDURES:

If **you** have established a Transplant Benefit Period, but the **Covered Transplant Procedure** is not performed as scheduled due to **your** medical condition or death, benefits will be paid for **Covered Transplant Services** up to and until the earlier of:

1. **Your** death; or
2. The date **your Physician** decides not to perform the **Covered Transplant Procedure**.

### [TRANSPLANT NURSE ADVISOR:

**We** will assign a transplant nurse advisor to facilitate transplant coverage determination, access to transplant facilities, and ongoing patient support related to transplantation during the Transplant Benefit Period. These services are included without any additional charge.]

## BENEFIT PROVISIONS

(Continued)

### TRAVEL, LODGING, AND MEALS BENEFIT:

Your Benefit. We will reimburse reasonable and necessary travel expenses, as determined by **us**, incurred by **you** [and one companion (two companions if **you** are a minor)] during a Transplant Benefit Period for travel related to a **Covered Transplant Procedure**. Travel expenses include transportation, lodging, and meals and are subject to the limits shown below.

Living Donor Benefit. We will reimburse reasonable and necessary travel expenses, as determined by **us**, incurred by [a living donor and one companion] during a Transplant Benefit Period for travel related to a **Covered Transplant Procedure**. Travel expenses include transportation, lodging, and meals and are subject to limits shown below.

Transportation includes: [automobile; boat; airplane; train; ground ambulance; and air ambulance (jet or helicopter). Ambulance transportation (ground and air) requires **our** prior approval. Automobile mileage reimbursement is based on current federal guidelines for mileage reimbursement.]

Reimbursement for travel expenses will only be provided once **we** have received itemized receipts and a completed Travel Expense Form (as supplied by **us**).

DESCRIPTION	BENEFIT LIMIT
Lodging and meals for <b>you</b> and companion(s)	Up to \$200 per day per <b>Covered Transplant Procedure</b>
Lodging and meals for living donor and companion	Up to \$200 per day per <b>Covered Transplant Procedure</b>
<b>The Maximum Travel Benefit</b> for all eligible travel expenses (transportation, lodging, and meals) incurred by <b>you</b> , a living donor, and all eligible companions are limited to a combined Maximum Travel Benefit of \$10,000 per <b>Covered Transplant Procedure</b> . These travel, lodging, and meal benefits are included within and reduce <b>your</b> Lifetime Limit.	

### [DISABILITY, LEAVE OF ABSENCE, OR LAYOFF:

If **you** are not actively at work as a result of a disability, leave of absence, or layoff, eligibility for benefits provided under the Policy will only be extended to **you** through the earliest of:

1. The continuance period established by the underlying **Medical Plan** for such absences; or
2. The 12 month period immediately following the date **your** disability, leave of absence or layoff first began.

This provision does not apply to Retirees covered under the **Medical Plan** and the Policy, or individuals continuing benefits under COBRA or any other federally mandated program.]

## CLAIMS PROVISIONS

### A. Filing Claims.

The Policy provides coverage for claims that are incurred within the **Policy Year** and submitted for payment within [twelve (12) months following the **Date of Service**]. Unless otherwise stated in the Policy, claims will not be considered for payments if received after [twelve (12) months following the **Date of Service**].

Claims must be filed in a manner approved by **us**, and must include the following information:

1. **Your** name and address;
2. **Your** ID Number;
3. **Provider's** name, address, and Tax ID Number;
4. Itemized bill that includes the CPT codes or description of each charge; and
5. Diagnosis.

### B. Claim Payment.

**We** will pay benefits for all **Covered Charges** in accordance with the terms of the Policy within 60 days after receiving all necessary information. Benefits are paid to **you** or to **your** assignee or designee. **We** may pay benefits directly to the **Provider** or to any relative **we** deem appropriate if a benefit is payable and **you** are: 1) a minor; 2) legally incapable of giving valid receipt and discharge of payment; or 3) deceased.

## APPEAL AND GRIEVANCE PROCEDURES

Appeals must be submitted for consideration within 180 days of the date of **our** payment (if the appeal is based upon **our** payment) or within 180 days of the date of our denial of coverage. Grievances regarding **our** services or product may be submitted at any time during the **Policy Year**.

**A. Appeal Process.** An appeal is a formal request for review of **our** determinations regarding transplant related services, including but not limited to **our** payment(s) and/or coverage denials. The following reviews are available to **you** upon filing an appeal:

1. Standard Review. A standard review of an appeal is available on a prospective or retrospective basis and must be requested in writing by **you** or **your** designee. A standard review is available in situations wherein the timeframe for the review does not jeopardize **your** life or health. **We** will conduct the review and provide a written determination within [thirty (30)] business days after receiving all necessary information to complete the review.
2. Expedited Review. An expedited review of an appeal is only available on a prospective basis and must be requested in writing by **you** or **your** designee. An expedited review is only available if the timeframe for the review could seriously jeopardize **your** life or health. **We** will coordinate the review and communicate the determination verbally within [seven (7)] business days after receiving all necessary information to complete the review. **We** will also provide a written determination within [three (3)] business days following **our** verbal communication.

All appeals are reviewed and determined by a Peer Reviewer. Peer Reviewers are **Physicians** who:

1. Are clinical peers;
2. Hold an active, unrestricted license to practice medicine;
3. Are in a similar specialty as typically manages the medical condition, procedure, or treatment as the treating **Physician**; and
4. Are neither the individual nor a subordinate of the individual who made the original coverage determination or denial.

**B. Grievance Process.** A grievance or complaint is an expression of dissatisfaction regarding **our** products or services. **You** or **your** designee may submit a grievance verbally or in writing. Depending on the nature of the grievance and whether or not a response is requested, **we** will respond verbally and/or in writing within thirty (30) business days following receipt of the grievance. Grievances will be considered when measuring the quality and effectiveness of **our** products and services.

## COORDINATION OF BENEFITS

- A. Applicability.** This Section applies when **you** make a claim for reimbursement of **Covered Charges**, and **you** are covered by **Additional Medical Coverage**. If this provision applies, review the Order-of-Benefit-Determination Rules, under the heading of the same name, to determine whether the Policy's coverage is payable before or after **Additional Medical Coverage**. The Policy's coverage will not be reduced when its coverage is payable first, as determined under the Order-of-Benefit-Determination Rules; but may be reduced when another plan's benefits are payable first, as determined under the Order-of-Benefit-Determination Rules as set forth below.
- B. Order-of-Benefit-Determination Rules.** When there is a basis for a claim under the Policy and **Additional Medical Coverage**, the Policy is secondary if: (1) the **Additional Medical Coverage** does not have rules coordinating its benefits with the Policy; or (2) the **Additional Medical Coverage's** rules, the Policy's rules, or both, require the Policy's coverage be determined after those of the **Additional Medical Coverage**, except as may occur under the gender rule exception in Item C.2, below.
- C. Filing Guidelines.** The general guidelines which follow discuss the order in which **you** should file claims when **you** are covered under **Additional Medical Coverage**, using the first of the rules which applies:
1. The **Additional Medical Coverage** that covers **you** as a subscriber is obligated to pay before the Policy covering **you** as a dependent.
  2. When the parents of a dependent child are neither separated nor divorced:
    - a. **You** must file first under the Policy or **Additional Medical Coverage** covering the dependent child of the parent whose birthday falls earlier in the year; then file under the Policy or **Additional Medical Coverage** of the parent whose birthday falls later in the year; but
    - b. If both parents have the same birthday, the **you** must file first under the Policy or **Additional Medical Coverage** which has covered the parent for the longer period of time, and then under the Policy or **Additional Medical Coverage** of the other parent.

**EXCEPTION:** If the **Additional Medical Coverage** does not have the "birthday rule," but instead has a rule based upon the parent's gender, and as a result the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination, the rule of the **Additional Medical Coverage** will determine the order.

3. When the parents of a dependent are separated or divorced:
  - a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with custody; then
  - b. **You** must file under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the **spouse** of the parent with custody; then
  - c. **You** must file under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the parent without custody.

**EXCEPTION:** If there is a court decree which establishes financial responsibility for medical, dental, or other health care expenses regarding the dependent child of parents who have separated or divorced:

- a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with such financial responsibility; then
- b. File under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the other parent.

If the specific terms of the court decree state that the parents have joint custody without stating that one parent is responsible for the child's medical, dental, or other health care expenses, file as described in Item C.2, above.

## COORDINATION OF BENEFITS

(Continued)

4. **You** must file first under the Policy or **Additional Medical Coverage** which covers **you** as a subscriber who is neither laid-off nor retired, or as a dependent of a subscriber; then file under the Policy or **Additional Medical Coverage** which covers **you** as a laid-off or retired subscriber or as a dependent of a laid-off or retired subscriber. Ignore this paragraph if the **Additional Medical Coverage** does not contain this paragraph and, as a result, the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination.
  5. When the order of payment cannot be determined in accordance with these general guidelines, file first under the Policy or **Additional Medical Coverage** which has covered **you** for the longer period of time, then under the Policy or **Additional Medical Coverage** which has covered **you** for the shorter period of time.
- D. Effect on the Policy's Coverage.** When **you** are covered under two or more policies, which together pay more than the **Covered Charges** for **Covered Transplant Services**, **we** will pay the Policy's benefits according to the Order-of-Benefit-Determination Rules. The Policy's benefit payments will not be affected when this Policy is primary. *However, when the Policy is secondary under the Order-of-Benefit-Determination Rules, benefits payable will be reduced (if necessary) so that combined benefits of all policies covering the Participant do not exceed the lesser of: 1) Covered Charges; or 2) the negotiated amount established between the primary insurer and the Provider.*
- E. Right to Receive and to Release Information.** To coordinate benefits, **we** will release or obtain information regarding a claim from any insurance company, organization, or person. **You** must furnish the **Company** with any information necessary to coordinate benefits.

**Right to Obtain Recovery.** **We** are not liable for any failure to coordinate benefits. If **we** pay full benefits on a claim for which it has only secondary liability, **we** may recover the difference from **you** or from any other appropriate party.

## EXCLUSIONS

We will not pay, in whole or in part, for any of the following:

- A. [Any service or supply not directly related to a **Covered Transplant Procedure**. This includes any service or supply rendered to treat the underlying disease before or after transplant (that is not part of the actual **Covered Transplant Procedure**).
- B. Services and supplies for treatment of complications related to a **Covered Transplant Procedure**, unless such complications are determined by **us** to be the immediate and direct result of a **Covered Transplant Procedure**.
- C. Charges for any transplant related services or supplies incurred prior to the **Policy Effective Date**.
- D. Charges for prescription drugs incurred prior to a **Covered Transplant Procedure**, except for **High Dose Chemotherapy** that is part of a **Covered Transplant Service**.
- E. Charges for prescription drugs incurred after discharge from a transplant hospitalization, except for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals.
- F. Chemotherapy and/or surgery prior to beginning **High Dose Chemotherapy** (including bone marrow/stem cell transplantation).
- G. Services provided for the removal of a transplanted solid organ, unless the removal is provided during a **Covered Transplant Procedure**.
- H. Services provided after: 1) a transplanted solid organ has been removed from the transplant recipient; or 2) disease has returned in a bone marrow or stem cell transplant recipient.
- I. Services for human leukocyte antigen typing of **you** or **your** relatives, compatibility testing, unrelated bone marrow/stem cell searches on registries, and harvest and/or storage of bone marrow/stem cells when bone marrow/stem cell transplant has not been reviewed and approved by **us**.
- J. Services and supplies for immunizations.
- K. Animal organ or artificial organ transplants.
- L. Charges for a stand-by **Physician**, unless otherwise approved by **us**.
- M. Services of a **Provider** who is a member of **your Immediate Family**.
- N. Services, supplies, or **Hospital** care which **we** determine are not **Medically Necessary** for the treatment of illness, injury, diseased condition, or impairment, except as specifically stated as covered.
- O. **Custodial Care**.
- P. Hospice care.
- Q. Charges for any **Experimental and/or Investigational Treatment**, except as specifically stated in the Policy.
- R. Charges paid or payable under Workers' Compensation.
- S. Preventive or routine care (including physicals, premarital examinations, any other routine or periodic examinations), dental services and supplies, education and training, except as specifically stated as covered.
- T. Research studies or screening examinations.
- U. Treatment of any illness or injury sustained as a result of an act of war.
- V. Services or supplies to the extent **you** are not legally obligated to pay for them.
- W. Expenses incurred before the **Policy Year** begins or after it ends, except as stated in the Policy.
- X. Rest cures or sanitarium care.
- Y. Services or supplies furnished by any **Provider** acting beyond the scope of such **Provider's** license.
- Z. Any service or supply that is a **Medicare** Part A or Part B liability.
- AA. Services or supplies received from a dental or medical department maintained by or on behalf of the **Policyholder**.
- BB. Services provided by any governmental agency to the extent that **you** are not charged for them, unless otherwise required by state or federal law.
- CC. Services or supplies not specifically stated as covered.
- DD. Telephone consultations, charges for failure to keep a scheduled visit, or charges for completing a claim form.
- EE. Recreational or diversional therapy.
- FF. Materials used in occupational therapy.
- GG. Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a **Provider** prescribes such items.
- HH. Services and supplies, which are eligible to be repaid under any private or public research fund whether or not such funding was applied for or received.

## EXCLUSIONS

(Continued)

- II. Services and supplies for treatment of complications or diseases incurred by a living donor, including, but not limited to, increase length of hospitalization or the costs to treat any complication or disease.
- JJ. Services and supplies incurred by any COBRA continuee whose COBRA continuation coverage was not offered and/or elected, and premiums were not paid, within the time frames required by COBRA.
- KK. **Prescription Drugs** for the treatment or prevention of a rejected organ or tissue following the end of the Transplant Benefit Period.
- LL. Services and supplies of any **Provider** located outside the United States of America, except for organ or tissue procurement services, unless otherwise prohibited by United States federal law.
- MM. Biological and/or mechanical devices used as a bridge to transplant unless specifically included in the Schedule of Benefits.
- NN. Charges for any transplant-related services or supplies incurred during the current **Policy Year** when the transplant procedure occurred prior to the **Policy Effective Date**. However, we will make an exception to this Exclusion for **Covered Charges** related to a **Covered Transplant Procedure you** received under a previous Organ & Tissue Transplant Policy issued by **us** to the **Policyholder**, as long as:
  1. There has been no break in coverage between the Transplant Policies issued by **us**; and
  2. The **Covered Charges** are for services or supplies incurred within the Transplant Benefit Period for the **Covered Transplant Procedure**.]

[**We** may, in certain circumstances for purposes of overall cost savings or efficiency and in **our** sole discretion, provide benefits for services that would otherwise be excluded from coverage. If **we** provide any benefit not covered under the Policy, this fact shall not be used against **us** in any similar case and **we** shall not be required to extend this benefit to any other **Participant**.]

## RIGHT TO AMEND RATES AND POLICY TERMS

**We** may revise the premium rates or any other terms of the Policy on the occurrence of any of the following:

- A. [The date the **Policyholder** amends the **Medical Plan**.
- B. The date the **Policyholder** requests a benefit change in the Policy.
- C. The date the **Policyholder** adds or deletes a subsidiary or affiliate.
- D. The date an increase or decrease in the number of **Participants** exceeds [25%] in any [one] month or [XX,25%] over any period of [XXX,three] consecutive months. The number of **Participants** will be derived from the **Policyholder's** monthly premium statements or any other reports obtained from the **Policyholder** or the **Medical Plan's Administrator**.
- E. The date **we** are notified by the state in which the **Policyholder** is located of any state imposed tax or assessment for which **we** are obligated to pay.
- F. The date of any change in the **Policyholder's** business that materially affects **our** risk.
- G. The date it is discovered that there has been a material misrepresentation or nondisclosure of information that **we** could reasonably have expected to have been disclosed to **us** by the **Policyholder** or the **Policyholder's Medical Plan Administrator**.]

## TERMINATION PROVISIONS

**We** may, at any time, cancel benefits under the Policy for the reasons specified in the Policy.

In addition, **your** coverage shall automatically terminate on the earliest of the following dates:

- A. The date the Policy is terminated, as specified in the Policy. (The **Policyholder** is responsible for notifying **you** of the termination of the Policy.)
- B. The date **you** cease to be a covered **Participant**.
- C. The date **we** receive written notice from **you** or the **Policyholder** instructing **us** to terminate **your** coverage. (Coverage will terminate on the date specified in the notice, if provided.)

## GENERAL PROVISIONS

- A. Defined Terms.** The Policy contains certain defined terms that have been capitalized. Please refer to the Definitions section of the Policy for a complete description of such terms.
- B. Incontestability.** **We** may declare the Policy null or cancel it, if the **Application** contains a material misrepresentation. However, this provision will not apply once the Policy has been in effective for two years.
- C. Representations Not Warranties.** A copy of the **Application** is attached to the Policy. All statements made by the **Policyholder** or by **Participants** applying for coverage will be considered representations and not warranties. No statement appearing on the **Application** will be used to contest the validity of the **Policyholder's** right to the benefits of the Policy, unless the **Policyholder** has been furnished a copy of the **Application**.
- D. Evidence of Insurability.** The **Policyholder** is required to provide **us** with verification that **you** are covered by the **Policyholder's Medical Plan**.
- E. Notice.** When **we** provide written notice to the **Policyholder's** last known address regarding the administration of the Policy, it is deemed to be notice to all affected parties. The **Policyholder** is responsible for giving **you** notice, if applicable.
- F. Legal Action.** No legal action may be brought under the Policy within 60 days after **we** receive a claim. No action may be brought after 3 years from the date the claim is required to be furnished to **us**.
- G. Information Release and Data Confidentiality.** The **Policyholder** and all **Participants** that need **Covered Transplant Services** must allow **us** access to medical information from all appropriate **Providers**. Such information is necessary in order for **us** to make proper benefit determinations. The information will not be used, disclosed, furnished, or made accessible to anyone other than **our** authorized employees and vendors contracted by **us** to carry out **our** obligations under the Policy. **We** and the **Policyholder** agree to establish and maintain administrative, technical and physical safeguards to protect the security, confidentiality and integrity of the medical information.
- H. Entire Contract.** The Policy and the signed **Application** form the entire contract between the **Policyholder** and **us**. No amendment to the Policy shall be effective unless confirmed by an Endorsement issued to form a part of the Policy. No agent or representative of the **Company**, other than an executive officer, may change the Policy or waive any of its provisions. No verbal statement by any executive officer or other employee of the **Company** is binding on **us**.
- I. Clerical Error.** A clerical error made by the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or **us** will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated. Any clerical error in data provided to **us** must be corrected and promptly reported to **us**. **We** will make appropriate adjustments to premiums due and/or benefit determinations. Any refund in premium due to **Policyholder** error is limited to the 12-month period prior to the date of the request for refund.
- J. Conformity with Statutes.** Any provision of the Policy that, on the **Policy Effective Date**, is in conflict with the requirements of state or federal statutes or regulations (in the applicable jurisdiction) is hereby amended to conform to the minimum requirements of such statutes and regulations.
- K. Not Liable for Provider Acts or Omissions.** **We** are not responsible for the quality of care **you** receive from any **Provider**. The Policy does not give anyone any claim, right, or cause of action against **us** based on what a **Provider** of health care or supplies does or does not do.
- L. Right of Recovery.** If **we** make any payment that according to the terms of the Policy should not have been made, including payment made in error, **we** may recover that incorrect payment from any appropriate party, whether or not it was due to **our** error. If the incorrect payment was made directly to **you**, **we** may deduct it when making future payments directly to **you**.

## GENERAL PROVISIONS

(Continued)

**M. Subrogation and Right of Reimbursement.** Another party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to **Covered Transplant Services**. Such party may include, but is not limited to, any of the following: (a) the party or parties who caused the need for the **Covered Transplant Procedure**; (b) the insurer or other indemnifier of the party or parties who caused the **Covered Transplant Procedure**; (c) a guarantor of the party or parties who caused the **Covered Transplant Procedure**; (d) a worker's compensation insurer; (e) any other person, entity, policy or plan that is liable or legally responsible in relation to the **Covered Transplant Procedure**. When this happens, **we** may, at **our** option, (a) subrogate, that is, take over the **Participant's** right to receive payments from such party (the **Participant** or his or her legal representative must transfer to **us** any rights he or she may have to take legal action arising from the **Covered Transplant Procedure** to recover any sums paid under the Policy on behalf of the **Participant**), or (b) recover from the **Participant** or his or her legal representative any benefits paid under the Policy from any payment the **Participant** is entitled to receive from the other party. The **Participant** or his or her legal representative must cooperate fully with **us** in asserting its subrogation and recovery rights. The **Participant** or his or her legal representative will, within 5 days of receiving **our** request, provide all information and sign and return all documents necessary to exercise **our** rights under this provision.

**We** will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration that the **Participant** receives or is entitled to receive from any of the sources listed above. This lien will not exceed the greater of (a) the amount recovered from any other party, or (b) the amount of benefits paid by the Policy for **Covered Charges** plus the amount of all future benefits which may become payable under the Policy which result from the **Covered Transplant Services**. The **Company** will have the right to offset or recover such benefits from the amount received from any other party.

If the **Participant** or his or her legal representative makes any recovery from any other party and fails to reimburse **us** for any **Covered Charges**, then the **Participant** or his or her legal representative will be personally liable to **us** for the **Covered Charges** paid under the Policy.

Our first lien rights will not be reduced due to the **Participant's** own negligence; or due to the **Participant** not being made whole; or due to attorney's fees and costs. **We** are secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. **We** have the right to recover interest at the rate of 1/2% per month commencing on the date the **Participant** or his or her legal representative recovers any funds from any other party. **We** are not subject to any state law doctrines, including, but not limited to, the common fund doctrine, which would purport to require **us** to reduce **our** recovery by any portion of a **Participant's** attorney's fees and costs.

This provision also applies to any funds recovered from any other party by or on behalf of any dependent, the estate of any **Participant**; or on behalf of any incapacitated person.

## DEFINITIONS

- A. Additional Medical Coverage** – means any other insurance that provides **you** with medical benefits covered under the Policy.
- B. Application** – means the **Policyholder's** completed Organ & Tissue Transplant Application.
- C. Company** – means AIG Life Insurance Company.
- D. Covered Charges** – means charges incurred during a Transplant Benefit Period that are **Reasonable and Customary**, in **our** judgment, for **Covered Transplant Services**. With respect to **Providers**, a charge will not be considered **Reasonable and Customary** if it is not in conformity with one or a combination of the following:
1. A negotiated rate based on services provided;
  2. A fixed rate per day; or
  3. The **Reasonable and Customary** allowance for similar **Providers** who perform similar **Covered Transplant Services**.
- E. Covered Transplant Procedure** – means a **Medically Necessary** adult or pediatric human organ and tissue transplants listed as a Covered Transplant in the Schedule of Benefits.
- F. Covered Transplant Services** – means the services shown as Covered Transplant Services in the Benefit Provisions.
- G. Custodial Care** – means care and services that assist in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, and using the toilet; feeding or preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.
- H. Date of Service** – means the date when the service was actually provided or the date on which the purchase was made.
- I. Diagnostic Services** – means the following procedures that are directly related to a **Covered Transplant Procedure** and ordered by a **Provider Individual** because of specific symptoms in order to determine a definite condition or disease: (i) radiology, ultrasound, and nuclear medicine; (ii) laboratory and pathology; and (iii) EKGs, EEGs, and other electronic diagnostic medical procedures.
- J. [Experimental and/or Investigational Treatment** – means any drug, device, procedure, facility, equipment, treatment plan, protocol, supply or service directly related to a **Covered Transplant Procedure** (i) that is deemed to be experimental or investigational in nature by an appropriate technological assessment body established by any state or federal government, or (ii) where **we**, in **our** sole discretion, determine that, at the time it is used, one or more of the following conditions is present:
1. Its use requires approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to the Federal Drug Administration (FDA).
  2. Its use is not yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or is subject to either:
    - a) A written investigational or research protocol or treatment plan; or
    - b) A written informed consent or protocol used by the **Transplant Facility** in which reference is made to the drug, device, procedure, protocol, or treatment plan as being experimental, investigative, educational, for a research study, a pilot study, or posing an uncertain outcome, or having an unusual risk; or
    - c) A written protocol, protocols or informed consent used by any other facility studying substantially the same drug, device, procedure or treatment which states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or
    - d) An ongoing review by an Institutional Review Board.

## DEFINITIONS

(Continued)

For individuals participating or eligible to participate in clinical trials, the following will be considered Experimental and/or Investigational:

1. Clinical trials that are a single institution or investigator study. Clinical trials performed at a National Cancer Institute (NCI) designated Comprehensive Cancer Center are exempt from this requirement.
2. With regard to adult bone marrow/stem cell transplants:
  - a. All Phase I or II clinical trials; and
  - b. All Phase III clinical trials that are not sponsored by the NCI or similar national oncology cooperative body.
3. With regard to pediatric bone marrow/stem cell transplants:
  - a. All Phase I-IV clinical trials that are not sponsored by the Children's Oncology Group.
4. All "off protocol" treatment wherein **you** are not actually enrolled in a clinical trial.

Drugs, devices, procedures, facilities, equipment, treatment plans, supplies, and services that fall into the categories listed above **are not** considered Experimental and/or Investigational if their use is required by state law or recognized as acceptable medical practice throughout the United States to treat **your** illness as a result of:

1. The positive endorsement, recommendation, or publication of standards of care by national medical bodies or panels, including but not limited to, National Comprehensive Cancer Network (NCCN), NCI, or the National Institutes of Health; or
2. Multiple published peer review articles, in recognized professional medical journal(s), concerning such drug, device, procedure or treatment plan and reflecting its reproducibility by non-affiliated sources which **we** determine to be authoritative; or
3. Trial results (that adequately demonstrate safety and efficacy), which indicate the drug, device, procedure, protocol, or treatment plan is at least as clinically effective and cost effective as current standard therapy; or
4. Specific state mandated coverage requirements.]

**K. High Dose Chemotherapy** – means the use of a chemotherapeutic agent or agents to treat cancer or cancer-like illness (with or without irradiation) in doses which exceed the FDA approved or commonly recognized dosage range for the drug or drugs employed. In order to be considered as an eligible expense, High Dose Chemotherapy must:

1. Be part of a protocol or treatment plan that includes the reinfusion of autologous bone marrow or stem cells, or infusion of allogeneic bone marrow or stem cells, immediately after the High Dose Chemotherapy regimen is completed; and
2. Be expected to result in effects upon the bone marrow which would likely be lethal if left untreated.

All drugs and/or radiopharmaceuticals are subject to the **Experimental and/or Investigational Treatment** definition in the Policy.

**L. Immediate Family** – means **your** [spouse, parent, child, sibling, grandparent, or grandchild.]

**M. Medical Plan** – means a plan of major medical benefits maintained by the **Policyholder**. It includes, but is not limited to coverage provided under: group health insurance; health maintenance organizations; self-insured plans; preferred provider organizations; prepayment coverage; any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee plan, a union welfare plan, an employee organization plan, or an employee benefit organization; any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization; any government program except **Medicare** or Medicaid; the medical payments and/or no-fault provisions of automobile insurance; and any other group type coverage as permitted by law.

**Medical Plan** does not include benefits provided under [a limited health care benefit plan (such as a critical illness, specified disease, or "mini-med"), nor benefits provided under a: dental; vision; outpatient prescription drug; and/or short-term disability plan.]

## DEFINITIONS

(Continued)

- N. Medically Necessary or Medical Necessity** – means those drugs, devices, procedures, treatments, services or supplies, provided by a **Provider**, which are required for treatment of illness, injury, diseased condition, or impairment, and are:
1. consistent with **your** diagnosis or symptoms and **you** are an appropriate candidate for the proposed treatment;
  2. appropriate treatment, according to generally accepted standards of medical practice;
  3. not provided only as a convenience to **you** or the **Provider**.
  4. not an **Experimental and/or Investigational Treatment**; and
  5. not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment. Any service or supply provided at a **Provider Facility** will not be considered Medically Necessary if **your** symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The fact that a **Provider Individual** may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary or make the charge a **Covered Charge**.

- O. Medicare** – means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
- P. Member** – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a member, or as a subscriber. Member does not include a dependant. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.
- Q. Participant** – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a **Member**, a subscriber, or a dependent who is also covered under the Policy. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.
- R. Premium Due Date** – means the date the **Policyholder's** premium is due. The Premium Due Date is shown in the Policy Face Page.
- S. Policy Effective Date** – means the Policy Effective Date as shown on the Policy Face Page which is the date that coverage begins under the Policy.
- T. Policy Year** – means the period of time shown in the Schedule of Benefits during which the Policy is in effect. The Policy Year is subject to early termination as set forth in the Termination Provisions.
- U. Pre-existing Condition** – means any condition for which **you** have, within the 24 months prior to the Effective Date of the Policy:
1. Been advised by an attending **Physician** that a transplant may be needed (regardless of the timeframe to transplant and regardless of the **Participant's** decision to move forward or not move forward with a **Transplant Consultation** or **Transplant Evaluation**;
  2. Had a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of the outcome);
  3. Been scheduled to have a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of when the **Transplant Consultation** and/or **Transplant Evaluation** was to be done and regardless of the outcome); and/or
  4. Received, or has been listed to receive, an organ or tissue transplant.

[In addition, if **you** have, within the 24 months prior to the **Policy Effective Date** of the Policy, received dialysis treatments or been diagnosed with Chronic Kidney Disease or End Stage Renal Disease (ESRD), **you** will be deemed to have a Pre-existing Condition.]

## DEFINITIONS

(Continued)

If **you** are added subsequent to the **Policy Effective Date** as a result of the acquisition of a new group, affiliate, division, and/or subsidiary, Pre-existing Condition will mean those conditions listed above that occurred within the 24 months prior to **your** effective date of coverage under the Policy.

**V. Provider** – means any of the facilities and individuals listed below:

1. **Provider Facilities** – means any of the following facilities:

- a. **Clinical Laboratory** – means a laboratory that performs clinical procedures and is not affiliated or associated with a Hospital, **Physician**, or other **Provider**.
- b. **Hospital** – means a facility which is a short-term general hospital and which: (1) is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **Physicians**, for compensation from its patients; (2) has organized departments of medicine and major surgery; and (3) provides 24-hour nursing service by or under the supervision of registered nurses. Surgical facilities may be either on premises or in facilities available to the hospital on a prearranged basis.
- c. **Pharmacy** – means a facility licensed as a Pharmacy by the state in which it operates.
- d. **Transplant Facility** – means the following facilities:
  - i. **Nonparticipating Transplant Facility** – Any **Hospital** that has not contracted with **us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Hospital** may be a Nonparticipating Transplant Facility with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.
  - ii. **Participating Transplant Facility** – Any **Hospital** contracting with **us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Hospital** may be a Participating Transplant Facility with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.

2. **Provider Individuals** – means any of the following individuals:

- a. **Occupational Therapist** – means a person who is licensed as an Occupational Therapist by the state in which he or she practices. If that state does not issue such licenses, an Occupational Therapist is a person certified as an Occupational Therapist by an appropriate professional body.
- b. **Physical Therapist** – means a person who is licensed as a Physical Therapist by the state in which he or she practices. If that state does not issue such licenses, a Physical Therapist is a person certified as a Physical Therapist by an appropriate professional body.
- c. **Physician** – means a person performing services within the scope of his or her license, who is a duly licensed: (1) doctor of medicine (MD); (2) doctor of osteopathy (DO); (3) dentist; (4) optometrist; or (5) psychologist.
- d. **Respiratory/Inhalation Therapist** – means a person who is licensed as a Respiratory/Inhalation Therapist by the state in which he or she practices. If that state does not issue such licenses, a Respiratory/Inhalation Therapist is a person certified as a Respiratory/Inhalation Therapist by an appropriate professional body.
- e. **Speech Pathologist** and **Speech Therapist** – means a person licensed as a Speech Pathologist or Speech Therapist by the state in which he or she practices. If that state does not issue such licenses, a Speech Pathologist or Speech Therapist is a person certified as such by an appropriate professional body.

**W. Reasonable and Customary** – means with respect to the word customary, the amount charged by a majority of **Providers** in the same geographic region for similar services or supplies and/or is relative to the value and worth of similar services; and with respect to the word reasonable, a charge that meets the above criteria and, that in **our** judgment, is not an excessive amount for similar services or supplies; or a charge that merits special consideration due to complexity of treatment in the opinion of a peer review committee or consultant. Due to the lack of insurance, if a **Provider** accepts as full payment an amount less than **Reasonable and Customary**, the lesser amount will be determined to be the maximum **Reasonable and Customary** amount. Benefits will be based on the lesser of the actual billed charge or the **Reasonable and Customary** charge.

## DEFINITIONS

(Continued)

- X. **Skilled Care** – means the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury. Skilled care must be performed by or under the supervision of **Provider Individuals**.
- Y. **Spouse** – means a person recognized as the **Member's** spouse under the **Medical Plan**.
- Z. **We, Us, Our** – means AIG Life Insurance Company.
- AA. **You, Your** – means the **Participant**, as defined in the Policy.



**AIG LIFE INSURANCE COMPANY**  
ONE ALICO PLAZA  
WILMINGTON, DELAWARE 19801

[ **Administrative Office:**  
Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, Indiana 46268  
(888) 449-2377]

### Organ & Tissue Transplant Certificate

**POLICYHOLDER:** [Policyholder Name]  
**POLICYHOLDER ADDRESS:** [Policyholder Address]  
**POLICY NUMBER:** [Policy Number]

**AIG Life Insurance Company** issues this Certificate as evidence of coverage under the Policy issued to the **Policyholder**, subject to all Policy provisions. The Policy may be amended, changed, cancelled or discontinued without the consent of any **Participant**.

**THIS IS LIMITED BENEFIT COVERAGE THAT IS NOT INTENDED  
AS MAJOR MEDICAL COVERAGE.**

**PLEASE READ THE CERTIFICATE CAREFULLY FOR A FULL DESCRIPTION  
OF THE BENEFITS, EXCLUSIONS, AND LIMITATIONS.**

**AIG Life Insurance Company**

Secretary

President

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## SCHEDULE OF BENEFITS

**POLICY YEAR:** [January 1, 2008 through December 31, 2008]

### COVERED TRANSPLANTS:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart                             | <input type="checkbox"/> Heart/ Lung              | <input type="checkbox"/> Autologous Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo              |
| <input type="checkbox"/> Lung/Double Lung                  | <input type="checkbox"/> Kidney/ Pancreas         | <input type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (related)    |
| <input type="checkbox"/> Kidney (living or deceased donor) | <input type="checkbox"/> Kidney/Liver             | <input type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (unrelated)] |
| <input type="checkbox"/> Pancreas                          | <input type="checkbox"/> Liver/Intestine          |   |
| <input type="checkbox"/> Liver (living or deceased donor)  | <input type="checkbox"/> Pancreas/Intestine       |   |
| <input type="checkbox"/> Intestine                         | <input type="checkbox"/> Liver/Pancreas/Intestine |   |
| <input type="checkbox"/> Ventricular Assist Device         | <input type="checkbox"/> Other (specify):         |   |

### TRANSPLANT BENEFIT PERIOD:

The Transplant Benefit Period begins [on the date of **Transplant Evaluation** for][ten (10) days before] a **Covered Transplant Procedure**.

The Transplant Benefit Period ends on the earliest of the following dates:

1. [The end of the 365th day following the **Covered Transplant Procedure**;
2. The date the **Participant's** Lifetime Limit has been reached under the Policy or under the **Medical Plan**;
3. The date the Policy terminates, but only if:
  - a. The **Policyholder** cancels the Policy prior to the last day of the current **Policy Year**; or
  - b. The **Participant's** Transplant Benefit Period has begun, but such **Participant** has not received a **Covered Transplant Procedure** as of the date of termination of the Policy; or
4. The date the **Participant's** COBRA benefits terminate, if applicable.
5. The date established by the Non-Performance of Covered Transplant Procedures provision.]

[If there is no **Transplant Evaluation**, the Transplant Benefit Period begins on the date of a **Covered Transplant Procedure**.]

[If a **Transplant Evaluation** occurs while the Policy is in force and results in a **Covered Transplant Procedure** that takes place during this **Policy Year**, the expenses for the **Transplant Evaluation** will be eligible for reimbursement even if it occurred prior to the Transplant Benefit Period. This benefit does not apply to individuals with a **Pre-existing Condition** unless the **Transplant Evaluation** occurs after the **Pre-existing Condition Waiting Period** has expired.]

For a Bone Marrow/Peripheral Stem Cell Tissue Transplant, the date the tissue is re-infused is deemed to be the date of the **Covered Transplant Procedure**.

All benefits provided during a Transplant Benefit Period that extend beyond the **Policy Year** will be based on the Policy terms in effect at the start of the Transplant Benefit Period.

A Transplant Benefit Period cannot begin prior to the date the **Participant** first becomes covered under the Policy.

**LIFETIME LIMIT:** [\$ for each **Participant**]

The following charges are included within and reduce each **Participant's** Lifetime Limit:

1. All benefits paid on behalf of the **Participant** (including covered donor charges) under the Policy and any preceding or succeeding Organ & Tissue Transplant Policy between **us** and the **Policyholder**; and
2. All benefits paid by **us** under the "Travel, Lodging, and Meals Benefit" provision.

## SCHEDULE OF BENEFITS

(Continued)

**[DEDUCTIBLE AMOUNT (APPLICABLE TO HIGH DEDUCTIBLE HEALTH PLANS ONLY):**

Although the Policy does not impose a **Deductible Amount**, if a **Participant** selects a high deductible health plan sponsored by the **Policyholder**, then the **Deductible Amount** set forth in such **Policyholder's** high deductible health plan must be paid by the **Participant** before benefits are payable under the Policy. This requirement is necessary in order for the **Participant** to remain eligible for the tax benefits afforded by the health savings account associated with the **Policyholder's** high deductible health plan.]

**REIMBURSEMENT AMOUNTS:**

- A. PARTICIPATING PROVIDER: ..... [100%] of **Covered Charges** for **Covered Transplant Services** provided through a **Participating Transplant Facility**. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.)
- B. NONPARTICIPATING PROVIDER: ..... [80%] of **Covered Charges** for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** with respect to the type of **Covered Transplant Procedure** performed. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.) Benefits for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** will not exceed the Maximum Amounts stated below:

COVERED TRANSPLANT PROCEDURE	MAXIMUM BENEFIT FOR ALL COVERED TRANSPLANT SERVICES PROVIDED BY A NONPARTICIPATING TRANSPLANT FACILITY
Heart	\$437,000
Lung (Single)	\$261,000
Lung (Double)	\$363,000
Kidney (living or deceased donor)	\$156,000
Pancreas	\$163,000
Liver (living or deceased donor)	\$196,000
Intestine	\$626,000
Heart/Lung	\$495,000
Kidney/Pancreas	\$200,000
Kidney/Liver	\$419,000
Liver/Intestine	\$700,000
Pancreas/Intestine	\$668,000
Liver/Pancreas/Intestine	\$716,000
Autologous Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b>	\$175,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - related	\$297,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - unrelated	\$380,000

- C. SECONDARY PAYOR: ..... When benefits under the Policy are considered secondary, as determined by the Coordination of Benefits provisions, benefit payments will be based on the lesser of: a) **Covered Charges**; or b) the negotiated amount established between the primary payor and the **Provider**.

**SCHEDULE OF BENEFITS**  
(Continued)

**ENDORSEMENTS:** Yes  No

If yes, please specify:  
[ ]

**POLICYHOLDER'S MEDICAL PLAN ADMINISTRATOR:**

[Administrator Name]

## BENEFIT PROVISIONS

Boldfaced terms have special meaning. Please refer to the Definitions section or Benefit Provision section for a complete description of such terms.

### INSURING AGREEMENT:

Subject to all terms, conditions, limitations, and exclusions, **we** will pay **Covered Charges** incurred by **you** for **Covered Transplant Services** performed in a **Transplant Facility** that are directly related to a **Covered Transplant Procedure**.

### NOTIFICATION REQUIREMENTS:

**We** must be notified as soon as possible by **you**, the **Policyholder**, or **your Physician** that a **Covered Transplant Procedure** is being considered. Notification must occur before the referral is made and services are rendered for any **Transplant Consultation** and/or **Transplant Evaluation**. Failure to provide this notification may result in a decrease or denial of benefits. Notifications must be submitted to:

[Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, IN 46268  
Attention: Transplant Nurse Advisor  
(888) 449-2377]

### COVERED TRANSPLANT SERVICES:

*The following services require our prior approval and are eligible for coverage if they are provided to **you**, performed within a **Transplant Facility**, and directly related to a **Covered Transplant Procedure**. [Complications of donation experienced by the living donor are not covered.]*

1. Transplant Consultation. **Transplant Consultation** means a consultation with a transplant **Physician** to determine if **your** condition is such that **you** qualify for further evaluation according to the **Transplant Facility's** established **Transplant Evaluation** protocol.
2. Transplant Evaluation. **Transplant Evaluation** means tests, labs, x-rays, scans, procedures (including dental evaluations, x-rays, and examinations), and consultations for **you** (and any applicable living donor) that are in compliance with the **Transplant Facility's** established transplant program protocol.
3. Solid Organ Procurement. **Solid Organ Procurement** means compatibility testing and procurement expenses for living and deceased donors; donor's surgical procedure to remove the organ or tissue; and inpatient and outpatient services for living donor.
4. Bone Marrow or Stem Cell Procurement. **Bone Marrow or Stem Cell Procurement** means expenses for:
  - a. Procurement from **you** for autologous bone marrow/stem cell transplant;
  - b. Procurement from a living donor for allogeneic bone marrow/stem cell transplant, including compatibility testing of relatives;
  - c. Testing/typing of potential unrelated donors;
  - d. Tests related to the procurement of bone marrow/stem cells, including human leukocyte antigen typing;
  - e. Collection and storage [(for up to 6 months)] of bone marrow/stem cells (autologous or allogeneic) for future use, as long as a bone marrow/stem cell transplant has been scheduled to occur [within the same 6 months]; and
  - f. Bone marrow/stem cell registry search expenses such as from the National Marrow Donor program (NMDP).

## BENEFIT PROVISIONS

(Continued)

5. Covered Transplant Procedure. **Covered Transplant Procedure** means a **Medically Necessary** adult or pediatric human organ and tissue transplants listed as a Covered Transplant in the Schedule of Benefits that is not **Experimental and/or Investigational Treatment**.
6. Transplant Hospitalization. **Transplant Hospitalization** means the hospitalization for the **Covered Transplant Procedure** including inpatient **Hospital** services, **Physician** services and ancillary services. For solid organ transplantation, coverage begins twenty-four (24) hours prior to the transplant procedure. Hospitalization of living solid organ donors is covered. Such services must be provided according to the **Transplant Facility's** established transplant program protocol. For bone marrow/stem cell transplants, coverage begins with the workup immediately prior to beginning **High Dose Chemotherapy** to include subsequent infusion of autologous or allogeneic bone marrow/stem cells. Bone marrow/stem cell transplantation may be performed as an inpatient or outpatient.
7. Follow-Up. **Follow-Up** means **Hospital** services (inpatient and outpatient), **Physician** services, labs, x-rays, procedures, and other diagnostic tests rendered by or at the **Transplant Facility** to determine the status of the transplanted organ or tissue after discharge from a **Transplant Hospitalization**. Such services must be provided according to the **Transplant Facility's** established transplant program follow-up guidelines or protocol.
8. Complications after Transplant for Recipient. **Complications after Transplant for Recipient** means services to treat complications experienced by the transplant recipient after transplant, such as:
  - a. Rejection of a solid organ;
  - b. Surgical complications; and
  - c. Graft versus host disease of transplanted bone marrow or stem cells.

Services may be rendered during the **Transplant Hospitalization** or after discharge from **Transplant Hospitalization**.

9. Acute Rehabilitation or Non-Acute Rehabilitation after Discharge from Transplant Hospitalization. **We** will pay for up to [a total of 15 days/visits] for home rehabilitation and physical therapy (inpatient or outpatient).
10. Home Health Care after Discharge from Transplant Hospitalization. **We** will pay for up to [a total 15 home health care visits] by a registered nurse to administer intravenous drugs, train the patient (and/or family) for self-administration of drugs, wound care, or similar procedures.
11. Durable Medical Equipment after Discharge from Transplant Hospitalization. **We** will pay for rental of durable medical equipment after discharge from the **Transplant Hospitalization**. This benefit is limited to the lesser of [a total 15 days of rental] or the purchase price of such equipment.
12. Prescription Drugs. **We** will pay for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals that are **Medically Necessary** after discharge from the **Transplant Hospitalization** for up to 365 days after the date of transplantation. Drugs used to treat conditions not directly related to the **Covered Transplant Procedure** are not covered.
13. Ventricular Assist Device (VAD). **We** will pay for expenses for the VAD and any related **Provider** expenses from the date of insertion up to [a total 5 days] following the date of insertion, provided that:
  - a. The VAD is approved by the Food and Drug Administration (FDA);
  - b. **You** are simultaneously listed as an acceptable transplant candidate and approved for transplant by **us**; and
  - c. **You** receive the VAD at a **Transplant Facility**.

[VAD related benefits are limited to a maximum of \$100,000 for each Transplant Benefit Period.]  
**Complications as a result of the insertion of a VAD are not covered under the Policy.**]

## BENEFIT PROVISIONS

(Continued)

### [PRE-EXISTING CONDITION WAITING PERIOD:

If **you** have a **Pre-existing Condition** on the **Policy Effective Date** (referred to in the Renewal Endorsement as the Original Policy Effective Date), **you** are required to fulfill a [12 month] waiting period before benefits are provided under the Policy. The waiting period does not apply if **you** become eligible for coverage after the **Policy Effective Date** (or Original Policy Effective Date, if applicable), unless **you** are added to the **Medical Plan** as a result of the **Policyholder** acquiring a new group, affiliate, division, and/or subsidiary.

If **you** receive a transplant during a **Pre-Existing Condition Waiting Period**, that transplant and all related charges are excluded from coverage under the Policy and subsequent renewals.]

### MULTIPLE TRANSPLANTS:

If **you** require more than one **Covered Transplant Procedure**, benefits are determined as follows:

1. **Covered Transplant Procedures** that are due to related causes are subject to the same Transplant Benefit Period established by the first **Covered Transplant Procedure**. However, if the related **Covered Transplant Procedures** are separate by at least 90 days, a separate Transplant Benefit Period will be established for each procedure.
2. **Covered Transplant Procedures** that are due to unrelated causes will each have their own Transplant Benefit Period.
3. In no event will benefits provided under the Policy exceed the **Participant's** Lifetime Limit shown in the Schedule of Benefits, regardless of the number of **Covered Transplant Procedures** performed.

### NON-PERFORMANCE OF COVERED TRANSPLANT PROCEDURES:

If **you** have established a Transplant Benefit Period, but the **Covered Transplant Procedure** is not performed as scheduled due to **your** medical condition or death, benefits will be paid for **Covered Transplant Services** up to and until the earlier of:

1. **Your** death; or
2. The date **your Physician** decides not to perform the **Covered Transplant Procedure**.

### [TRANSPLANT NURSE ADVISOR:

**We** will assign a transplant nurse advisor to facilitate transplant coverage determination, access to transplant facilities, and ongoing patient support related to transplantation during the Transplant Benefit Period. These services are included without any additional charge.]

## BENEFIT PROVISIONS

(Continued)

### TRAVEL, LODGING, AND MEALS BENEFIT:

Your Benefit. We will reimburse reasonable and necessary travel expenses, as determined by us, incurred by you [and one companion (two companions if you are a minor)] during a Transplant Benefit Period for travel related to a **Covered Transplant Procedure**. Travel expenses include transportation, lodging, and meals and are subject to the limits shown below.

Living Donor Benefit. We will reimburse reasonable and necessary travel expenses, as determined by us, incurred by [a living donor and one companion] during a Transplant Benefit Period for travel related to a **Covered Transplant Procedure**. Travel expenses include transportation, lodging, and meals and are subject to limits shown below.

Transportation includes: [automobile; boat; airplane; train; ground ambulance; and air ambulance (jet or helicopter). Ambulance transportation (ground and air) requires our prior approval. Automobile mileage reimbursement is based on current federal guidelines for mileage reimbursement.]

Reimbursement for travel expenses will only be provided once we have received itemized receipts and a completed Travel Expense Form (as supplied by us).

DESCRIPTION	BENEFIT LIMIT
Lodging and meals for you and companion(s)	Up to \$200 per day per <b>Covered Transplant Procedure</b>
Lodging and meals for living donor and companion	Up to \$200 per day per <b>Covered Transplant Procedure</b>
<b>The Maximum Travel Benefit</b> for all eligible travel expenses (transportation, lodging, and meals) incurred by you, a living donor, and all eligible companions are limited to a combined Maximum Travel Benefit of \$10,000 per <b>Covered Transplant Procedure</b> . These travel, lodging, and meal benefits are included within and reduce your Lifetime Limit.	

### [DISABILITY, LEAVE OF ABSENCE, OR LAYOFF:

If you are not actively at work as a result of a disability, leave of absence, or layoff, eligibility for benefits provided under the Policy will only be extended to you through the earliest of:

1. The continuance period established by the underlying **Medical Plan** for such absences; or
2. The 12 month period immediately following the date your disability, leave of absence or layoff first began.

This provision does not apply to Retirees covered under the **Medical Plan** and the Policy, or individuals continuing benefits under COBRA or any other federally mandated program.]

## CLAIMS PROVISIONS

### A. Filing Claims.

The Policy provides coverage for claims that are incurred within the **Policy Year** and submitted for payment within [twelve (12) months following the **Date of Service**]. Unless otherwise stated in the Policy, claims will not be considered for payments if received after [twelve (12) months following the **Date of Service**].

Claims must be filed in a manner approved by **us**, and must include the following information:

1. **Your** name and address;
2. **Your** ID Number;
3. **Provider's** name, address, and Tax ID Number;
4. Itemized bill that includes the CPT codes or description of each charge; and
5. Diagnosis.

### B. Claim Payment.

**We** will pay benefits for all **Covered Charges** in accordance with the terms of the Policy within 60 days after receiving all necessary information. Benefits are paid to **you** or to **your** assignee or designee. **We** may pay benefits directly to the **Provider** or to any relative **we** deem appropriate if a benefit is payable and **you** are: 1) a minor; 2) legally incapable of giving valid receipt and discharge of payment; or 3) deceased.

## APPEAL AND GRIEVANCE PROCEDURES

Appeals must be submitted for consideration within 180 days of the date of **our** payment (if the appeal is based upon **our** payment) or within 180 days of the date of our denial of coverage. Grievances regarding **our** services or product may be submitted at any time during the **Policy Year**.

**A. Appeal Process.** An appeal is a formal request for review of **our** determinations regarding transplant related services, including but not limited to **our** payment(s) and/or coverage denials. The following reviews are available to **you** upon filing an appeal:

1. Standard Review. A standard review of an appeal is available on a prospective or retrospective basis and must be requested in writing by **you** or **your** designee. A standard review is available in situations wherein the timeframe for the review does not jeopardize **your** life or health. **We** will conduct the review and provide a written determination within [thirty (30)] business days after receiving all necessary information to complete the review.
2. Expedited Review. An expedited review of an appeal is only available on a prospective basis and must be requested in writing by **you** or **your** designee. An expedited review is only available if the timeframe for the review could seriously jeopardize **your** life or health. **We** will coordinate the review and communicate the determination verbally within [seven (7)] business days after receiving all necessary information to complete the review. **We** will also provide a written determination within [three (3)] business days following **our** verbal communication.

All appeals are reviewed and determined by a Peer Reviewer. Peer Reviewers are **Physicians** who:

1. Are clinical peers;
2. Hold an active, unrestricted license to practice medicine;
3. Are in a similar specialty as typically manages the medical condition, procedure, or treatment as the treating **Physician**; and
4. Are neither the individual nor a subordinate of the individual who made the original coverage determination or denial.

**B. Grievance Process.** A grievance or complaint is an expression of dissatisfaction regarding **our** products or services. **You** or **your** designee may submit a grievance verbally or in writing. Depending on the nature of the grievance and whether or not a response is requested, **we** will respond verbally and/or in writing within thirty (30) business days following receipt of the grievance. Grievances will be considered when measuring the quality and effectiveness of **our** products and services.

## COORDINATION OF BENEFITS

- A. Applicability.** This Section applies when **you** make a claim for reimbursement of **Covered Charges**, and **you** are covered by **Additional Medical Coverage**. If this provision applies, review the Order-of-Benefit-Determination Rules, under the heading of the same name, to determine whether the Policy's coverage is payable before or after **Additional Medical Coverage**. The Policy's coverage will not be reduced when its coverage is payable first, as determined under the Order-of-Benefit-Determination Rules; but may be reduced when another plan's benefits are payable first, as determined under the Order-of-Benefit-Determination Rules as set forth below.
- B. Order-of-Benefit-Determination Rules.** When there is a basis for a claim under the Policy and **Additional Medical Coverage**, the Policy is secondary if: (1) the **Additional Medical Coverage** does not have rules coordinating its benefits with the Policy; or (2) the **Additional Medical Coverage's** rules, the Policy's rules, or both, require the Policy's coverage be determined after those of the **Additional Medical Coverage**, except as may occur under the gender rule exception in Item C.2, below.
- C. Filing Guidelines.** The general guidelines which follow discuss the order in which **you** should file claims when **you** are covered under **Additional Medical Coverage**, using the first of the rules which applies:
1. The **Additional Medical Coverage** that covers **you** as a subscriber is obligated to pay before the Policy covering **you** as a dependent.
  2. When the parents of a dependent child are neither separated nor divorced:
    - a. **You** must file first under the Policy or **Additional Medical Coverage** covering the dependent child of the parent whose birthday falls earlier in the year; then file under the Policy or **Additional Medical Coverage** of the parent whose birthday falls later in the year; but
    - b. If both parents have the same birthday, the **you** must file first under the Policy or **Additional Medical Coverage** which has covered the parent for the longer period of time, and then under the Policy or **Additional Medical Coverage** of the other parent.

**EXCEPTION:** If the **Additional Medical Coverage** does not have the "birthday rule," but instead has a rule based upon the parent's gender, and as a result the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination, the rule of the **Additional Medical Coverage** will determine the order.

3. When the parents of a dependent are separated or divorced:
  - a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with custody; then
  - b. **You** must file under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the **spouse** of the parent with custody; then
  - c. **You** must file under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the parent without custody.

**EXCEPTION:** If there is a court decree which establishes financial responsibility for medical, dental, or other health care expenses regarding the dependent child of parents who have separated or divorced:

- a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with such financial responsibility; then
- b. File under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the other parent.

If the specific terms of the court decree state that the parents have joint custody without stating that one parent is responsible for the child's medical, dental, or other health care expenses, file as described in Item C.2, above.

## COORDINATION OF BENEFITS

(Continued)

4. **You** must file first under the Policy or **Additional Medical Coverage** which covers **you** as a subscriber who is neither laid-off nor retired, or as a dependent of a subscriber; then file under the Policy or **Additional Medical Coverage** which covers **you** as a laid-off or retired subscriber or as a dependent of a laid-off or retired subscriber. Ignore this paragraph if the **Additional Medical Coverage** does not contain this paragraph and, as a result, the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination.
  5. When the order of payment cannot be determined in accordance with these general guidelines, file first under the Policy or **Additional Medical Coverage** which has covered **you** for the longer period of time, then under the Policy or **Additional Medical Coverage** which has covered **you** for the shorter period of time.
- D. Effect on the Policy's Coverage.** When **you** are covered under two or more policies, which together pay more than the **Covered Charges** for **Covered Transplant Services**, **we** will pay the Policy's benefits according to the Order-of-Benefit-Determination Rules. The Policy's benefit payments will not be affected when this Policy is primary. **However, when the Policy is secondary under the Order-of-Benefit-Determination Rules, benefits payable will be reduced (if necessary) so that combined benefits of all policies covering the Participant do not exceed the lesser of: 1) Covered Charges; or 2) the negotiated amount established between the primary insurer and the Provider.**
- E. Right to Receive and to Release Information.** To coordinate benefits, **we** will release or obtain information regarding a claim from any insurance company, organization, or person. **You** must furnish the **Company** with any information necessary to coordinate benefits.

**Right to Obtain Recovery.** **We** are not liable for any failure to coordinate benefits. If **we** pay full benefits on a claim for which it has only secondary liability, **we** may recover the difference from **you** or from any other appropriate party.

## EXCLUSIONS

We will not pay, in whole or in part, for any of the following:

- A. [Any service or supply not directly related to a **Covered Transplant Procedure**. This includes any service or supply rendered to treat the underlying disease before or after transplant (that is not part of the actual **Covered Transplant Procedure**).
- B. Services and supplies for treatment of complications related to a **Covered Transplant Procedure**, unless such complications are determined by **us** to be the immediate and direct result of a **Covered Transplant Procedure**.
- C. Charges for any transplant related services or supplies incurred prior to the **Policy Effective Date**.
- D. Charges for prescription drugs incurred prior to a **Covered Transplant Procedure**, except for **High Dose Chemotherapy** that is part of a **Covered Transplant Service**.
- E. Charges for prescription drugs incurred after discharge from a transplant hospitalization, except for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals.
- F. Chemotherapy and/or surgery prior to beginning **High Dose Chemotherapy** (including bone marrow/stem cell transplantation).
- G. Services provided for the removal of a transplanted solid organ, unless the removal is provided during a **Covered Transplant Procedure**.
- H. Services provided after: 1) a transplanted solid organ has been removed from the transplant recipient; or 2) disease has returned in a bone marrow or stem cell transplant recipient.
- I. Services for human leukocyte antigen typing of **you** or **your** relatives, compatibility testing, unrelated bone marrow/stem cell searches on registries, and harvest and/or storage of bone marrow/stem cells when bone marrow/stem cell transplant has not been reviewed and approved by **us**.
- J. Services and supplies for immunizations.
- K. Animal organ or artificial organ transplants.
- L. Charges for a stand-by **Physician**, unless otherwise approved by **us**.
- M. Services of a **Provider** who is a member of **your Immediate Family**.
- N. Services, supplies, or **Hospital** care which **we** determine are not **Medically Necessary** for the treatment of illness, injury, diseased condition, or impairment, except as specifically stated as covered.
- O. **Custodial Care**.
- P. Hospice care.
- Q. Charges for any **Experimental and/or Investigational Treatment**, except as specifically stated in the Policy.
- R. Charges paid or payable under Workers' Compensation.
- S. Preventive or routine care (including physicals, premarital examinations, any other routine or periodic examinations), dental services and supplies, education and training, except as specifically stated as covered.
- T. Research studies or screening examinations.
- U. Treatment of any illness or injury sustained as a result of an act of war.
- V. Services or supplies to the extent **you** are not legally obligated to pay for them.
- W. Expenses incurred before the **Policy Year** begins or after it ends, except as stated in the Policy.
- X. Rest cures or sanitarium care.
- Y. Services or supplies furnished by any **Provider** acting beyond the scope of such **Provider's** license.
- Z. Any service or supply that is a **Medicare** Part A or Part B liability.
- AA. Services or supplies received from a dental or medical department maintained by or on behalf of the **Policyholder**.
- BB. Services provided by any governmental agency to the extent that **you** are not charged for them, unless otherwise required by state or federal law.
- CC. Services or supplies not specifically stated as covered.
- DD. Telephone consultations, charges for failure to keep a scheduled visit, or charges for completing a claim form.
- EE. Recreational or diversional therapy.
- FF. Materials used in occupational therapy.
- GG. Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a **Provider** prescribes such items.
- HH. Services and supplies, which are eligible to be repaid under any private or public research fund whether or not such funding was applied for or received.

## EXCLUSIONS

(Continued)

- II. Services and supplies for treatment of complications or diseases incurred by a living donor, including, but not limited to, increase length of hospitalization or the costs to treat any complication or disease.
- JJ. Services and supplies incurred by any COBRA continuee whose COBRA continuation coverage was not offered and/or elected, and premiums were not paid, within the time frames required by COBRA.
- KK. **Prescription Drugs** for the treatment or prevention of a rejected organ or tissue following the end of the Transplant Benefit Period.
- LL. Services and supplies of any **Provider** located outside the United States of America, except for organ or tissue procurement services, unless otherwise prohibited by United States federal law.
- MM. Biological and/or mechanical devices used as a bridge to transplant unless specifically included in the Schedule of Benefits.
- NN. Charges for any transplant-related services or supplies incurred during the current **Policy Year** when the transplant procedure occurred prior to the **Policy Effective Date**. However, we will make an exception to this Exclusion for **Covered Charges** related to a **Covered Transplant Procedure you** received under a previous Organ & Tissue Transplant Policy issued by **us** to the **Policyholder**, as long as:
  1. There has been no break in coverage between the Transplant Policies issued by **us**; and
  2. The **Covered Charges** are for services or supplies incurred within the Transplant Benefit Period for the **Covered Transplant Procedure**.]

[**We** may, in certain circumstances for purposes of overall cost savings or efficiency and in **our** sole discretion, provide benefits for services that would otherwise be excluded from coverage. If **we** provide any benefit not covered under the Policy, this fact shall not be used against **us** in any similar case and **we** shall not be required to extend this benefit to any other **Participant**.]

## RIGHT TO AMEND RATES AND POLICY TERMS

**We** may revise the premium rates or any other terms of the Policy on the occurrence of any of the following:

- A. [The date the **Policyholder** amends the **Medical Plan**.
- B. The date the **Policyholder** requests a benefit change in the Policy.
- C. The date the **Policyholder** adds or deletes a subsidiary or affiliate.
- D. The date an increase or decrease in the number of **Participants** exceeds [25%] in any [one] month or [XX,25%] over any period of [XXX,three] consecutive months. The number of **Participants** will be derived from the **Policyholder's** monthly premium statements or any other reports obtained from the **Policyholder** or the **Medical Plan's Administrator**.
- E. The date **we** are notified by the state in which the **Policyholder** is located of any state imposed tax or assessment for which **we** are obligated to pay.
- F. The date of any change in the **Policyholder's** business that materially affects **our** risk.
- G. The date it is discovered that there has been a material misrepresentation or nondisclosure of information that **we** could reasonably have expected to have been disclosed to **us** by the **Policyholder** or the **Policyholder's Medical Plan Administrator**.]

## TERMINATION PROVISIONS

**We** may, at any time, cancel benefits under the Policy for the reasons specified in the Policy.

In addition, **your** coverage shall automatically terminate on the earliest of the following dates:

- A. The date the Policy is terminated, as specified in the Policy. (The **Policyholder** is responsible for notifying **you** of the termination of the Policy.)
- B. The date **you** cease to be a covered **Participant**.
- C. The date **we** receive written notice from **you** or the **Policyholder** instructing **us** to terminate **your** coverage. (Coverage will terminate on the date specified in the notice, if provided.)

## GENERAL PROVISIONS

- A. Defined Terms.** The Policy contains certain defined terms that have been capitalized. Please refer to the Definitions section of the Policy for a complete description of such terms.
- B. Incontestability.** **We** may declare the Policy null or cancel it, if the **Application** contains a material misrepresentation. However, this provision will not apply once the Policy has been in effective for two years.
- C. Representations Not Warranties.** A copy of the **Application** is attached to the Policy. All statements made by the **Policyholder** or by **Participants** applying for coverage will be considered representations and not warranties. No statement appearing on the **Application** will be used to contest the validity of the **Policyholder's** right to the benefits of the Policy, unless the **Policyholder** has been furnished a copy of the **Application**.
- D. Evidence of Insurability.** The **Policyholder** is required to provide **us** with verification that **you** are covered by the **Policyholder's Medical Plan**.
- E. Notice.** When **we** provide written notice to the **Policyholder's** last known address regarding the administration of the Policy, it is deemed to be notice to all affected parties. The **Policyholder** is responsible for giving **you** notice, if applicable.
- F. Legal Action.** No legal action may be brought under the Policy within 60 days after **we** receive a claim. No action may be brought after 3 years from the date the claim is required to be furnished to **us**.
- G. Information Release and Data Confidentiality.** The **Policyholder** and all **Participants** that need **Covered Transplant Services** must allow **us** access to medical information from all appropriate **Providers**. Such information is necessary in order for **us** to make proper benefit determinations. The information will not be used, disclosed, furnished, or made accessible to anyone other than **our** authorized employees and vendors contracted by **us** to carry out **our** obligations under the Policy. **We** and the **Policyholder** agree to establish and maintain administrative, technical and physical safeguards to protect the security, confidentiality and integrity of the medical information.
- H. Entire Contract.** The Policy and the signed **Application** form the entire contract between the **Policyholder** and **us**. No amendment to the Policy shall be effective unless confirmed by an Endorsement issued to form a part of the Policy. No agent or representative of the **Company**, other than an executive officer, may change the Policy or waive any of its provisions. No verbal statement by any executive officer or other employee of the **Company** is binding on **us**.
- I. Clerical Error.** A clerical error made by the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or **us** will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated. Any clerical error in data provided to **us** must be corrected and promptly reported to **us**. **We** will make appropriate adjustments to premiums due and/or benefit determinations. Any refund in premium due to **Policyholder** error is limited to the 12-month period prior to the date of the request for refund.
- J. Conformity with Statutes.** Any provision of the Policy that, on the **Policy Effective Date**, is in conflict with the requirements of state or federal statutes or regulations (in the applicable jurisdiction) is hereby amended to conform to the minimum requirements of such statutes and regulations.
- K. Not Liable for Provider Acts or Omissions.** **We** are not responsible for the quality of care **you** receive from any **Provider**. The Policy does not give anyone any claim, right, or cause of action against **us** based on what a **Provider** of health care or supplies does or does not do.
- L. Right of Recovery.** If **we** make any payment that according to the terms of the Policy should not have been made, including payment made in error, **we** may recover that incorrect payment from any appropriate party, whether or not it was due to **our** error. If the incorrect payment was made directly to **you**, **we** may deduct it when making future payments directly to **you**.

## GENERAL PROVISIONS

(Continued)

**M. Subrogation and Right of Reimbursement.** Another party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to **Covered Transplant Services**. Such party may include, but is not limited to, any of the following: (a) the party or parties who caused the need for the **Covered Transplant Procedure**; (b) the insurer or other indemnifier of the party or parties who caused the **Covered Transplant Procedure**; (c) a guarantor of the party or parties who caused the **Covered Transplant Procedure**; (d) a worker's compensation insurer; (e) any other person, entity, policy or plan that is liable or legally responsible in relation to the **Covered Transplant Procedure**. When this happens, **we** may, at **our** option, (a) subrogate, that is, take over the **Participant's** right to receive payments from such party (the **Participant** or his or her legal representative must transfer to **us** any rights he or she may have to take legal action arising from the **Covered Transplant Procedure** to recover any sums paid under the Policy on behalf of the **Participant**), or (b) recover from the **Participant** or his or her legal representative any benefits paid under the Policy from any payment the **Participant** is entitled to receive from the other party. The **Participant** or his or her legal representative must cooperate fully with **us** in asserting its subrogation and recovery rights. The **Participant** or his or her legal representative will, within 5 days of receiving **our** request, provide all information and sign and return all documents necessary to exercise **our** rights under this provision.

**We** will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration that the **Participant** receives or is entitled to receive from any of the sources listed above. This lien will not exceed the greater of (a) the amount recovered from any other party, or (b) the amount of benefits paid by the Policy for **Covered Charges** plus the amount of all future benefits which may become payable under the Policy which result from the **Covered Transplant Services**. The **Company** will have the right to offset or recover such benefits from the amount received from any other party.

If the **Participant** or his or her legal representative makes any recovery from any other party and fails to reimburse **us** for any **Covered Charges**, then the **Participant** or his or her legal representative will be personally liable to **us** for the **Covered Charges** paid under the Policy.

Our first lien rights will not be reduced due to the **Participant's** own negligence; or due to the **Participant** not being made whole; or due to attorney's fees and costs. **We** are secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. **We** have the right to recover interest at the rate of 1/2% per month commencing on the date the **Participant** or his or her legal representative recovers any funds from any other party. **We** are not subject to any state law doctrines, including, but not limited to, the common fund doctrine, which would purport to require **us** to reduce **our** recovery by any portion of a **Participant's** attorney's fees and costs.

This provision also applies to any funds recovered from any other party by or on behalf of any dependent, the estate of any **Participant**; or on behalf of any incapacitated person.

## DEFINITIONS

- A. Additional Medical Coverage** – means any other insurance that provides **you** with medical benefits covered under the Policy.
- B. Application** – means the **Policyholder's** completed Organ & Tissue Transplant Application.
- C. Company** – means AIG Life Insurance Company.
- D. Covered Charges** – means charges incurred during a Transplant Benefit Period that are **Reasonable and Customary**, in **our** judgment, for **Covered Transplant Services**. With respect to **Providers**, a charge will not be considered **Reasonable and Customary** if it is not in conformity with one or a combination of the following:
1. A negotiated rate based on services provided;
  2. A fixed rate per day; or
  3. The **Reasonable and Customary** allowance for similar **Providers** who perform similar **Covered Transplant Services**.
- E. Covered Transplant Procedure** – means a **Medically Necessary** adult or pediatric human organ and tissue transplants listed as a Covered Transplant in the Schedule of Benefits.
- F. Covered Transplant Services** – means the services shown as Covered Transplant Services in the Benefit Provisions.
- G. Custodial Care** – means care and services that assist in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, and using the toilet; feeding or preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.
- H. Date of Service** – means the date when the service was actually provided or the date on which the purchase was made.
- I. Diagnostic Services** – means the following procedures that are directly related to a **Covered Transplant Procedure** and ordered by a **Provider Individual** because of specific symptoms in order to determine a definite condition or disease: (i) radiology, ultrasound, and nuclear medicine; (ii) laboratory and pathology; and (iii) EKGs, EEGs, and other electronic diagnostic medical procedures.
- J. [Experimental and/or Investigational Treatment** – means any drug, device, procedure, facility, equipment, treatment plan, protocol, supply or service directly related to a **Covered Transplant Procedure** (i) that is deemed to be experimental or investigational in nature by an appropriate technological assessment body established by any state or federal government, or (ii) where **we**, in **our** sole discretion, determine that, at the time it is used, one or more of the following conditions is present:
1. Its use requires approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to the Federal Drug Administration (FDA).
  2. Its use is not yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or is subject to either:
    - a) A written investigational or research protocol or treatment plan; or
    - b) A written informed consent or protocol used by the **Transplant Facility** in which reference is made to the drug, device, procedure, protocol, or treatment plan as being experimental, investigative, educational, for a research study, a pilot study, or posing an uncertain outcome, or having an unusual risk; or
    - c) A written protocol, protocols or informed consent used by any other facility studying substantially the same drug, device, procedure or treatment which states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or
    - d) An ongoing review by an Institutional Review Board.

## DEFINITIONS

(Continued)

For individuals participating or eligible to participate in clinical trials, the following will be considered Experimental and/or Investigational:

1. Clinical trials that are a single institution or investigator study. Clinical trials performed at a National Cancer Institute (NCI) designated Comprehensive Cancer Center are exempt from this requirement.
2. With regard to adult bone marrow/stem cell transplants:
  - a. All Phase I or II clinical trials; and
  - b. All Phase III clinical trials that are not sponsored by the NCI or similar national oncology cooperative body.
3. With regard to pediatric bone marrow/stem cell transplants:
  - a. All Phase I-IV clinical trials that are not sponsored by the Children's Oncology Group.
4. All "off protocol" treatment wherein **you** are not actually enrolled in a clinical trial.

Drugs, devices, procedures, facilities, equipment, treatment plans, supplies, and services that fall into the categories listed above **are not** considered Experimental and/or Investigational if their use is required by state law or recognized as acceptable medical practice throughout the United States to treat **your** illness as a result of:

1. The positive endorsement, recommendation, or publication of standards of care by national medical bodies or panels, including but not limited to, National Comprehensive Cancer Network (NCCN), NCI, or the National Institutes of Health; or
2. Multiple published peer review articles, in recognized professional medical journal(s), concerning such drug, device, procedure or treatment plan and reflecting its reproducibility by non-affiliated sources which **we** determine to be authoritative; or
3. Trial results (that adequately demonstrate safety and efficacy), which indicate the drug, device, procedure, protocol, or treatment plan is at least as clinically effective and cost effective as current standard therapy; or
4. Specific state mandated coverage requirements.]

**K. High Dose Chemotherapy** – means the use of a chemotherapeutic agent or agents to treat cancer or cancer-like illness (with or without irradiation) in doses which exceed the FDA approved or commonly recognized dosage range for the drug or drugs employed. In order to be considered as an eligible expense, High Dose Chemotherapy must:

1. Be part of a protocol or treatment plan that includes the reinfusion of autologous bone marrow or stem cells, or infusion of allogeneic bone marrow or stem cells, immediately after the High Dose Chemotherapy regimen is completed; and
2. Be expected to result in effects upon the bone marrow which would likely be lethal if left untreated.

All drugs and/or radiopharmaceuticals are subject to the **Experimental and/or Investigational Treatment** definition in the Policy.

**L. Immediate Family** – means **your** [spouse, parent, child, sibling, grandparent, or grandchild.]

**M. Medical Plan** – means a plan of major medical benefits maintained by the **Policyholder**. It includes, but is not limited to coverage provided under: group health insurance; health maintenance organizations; self-insured plans; preferred provider organizations; prepayment coverage; any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee plan, a union welfare plan, an employee organization plan, or an employee benefit organization; any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization; any government program except **Medicare** or Medicaid; the medical payments and/or no-fault provisions of automobile insurance; and any other group type coverage as permitted by law.

**Medical Plan** does not include benefits provided under [a limited health care benefit plan (such as a critical illness, specified disease, or "mini-med"), nor benefits provided under a: dental; vision; outpatient prescription drug; and/or short-term disability plan.]

## DEFINITIONS

(Continued)

- N. Medically Necessary or Medical Necessity** – means those drugs, devices, procedures, treatments, services or supplies, provided by a **Provider**, which are required for treatment of illness, injury, diseased condition, or impairment, and are:
1. consistent with **your** diagnosis or symptoms and **you** are an appropriate candidate for the proposed treatment;
  2. appropriate treatment, according to generally accepted standards of medical practice;
  3. not provided only as a convenience to **you** or the **Provider**.
  4. not an **Experimental and/or Investigational Treatment**; and
  5. not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment. Any service or supply provided at a **Provider Facility** will not be considered Medically Necessary if **your** symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The fact that a **Provider Individual** may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary or make the charge a **Covered Charge**.

- O. Medicare** – means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
- P. Member** – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a member, or as a subscriber. Member does not include a dependant. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.
- Q. Participant** – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a **Member**, a subscriber, or a dependent who is also covered under the Policy. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.
- R. Premium Due Date** – means the date the **Policyholder's** premium is due. The Premium Due Date is shown in the Policy Face Page.
- S. Policy Effective Date** – means the Policy Effective Date as shown on the Policy Face Page which is the date that coverage begins under the Policy.
- T. Policy Year** – means the period of time shown in the Schedule of Benefits during which the Policy is in effect. The Policy Year is subject to early termination as set forth in the Termination Provisions.
- U. Pre-existing Condition** – means any condition for which **you** have, within the 24 months prior to the Effective Date of the Policy:
1. Been advised by an attending **Physician** that a transplant may be needed (regardless of the timeframe to transplant and regardless of the **Participant's** decision to move forward or not move forward with a **Transplant Consultation** or **Transplant Evaluation**;
  2. Had a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of the outcome);
  3. Been scheduled to have a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of when the **Transplant Consultation** and/or **Transplant Evaluation** was to be done and regardless of the outcome); and/or
  4. Received, or has been listed to receive, an organ or tissue transplant.

[In addition, if **you** have, within the 24 months prior to the **Policy Effective Date** of the Policy, received dialysis treatments or been diagnosed with Chronic Kidney Disease or End Stage Renal Disease (ESRD), **you** will be deemed to have a Pre-existing Condition.]

## DEFINITIONS

(Continued)

If **you** are added subsequent to the **Policy Effective Date** as a result of the acquisition of a new group, affiliate, division, and/or subsidiary, Pre-existing Condition will mean those conditions listed above that occurred within the 24 months prior to **your** effective date of coverage under the Policy.

**V. Provider** – means any of the facilities and individuals listed below:

1. **Provider Facilities** – means any of the following facilities:

- a. **Clinical Laboratory** – means a laboratory that performs clinical procedures and is not affiliated or associated with a Hospital, **Physician**, or other **Provider**.
- b. **Hospital** – means a facility which is a short-term general hospital and which: (1) is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **Physicians**, for compensation from its patients; (2) has organized departments of medicine and major surgery; and (3) provides 24-hour nursing service by or under the supervision of registered nurses. Surgical facilities may be either on premises or in facilities available to the hospital on a prearranged basis.
- c. **Pharmacy** – means a facility licensed as a Pharmacy by the state in which it operates.
- d. **Transplant Facility** – means the following facilities:
  - i. **Nonparticipating Transplant Facility** – Any **Hospital** that has not contracted with **us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Hospital** may be a Nonparticipating Transplant Facility with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.
  - ii. **Participating Transplant Facility** – Any **Hospital** contracting with **us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Hospital** may be a Participating Transplant Facility with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.

2. **Provider Individuals** – means any of the following individuals:

- a. **Occupational Therapist** – means a person who is licensed as an Occupational Therapist by the state in which he or she practices. If that state does not issue such licenses, an Occupational Therapist is a person certified as an Occupational Therapist by an appropriate professional body.
- b. **Physical Therapist** – means a person who is licensed as a Physical Therapist by the state in which he or she practices. If that state does not issue such licenses, a Physical Therapist is a person certified as a Physical Therapist by an appropriate professional body.
- c. **Physician** – means a person performing services within the scope of his or her license, who is a duly licensed: (1) doctor of medicine (MD); (2) doctor of osteopathy (DO); (3) dentist; (4) optometrist; or (5) psychologist.
- d. **Respiratory/Inhalation Therapist** – means a person who is licensed as a Respiratory/Inhalation Therapist by the state in which he or she practices. If that state does not issue such licenses, a Respiratory/Inhalation Therapist is a person certified as a Respiratory/Inhalation Therapist by an appropriate professional body.
- e. **Speech Pathologist** and **Speech Therapist** – means a person licensed as a Speech Pathologist or Speech Therapist by the state in which he or she practices. If that state does not issue such licenses, a Speech Pathologist or Speech Therapist is a person certified as such by an appropriate professional body.

**W. Reasonable and Customary** – means with respect to the word customary, the amount charged by a majority of **Providers** in the same geographic region for similar services or supplies and/or is relative to the value and worth of similar services; and with respect to the word reasonable, a charge that meets the above criteria and, that in **our** judgment, is not an excessive amount for similar services or supplies; or a charge that merits special consideration due to complexity of treatment in the opinion of a peer review committee or consultant. Due to the lack of insurance, if a **Provider** accepts as full payment an amount less than **Reasonable and Customary**, the lesser amount will be determined to be the maximum **Reasonable and Customary** amount. Benefits will be based on the lesser of the actual billed charge or the **Reasonable and Customary** charge.

## DEFINITIONS

(Continued)

- X. **Skilled Care** – means the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury. Skilled care must be performed by or under the supervision of **Provider Individuals**.
- Y. **Spouse** – means a person recognized as the **Member's** spouse under the **Medical Plan**.
- Z. **We, Us, Our** – means AIG Life Insurance Company.
- AA. **You, Your** – means the **Participant**, as defined in the Policy.



**AIG LIFE INSURANCE COMPANY**  
 ONE ALICO PLAZA  
 WILMINGTON, DELAWARE 19801

**[Administrative Office:**  
 Medical Excess LLC  
 8777 Purdue Road, #330  
 Indianapolis, Indiana 46268  
 (888) 449-2377]

### Organ & Tissue Transplant Application

<b>Policy Applicant:</b> ABC Company		<b>Telephone:</b> 555-111-2222	<b>Tax ID:</b> 99-9999999
<b>Street Address:</b> 123 Main Street			
<b>City:</b> Any City		<b>State:</b> Any State	<b>Zip Code:</b> 12345
<b>Name(s) of Affiliates to be Included:</b> XYZ Company		<b>Locations:</b> Any Town, Any State	
The Applicant is: <input checked="" type="checkbox"/> Single Employer <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other			
Does the Applicant currently have major medical coverage in force? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Applicants that do not have major medical coverage in force, or that only have medical coverage provided through a limited benefit plan (such as a critical illness, specified disease, or "mini-med" plan) are not eligible for this Policy.			
<b>Name of Agent/Broker:</b> Brokers R Us		<b>Contact Name:</b> Joe Broker	
<b>Agent/Broker's Phone Number:</b> 555-666-7777		<b>Agent/Broker's License Number:</b> 88-888888	
<b>Covered Transplants:</b>			
<input checked="" type="checkbox"/> Heart	<input checked="" type="checkbox"/> Heart/Lung	<input checked="" type="checkbox"/> Autologous Bone Marrow Peripheral Stem Cell Including High Dose Chemo <input checked="" type="checkbox"/> Allogeneic Bone Marrow Peripheral Stem Cell Including High Dose Chemo (related) <input checked="" type="checkbox"/> Allogeneic Bone Marrow Peripheral Stem Cell Including High Dose Chemo (non-related)	
<input checked="" type="checkbox"/> Lung/Double Lung	<input checked="" type="checkbox"/> Kidney/Pancreas		
<input checked="" type="checkbox"/> Kidney (living/deceased donor)	<input checked="" type="checkbox"/> Kidney/Liver		
<input checked="" type="checkbox"/> Pancreas	<input checked="" type="checkbox"/> Liver/Intestine		
<input checked="" type="checkbox"/> Liver (living/deceased donor)	<input checked="" type="checkbox"/> Pancreas/Intestine		
<input checked="" type="checkbox"/> Intestine	<input checked="" type="checkbox"/> Liver/Pancreas/Intestine		
<input type="checkbox"/> Ventricular Assist Device	<input type="checkbox"/> Other (specify):		
Benefit Period Start Date: <input checked="" type="checkbox"/> Date of Evaluation <input type="checkbox"/> 10 Days Before Transplant <input type="checkbox"/> Other (Specify) _____ ]			
Benefit Period End Date: <input checked="" type="checkbox"/> 365 Days After Transplant <input type="checkbox"/> Other (Specify) _____ ]			
Lifetime Limit: <input checked="" type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> Other (Specify) _____ ]			
Non-Participating Provider Reimbursement: <input checked="" type="checkbox"/> 80% <input type="checkbox"/> Other (Specify) _____ ]			
<b>Name of Medical Plan Administrator:</b> A-1 Administrators, Inc.		<b>Requested Policy Effective Date (subject to acceptance):</b> 1/1/2009	
Eligible Persons to be Covered Under the Policy: <input checked="" type="checkbox"/> Employee <input type="checkbox"/> Retiree <input checked="" type="checkbox"/> COBRA Continuee <input type="checkbox"/> Member <input type="checkbox"/> Subscriber <input checked="" type="checkbox"/> Spouse <input checked="" type="checkbox"/> Dependents <input type="checkbox"/> Other (Specify) _____ ]			

[ Within the past 24 months, have any individuals to be covered under the Policy (including but not limited to employees, members, and/or dependents):

- [1. Been advised by an attending physician that a transplant is needed?]
- [2. Had, a transplant consultation, workup, or evaluation?]
- [3. Been scheduled to have a transplant consultation, workup, or evaluation?]
- [4. Received, or has been listed to receive, an organ or tissue transplant?]
- [5. Received dialysis treatments, or been diagnosed with Chronic Kidney Disease or End Stage Renal Disease?]

Yes    No

If "Yes", please provide a current list of all such persons who meet any the above criteria, complete with diagnosis, and: transplant type; dates of evaluation or acceptance by transplant facility; and transplant facility where listed, if applicable.

John Doe, liver transplant scheduled for 3/1/2009 at Mayo Clinic

**FRAUD WARNING**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

The Applicant hereby applies for Organ & Tissue Transplant insurance coverage and:

- 1. Represents that the answers included in this Application have been reviewed and are true and complete to the best of the Applicant's knowledge and belief;
- 2. Understands and agrees that insurance applied for shall not become effective until the Application is approved by the Company; and
- 3. Agrees that if the insurance applied for is approved by the Company, the Applicant will pay all premium due after the effective date of insurance, including any premium which may accumulate between the effective date of the insurance and the date the Policy is issued.

This Application, as it may be amended, will become part of the Policy, if issued.

Applicant's Signature: \_\_\_\_\_  
Individual authorized to sign as Applicant

Date: 12/15/2008

Printed Name: Joe Smith  
Title: President and CEO

Producer's Signature: \_\_\_\_\_  
Individual authorized to sign for Producer

Date: 12/15/2008

Printed Name: Joe Broker



**AIG LIFE INSURANCE COMPANY**  
ONE ALICO PLAZA  
WILMINGTON, DELAWARE 19801

[Administrative Office:  
Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, Indiana 46268  
(888) 449-2377]

## Organ & Tissue Transplant Renewal Endorsement

This Endorsement is attached to and made a part of the following Organ & Tissue Transplant Policy:

Policyholder: [ABC Company]  
Original Policy Number: [289-1234]  
Original Policy Effective Date: [January 1, 2009]

It is agreed that the above referenced Organ & Tissue Transplant Policy is renewed for the **Policy Year** stated in the attached Renewal Schedule of Benefits. The Policy Number and all terms and conditions set forth in the attached Renewal Schedule of Benefits replace and supersede all previously issued Schedules of Benefits.

This Endorsement is subject to all the provisions of the Policy. Payment of the premium for the insurance provided by the Policy as endorsed constitutes acceptance by the Policyholder of the terms of this Endorsement.

This Policy is signed for the **Company** by its Secretary and President.

**AIG Life Insurance Company**

Handwritten signature of Elizabeth M. Tuck in cursive script.

Secretary

Handwritten signature of Matthew E. Winters in cursive script.

President

## RENEWAL SCHEDULE OF BENEFITS

**POLICY YEAR:** [January 1, 2010 through December 31, 2010]

**CURRENT ENROLLMENT:** [230]

**MINIMUM ENROLLMENT:** [50]

**PREMIUMS PER MONTH:**

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> Heart                             | <input checked="" type="checkbox"/> Heart/ Lung              | <input checked="" type="checkbox"/> Autologous Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo              |
| <input checked="" type="checkbox"/> Lung/Double Lung                  | <input checked="" type="checkbox"/> Kidney/ Pancreas         | <input checked="" type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (related)    |
| <input checked="" type="checkbox"/> Kidney (living or deceased donor) | <input checked="" type="checkbox"/> Kidney/Liver             | <input checked="" type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (unrelated)] |
| <input checked="" type="checkbox"/> Pancreas                          | <input checked="" type="checkbox"/> Liver/Intestine          |  |
| <input checked="" type="checkbox"/> Liver (living or deceased donor)  | <input checked="" type="checkbox"/> Pancreas/Intestine       |  |
| <input checked="" type="checkbox"/> Intestine                         | <input checked="" type="checkbox"/> Liver/Pancreas/Intestine |  |
| <input type="checkbox"/> Ventricular Assist Device                    | <input type="checkbox"/> Other (specify):                    |  |

### TRANSPLANT BENEFIT PERIOD:

The Transplant Benefit Period begins [on the date of **Transplant Evaluation** for][ten (10) days before] a **Covered Transplant Procedure**.

The Transplant Benefit Period ends on the earliest of the following dates:

1. [The end of the 365th day following the **Covered Transplant Procedure**;
2. The date the **Participant's** Lifetime Limit has been reached under the Policy or under the **Medical Plan**;
3. The date the Policy terminates, but only if:
  - a. The **Policyholder** cancels the Policy prior to the last day of the current **Policy Year**; or
  - b. The **Participant's** Transplant Benefit Period has begun, but such **Participant** has not received a **Covered Transplant Procedure** as of the date of termination of the Policy; or
4. The date the **Participant's** COBRA benefits terminate, if applicable.]
5. The date established by the Non-Performance of Covered Transplant Procedures provision.]

[If there is no **Transplant Evaluation**, the Transplant Benefit Period begins on the date of a **Covered Transplant Procedure**.]

[If a **Transplant Evaluation** occurs while the Policy is in force and results in a **Covered Transplant Procedure** that takes place during this **Policy Year**, the expenses for the **Transplant Evaluation** will be eligible for reimbursement even if it occurred prior to the Transplant Benefit Period. This benefit does not apply to individuals with a **Pre-existing Condition** unless the **Transplant Evaluation** occurs after the **Pre-existing Condition Waiting Period** has expired.]

For a Bone Marrow/Peripheral Stem Cell Tissue Transplant, the date the tissue is re-infused is deemed to be the date of the **Covered Transplant Procedure**.

All benefits provided during a Transplant Benefit Period that extend beyond the **Policy Year** will be based on the Policy terms in effect at the start of the Transplant Benefit Period.

A Transplant Benefit Period cannot begin prior to the date the **Participant** first becomes covered under the Policy.

## RENEWAL SCHEDULE OF BENEFITS

(Continued)

**LIFETIME LIMIT:** [\$            for each **Participant**]

The following charges are included within and reduce each **Participant's** Lifetime Limit:

1. All benefits paid on behalf of the **Participant** (including covered donor charges) under the Policy and any preceding or succeeding Organ & Tissue Transplant Policy between **us** and the **Policyholder**; and
2. All benefits paid by **us** under the "Travel, Lodging, and Meals Benefit" provision.

**[DEDUCTIBLE AMOUNT (APPLICABLE TO HIGH DEDUCTIBLE HEALTH PLANS ONLY):**

Although the Policy does not impose a **Deductible Amount**, if a **Participant** selects a high deductible health plan sponsored by the **Policyholder**, then the **Deductible Amount** set forth in such **Policyholder's** high deductible health plan must be paid by the **Participant** before benefits are payable under the Policy. This requirement is necessary in order for the **Participant** to remain eligible for the tax benefits afforded by the health savings account associated with the **Policyholder's** high deductible health plan.]

**REIMBURSEMENT AMOUNTS:**

- A. PARTICIPATING PROVIDER: ..... [100%] of **Covered Charges** for **Covered Transplant Services** provided through a **Participating Transplant Facility**. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.)
- B. NONPARTICIPATING PROVIDER: ..... [80%] of **Covered Charges** for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** with respect to the type of **Covered Transplant Procedure** performed. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.) Benefits for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** will not exceed the Maximum Amounts stated below:

COVERED TRANSPLANT PROCEDURE	MAXIMUM BENEFIT FOR ALL COVERED TRANSPLANT SERVICES PROVIDED BY A NONPARTICIPATING TRANSPLANT FACILITY
Heart	\$437,000
Lung (Single)	\$261,000
Lung (Double)	\$363,000
Kidney (living or deceased donor)	\$156,000
Pancreas	\$163,000
Liver (living or deceased donor)	\$196,000
Intestine	\$626,000
Heart/Lung	\$495,000
Kidney/Pancreas	\$200,000
Kidney/Liver	\$419,000
Liver/Intestine	\$700,000
Pancreas/Intestine	\$668,000
Liver/Pancreas/Intestine	\$716,000
Autologous Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b>	\$175,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - related	\$297,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - unrelated	\$380,000

## RENEWAL SCHEDULE OF BENEFITS

(Continued)

C. SECONDARY PAYOR: ..... When benefits under the Policy are considered secondary, as determined by the Coordination of Benefits provisions, benefit payments will be based on the lesser of: a) **Covered Charges**; or b) the negotiated amount established between the primary payor and the **Provider**.

**ENDORSEMENTS:** Yes  No

If yes, please specify:

[ ]

**POLICYHOLDER'S MEDICAL PLAN ADMINISTRATOR:**

[A-1 Administrator, Inc.]



AIG LIFE INSURANCE COMPANY  
ONE ALICO PLAZA  
WILMINGTON, DELAWARE 19801

**AMENDMENT  
for  
Organ & Tissue Transplant Policy/Certificate**

**AMENDMENT NO.:** [1]  
**AMENDMENT EFFECTIVE DATE:** [January 1, 2009]

Attached to and made part of Policy No.: [289-1234] that was issued to [ABC Company] on January 1, 2009.

This Amendment form is made a part of the Policy/Certificate to which it is attached as of the Effective Date shown above. Any changes in premium apply as of the first premium due date on or after the Effective Date of this Amendment.

The Policy/Certificate is changed as follows:

[Insert appropriate variables here]

This Amendment ends at the same time as the Policy, and is subject to all of the terms, limitations and conditions of the Policy, except as stated above.

IN WITNESS WHEREOF, AIG Life Insurance Company has caused this Amendment to be executed as of the Effective Date shown above.

Secretary

President

*SERFF Tracking Number:* MCHX-125933550      *State:* Arkansas  
*Filing Company:* AIG Life Insurance Company      *State Tracking Number:* 41029  
*Company Tracking Number:* OT-2008  
*TOI:* H09G Group Health - Organ & Tissue      *Sub-TOI:* H09G.000 Health - Organ & Tissue Transplant -  
Transplant - Limited Benefit      Limited Benefit  
*Product Name:* OT-2008 AIG Life Insurance Co Organ & Tissue Trans  
*Project Name/Number:* OT-2008 AIG Life Insurance Co Organ & Tissue Transplant Policy/OT-2008 AIG Life Insurance Co Organ & Tissue Transplant  
Policy

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-125933550 State: Arkansas  
 Filing Company: AIG Life Insurance Company State Tracking Number: 41029  
 Company Tracking Number: OT-2008  
 TOI: H09G Group Health - Organ & Tissue Sub-TOI: H09G.000 Health - Organ & Tissue Transplant -  
 Transplant - Limited Benefit Limited Benefit  
 Product Name: OT-2008 AIG Life Insurance Co Organ & Tissue Trans  
 Project Name/Number: OT-2008 AIG Life Insurance Co Organ & Tissue Transplant Policy/OT-2008 AIG Life Insurance Co Organ & Tissue Transplant  
 Policy

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Certification/Notice	<b>Review Status:</b>	Approved-Closed	12/12/2008
<b>Comments:</b>				
<b>Attachments:</b>				
	AR Compliance with Rule 19.PDF			
	AR Compliance with Rule 49.PDF			
<b>Satisfied -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	12/12/2008
<b>Comments:</b>				
	See forms tab			
<b>Satisfied -Name:</b>	Cover Letter	<b>Review Status:</b>	Approved-Closed	12/12/2008
<b>Comments:</b>				
<b>Attachment:</b>				
	Cover Letter.PDF			
<b>Satisfied -Name:</b>	Authorization Letter	<b>Review Status:</b>	Approved-Closed	12/12/2008
<b>Comments:</b>				
<b>Attachment:</b>				
	Authorization Letter.PDF			
<b>Satisfied -Name:</b>	Form Listing	<b>Review Status:</b>	Approved-Closed	12/12/2008
<b>Comments:</b>				
<b>Attachment:</b>				
	Form Listing.PDF			

SERFF Tracking Number: MCHX-125933550 State: Arkansas  
Filing Company: AIG Life Insurance Company State Tracking Number: 41029  
Company Tracking Number: OT-2008  
TOI: H09G Group Health - Organ & Tissue Sub-TOI: H09G.000 Health - Organ & Tissue Transplant -  
Transplant - Limited Benefit Limited Benefit  
Product Name: OT-2008 AIG Life Insurance Co Organ & Tissue Trans  
Project Name/Number: OT-2008 AIG Life Insurance Co Organ & Tissue Transplant Policy/OT-2008 AIG Life Insurance Co Organ & Tissue Transplant  
Policy

**Satisfied -Name:** AR Readability **Review Status:** Approved-Closed 12/12/2008  
**Comments:**  
**Attachment:**  
AR Readability.PDF

**Satisfied -Name:** Statement of Variability **Review Status:** Approved-Closed 12/12/2008  
**Comments:**  
**Attachment:**  
Statement of Variability.PDF

**Satisfied -Name:** 12.12.08 Resubmission letter **Review Status:** Approved-Closed 12/12/2008  
**Comments:**  
**Attachment:**  
12\_12\_08 Resubmission letter.PDF

**Satisfied -Name:** Revised Form Listing **Review Status:** Approved-Closed 12/12/2008  
**Comments:**  
**Attachment:**  
Revised Form Listing.PDF

**Satisfied -Name:** Revised Readability **Review Status:** Approved-Closed 12/12/2008  
**Comments:**  
**Attachment:**  
Revised Readability.PDF

## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: AIG Life Insurance Company

Form Number(s): OT-2008  
OT-2008-CERT  
OT-2008-APP  
OT-2008-RENEWAL  
OT-2008-AMD

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



---

Signature of Company Officer

David Friedly  
Name

Vice President of Operations  
Title

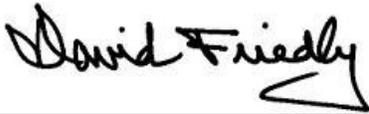
12.3.08  
Date

**CERTIFICATE OF COMPLIANCE**

Insurer: AIG Life Insurance Company

Form Numbers: OT-2008  
OT-2008-CERT  
OT-2008-APP,  
OT-2008-RENEWAL  
OT-2008-AMD

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



---

Signature of Company Officer

David Friedly

---

Name

Vice President of Operations

---

Title

12.3.08

---

Date

.....  
**McHugh Consulting Resources, Inc.**

December 5, 2008

**SUBMITTED VIA SERFF**

Commissioner Julie Benafield Bowman  
Arkansas Department of Insurance  
Compliance – Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

RE:   AIG LIFE INSURANCE COMPANY (NAIC #: 66842)  
      OT-2008                     Organ & Tissue Transplant Policy  
      OT-2008-CERT            Organ & Tissue Transplant Certificate  
      OT-2008-APP             Policyholder Application  
      OT-2008-RENEWAL        Renewal Endorsement  
      OT-2008-AMD             Policy/Certificate Amendment

Dear Commissioner Benafield Bowman

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of AIG Life Insurance Company. We have provided an authorization letter for your files.

The referenced forms are submitted on behalf of AIG Life Insurance Company for your review and approval. These are new forms that will replace our Organ & Tissue Transplant Policy (M20001, et al.) that is currently available in your state. However, we do not wish to withdraw the current approved forms. These forms were approved by Delaware, our domicile state, on November 24, 2008.

Although these forms are being filed using the Uniform Coding Matrix identifier H09G.000, we would like to point out that our product provides benefits on an expense incurred basis (not a daily scheduled amount). These forms will only be marketed to self-funded plan sponsors that are categorized as large groups in your state (including Associations, Single Employer Trusts, and Multi-Employer Trusts, if allowed in your state). The product is a non-contributory product designed to relieve the plan sponsor of catastrophic medical expenses related to transplant procedures. The forms contain variable text that has been indicated with brackets. In order to assist your review of the bracketed text, we have enclosed a Statement of Variable Language.

Amendment OT-2008-AMD is an administrative amendment designed to accommodate language changes due to: a) subsequent state requirements; and/or b) Policyholder requirements. It may also be used to specify administrative information related to the Policy and/or Certificate.

This product will be marketed through licensed brokers/agents.

If allowed in your state, it is our intent to deem these forms approved if we have not received a disposition upon the expiration of the initial review period. ....

Enclosed, please find any required certifications and/or transmittal forms. If you have any questions or concerns regarding this submission, please do not hesitate to contact us. We thank you in advance for your time and consideration.

Sincerely,

A handwritten signature in cursive script that reads "Betty Dabrowski".

Betty Dabrowski  
Consultant



## Medical Excess

One MacArthur Place, Suite 620  
South Coast Metro, CA 92707  
Phone: 714.436.3600  
Toll Free: 800.634.7462  
Fax: 714.436.3620

October 28, 2008

**RE: AIG Life Insurance Company  
NAIC Company Code: 66842  
See Attached Forms Listing for AIG Life Insurance Company**

Dear Regulator:

Please accept this letter as authorization from AIG Life Insurance Company for McHugh Consulting Resources, Inc. to file any or all policy forms as referenced on the attached form listing on behalf of AIG Life Insurance Company.

Best regards,

A handwritten signature in black ink that reads "Roger Swibold". The signature is written in a cursive style.

Roger Swibold  
Director of Contracts & Compliance  
Tel: (714) 436-3615  
Fax: (714) 436-3631  
Email: roger.swibold@aig.com



**AIG LIFE INSURANCE COMPANY  
ORGAN & TISSUE TRANSPLANT  
FORMS LISTING**

<b>Form Number</b>	<b>Description</b>
OT-2008	Organ & Tissue Transplant Policy
OT-2008-CERT	Organ & Tissue Transplant Certificate
OT-2008-APP	Policyholder Application
OT-2008-RENEWAL	Renewal Endorsement
OT-2008-AMD	Policy/Certificate Amendment

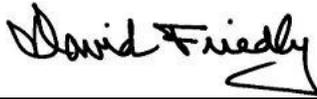
**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** AIG Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
OT-2008	44.6
OT-2008-CERT	44.6
OT-2008-APP	53
OT-2008-RENEWAL	63
OT-2008-AMD	49

Signed: \_\_\_\_\_



Name:

David Friedly

Title:

Vice President of Operations.

Date:

12.3.08

**STATEMENT OF VARIABLE LANGUAGE  
for Policy Form: OT-2008, et al.**

General Information

The page numbers are illustrative and may vary depending on the pagination of the final Policy language.

All time frames and dates in terms of days, months and years have been bracketed. The time frames that appear are our standard time frames and are the most restrictive time frames we will utilize (unless otherwise indicated in this Statement of Variable Language). The bracketed language will allow us to liberalize the terms of the Agreement if requested by the Plan Sponsor.

All dollar amounts and percentages have been bracketed. The dollar amounts and percentages that appear are our standards and are the most restrictive we will utilize (unless otherwise indicated in this Statement of Variable Language). The bracketed language will allow us to liberalize the terms of the Policy if requested by the Policyholder.

The variable information provided for this Policy Form will also apply to the Certificate Form (OT-2008-CERT) and the Renewal Endorsement Form (OT-2008-RENEWAL).

Page 1 (Face Page)

Illustrative information will be Policyholder specific.

Our Administrative Office address appears as variable, to allow for a change of address without the need to re-file the document.

Page 2

The page numbers found in the Table of Contents may vary depending on the pagination of the final Policy language.

Page 3

Item C. The address for remitting premium is variable and subject to change.

Item E. Sub-items 1-7 may appear as is, or any of the sub-items may be deleted.

Page 4

Item I. All of the time frames found in Item I reflect our current standard, and may vary in a manner that is less restrictive for the Policyholder.

Page 7

Most of the variable text is self-explanatory.

The list of Covered Transplants has been bracketed so that we may add other transplants to the list if medical science proves that such transplants are acceptable.

Page 7 (continued)

Transplant Benefit Period:

With regard to the “begin date”, there are two different dates that may be elected by the Policyholder. The elected date will appear in the issued Policy.

With regard to the “end date”, Items 1-5 have been bracketed to allow us to remove any of the Items at our discretion.

With regard to the two paragraphs following Items 1-5, either one or the other paragraph will appear depending on the Transplant Benefit Period “begin date” elected by the Policyholder.

Page 8

Although the Deductible Amount paragraph is designed in a manner that could be included in all Policies, we want the ability to delete it if we know for a fact that the Policyholder does not have a High Deductible Health Plan.

The Covered Transplant Procedure Chart has been bracketed to allow us to: 1) delete from; or 2) add to the list. In addition, we want the availability to increase the maximum dollar amounts if increases become appropriate and necessary. Dollar amounts will not be reduced.

Page 10

Notification Requirements. Our address has been bracketed to allow for any other address that may become appropriate in the future.

Covered Transplant Services. We have bracketed the statement, “Complications of donation experienced by the living donor are not covered,” in case we choose to cover such complication at some point in the future. Currently, such complications should be covered by the donor’s own medical insurance.

Page 11

Item 13 may appear as is, or be deleted in its entirety. If the VAD benefit does appear in the Policy, we have added the flexibility to apply, or not apply, a VAD maximum benefit.

Page 12

The Pre-existing Condition Waiting Period may appear as is, or may be deleted in its entirety. In addition, if the Waiting Period applies, we may vary the time frame to a number of months less than 12 months.

Transplant Nurse Advisor. This provision will appear as is or be deleted in its entirety. In addition, we would like the ability to change the title, if appropriate and necessary.

## Page 13

We have bracketed all references to providing benefits to a travel companion so that we can either: 1) delete the benefit; or 2) provide coverage for more than one travel companion.

The description of what Transportation includes is bracketed to allow us to revise the list, as appropriate and necessary.

The benefit chart is bracketed to allow us to revise the benefit, as appropriate and necessary.

The Disability, Leave of Absence, or Layoff provision may appear as is, or be deleted in its entirety.

## Page 18-19

With regard to excluded Items A – NN, each separate Item may: 1) appear as is; 2) be deleted in its entirety; or 3) be revised.

The last paragraph under the Exclusions Provisions may appear as is or be deleted in its entirety.

## Page 20

We have restated portions of the Policyholder Provisions (Right to Amend Rates and Policy Terms, and termination Provisions) here in the Certificate pages, because they are provisions that may have an impact on the certificateholder. These provisions may be revised as noted on Pages 3 and 4, above.

## Page 23

The definition of Experimental and/or Investigational Treatment has been bracketed to allow for our language to change if medical science changes and a manner that no longer renders a particular procedure E&I. We will not change our definition in a manner that is considered more restrictive than it now appears.

## Page 24

Item L. The definition of Immediate Family may appear as is or be revised in a manner that is less restrictive than it now appears.

Item M. The last sentence of this definition has been bracketed to allow us to revise the language, as appropriate and/or necessary.

## Page 25

Item P. The definition of Member is bracketed to allow us to revise, as necessary, to more appropriately reflect those individuals covered under the Policyholder's underlying self-funded plan.

Item U. The last sentence on page 25 will appear as is, be deleted in its entirety, or be revised if we determine it is necessary to change our definition.

**STATEMENT OF VARIABLE LANGUAGE  
for APPLICATION OT-2008-APP**

Although most of the variable information on the Application is self explanatory, the information at the top of the 2<sup>nd</sup> page (down to the bottom of the chart) may appear as is, be deleted in its entirety, or revised if we determine it is necessary to expand the list of medical issues of which we need to be aware.

.....

# McHugh Consulting Resources, Inc.

December 12, 2008

**SUBMITTED VIA SERFF**

Rosalind Minor  
Arkansas Department of Insurance  
Compliance – Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

RE:   AIG LIFE INSURANCE COMPANY (NAIC #: 66842)  
      OT-2008-AR                   Organ & Tissue Transplant Policy  
      OT-2008-CERT-AR           Organ & Tissue Transplant Certificate  
      OT-2008-APP                Policyholder Application  
      OT-2008-RENEWAL          Renewal Endorsement  
      OT-2008-AMD                Policy/Certificate Amendment

**SERFF Tracking Number: MCHX-125933550**

Dear Ms. Minor:

AIG Life Insurance has provided the following response to your December 11, 2008, objection letter:

With regard to the Subrogation and Right of Reimbursement provisions found in our Policy and Certificate forms, please be advised that pursuant to your Department's position, we have deleted the sentence and paragraph in question. As a result, we also revised the Policy and Certificate form numbers to include an "AR" suffix to indicate that these are now state specific forms.

Should you have any questions, please feel free to contact me.

Sincerely,



Betty Dabrowski  
Consultant

**AIG LIFE INSURANCE COMPANY  
ORGAN & TISSUE TRANSPLANT  
FORMS LISTING**

<b>Form Number</b>	<b>Description</b>
OT-2008-AR	Organ & Tissue Transplant Policy
OT-2008-CERT-AR	Organ & Tissue Transplant Certificate
OT-2008-APP	Policyholder Application
OT-2008-RENEWAL	Renewal Endorsement
OT-2008-AMD	Policy/Certificate Amendment

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** AIG Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
OT-2008-AR	44.6
OT-2008-CERT-AR	44.6
OT-2008-APP	53
OT-2008-RENEWAL	63
OT-2008-AMD	49

Signed: \_\_\_\_\_



Name:

David Friedly

Title:

Vice President of Operations.

Date:

12.12.08





**AIG LIFE INSURANCE COMPANY**  
ONE ALICO PLAZA  
WILMINGTON, DELAWARE 19801

[ **Administrative Office:**  
Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, Indiana 46268  
(888) 449-2377]

### Organ & Tissue Transplant Policy

**POLICYHOLDER:** [ABC Company]  
**POLICYHOLDER ADDRESS:** [123 Main Street, Any City, Any State, 12345]  
**POLICY NUMBER:** [289-1234]  
**POLICY EFFECTIVE DATE:** [January 1, 2009]  
**POLICY ANNIVERSARY DATE:** [January 1] of each succeeding year  
**PREMIUM DUE DATE:** First premium payment is due on the **Policy Effective Date** above. Thereafter, each premium payment is due on the first day of the month.  
**INITIAL ENROLLMENT:** [151]  
**MINIMUM ENROLLMENT:** [50]  
**PREMIUMS PER MONTH:**

**AIG Life Insurance Company** will provide the Policy benefits to each **Participant** in consideration and acceptance of the **Policyholder's** signed **Application** and premium, and subject to all Policy provisions.

This Policy becomes effective at 12:01 a.m. Standard Time on the **Policy Effective Date** shown above, and replaces any previous agreement relating to transplant services between the **Policyholder** and the **Company**. The first premium payment and all subsequent premium payments are due on the **Premium Due Date** shown above.

***THIS IS A LIMITED BENEFIT POLICY AND IS NOT INTENDED TO BE A MAJOR MEDICAL HEALTH PLAN.***

***PLEASE READ THIS POLICY AND CERTIFICATE CAREFULLY FOR A FULL DESCRIPTION OF THE BENEFITS, EXCLUSIONS, AND LIMITATIONS.***

This Policy is signed for the **Company** by its Secretary and President.

**AIG Life Insurance Company**

*Elizabeth M. Tuck*  
Secretary

*Matthew E. Wintz*  
President

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## POLICYHOLDER PROVISIONS

- A. Defined Terms.** Boldfaced terms have special meaning. Please refer to the Definitions section or Benefit Provision section of this Policy for a complete description of such terms.
- B. Coverage.** **Participants** are entitled to coverage for **Covered Transplant Services**, subject to the terms, conditions, limitations, and exclusions set forth in this **Policy** as further described in Paragraph M below of this Provision.
- C. Payment of Premiums.** All premiums must be paid by the **Premium Due Date** shown in the Policy Face Page. Premiums shall be remitted to **us** at the following address:

[ Medical Excess LLC  
Dept. 2173  
Los Angeles, CA 90084-2173 ]

- D. Grace Period.** Unless **we** or the **Policyholder** have given written notice of cancellation, a grace period of 31 days shall apply for the payment of any premiums due (except the first premium payment which is due on the **Policy Effective Date**). At the end of the 31-day grace period, **we** may cancel this Policy without further notice. During the grace period, the contract will remain in force, provided that, **we** receive the entire premium payment prior the end of the grace period. Failure to pay the entire premium prior to the end of the grace period will result in cancellation back to the applicable **Premium Due Date**.

**We** are not obligated to pay any claims incurred by a **Participant** during the grace period, until the premium due is received. It is possible that **we** may inadvertently accept premium payment from the **Policyholder** after the grace period has expired. This acceptance does not obligate **us** to reinstate this Policy. Unless this Policy is reinstated, the payment will be refunded within a reasonable time after the error is discovered.

- E. Right To Amend Rates And Policy Terms.** **We** may revise the premium rates or any other terms of this Policy on:
1. [The date the **Policyholder** amends the **Medical Plan**.
  2. The date a benefit change is made to this **Policy** at the **Policyholder's** request.
  3. The date the **Policyholder** adds or deletes a subsidiary or affiliate.
  4. The date an increase or decrease in the number of **Participants** exceeds [25%] in any [one] month or [XX,25%] over any period of [XXX,three] consecutive months. The number of **Participants** will be derived from the **Policyholder's** monthly premium statements or any other reports obtained from the **Policyholder** or the **Medical Plan's Administrator**.
  5. The date **we** are notified by the state in which the **Policyholder** is located of any state imposed tax or assessment for which **we** are obligated to pay.
  6. The date of any change in the **Policyholder's** business that materially affects **our** risk.
  7. The date it is discovered that there has been a material misrepresentation or nondisclosure of information that **we** could reasonably have expected to have been disclosed to **us** by the **Policyholder** or the **Policyholder's Medical Plan Administrator**.]
- F. Incontestability.** **We** may declare this Policy void back to the inception date of the **Policy Year** or cancel this Policy, if the **Application** contains a material misrepresentation. However, this provision will not apply once this Policy has been continuously in effective for two years.
- G. Representations Not Warranties.** A copy of the **Application** is attached to this Policy. All statements made by the **Policyholder** or by **Participants** applying for coverage will be considered representations and not warranties. No statement appearing on the **Application** will be used to contest the validity of the **Policyholder's** right to the benefits of this Policy, unless the **Policyholder** has been furnished a copy of the **Application**.
- H. Evidence of Insurability.** **We** may ask the **Policyholder** for verification that a **Participant** is covered under the **Policyholder's Medical Plan**.

## POLICYHOLDER PROVISIONS

(Continued)

- I. **Policy Termination.** This Policy may be cancelled by the **Policyholder** or **us**, for any reason, on the date specified in writing by either party, provided that the other party is notified not less than [31] calendar days in advance of the date of termination. If the **Policyholder** provides notice without a specified termination date, termination will be effective the first **Premium Due Date** following **our** receipt of the written notice of termination.

*If the Policy terminates during a Policy Year (other than a Policy Anniversary Date), coverage provided to Participants will be terminated immediately, regardless of whether a Participant is in the middle of an established Transplant Benefit Period.*

**We** may cancel this Policy if the **Policyholder's** enrollment drops below the Minimum Enrollment shown on the Policy Face Page. However, **we** must provide written notification to the **Policyholder** of such cancellation not less than [ten (10) days] in advance of the termination date.

This Policy may be cancelled without notification, upon the earliest of the following dates:

1. [The date the **Medical Plan** is discontinued.
  2. The date the **Policyholder's Medical Plan Administrator** listed in the Schedule of Benefits is changed to an administrator that **we** have not authorized.
  3. The date it is determined that the **Policyholder's Medical Plan Administrator** is not properly licensed as required by state law.
  4. The date the **Medical Plan** is found to be in violation of federal or state law. **We** reserve the right to allow the **Medical Plan** [90] calendar days within which to achieve compliance. Failure to comply by such date will result in termination of this Policy.
  5. Upon the **Policy Effective Date**, if the **Policyholder** fails to provide **us** (within the first [90] days of the **Policy Effective Period**) with requested materials or information necessary for **our** final review and approval of the premium rates. If this Policy is terminated under this provision, **we** will return the premium paid by the applicant for the current **Policy Year**, and **we** will have no liability under the terms of this **Policy** for the current **Policy Year**.
  6. Upon the **Premium Due Date** if **we** do not receive premiums within the specified Grace Period.
  7. The date the **Policyholder** becomes insolvent or files for bankruptcy, unless **we** and an appointed Trustee in Bankruptcy agree to continue the coverage during a period of reorganization.]
- J. **Notice.** When **we** provide written notice to the **Policyholder's** last known address regarding the administration of this Policy, it is deemed to be notice to all affected parties including all **Participants**. The **Policyholder** is responsible for giving notice to **Participants**, if applicable.
- K. **Legal Action.** No legal action may be brought under this Policy within 60 days after **we** receive a claim. No action may be brought after 3 years from the date the claim is required to be furnished to **us**.
- L. **Information Release and Data Confidentiality.** The **Policyholder** and all **Participants** that need **Covered Transplant Services** must allow **us** access to medical information from all appropriate **Providers**. Such information is necessary in order for **us** to make proper benefit determinations. The information will not be used, disclosed, furnished, or made accessible to anyone other than **our** authorized employees and vendors contracted by **us** to carry out **our** obligations under this Policy. In accordance with the applicable law, **we** and the **Policyholder** agree to establish and maintain administrative, technical and physical safeguards to protect the security, confidentiality and integrity of the medical information.
- M. **Entire Contract.** This Policy (along with the Certificate) and the signed **Application** form the entire contract between the **Policyholder** and **us**. No amendment to this Policy shall be effective unless confirmed by a written Endorsement agreed to and issued by **us**. No agent or representative of the **Company**, other than an executive officer, may change this Policy or waive any of its provisions. No verbal statement by any executive officer or other employee of the **Company** is binding on **us**.

## POLICYHOLDER PROVISIONS

(Continued)

- N. Audit.** We shall have the right to inspect and audit all records and procedures of the: 1) **Policyholder**; 2) its **Medical Plan Administrator**; or 3) any other organization involved in the administration or adjudication of claims. In addition, we shall have the right to require premium records, proof of eligibility, and claim payment information in a manner that meets our requirements.
- O. Clerical Error.** A clerical error made by the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or us will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated. Any clerical error in data provided to us must be corrected and promptly reported to us. We will make appropriate adjustments to premiums due and/or benefit determinations. Any refund in premium due to **Policyholder** error is limited to the [12-month period prior to the date of the request for refund].
- P. Conformity with Statutes.** Any provision of this Policy that, on the **Policy Effective Date**, is in conflict with the requirements of state or federal statutes or regulations (in the applicable jurisdiction) is hereby amended to conform to the minimum requirements of such statutes and regulations.
- Q. Subrogation and Right of Reimbursement.** Another party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to **Covered Transplant Services**. Such party may include, but is not limited to, any of the following: a) the party or parties who caused the need for the **Covered Transplant Procedure**; b) the insurer or other indemnifier of the party or parties who caused the **Covered Transplant Procedure**; c) a guarantor of the party or parties who caused the **Covered Transplant Procedure**; d) a worker's compensation insurer; or e) any other person, entity, policy or plan that is liable or legally responsible in relation to the **Covered Transplant Procedure**. When this happens, we may, at our option: a) subrogate, that is, take over the **Participant's** right to receive payments from such party (the **Participant** or his or her legal representative must transfer to us any rights he or she may have to take legal action arising from the **Covered Transplant Procedure** to recover any sums paid under this Policy on behalf of the **Participant**); or b) recover from the **Participant** or his or her legal representative any benefits paid under this Policy from any payment the **Participant** is entitled to receive from the other party. The **Participant** or his or her legal representative must cooperate fully with us in asserting its subrogation and recovery rights. The **Participant** or his or her legal representative will, within 5 days of receiving our request, provide all information and sign and return all documents necessary to exercise our rights under this provision.

We will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration that the **Participant** receives or is entitled to receive from any of the sources listed above. This lien will not exceed the greater of: a) the amount recovered from any other party; or b) the amount of benefits paid by this Policy for **Covered Charges** plus the amount of all future benefits which may become payable under this Policy which result from the **Covered Transplant Services**. The **Company** will have the right to offset or recover such benefits from the amount received from any other party.

If the **Participant** or his or her legal representative makes any recovery from any other party and fails to reimburse us for any **Covered Charges**, then the **Participant** or his or her legal representative will be personally liable to us for the **Covered Charges** paid under this Policy. We may reduce future benefits payable under this Policy for any **Covered Charges** by the payment that the **Participant** or his or her legal representative has received from any other party.

Our first lien rights will not be reduced due to the **Participant's** own negligence; or due to the **Participant** not being made whole; or due to attorney's fees and costs. We are secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. We have the right to recover interest at the rate of [1/2% per month] commencing on the date the **Participant** or his or her legal representative recovers any funds from any other party. We are not subject to any state law doctrines, including, but not limited to, the common fund doctrine, which would purport to require us to reduce our recovery by any portion of a **Participant's** attorney's fees and costs.

## POLICYHOLDER PROVISIONS

(Continued)

**We** will not pay for future **Covered Charges** until such **Covered Charges** have exceeded all amounts that were recovered or are to be recovered by or on behalf of a **Participant**. If the **Participant** resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and this Policy takes secondary status. This Policy will reduce benefits for an amount equal to, but not less than, that state's mandatory minimum personal injury protection or medical payment requirement.

This provision also applies to any funds recovered from any other party by or on behalf of any dependent, the estate of any **Participant**; or on behalf of any incapacitated person.

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The following pages comprise the Certificate of Coverage delivered to the **Policyholder** for delivery to each **Member**.

The Certificate of Coverage is part of this Policy.

## SCHEDULE OF BENEFITS

**POLICY YEAR:** [January 1, 2009 through December 31, 2009]

### COVERED TRANSPLANTS:

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> Heart                             | <input checked="" type="checkbox"/> Heart/ Lung              | <input checked="" type="checkbox"/> Autologous Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo              |
| <input checked="" type="checkbox"/> Lung/Double Lung                  | <input checked="" type="checkbox"/> Kidney/ Pancreas         | <input checked="" type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (related)    |
| <input checked="" type="checkbox"/> Kidney (living or deceased donor) | <input checked="" type="checkbox"/> Kidney/Liver             | <input checked="" type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (unrelated)] |
| <input checked="" type="checkbox"/> Pancreas                          | <input checked="" type="checkbox"/> Liver/Intestine          |  |
| <input checked="" type="checkbox"/> Liver (living or deceased donor)  | <input checked="" type="checkbox"/> Pancreas/Intestine       |  |
| <input checked="" type="checkbox"/> Intestine                         | <input checked="" type="checkbox"/> Liver/Pancreas/Intestine |  |
| <input type="checkbox"/> Ventricular Assist Device                    | <input type="checkbox"/> Other (specify):                    |  |

### TRANSPLANT BENEFIT PERIOD:

The Transplant Benefit Period begins [on the date of **Transplant Evaluation** for][ten (10) days before] a **Covered Transplant Procedure**.

The Transplant Benefit Period ends on the earliest of the following dates:

1. [The end of the 365th day following the **Covered Transplant Procedure**;
2. The date the **Participant's** Lifetime Limit has been reached under the Policy or under the **Medical Plan**;
3. The date the Policy terminates, but only if:
  - a. The **Policyholder** cancels the Policy prior to the last day of the current **Policy Year**; or
  - b. The **Participant's** Transplant Benefit Period has begun, but such **Participant** has not received a **Covered Transplant Procedure** as of the date of termination of the Policy; or
4. The date the **Participant's** COBRA benefits terminate, if applicable.
5. The date established by the Non-Performance of Covered Transplant Procedures provision.]

[If there is no **Transplant Evaluation**, the Transplant Benefit Period begins on the date of a **Covered Transplant Procedure**.]

[If a **Transplant Evaluation** occurs while the Policy is in force and results in a **Covered Transplant Procedure** that takes place during this **Policy Year**, the expenses for the **Transplant Evaluation** will be eligible for reimbursement even if it occurred prior to the Transplant Benefit Period. This benefit does not apply to individuals with a **Pre-existing Condition** unless the **Transplant Evaluation** occurs after the **Pre-existing Condition Waiting Period** has expired.]

For a Bone Marrow/Peripheral Stem Cell Tissue Transplant, the date the tissue is re-infused is deemed to be the date of the **Covered Transplant Procedure**.

All benefits provided during a Transplant Benefit Period that extend beyond the **Policy Year** will be based on the Policy terms in effect at the start of the Transplant Benefit Period.

A Transplant Benefit Period cannot begin prior to the date the **Participant** first becomes covered under the Policy.

**LIFETIME LIMIT:** [\$\$1,000,000.00 for each **Participant**]

The following charges are included within and reduce each **Participant's** Lifetime Limit:

1. All benefits paid on behalf of the **Participant** (including covered donor charges) under the Policy and any preceding or succeeding Organ & Tissue Transplant Policy between **us** and the **Policyholder**; and
2. All benefits paid by **us** under the "Travel, Lodging, and Meals Benefit" provision.

## SCHEDULE OF BENEFITS

(Continued)

### [DEDUCTIBLE AMOUNT (APPLICABLE TO HIGH DEDUCTIBLE HEALTH PLANS ONLY):

Although the Policy does not impose a **Deductible Amount**, if a **Participant** selects a high deductible health plan sponsored by the **Policyholder**, then the **Deductible Amount** set forth in such **Policyholder's** high deductible health plan must be paid by the **Participant** before benefits are payable under the Policy. This requirement is necessary in order for the **Participant** to remain eligible for the tax benefits afforded by the health savings account associated with the **Policyholder's** high deductible health plan.]

### REIMBURSEMENT AMOUNTS:

- A. PARTICIPATING PROVIDER: ..... [100%] of **Covered Charges** for **Covered Transplant Services** provided through a **Participating Transplant Facility**. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.)
- B. NONPARTICIPATING PROVIDER: ..... [80%] of **Covered Charges** for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** with respect to the type of **Covered Transplant Procedure** performed. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.) Benefits for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** will not exceed the Maximum Amounts stated below:

COVERED TRANSPLANT PROCEDURE	MAXIMUM BENEFIT FOR ALL COVERED TRANSPLANT SERVICES PROVIDED BY A NONPARTICIPATING TRANSPLANT FACILITY
Heart	\$437,000
Lung (Single)	\$261,000
Lung (Double)	\$363,000
Kidney (living or deceased donor)	\$156,000
Pancreas	\$163,000
Liver (living or deceased donor)	\$196,000
Intestine	\$626,000
Heart/Lung	\$495,000
Kidney/Pancreas	\$200,000
Kidney/Liver	\$419,000
Liver/Intestine	\$700,000
Pancreas/Intestine	\$668,000
Liver/Pancreas/Intestine	\$716,000
Autologous Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b>	\$175,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - related	\$297,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - unrelated	\$380,000

- C. SECONDARY PAYOR: ..... When benefits under the Policy are considered secondary, as determined by the Coordination of Benefits provisions, benefit payments will be based on the lesser of: a) **Covered Charges**; or b) the negotiated amount established between the primary payor and the **Provider**.

**SCHEDULE OF BENEFITS**  
(Continued)

**ENDORSEMENTS:** Yes  No

If yes, please specify:  
[ ]

**POLICYHOLDER'S MEDICAL PLAN ADMINISTRATOR:**

[A-1 Administrator, Inc.]

## BENEFIT PROVISIONS

Boldfaced terms have special meaning. Please refer to the Definitions section or Benefit Provision section for a complete description of such terms.

### INSURING AGREEMENT:

Subject to all terms, conditions, limitations, and exclusions, **we** will pay **Covered Charges** incurred by **you** for **Covered Transplant Services** performed in a **Transplant Facility** that are directly related to a **Covered Transplant Procedure**.

### NOTIFICATION REQUIREMENTS:

**We** must be notified as soon as possible by **you**, the **Policyholder**, or **your Physician** that a **Covered Transplant Procedure** is being considered. Notification must occur before the referral is made and services are rendered for any **Transplant Consultation** and/or **Transplant Evaluation**. Failure to provide this notification may result in a decrease or denial of benefits. Notifications must be submitted to:

[Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, IN 46268  
Attention: Transplant Nurse Advisor  
(888) 449-2377]

### COVERED TRANSPLANT SERVICES:

*The following services require our prior approval and are eligible for coverage if they are provided to **you**, performed within a **Transplant Facility**, and directly related to a **Covered Transplant Procedure**. [Complications of donation experienced by the living donor are not covered.]*

1. Transplant Consultation. **Transplant Consultation** means a consultation with a transplant **Physician** to determine if **your** condition is such that **you** qualify for further evaluation according to the **Transplant Facility's** established **Transplant Evaluation** protocol.
2. Transplant Evaluation. **Transplant Evaluation** means tests, labs, x-rays, scans, procedures (including dental evaluations, x-rays, and examinations), and consultations for **you** (and any applicable living donor) that are in compliance with the **Transplant Facility's** established transplant program protocol.
3. Solid Organ Procurement. **Solid Organ Procurement** means compatibility testing and procurement expenses for living and deceased donors; donor's surgical procedure to remove the organ or tissue; and inpatient and outpatient services for living donor.
4. Bone Marrow or Stem Cell Procurement. **Bone Marrow or Stem Cell Procurement** means expenses for:
  - a. Procurement from **you** for autologous bone marrow/stem cell transplant;
  - b. Procurement from a living donor for allogeneic bone marrow/stem cell transplant, including compatibility testing of relatives;
  - c. Testing/typing of potential unrelated donors;
  - d. Tests related to the procurement of bone marrow/stem cells, including human leukocyte antigen typing;
  - e. Collection and storage [(for up to 6 months)] of bone marrow/stem cells (autologous or allogeneic) for future use, as long as a bone marrow/stem cell transplant has been scheduled to occur [within the same 6 months]; and
  - f. Bone marrow/stem cell registry search expenses such as from the National Marrow Donor program (NMDP).

## BENEFIT PROVISIONS

(Continued)

5. Covered Transplant Procedure. **Covered Transplant Procedure** means a **Medically Necessary** adult or pediatric human organ and tissue transplants listed as a Covered Transplant in the Schedule of Benefits that is not **Experimental and/or Investigational Treatment**.
6. Transplant Hospitalization. **Transplant Hospitalization** means the hospitalization for the **Covered Transplant Procedure** including inpatient **Hospital** services, **Physician** services and ancillary services. For solid organ transplantation, coverage begins twenty-four (24) hours prior to the transplant procedure. Hospitalization of living solid organ donors is covered. Such services must be provided according to the **Transplant Facility's** established transplant program protocol. For bone marrow/stem cell transplants, coverage begins with the workup immediately prior to beginning **High Dose Chemotherapy** to include subsequent infusion of autologous or allogeneic bone marrow/stem cells. Bone marrow/stem cell transplantation may be performed as an inpatient or outpatient.
7. Follow-Up. **Follow-Up** means **Hospital** services (inpatient and outpatient), **Physician** services, labs, x-rays, procedures, and other diagnostic tests rendered by or at the **Transplant Facility** to determine the status of the transplanted organ or tissue after discharge from a **Transplant Hospitalization**. Such services must be provided according to the **Transplant Facility's** established transplant program follow-up guidelines or protocol.
8. Complications after Transplant for Recipient. **Complications after Transplant for Recipient** means services to treat complications experienced by the transplant recipient after transplant, such as:
  - a. Rejection of a solid organ;
  - b. Surgical complications; and
  - c. Graft versus host disease of transplanted bone marrow or stem cells.

Services may be rendered during the **Transplant Hospitalization** or after discharge from **Transplant Hospitalization**.

9. Acute Rehabilitation or Non-Acute Rehabilitation after Discharge from Transplant Hospitalization. **We** will pay for up to [a total of 15 days/visits] for home rehabilitation and physical therapy (inpatient or outpatient).
10. Home Health Care after Discharge from Transplant Hospitalization. **We** will pay for up to [a total 15 home health care visits] by a registered nurse to administer intravenous drugs, train the patient (and/or family) for self-administration of drugs, wound care, or similar procedures.
11. Durable Medical Equipment after Discharge from Transplant Hospitalization. **We** will pay for rental of durable medical equipment after discharge from the **Transplant Hospitalization**. This benefit is limited to the lesser of [a total 15 days of rental] or the purchase price of such equipment.
12. Prescription Drugs. **We** will pay for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals that are **Medically Necessary** after discharge from the **Transplant Hospitalization** for up to 365 days after the date of transplantation. Drugs used to treat conditions not directly related to the **Covered Transplant Procedure** are not covered.
13. Ventricular Assist Device (VAD). **We** will pay for expenses for the VAD and any related **Provider** expenses from the date of insertion up to [a total 5 days] following the date of insertion, provided that:
  - a. The VAD is approved by the Food and Drug Administration (FDA);
  - b. **You** are simultaneously listed as an acceptable transplant candidate and approved for transplant by **us**; and
  - c. **You** receive the VAD at a **Transplant Facility**.

[VAD related benefits are limited to a maximum of \$100,000 for each Transplant Benefit Period.]  
**Complications as a result of the insertion of a VAD are not covered under the Policy.**]

## BENEFIT PROVISIONS

(Continued)

### [PRE-EXISTING CONDITION WAITING PERIOD:

If **you** have a **Pre-existing Condition** on the **Policy Effective Date** (referred to in the Renewal Endorsement as the Original Policy Effective Date), **you** are required to fulfill a [12 month] waiting period before benefits are provided under the Policy. The waiting period does not apply if **you** become eligible for coverage after the **Policy Effective Date** (or Original Policy Effective Date, if applicable), unless **you** are added to the **Medical Plan** as a result of the **Policyholder** acquiring a new group, affiliate, division, and/or subsidiary.

If **you** receive a transplant during a **Pre-Existing Condition Waiting Period**, that transplant and all related charges are excluded from coverage under the Policy and subsequent renewals.]

### MULTIPLE TRANSPLANTS:

If **you** require more than one **Covered Transplant Procedure**, benefits are determined as follows:

1. **Covered Transplant Procedures** that are due to related causes are subject to the same Transplant Benefit Period established by the first **Covered Transplant Procedure**. However, if the related **Covered Transplant Procedures** are separate by at least 90 days, a separate Transplant Benefit Period will be established for each procedure.
2. **Covered Transplant Procedures** that are due to unrelated causes will each have their own Transplant Benefit Period.
3. In no event will benefits provided under the Policy exceed the **Participant's** Lifetime Limit shown in the Schedule of Benefits, regardless of the number of **Covered Transplant Procedures** performed.

### NON-PERFORMANCE OF COVERED TRANSPLANT PROCEDURES:

If **you** have established a Transplant Benefit Period, but the **Covered Transplant Procedure** is not performed as scheduled due to **your** medical condition or death, benefits will be paid for **Covered Transplant Services** up to and until the earlier of:

1. **Your** death; or
2. The date **your Physician** decides not to perform the **Covered Transplant Procedure**.

### [TRANSPLANT NURSE ADVISOR:

**We** will assign a transplant nurse advisor to facilitate transplant coverage determination, access to transplant facilities, and ongoing patient support related to transplantation during the Transplant Benefit Period. These services are included without any additional charge.]

## BENEFIT PROVISIONS

(Continued)

### TRAVEL, LODGING, AND MEALS BENEFIT:

Your Benefit. We will reimburse reasonable and necessary travel expenses, as determined by us, incurred by you [and one companion (two companions if you are a minor)] during a Transplant Benefit Period for travel related to a **Covered Transplant Procedure**. Travel expenses include transportation, lodging, and meals and are subject to the limits shown below.

Living Donor Benefit. We will reimburse reasonable and necessary travel expenses, as determined by us, incurred by [a living donor and one companion] during a Transplant Benefit Period for travel related to a **Covered Transplant Procedure**. Travel expenses include transportation, lodging, and meals and are subject to limits shown below.

Transportation includes: [automobile; boat; airplane; train; ground ambulance; and air ambulance (jet or helicopter). Ambulance transportation (ground and air) requires our prior approval. Automobile mileage reimbursement is based on current federal guidelines for mileage reimbursement.]

Reimbursement for travel expenses will only be provided once we have received itemized receipts and a completed Travel Expense Form (as supplied by us).

DESCRIPTION	BENEFIT LIMIT
Lodging and meals for you and companion(s)	Up to \$200 per day per <b>Covered Transplant Procedure</b>
Lodging and meals for living donor and companion	Up to \$200 per day per <b>Covered Transplant Procedure</b>
<b>The Maximum Travel Benefit</b> for all eligible travel expenses (transportation, lodging, and meals) incurred by you, a living donor, and all eligible companions are limited to a combined Maximum Travel Benefit of \$10,000 per <b>Covered Transplant Procedure</b> . These travel, lodging, and meal benefits are included within and reduce your Lifetime Limit.	

### [DISABILITY, LEAVE OF ABSENCE, OR LAYOFF:

If you are not actively at work as a result of a disability, leave of absence, or layoff, eligibility for benefits provided under the Policy will only be extended to you through the earliest of:

1. The continuance period established by the underlying **Medical Plan** for such absences; or
2. The 12 month period immediately following the date your disability, leave of absence or layoff first began.

This provision does not apply to Retirees covered under the **Medical Plan** and the Policy, or individuals continuing benefits under COBRA or any other federally mandated program.]

## CLAIMS PROVISIONS

### A. Filing Claims.

The Policy provides coverage for claims that are incurred within the **Policy Year** and submitted for payment within [twelve (12) months following the **Date of Service**]. Unless otherwise stated in the Policy, claims will not be considered for payments if received after [twelve (12) months following the **Date of Service**].

Claims must be filed in a manner approved by **us**, and must include the following information:

1. **Your** name and address;
2. **Your** ID Number;
3. **Provider's** name, address, and Tax ID Number;
4. Itemized bill that includes the CPT codes or description of each charge; and
5. Diagnosis.

### B. Claim Payment.

**We** will pay benefits for all **Covered Charges** in accordance with the terms of the Policy within 60 days after receiving all necessary information. Benefits are paid to **you** or to **your** assignee or designee. **We** may pay benefits directly to the **Provider** or to any relative **we** deem appropriate if a benefit is payable and **you** are: 1) a minor; 2) legally incapable of giving valid receipt and discharge of payment; or 3) deceased.

## APPEAL AND GRIEVANCE PROCEDURES

Appeals must be submitted for consideration within 180 days of the date of **our** payment (if the appeal is based upon **our** payment) or within 180 days of the date of our denial of coverage. Grievances regarding **our** services or product may be submitted at any time during the **Policy Year**.

**A. Appeal Process.** An appeal is a formal request for review of **our** determinations regarding transplant related services, including but not limited to **our** payment(s) and/or coverage denials. The following reviews are available to **you** upon filing an appeal:

1. Standard Review. A standard review of an appeal is available on a prospective or retrospective basis and must be requested in writing by **you** or **your** designee. A standard review is available in situations wherein the timeframe for the review does not jeopardize **your** life or health. **We** will conduct the review and provide a written determination within [thirty (30)] business days after receiving all necessary information to complete the review.
2. Expedited Review. An expedited review of an appeal is only available on a prospective basis and must be requested in writing by **you** or **your** designee. An expedited review is only available if the timeframe for the review could seriously jeopardize **your** life or health. **We** will coordinate the review and communicate the determination verbally within [seven (7)] business days after receiving all necessary information to complete the review. **We** will also provide a written determination within [three (3)] business days following **our** verbal communication.

All appeals are reviewed and determined by a Peer Reviewer. Peer Reviewers are **Physicians** who:

1. Are clinical peers;
2. Hold an active, unrestricted license to practice medicine;
3. Are in a similar specialty as typically manages the medical condition, procedure, or treatment as the treating **Physician**; and
4. Are neither the individual nor a subordinate of the individual who made the original coverage determination or denial.

**B. Grievance Process.** A grievance or complaint is an expression of dissatisfaction regarding **our** products or services. **You** or **your** designee may submit a grievance verbally or in writing. Depending on the nature of the grievance and whether or not a response is requested, **we** will respond verbally and/or in writing within thirty (30) business days following receipt of the grievance. Grievances will be considered when measuring the quality and effectiveness of **our** products and services.

## COORDINATION OF BENEFITS

- A. Applicability.** This Section applies when **you** make a claim for reimbursement of **Covered Charges**, and **you** are covered by **Additional Medical Coverage**. If this provision applies, review the Order-of-Benefit-Determination Rules, under the heading of the same name, to determine whether the Policy's coverage is payable before or after **Additional Medical Coverage**. The Policy's coverage will not be reduced when its coverage is payable first, as determined under the Order-of-Benefit-Determination Rules; but may be reduced when another plan's benefits are payable first, as determined under the Order-of-Benefit-Determination Rules as set forth below.
- B. Order-of-Benefit-Determination Rules.** When there is a basis for a claim under the Policy and **Additional Medical Coverage**, the Policy is secondary if: (1) the **Additional Medical Coverage** does not have rules coordinating its benefits with the Policy; or (2) the **Additional Medical Coverage's** rules, the Policy's rules, or both, require the Policy's coverage be determined after those of the **Additional Medical Coverage**, except as may occur under the gender rule exception in Item C.2, below.
- C. Filing Guidelines.** The general guidelines which follow discuss the order in which **you** should file claims when **you** are covered under **Additional Medical Coverage**, using the first of the rules which applies:
1. The **Additional Medical Coverage** that covers **you** as a subscriber is obligated to pay before the Policy covering **you** as a dependent.
  2. When the parents of a dependent child are neither separated nor divorced:
    - a. **You** must file first under the Policy or **Additional Medical Coverage** covering the dependent child of the parent whose birthday falls earlier in the year; then file under the Policy or **Additional Medical Coverage** of the parent whose birthday falls later in the year; but
    - b. If both parents have the same birthday, the **you** must file first under the Policy or **Additional Medical Coverage** which has covered the parent for the longer period of time, and then under the Policy or **Additional Medical Coverage** of the other parent.

**EXCEPTION:** If the **Additional Medical Coverage** does not have the "birthday rule," but instead has a rule based upon the parent's gender, and as a result the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination, the rule of the **Additional Medical Coverage** will determine the order.

3. When the parents of a dependent are separated or divorced:
  - a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with custody; then
  - b. **You** must file under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the **spouse** of the parent with custody; then
  - c. **You** must file under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the parent without custody.

**EXCEPTION:** If there is a court decree which establishes financial responsibility for medical, dental, or other health care expenses regarding the dependent child of parents who have separated or divorced:

- a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with such financial responsibility; then
- b. File under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the other parent.

If the specific terms of the court decree state that the parents have joint custody without stating that one parent is responsible for the child's medical, dental, or other health care expenses, file as described in Item C.2, above.

## COORDINATION OF BENEFITS

(Continued)

4. **You** must file first under the Policy or **Additional Medical Coverage** which covers **you** as a subscriber who is neither laid-off nor retired, or as a dependent of a subscriber; then file under the Policy or **Additional Medical Coverage** which covers **you** as a laid-off or retired subscriber or as a dependent of a laid-off or retired subscriber. Ignore this paragraph if the **Additional Medical Coverage** does not contain this paragraph and, as a result, the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination.
  5. When the order of payment cannot be determined in accordance with these general guidelines, file first under the Policy or **Additional Medical Coverage** which has covered **you** for the longer period of time, then under the Policy or **Additional Medical Coverage** which has covered **you** for the shorter period of time.
- D. Effect on the Policy's Coverage.** When **you** are covered under two or more policies, which together pay more than the **Covered Charges** for **Covered Transplant Services**, **we** will pay the Policy's benefits according to the Order-of-Benefit-Determination Rules. The Policy's benefit payments will not be affected when this Policy is primary. **However, when the Policy is secondary under the Order-of-Benefit-Determination Rules, benefits payable will be reduced (if necessary) so that combined benefits of all policies covering the Participant do not exceed the lesser of: 1) Covered Charges; or 2) the negotiated amount established between the primary insurer and the Provider.**
- E. Right to Receive and to Release Information.** To coordinate benefits, **we** will release or obtain information regarding a claim from any insurance company, organization, or person. **You** must furnish the **Company** with any information necessary to coordinate benefits.

**Right to Obtain Recovery.** **We** are not liable for any failure to coordinate benefits. If **we** pay full benefits on a claim for which it has only secondary liability, **we** may recover the difference from **you** or from any other appropriate party.

## EXCLUSIONS

We will not pay, in whole or in part, for any of the following:

- A. [Any service or supply not directly related to a **Covered Transplant Procedure**. This includes any service or supply rendered to treat the underlying disease before or after transplant (that is not part of the actual **Covered Transplant Procedure**).
- B. Services and supplies for treatment of complications related to a **Covered Transplant Procedure**, unless such complications are determined by **us** to be the immediate and direct result of a **Covered Transplant Procedure**.
- C. Charges for any transplant related services or supplies incurred prior to the **Policy Effective Date**.
- D. Charges for prescription drugs incurred prior to a **Covered Transplant Procedure**, except for **High Dose Chemotherapy** that is part of a **Covered Transplant Service**.
- E. Charges for prescription drugs incurred after discharge from a transplant hospitalization, except for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals.
- F. Chemotherapy and/or surgery prior to beginning **High Dose Chemotherapy** (including bone marrow/stem cell transplantation).
- G. Services provided for the removal of a transplanted solid organ, unless the removal is provided during a **Covered Transplant Procedure**.
- H. Services provided after: 1) a transplanted solid organ has been removed from the transplant recipient; or 2) disease has returned in a bone marrow or stem cell transplant recipient.
- I. Services for human leukocyte antigen typing of **you** or **your** relatives, compatibility testing, unrelated bone marrow/stem cell searches on registries, and harvest and/or storage of bone marrow/stem cells when bone marrow/stem cell transplant has not been reviewed and approved by **us**.
- J. Services and supplies for immunizations.
- K. Animal organ or artificial organ transplants.
- L. Charges for a stand-by **Physician**, unless otherwise approved by **us**.
- M. Services of a **Provider** who is a member of **your Immediate Family**.
- N. Services, supplies, or **Hospital** care which **we** determine are not **Medically Necessary** for the treatment of illness, injury, diseased condition, or impairment, except as specifically stated as covered.
- O. **Custodial Care**.
- P. Hospice care.
- Q. Charges for any **Experimental and/or Investigational Treatment**, except as specifically stated in the Policy.
- R. Charges paid or payable under Workers' Compensation.
- S. Preventive or routine care (including physicals, premarital examinations, any other routine or periodic examinations), dental services and supplies, education and training, except as specifically stated as covered.
- T. Research studies or screening examinations.
- U. Treatment of any illness or injury sustained as a result of an act of war.
- V. Services or supplies to the extent **you** are not legally obligated to pay for them.
- W. Expenses incurred before the **Policy Year** begins or after it ends, except as stated in the Policy.
- X. Rest cures or sanitarium care.
- Y. Services or supplies furnished by any **Provider** acting beyond the scope of such **Provider's** license.
- Z. Any service or supply that is a **Medicare** Part A or Part B liability.
- AA. Services or supplies received from a dental or medical department maintained by or on behalf of the **Policyholder**.
- BB. Services provided by any governmental agency to the extent that **you** are not charged for them, unless otherwise required by state or federal law.
- CC. Services or supplies not specifically stated as covered.
- DD. Telephone consultations, charges for failure to keep a scheduled visit, or charges for completing a claim form.
- EE. Recreational or diversional therapy.
- FF. Materials used in occupational therapy.
- GG. Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a **Provider** prescribes such items.
- HH. Services and supplies, which are eligible to be repaid under any private or public research fund whether or not such funding was applied for or received.

## EXCLUSIONS

(Continued)

- II. Services and supplies for treatment of complications or diseases incurred by a living donor, including, but not limited to, increase length of hospitalization or the costs to treat any complication or disease.
- JJ. Services and supplies incurred by any COBRA continuee whose COBRA continuation coverage was not offered and/or elected, and premiums were not paid, within the time frames required by COBRA.
- KK. **Prescription Drugs** for the treatment or prevention of a rejected organ or tissue following the end of the Transplant Benefit Period.
- LL. Services and supplies of any **Provider** located outside the United States of America, except for organ or tissue procurement services, unless otherwise prohibited by United States federal law.
- MM. Biological and/or mechanical devices used as a bridge to transplant unless specifically included in the Schedule of Benefits.
- NN. Charges for any transplant-related services or supplies incurred during the current **Policy Year** when the transplant procedure occurred prior to the **Policy Effective Date**. However, we will make an exception to this Exclusion for **Covered Charges** related to a **Covered Transplant Procedure you** received under a previous Organ & Tissue Transplant Policy issued by **us** to the **Policyholder**, as long as:
  1. There has been no break in coverage between the Transplant Policies issued by **us**; and
  2. The **Covered Charges** are for services or supplies incurred within the Transplant Benefit Period for the **Covered Transplant Procedure**.]

[**We** may, in certain circumstances for purposes of overall cost savings or efficiency and in **our** sole discretion, provide benefits for services that would otherwise be excluded from coverage. If **we** provide any benefit not covered under the Policy, this fact shall not be used against **us** in any similar case and **we** shall not be required to extend this benefit to any other **Participant**.]

## RIGHT TO AMEND RATES AND POLICY TERMS

**We** may revise the premium rates or any other terms of the Policy on the occurrence of any of the following:

- A. [The date the **Policyholder** amends the **Medical Plan**.
- B. The date the **Policyholder** requests a benefit change in the Policy.
- C. The date the **Policyholder** adds or deletes a subsidiary or affiliate.
- D. The date an increase or decrease in the number of **Participants** exceeds [25%] in any [one] month or [XX,25%] over any period of [XXX,three] consecutive months. The number of **Participants** will be derived from the **Policyholder's** monthly premium statements or any other reports obtained from the **Policyholder** or the **Medical Plan's Administrator**.
- E. The date **we** are notified by the state in which the **Policyholder** is located of any state imposed tax or assessment for which **we** are obligated to pay.
- F. The date of any change in the **Policyholder's** business that materially affects **our** risk.
- G. The date it is discovered that there has been a material misrepresentation or nondisclosure of information that **we** could reasonably have expected to have been disclosed to **us** by the **Policyholder** or the **Policyholder's Medical Plan Administrator**.]

## TERMINATION PROVISIONS

**We** may, at any time, cancel benefits under the Policy for the reasons specified in the Policy.

In addition, **your** coverage shall automatically terminate on the earliest of the following dates:

- A. The date the Policy is terminated, as specified in the Policy. (The **Policyholder** is responsible for notifying **you** of the termination of the Policy.)
- B. The date **you** cease to be a covered **Participant**.
- C. The date **we** receive written notice from **you** or the **Policyholder** instructing **us** to terminate **your** coverage. (Coverage will terminate on the date specified in the notice, if provided.)

## GENERAL PROVISIONS

- A. Defined Terms.** The Policy contains certain defined terms that have been capitalized. Please refer to the Definitions section of the Policy for a complete description of such terms.
- B. Incontestability.** **We** may declare the Policy null or cancel it, if the **Application** contains a material misrepresentation. However, this provision will not apply once the Policy has been in effective for two years.
- C. Representations Not Warranties.** A copy of the **Application** is attached to the Policy. All statements made by the **Policyholder** or by **Participants** applying for coverage will be considered representations and not warranties. No statement appearing on the **Application** will be used to contest the validity of the **Policyholder's** right to the benefits of the Policy, unless the **Policyholder** has been furnished a copy of the **Application**.
- D. Evidence of Insurability.** The **Policyholder** is required to provide **us** with verification that **you** are covered by the **Policyholder's Medical Plan**.
- E. Notice.** When **we** provide written notice to the **Policyholder's** last known address regarding the administration of the Policy, it is deemed to be notice to all affected parties. The **Policyholder** is responsible for giving **you** notice, if applicable.
- F. Legal Action.** No legal action may be brought under the Policy within 60 days after **we** receive a claim. No action may be brought after 3 years from the date the claim is required to be furnished to **us**.
- G. Information Release and Data Confidentiality.** The **Policyholder** and all **Participants** that need **Covered Transplant Services** must allow **us** access to medical information from all appropriate **Providers**. Such information is necessary in order for **us** to make proper benefit determinations. The information will not be used, disclosed, furnished, or made accessible to anyone other than **our** authorized employees and vendors contracted by **us** to carry out **our** obligations under the Policy. **We** and the **Policyholder** agree to establish and maintain administrative, technical and physical safeguards to protect the security, confidentiality and integrity of the medical information.
- H. Entire Contract.** The Policy and the signed **Application** form the entire contract between the **Policyholder** and **us**. No amendment to the Policy shall be effective unless confirmed by an Endorsement issued to form a part of the Policy. No agent or representative of the **Company**, other than an executive officer, may change the Policy or waive any of its provisions. No verbal statement by any executive officer or other employee of the **Company** is binding on **us**.
- I. Clerical Error.** A clerical error made by the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or **us** will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated. Any clerical error in data provided to **us** must be corrected and promptly reported to **us**. **We** will make appropriate adjustments to premiums due and/or benefit determinations. Any refund in premium due to **Policyholder** error is limited to the 12-month period prior to the date of the request for refund.
- J. Conformity with Statutes.** Any provision of the Policy that, on the **Policy Effective Date**, is in conflict with the requirements of state or federal statutes or regulations (in the applicable jurisdiction) is hereby amended to conform to the minimum requirements of such statutes and regulations.
- K. Not Liable for Provider Acts or Omissions.** **We** are not responsible for the quality of care **you** receive from any **Provider**. The Policy does not give anyone any claim, right, or cause of action against **us** based on what a **Provider** of health care or supplies does or does not do.
- L. Right of Recovery.** If **we** make any payment that according to the terms of the Policy should not have been made, including payment made in error, **we** may recover that incorrect payment from any appropriate party, whether or not it was due to **our** error. If the incorrect payment was made directly to **you**, **we** may deduct it when making future payments directly to **you**.

## GENERAL PROVISIONS

(Continued)

**M. Subrogation and Right of Reimbursement.** Another party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to **Covered Transplant Services**. Such party may include, but is not limited to, any of the following: (a) the party or parties who caused the need for the **Covered Transplant Procedure**; (b) the insurer or other indemnifier of the party or parties who caused the **Covered Transplant Procedure**; (c) a guarantor of the party or parties who caused the **Covered Transplant Procedure**; (d) a worker's compensation insurer; (e) any other person, entity, policy or plan that is liable or legally responsible in relation to the **Covered Transplant Procedure**. When this happens, **we** may, at **our** option, (a) subrogate, that is, take over the **Participant's** right to receive payments from such party (the **Participant** or his or her legal representative must transfer to **us** any rights he or she may have to take legal action arising from the **Covered Transplant Procedure** to recover any sums paid under the Policy on behalf of the **Participant**), or (b) recover from the **Participant** or his or her legal representative any benefits paid under the Policy from any payment the **Participant** is entitled to receive from the other party. The **Participant** or his or her legal representative must cooperate fully with **us** in asserting its subrogation and recovery rights. The **Participant** or his or her legal representative will, within 5 days of receiving **our** request, provide all information and sign and return all documents necessary to exercise **our** rights under this provision.

**We** will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration that the **Participant** receives or is entitled to receive from any of the sources listed above. This lien will not exceed the greater of (a) the amount recovered from any other party, or (b) the amount of benefits paid by the Policy for **Covered Charges** plus the amount of all future benefits which may become payable under the Policy which result from the **Covered Transplant Services**. The **Company** will have the right to offset or recover such benefits from the amount received from any other party.

If the **Participant** or his or her legal representative makes any recovery from any other party and fails to reimburse **us** for any **Covered Charges**, then the **Participant** or his or her legal representative will be personally liable to **us** for the **Covered Charges** paid under the Policy. **We** may reduce future benefits payable under the Policy for any **Covered Charges** by the payment that the **Participant** or his or her legal representative has received from any other party.

Our first lien rights will not be reduced due to the **Participant's** own negligence; or due to the **Participant** not being made whole; or due to attorney's fees and costs. **We** are secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. **We** have the right to recover interest at the rate of 1/2% per month commencing on the date the **Participant** or his or her legal representative recovers any funds from any other party. **We** are not subject to any state law doctrines, including, but not limited to, the common fund doctrine, which would purport to require **us** to reduce **our** recovery by any portion of a **Participant's** attorney's fees and costs.

**We** will not pay for future **Covered Charges** until such **Covered Charges** have exceeded all amounts that were recovered or are to be recovered by or on behalf of a **Participant**. If the **Participant** resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the Policy takes secondary status. The Policy will reduce benefits for an amount equal to, but not less than, that state's mandatory minimum personal injury protection or medical payment requirement.

This provision also applies to any funds recovered from any other party by or on behalf of any dependent, the estate of any **Participant**; or on behalf of any incapacitated person.

## DEFINITIONS

- A. Additional Medical Coverage** – means any other insurance that provides **you** with medical benefits covered under the Policy.
- B. Application** – means the **Policyholder's** completed Organ & Tissue Transplant Application.
- C. Company** – means AIG Life Insurance Company.
- D. Covered Charges** – means charges incurred during a Transplant Benefit Period that are **Reasonable and Customary**, in **our** judgment, for **Covered Transplant Services**. With respect to **Providers**, a charge will not be considered **Reasonable and Customary** if it is not in conformity with one or a combination of the following:
1. A negotiated rate based on services provided;
  2. A fixed rate per day; or
  3. The **Reasonable and Customary** allowance for similar **Providers** who perform similar **Covered Transplant Services**.
- E. Covered Transplant Procedure** – means a **Medically Necessary** adult or pediatric human organ and tissue transplants listed as a Covered Transplant in the Schedule of Benefits.
- F. Covered Transplant Services** – means the services shown as Covered Transplant Services in the Benefit Provisions.
- G. Custodial Care** – means care and services that assist in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, and using the toilet; feeding or preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.
- H. Date of Service** – means the date when the service was actually provided or the date on which the purchase was made.
- I. Diagnostic Services** – means the following procedures that are directly related to a **Covered Transplant Procedure** and ordered by a **Provider Individual** because of specific symptoms in order to determine a definite condition or disease: (i) radiology, ultrasound, and nuclear medicine; (ii) laboratory and pathology; and (iii) EKGs, EEGs, and other electronic diagnostic medical procedures.
- J. [Experimental and/or Investigational Treatment** – means any drug, device, procedure, facility, equipment, treatment plan, protocol, supply or service directly related to a **Covered Transplant Procedure** (i) that is deemed to be experimental or investigational in nature by an appropriate technological assessment body established by any state or federal government, or (ii) where **we**, in **our** sole discretion, determine that, at the time it is used, one or more of the following conditions is present:
1. Its use requires approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to the Federal Drug Administration (FDA).
  2. Its use is not yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or is subject to either:
    - a) A written investigational or research protocol or treatment plan; or
    - b) A written informed consent or protocol used by the **Transplant Facility** in which reference is made to the drug, device, procedure, protocol, or treatment plan as being experimental, investigative, educational, for a research study, a pilot study, or posing an uncertain outcome, or having an unusual risk; or
    - c) A written protocol, protocols or informed consent used by any other facility studying substantially the same drug, device, procedure or treatment which states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or
    - d) An ongoing review by an Institutional Review Board.

## DEFINITIONS

(Continued)

For individuals participating or eligible to participate in clinical trials, the following will be considered Experimental and/or Investigational:

1. Clinical trials that are a single institution or investigator study. Clinical trials performed at a National Cancer Institute (NCI) designated Comprehensive Cancer Center are exempt from this requirement.
2. With regard to adult bone marrow/stem cell transplants:
  - a. All Phase I or II clinical trials; and
  - b. All Phase III clinical trials that are not sponsored by the NCI or similar national oncology cooperative body.
3. With regard to pediatric bone marrow/stem cell transplants:
  - a. All Phase I-IV clinical trials that are not sponsored by the Children's Oncology Group.
4. All "off protocol" treatment wherein **you** are not actually enrolled in a clinical trial.

Drugs, devices, procedures, facilities, equipment, treatment plans, supplies, and services that fall into the categories listed above **are not** considered Experimental and/or Investigational if their use is required by state law or recognized as acceptable medical practice throughout the United States to treat **your** illness as a result of:

1. The positive endorsement, recommendation, or publication of standards of care by national medical bodies or panels, including but not limited to, National Comprehensive Cancer Network (NCCN), NCI, or the National Institutes of Health; or
2. Multiple published peer review articles, in recognized professional medical journal(s), concerning such drug, device, procedure or treatment plan and reflecting its reproducibility by non-affiliated sources which **we** determine to be authoritative; or
3. Trial results (that adequately demonstrate safety and efficacy), which indicate the drug, device, procedure, protocol, or treatment plan is at least as clinically effective and cost effective as current standard therapy; or
4. Specific state mandated coverage requirements.]

**K. High Dose Chemotherapy** – means the use of a chemotherapeutic agent or agents to treat cancer or cancer-like illness (with or without irradiation) in doses which exceed the FDA approved or commonly recognized dosage range for the drug or drugs employed. In order to be considered as an eligible expense, High Dose Chemotherapy must:

1. Be part of a protocol or treatment plan that includes the reinfusion of autologous bone marrow or stem cells, or infusion of allogeneic bone marrow or stem cells, immediately after the High Dose Chemotherapy regimen is completed; and
2. Be expected to result in effects upon the bone marrow which would likely be lethal if left untreated.

All drugs and/or radiopharmaceuticals are subject to the **Experimental and/or Investigational Treatment** definition in the Policy.

**L. Immediate Family** – means **your** [spouse, parent, child, sibling, grandparent, or grandchild.]

**M. Medical Plan** – means a plan of major medical benefits maintained by the **Policyholder**. It includes, but is not limited to coverage provided under: group health insurance; health maintenance organizations; self-insured plans; preferred provider organizations; prepayment coverage; any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee plan, a union welfare plan, an employee organization plan, or an employee benefit organization; any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization; any government program except **Medicare** or Medicaid; the medical payments and/or no-fault provisions of automobile insurance; and any other group type coverage as permitted by law.

**Medical Plan** does not include benefits provided under [a limited health care benefit plan (such as a critical illness, specified disease, or "mini-med"), nor benefits provided under a: dental; vision; outpatient prescription drug; and/or short-term disability plan.]

## DEFINITIONS

(Continued)

- N. Medically Necessary or Medical Necessity** – means those drugs, devices, procedures, treatments, services or supplies, provided by a **Provider**, which are required for treatment of illness, injury, diseased condition, or impairment, and are:
1. consistent with **your** diagnosis or symptoms and **you** are an appropriate candidate for the proposed treatment;
  2. appropriate treatment, according to generally accepted standards of medical practice;
  3. not provided only as a convenience to **you** or the **Provider**;
  4. not an **Experimental and/or Investigational Treatment**; and
  5. not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment. Any service or supply provided at a **Provider Facility** will not be considered Medically Necessary if **your** symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The fact that a **Provider Individual** may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary or make the charge a **Covered Charge**.

- O. Medicare** – means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
- P. Member** – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a member, or as a subscriber. Member does not include a dependant. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.
- Q. Participant** – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a **Member**, a subscriber, or a dependent who is also covered under the Policy. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.
- R. Premium Due Date** – means the date the **Policyholder's** premium is due. The Premium Due Date is shown in the Policy Face Page.
- S. Policy Effective Date** – means the Policy Effective Date as shown on the Policy Face Page which is the date that coverage begins under the Policy.
- T. Policy Year** – means the period of time shown in the Schedule of Benefits during which the Policy is in effect. The Policy Year is subject to early termination as set forth in the Termination Provisions.
- U. Pre-existing Condition** – means any condition for which **you** have, within the 24 months prior to the Effective Date of the Policy:
1. Been advised by an attending **Physician** that a transplant may be needed (regardless of the timeframe to transplant and regardless of the **Participant's** decision to move forward or not move forward with a **Transplant Consultation** or **Transplant Evaluation**;
  2. Had a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of the outcome);
  3. Been scheduled to have a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of when the **Transplant Consultation** and/or **Transplant Evaluation** was to be done and regardless of the outcome); and/or
  4. Received, or has been listed to receive, an organ or tissue transplant.

[In addition, if **you** have, within the 24 months prior to the **Policy Effective Date** of the Policy, received dialysis treatments or been diagnosed with Chronic Kidney Disease or End Stage Renal Disease (ESRD), **you** will be deemed to have a Pre-existing Condition.]

## DEFINITIONS

(Continued)

If **you** are added subsequent to the **Policy Effective Date** as a result of the acquisition of a new group, affiliate, division, and/or subsidiary, Pre-existing Condition will mean those conditions listed above that occurred within the 24 months prior to **your** effective date of coverage under the Policy.

**V. Provider** – means any of the facilities and individuals listed below:

1. **Provider Facilities** – means any of the following facilities:

- a. **Clinical Laboratory** – means a laboratory that performs clinical procedures and is not affiliated or associated with a Hospital, **Physician**, or other Provider.
- b. **Hospital** – means a facility which is a short-term general hospital and which: (1) is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **Physicians**, for compensation from its patients; (2) has organized departments of medicine and major surgery; and (3) provides 24-hour nursing service by or under the supervision of registered nurses. Surgical facilities may be either on premises or in facilities available to the hospital on a prearranged basis.
- c. **Pharmacy** – means a facility licensed as a Pharmacy by the state in which it operates.
- d. **Transplant Facility** – means the following facilities:
  - i. **Nonparticipating Transplant Facility** – Any **Hospital** that has not contracted with **us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Hospital** may be a Nonparticipating Transplant Facility with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.
  - ii. **Participating Transplant Facility** – Any **Hospital** contracting with **us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Hospital** may be a Participating Transplant Facility with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.

2. **Provider Individuals** – means any of the following individuals:

- a. **Occupational Therapist** – means a person who is licensed as an Occupational Therapist by the state in which he or she practices. If that state does not issue such licenses, an Occupational Therapist is a person certified as an Occupational Therapist by an appropriate professional body.
- b. **Physical Therapist** – means a person who is licensed as a Physical Therapist by the state in which he or she practices. If that state does not issue such licenses, a Physical Therapist is a person certified as a Physical Therapist by an appropriate professional body.
- c. **Physician** – means a person performing services within the scope of his or her license, who is a duly licensed: (1) doctor of medicine (MD); (2) doctor of osteopathy (DO); (3) dentist; (4) optometrist; or (5) psychologist.
- d. **Respiratory/Inhalation Therapist** – means a person who is licensed as a Respiratory/Inhalation Therapist by the state in which he or she practices. If that state does not issue such licenses, a Respiratory/Inhalation Therapist is a person certified as a Respiratory/Inhalation Therapist by an appropriate professional body.
- e. **Speech Pathologist** and **Speech Therapist** – means a person licensed as a Speech Pathologist or Speech Therapist by the state in which he or she practices. If that state does not issue such licenses, a Speech Pathologist or Speech Therapist is a person certified as such by an appropriate professional body.

**W. Reasonable and Customary** – means with respect to the word customary, the amount charged by a majority of **Providers** in the same geographic region for similar services or supplies and/or is relative to the value and worth of similar services; and with respect to the word reasonable, a charge that meets the above criteria and, that in **our** judgment, is not an excessive amount for similar services or supplies; or a charge that merits special consideration due to complexity of treatment in the opinion of a peer review committee or consultant. Due to the lack of insurance, if a **Provider** accepts as full payment an amount less than **Reasonable and Customary**, the lesser amount will be determined to be the maximum **Reasonable and Customary** amount. Benefits will be based on the lesser of the actual billed charge or the **Reasonable and Customary** charge.

## DEFINITIONS

(Continued)

- X. **Skilled Care** – means the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury. Skilled care must be performed by or under the supervision of **Provider Individuals**.
- Y. **Spouse** – means a person recognized as the **Member's** spouse under the **Medical Plan**.
- Z. **We, Us, Our** – means AIG Life Insurance Company.
- AA. **You, Your** – means the **Participant**, as defined in the Policy.



**AIG LIFE INSURANCE COMPANY**  
ONE ALICO PLAZA  
WILMINGTON, DELAWARE 19801

[ **Administrative Office:**  
Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, Indiana 46268  
(888) 449-2377]

### Organ & Tissue Transplant Certificate

**POLICYHOLDER:** [ABC Company]  
**POLICYHOLDER ADDRESS:** [123 Main Street, Any City, Any State, 12345]  
**POLICY NUMBER:** [289-1234]

**AIG Life Insurance Company** issues this Certificate as evidence of coverage under the Policy issued to the **Policyholder**, subject to all Policy provisions. The Policy may be amended, changed, cancelled or discontinued without the consent of any **Participant**.

**THIS IS LIMITED BENEFIT COVERAGE THAT IS NOT INTENDED  
AS MAJOR MEDICAL COVERAGE.**

**PLEASE READ THE CERTIFICATE CAREFULLY FOR A FULL DESCRIPTION  
OF THE BENEFITS, EXCLUSIONS, AND LIMITATIONS.**

**AIG Life Insurance Company**

Secretary

President

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## SCHEDULE OF BENEFITS

**POLICY YEAR:** [January 1, 2009 through December 31, 2009]

### COVERED TRANSPLANTS:

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> Heart                             | <input checked="" type="checkbox"/> Heart/ Lung              | <input checked="" type="checkbox"/> Autologous Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo              |
| <input checked="" type="checkbox"/> Lung/Double Lung                  | <input checked="" type="checkbox"/> Kidney/ Pancreas         | <input checked="" type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (related)    |
| <input checked="" type="checkbox"/> Kidney (living or deceased donor) | <input checked="" type="checkbox"/> Kidney/Liver             | <input checked="" type="checkbox"/> Allogeneic Bone Marrow<br>Peripheral Stem Cell<br>Including High Dose Chemo (unrelated)] |
| <input checked="" type="checkbox"/> Pancreas                          | <input checked="" type="checkbox"/> Liver/Intestine          |  |
| <input checked="" type="checkbox"/> Liver (living or deceased donor)  | <input checked="" type="checkbox"/> Pancreas/Intestine       |  |
| <input checked="" type="checkbox"/> Intestine                         | <input checked="" type="checkbox"/> Liver/Pancreas/Intestine |  |
| <input type="checkbox"/> Ventricular Assist Device                    | <input type="checkbox"/> Other (specify):                    |  |

### TRANSPLANT BENEFIT PERIOD:

The Transplant Benefit Period begins [on the date of **Transplant Evaluation** for][ten (10) days before] a **Covered Transplant Procedure**.

The Transplant Benefit Period ends on the earliest of the following dates:

1. [The end of the 365th day following the **Covered Transplant Procedure**;
2. The date the **Participant's** Lifetime Limit has been reached under the Policy or under the **Medical Plan**;
3. The date the Policy terminates, but only if:
  - a. The **Policyholder** cancels the Policy prior to the last day of the current **Policy Year**; or
  - b. The **Participant's** Transplant Benefit Period has begun, but such **Participant** has not received a **Covered Transplant Procedure** as of the date of termination of the Policy; or
4. The date the **Participant's** COBRA benefits terminate, if applicable.
5. The date established by the Non-Performance of Covered Transplant Procedures provision.]

[If there is no **Transplant Evaluation**, the Transplant Benefit Period begins on the date of a **Covered Transplant Procedure**.]

[If a **Transplant Evaluation** occurs while the Policy is in force and results in a **Covered Transplant Procedure** that takes place during this **Policy Year**, the expenses for the **Transplant Evaluation** will be eligible for reimbursement even if it occurred prior to the Transplant Benefit Period. This benefit does not apply to individuals with a **Pre-existing Condition** unless the **Transplant Evaluation** occurs after the **Pre-existing Condition Waiting Period** has expired.]

For a Bone Marrow/Peripheral Stem Cell Tissue Transplant, the date the tissue is re-infused is deemed to be the date of the **Covered Transplant Procedure**.

All benefits provided during a Transplant Benefit Period that extend beyond the **Policy Year** will be based on the Policy terms in effect at the start of the Transplant Benefit Period.

A Transplant Benefit Period cannot begin prior to the date the **Participant** first becomes covered under the Policy.

**LIFETIME LIMIT:** [\$1,000,000 for each **Participant**]

The following charges are included within and reduce each **Participant's** Lifetime Limit:

1. All benefits paid on behalf of the **Participant** (including covered donor charges) under the Policy and any preceding or succeeding Organ & Tissue Transplant Policy between **us** and the **Policyholder**; and
2. All benefits paid by **us** under the "Travel, Lodging, and Meals Benefit" provision.

## SCHEDULE OF BENEFITS

(Continued)

**[DEDUCTIBLE AMOUNT (APPLICABLE TO HIGH DEDUCTIBLE HEALTH PLANS ONLY):**

Although the Policy does not impose a **Deductible Amount**, if a **Participant** selects a high deductible health plan sponsored by the **Policyholder**, then the **Deductible Amount** set forth in such **Policyholder's** high deductible health plan must be paid by the **Participant** before benefits are payable under the Policy. This requirement is necessary in order for the **Participant** to remain eligible for the tax benefits afforded by the health savings account associated with the **Policyholder's** high deductible health plan.]

**REIMBURSEMENT AMOUNTS:**

- A. PARTICIPATING PROVIDER: ..... [100%] of **Covered Charges** for **Covered Transplant Services** provided through a **Participating Transplant Facility**. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.)
- B. NONPARTICIPATING PROVIDER: ..... [80%] of **Covered Charges** for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** with respect to the type of **Covered Transplant Procedure** performed. (All Participants subject to a Deductible Amount must meet the Deductible Amount before Covered Charges are eligible for reimbursement.) Benefits for **Covered Transplant Services** provided through a **Nonparticipating Transplant Facility** will not exceed the Maximum Amounts stated below:

COVERED TRANSPLANT PROCEDURE	MAXIMUM BENEFIT FOR ALL COVERED TRANSPLANT SERVICES PROVIDED BY A NONPARTICIPATING TRANSPLANT FACILITY
Heart	\$437,000
Lung (Single)	\$261,000
Lung (Double)	\$363,000
Kidney (living or deceased donor)	\$156,000
Pancreas	\$163,000
Liver (living or deceased donor)	\$196,000
Intestine	\$626,000
Heart/Lung	\$495,000
Kidney/Pancreas	\$200,000
Kidney/Liver	\$419,000
Liver/Intestine	\$700,000
Pancreas/Intestine	\$668,000
Liver/Pancreas/Intestine	\$716,000
Autologous Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b>	\$175,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - related	\$297,000
Allogeneic Bone Marrow/Peripheral Stem Cell Including <b>High Dose Chemotherapy</b> - unrelated	\$380,000

- C. SECONDARY PAYOR: ..... When benefits under the Policy are considered secondary, as determined by the Coordination of Benefits provisions, benefit payments will be based on the lesser of: a) **Covered Charges**; or b) the negotiated amount established between the primary payor and the **Provider**.

**SCHEDULE OF BENEFITS**  
(Continued)

**ENDORSEMENTS:** Yes  No

If yes, please specify:  
[ ]

**POLICYHOLDER'S MEDICAL PLAN ADMINISTRATOR:**

[A-1 Administrator, Inc.]

## BENEFIT PROVISIONS

Boldfaced terms have special meaning. Please refer to the Definitions section or Benefit Provision section for a complete description of such terms.

### INSURING AGREEMENT:

Subject to all terms, conditions, limitations, and exclusions, **we** will pay **Covered Charges** incurred by **you** for **Covered Transplant Services** performed in a **Transplant Facility** that are directly related to a **Covered Transplant Procedure**.

### NOTIFICATION REQUIREMENTS:

**We** must be notified as soon as possible by **you**, the **Policyholder**, or **your Physician** that a **Covered Transplant Procedure** is being considered. Notification must occur before the referral is made and services are rendered for any **Transplant Consultation** and/or **Transplant Evaluation**. Failure to provide this notification may result in a decrease or denial of benefits. Notifications must be submitted to:

[Medical Excess LLC  
8777 Purdue Road, #330  
Indianapolis, IN 46268  
Attention: Transplant Nurse Advisor  
(888) 449-2377]

### COVERED TRANSPLANT SERVICES:

*The following services require our prior approval and are eligible for coverage if they are provided to **you**, performed within a **Transplant Facility**, and directly related to a **Covered Transplant Procedure**. [Complications of donation experienced by the living donor are not covered.]*

1. Transplant Consultation. **Transplant Consultation** means a consultation with a transplant **Physician** to determine if **your** condition is such that **you** qualify for further evaluation according to the **Transplant Facility's** established **Transplant Evaluation** protocol.
2. Transplant Evaluation. **Transplant Evaluation** means tests, labs, x-rays, scans, procedures (including dental evaluations, x-rays, and examinations), and consultations for **you** (and any applicable living donor) that are in compliance with the **Transplant Facility's** established transplant program protocol.
3. Solid Organ Procurement. **Solid Organ Procurement** means compatibility testing and procurement expenses for living and deceased donors; donor's surgical procedure to remove the organ or tissue; and inpatient and outpatient services for living donor.
4. Bone Marrow or Stem Cell Procurement. **Bone Marrow or Stem Cell Procurement** means expenses for:
  - a. Procurement from **you** for autologous bone marrow/stem cell transplant;
  - b. Procurement from a living donor for allogeneic bone marrow/stem cell transplant, including compatibility testing of relatives;
  - c. Testing/typing of potential unrelated donors;
  - d. Tests related to the procurement of bone marrow/stem cells, including human leukocyte antigen typing;
  - e. Collection and storage [(for up to 6 months)] of bone marrow/stem cells (autologous or allogeneic) for future use, as long as a bone marrow/stem cell transplant has been scheduled to occur [within the same 6 months]; and
  - f. Bone marrow/stem cell registry search expenses such as from the National Marrow Donor program (NMDP).

## BENEFIT PROVISIONS

(Continued)

5. Covered Transplant Procedure. **Covered Transplant Procedure** means a **Medically Necessary** adult or pediatric human organ and tissue transplants listed as a Covered Transplant in the Schedule of Benefits that is not **Experimental and/or Investigational Treatment**.
6. Transplant Hospitalization. **Transplant Hospitalization** means the hospitalization for the **Covered Transplant Procedure** including inpatient **Hospital** services, **Physician** services and ancillary services. For solid organ transplantation, coverage begins twenty-four (24) hours prior to the transplant procedure. Hospitalization of living solid organ donors is covered. Such services must be provided according to the **Transplant Facility's** established transplant program protocol. For bone marrow/stem cell transplants, coverage begins with the workup immediately prior to beginning **High Dose Chemotherapy** to include subsequent infusion of autologous or allogeneic bone marrow/stem cells. Bone marrow/stem cell transplantation may be performed as an inpatient or outpatient.
7. Follow-Up. **Follow-Up** means **Hospital** services (inpatient and outpatient), **Physician** services, labs, x-rays, procedures, and other diagnostic tests rendered by or at the **Transplant Facility** to determine the status of the transplanted organ or tissue after discharge from a **Transplant Hospitalization**. Such services must be provided according to the **Transplant Facility's** established transplant program follow-up guidelines or protocol.
8. Complications after Transplant for Recipient. **Complications after Transplant for Recipient** means services to treat complications experienced by the transplant recipient after transplant, such as:
  - a. Rejection of a solid organ;
  - b. Surgical complications; and
  - c. Graft versus host disease of transplanted bone marrow or stem cells.

Services may be rendered during the **Transplant Hospitalization** or after discharge from **Transplant Hospitalization**.

9. Acute Rehabilitation or Non-Acute Rehabilitation after Discharge from Transplant Hospitalization. **We** will pay for up to [a total of 15 days/visits] for home rehabilitation and physical therapy (inpatient or outpatient).
10. Home Health Care after Discharge from Transplant Hospitalization. **We** will pay for up to [a total 15 home health care visits] by a registered nurse to administer intravenous drugs, train the patient (and/or family) for self-administration of drugs, wound care, or similar procedures.
11. Durable Medical Equipment after Discharge from Transplant Hospitalization. **We** will pay for rental of durable medical equipment after discharge from the **Transplant Hospitalization**. This benefit is limited to the lesser of [a total 15 days of rental] or the purchase price of such equipment.
12. Prescription Drugs. **We** will pay for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals that are **Medically Necessary** after discharge from the **Transplant Hospitalization** for up to 365 days after the date of transplantation. Drugs used to treat conditions not directly related to the **Covered Transplant Procedure** are not covered.
13. Ventricular Assist Device (VAD). **We** will pay for expenses for the VAD and any related **Provider** expenses from the date of insertion up to [a total 5 days] following the date of insertion, provided that:
  - a. The VAD is approved by the Food and Drug Administration (FDA);
  - b. **You** are simultaneously listed as an acceptable transplant candidate and approved for transplant by **us**; and
  - c. **You** receive the VAD at a **Transplant Facility**.

[VAD related benefits are limited to a maximum of \$100,000 for each Transplant Benefit Period.]  
**Complications as a result of the insertion of a VAD are not covered under the Policy.**

## BENEFIT PROVISIONS

(Continued)

### [PRE-EXISTING CONDITION WAITING PERIOD:

If **you** have a **Pre-existing Condition** on the **Policy Effective Date** (referred to in the Renewal Endorsement as the Original Policy Effective Date), **you** are required to fulfill a [12 month] waiting period before benefits are provided under the Policy. The waiting period does not apply if **you** become eligible for coverage after the **Policy Effective Date** (or Original Policy Effective Date, if applicable), unless **you** are added to the **Medical Plan** as a result of the **Policyholder** acquiring a new group, affiliate, division, and/or subsidiary.

If **you** receive a transplant during a **Pre-Existing Condition Waiting Period**, that transplant and all related charges are excluded from coverage under the Policy and subsequent renewals.]

### MULTIPLE TRANSPLANTS:

If **you** require more than one **Covered Transplant Procedure**, benefits are determined as follows:

1. **Covered Transplant Procedures** that are due to related causes are subject to the same Transplant Benefit Period established by the first **Covered Transplant Procedure**. However, if the related **Covered Transplant Procedures** are separate by at least 90 days, a separate Transplant Benefit Period will be established for each procedure.
2. **Covered Transplant Procedures** that are due to unrelated causes will each have their own Transplant Benefit Period.
3. In no event will benefits provided under the Policy exceed the **Participant's** Lifetime Limit shown in the Schedule of Benefits, regardless of the number of **Covered Transplant Procedures** performed.

### NON-PERFORMANCE OF COVERED TRANSPLANT PROCEDURES:

If **you** have established a Transplant Benefit Period, but the **Covered Transplant Procedure** is not performed as scheduled due to **your** medical condition or death, benefits will be paid for **Covered Transplant Services** up to and until the earlier of:

1. **Your** death; or
2. The date **your Physician** decides not to perform the **Covered Transplant Procedure**.

### [TRANSPLANT NURSE ADVISOR:

**We** will assign a transplant nurse advisor to facilitate transplant coverage determination, access to transplant facilities, and ongoing patient support related to transplantation during the Transplant Benefit Period. These services are included without any additional charge.]

## BENEFIT PROVISIONS

(Continued)

### TRAVEL, LODGING, AND MEALS BENEFIT:

Your Benefit. We will reimburse reasonable and necessary travel expenses, as determined by us, incurred by you [and one companion (two companions if you are a minor)] during a Transplant Benefit Period for travel related to a **Covered Transplant Procedure**. Travel expenses include transportation, lodging, and meals and are subject to the limits shown below.

Living Donor Benefit. We will reimburse reasonable and necessary travel expenses, as determined by us, incurred by [a living donor and one companion] during a Transplant Benefit Period for travel related to a **Covered Transplant Procedure**. Travel expenses include transportation, lodging, and meals and are subject to limits shown below.

Transportation includes: [automobile; boat; airplane; train; ground ambulance; and air ambulance (jet or helicopter). Ambulance transportation (ground and air) requires our prior approval. Automobile mileage reimbursement is based on current federal guidelines for mileage reimbursement.]

Reimbursement for travel expenses will only be provided once we have received itemized receipts and a completed Travel Expense Form (as supplied by us).

DESCRIPTION	BENEFIT LIMIT
Lodging and meals for you and companion(s)	Up to \$200 per day per <b>Covered Transplant Procedure</b>
Lodging and meals for living donor and companion	Up to \$200 per day per <b>Covered Transplant Procedure</b>
<b>The Maximum Travel Benefit</b> for all eligible travel expenses (transportation, lodging, and meals) incurred by you, a living donor, and all eligible companions are limited to a combined Maximum Travel Benefit of \$10,000 per <b>Covered Transplant Procedure</b> . These travel, lodging, and meal benefits are included within and reduce your Lifetime Limit.	

### [DISABILITY, LEAVE OF ABSENCE, OR LAYOFF:

If you are not actively at work as a result of a disability, leave of absence, or layoff, eligibility for benefits provided under the Policy will only be extended to you through the earliest of:

1. The continuance period established by the underlying **Medical Plan** for such absences; or
2. The 12 month period immediately following the date your disability, leave of absence or layoff first began.

This provision does not apply to Retirees covered under the **Medical Plan** and the Policy, or individuals continuing benefits under COBRA or any other federally mandated program.]

## CLAIMS PROVISIONS

### A. Filing Claims.

The Policy provides coverage for claims that are incurred within the **Policy Year** and submitted for payment within [twelve (12) months following the **Date of Service**]. Unless otherwise stated in the Policy, claims will not be considered for payments if received after [twelve (12) months following the **Date of Service**].

Claims must be filed in a manner approved by **us**, and must include the following information:

1. **Your** name and address;
2. **Your** ID Number;
3. **Provider's** name, address, and Tax ID Number;
4. Itemized bill that includes the CPT codes or description of each charge; and
5. Diagnosis.

### B. Claim Payment.

**We** will pay benefits for all **Covered Charges** in accordance with the terms of the Policy within 60 days after receiving all necessary information. Benefits are paid to **you** or to **your** assignee or designee. **We** may pay benefits directly to the **Provider** or to any relative **we** deem appropriate if a benefit is payable and **you** are: 1) a minor; 2) legally incapable of giving valid receipt and discharge of payment; or 3) deceased.

## APPEAL AND GRIEVANCE PROCEDURES

Appeals must be submitted for consideration within 180 days of the date of **our** payment (if the appeal is based upon **our** payment) or within 180 days of the date of our denial of coverage. Grievances regarding **our** services or product may be submitted at any time during the **Policy Year**.

**A. Appeal Process.** An appeal is a formal request for review of **our** determinations regarding transplant related services, including but not limited to **our** payment(s) and/or coverage denials. The following reviews are available to **you** upon filing an appeal:

1. Standard Review. A standard review of an appeal is available on a prospective or retrospective basis and must be requested in writing by **you** or **your** designee. A standard review is available in situations wherein the timeframe for the review does not jeopardize **your** life or health. **We** will conduct the review and provide a written determination within [thirty (30)] business days after receiving all necessary information to complete the review.
2. Expedited Review. An expedited review of an appeal is only available on a prospective basis and must be requested in writing by **you** or **your** designee. An expedited review is only available if the timeframe for the review could seriously jeopardize **your** life or health. **We** will coordinate the review and communicate the determination verbally within [seven (7)] business days after receiving all necessary information to complete the review. **We** will also provide a written determination within [three (3)] business days following **our** verbal communication.

All appeals are reviewed and determined by a Peer Reviewer. Peer Reviewers are **Physicians** who:

1. Are clinical peers;
2. Hold an active, unrestricted license to practice medicine;
3. Are in a similar specialty as typically manages the medical condition, procedure, or treatment as the treating **Physician**; and
4. Are neither the individual nor a subordinate of the individual who made the original coverage determination or denial.

**B. Grievance Process.** A grievance or complaint is an expression of dissatisfaction regarding **our** products or services. **You** or **your** designee may submit a grievance verbally or in writing. Depending on the nature of the grievance and whether or not a response is requested, **we** will respond verbally and/or in writing within thirty (30) business days following receipt of the grievance. Grievances will be considered when measuring the quality and effectiveness of **our** products and services.

## COORDINATION OF BENEFITS

- A. Applicability.** This Section applies when **you** make a claim for reimbursement of **Covered Charges**, and **you** are covered by **Additional Medical Coverage**. If this provision applies, review the Order-of-Benefit-Determination Rules, under the heading of the same name, to determine whether the **Policy's** coverage is payable before or after **Additional Medical Coverage**. The Policy's coverage will not be reduced when its coverage is payable first, as determined under the Order-of-Benefit-Determination Rules; but may be reduced when another plan's benefits are payable first, as determined under the Order-of-Benefit-Determination Rules as set forth below.
- B. Order-of-Benefit-Determination Rules.** When there is a basis for a claim under the Policy and **Additional Medical Coverage**, the Policy is secondary if: (1) the **Additional Medical Coverage** does not have rules coordinating its benefits with the Policy; or (2) the **Additional Medical Coverage's** rules, the Policy's rules, or both, require the Policy's coverage be determined after those of the **Additional Medical Coverage**, except as may occur under the gender rule exception in Item C.2, below.
- C. Filing Guidelines.** The general guidelines which follow discuss the order in which **you** should file claims when **you** are covered under **Additional Medical Coverage**, using the first of the rules which applies:
1. The **Additional Medical Coverage** that covers **you** as a subscriber is obligated to pay before the Policy covering **you** as a dependent.
  2. When the parents of a dependent child are neither separated nor divorced:
    - a. **You** must file first under the Policy or **Additional Medical Coverage** covering the dependent child of the parent whose birthday falls earlier in the year; then file under the Policy or **Additional Medical Coverage** of the parent whose birthday falls later in the year; but
    - b. If both parents have the same birthday, the **you** must file first under the Policy or **Additional Medical Coverage** which has covered the parent for the longer period of time, and then under the Policy or **Additional Medical Coverage** of the other parent.

**EXCEPTION:** If the **Additional Medical Coverage** does not have the "birthday rule," but instead has a rule based upon the parent's gender, and as a result the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination, the rule of the **Additional Medical Coverage** will determine the order.

3. When the parents of a dependent are separated or divorced:
  - a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with custody; then
  - b. **You** must file under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the **spouse** of the parent with custody; then
  - c. **You** must file under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the parent without custody.

**EXCEPTION:** If there is a court decree which establishes financial responsibility for medical, dental, or other health care expenses regarding the dependent child of parents who have separated or divorced:

- a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with such financial responsibility; then
- b. File under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the other parent.

If the specific terms of the court decree state that the parents have joint custody without stating that one parent is responsible for the child's medical, dental, or other health care expenses, file as described in Item C.2, above.

## COORDINATION OF BENEFITS

(Continued)

4. **You** must file first under the Policy or **Additional Medical Coverage** which covers **you** as a subscriber who is neither laid-off nor retired, or as a dependent of a subscriber; then file under the Policy or **Additional Medical Coverage** which covers **you** as a laid-off or retired subscriber or as a dependent of a laid-off or retired subscriber. Ignore this paragraph if the **Additional Medical Coverage** does not contain this paragraph and, as a result, the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination.
  5. When the order of payment cannot be determined in accordance with these general guidelines, file first under the Policy or **Additional Medical Coverage** which has covered **you** for the longer period of time, then under the Policy or **Additional Medical Coverage** which has covered **you** for the shorter period of time.
- D. Effect on the Policy's Coverage.** When **you** are covered under two or more policies, which together pay more than the **Covered Charges** for **Covered Transplant Services**, **we** will pay the Policy's benefits according to the Order-of-Benefit-Determination Rules. The Policy's benefit payments will not be affected when this Policy is primary. **However, when the Policy is secondary under the Order-of-Benefit-Determination Rules, benefits payable will be reduced (if necessary) so that combined benefits of all policies covering the Participant do not exceed the lesser of: 1) Covered Charges; or 2) the negotiated amount established between the primary insurer and the Provider.**
- E. Right to Receive and to Release Information.** To coordinate benefits, **we** will release or obtain information regarding a claim from any insurance company, organization, or person. **You** must furnish the **Company** with any information necessary to coordinate benefits.

**Right to Obtain Recovery.** **We** are not liable for any failure to coordinate benefits. If **we** pay full benefits on a claim for which it has only secondary liability, **we** may recover the difference from **you** or from any other appropriate party.

## EXCLUSIONS

We will not pay, in whole or in part, for any of the following:

- A. [Any service or supply not directly related to a **Covered Transplant Procedure**. This includes any service or supply rendered to treat the underlying disease before or after transplant (that is not part of the actual **Covered Transplant Procedure**).
- B. Services and supplies for treatment of complications related to a **Covered Transplant Procedure**, unless such complications are determined by **us** to be the immediate and direct result of a **Covered Transplant Procedure**.
- C. Charges for any transplant related services or supplies incurred prior to the **Policy Effective Date**.
- D. Charges for prescription drugs incurred prior to a **Covered Transplant Procedure**, except for **High Dose Chemotherapy** that is part of a **Covered Transplant Service**.
- E. Charges for prescription drugs incurred after discharge from a transplant hospitalization, except for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals.
- F. Chemotherapy and/or surgery prior to beginning **High Dose Chemotherapy** (including bone marrow/stem cell transplantation).
- G. Services provided for the removal of a transplanted solid organ, unless the removal is provided during a **Covered Transplant Procedure**.
- H. Services provided after: 1) a transplanted solid organ has been removed from the transplant recipient; or 2) disease has returned in a bone marrow or stem cell transplant recipient.
- I. Services for human leukocyte antigen typing of **you** or **your** relatives, compatibility testing, unrelated bone marrow/stem cell searches on registries, and harvest and/or storage of bone marrow/stem cells when bone marrow/stem cell transplant has not been reviewed and approved by **us**.
- J. Services and supplies for immunizations.
- K. Animal organ or artificial organ transplants.
- L. Charges for a stand-by **Physician**, unless otherwise approved by **us**.
- M. Services of a **Provider** who is a member of **your Immediate Family**.
- N. Services, supplies, or **Hospital** care which **we** determine are not **Medically Necessary** for the treatment of illness, injury, diseased condition, or impairment, except as specifically stated as covered.
- O. **Custodial Care**.
- P. Hospice care.
- Q. Charges for any **Experimental and/or Investigational Treatment**, except as specifically stated in the Policy.
- R. Charges paid or payable under Workers' Compensation.
- S. Preventive or routine care (including physicals, premarital examinations, any other routine or periodic examinations), dental services and supplies, education and training, except as specifically stated as covered.
- T. Research studies or screening examinations.
- U. Treatment of any illness or injury sustained as a result of an act of war.
- V. Services or supplies to the extent **you** are not legally obligated to pay for them.
- W. Expenses incurred before the **Policy Year** begins or after it ends, except as stated in the Policy.
- X. Rest cures or sanitarium care.
- Y. Services or supplies furnished by any **Provider** acting beyond the scope of such **Provider's** license.
- Z. Any service or supply that is a **Medicare** Part A or Part B liability.
- AA. Services or supplies received from a dental or medical department maintained by or on behalf of the **Policyholder**.
- BB. Services provided by any governmental agency to the extent that **you** are not charged for them, unless otherwise required by state or federal law.
- CC. Services or supplies not specifically stated as covered.
- DD. Telephone consultations, charges for failure to keep a scheduled visit, or charges for completing a claim form.
- EE. Recreational or diversional therapy.
- FF. Materials used in occupational therapy.
- GG. Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a **Provider** prescribes such items.
- HH. Services and supplies, which are eligible to be repaid under any private or public research fund whether or not such funding was applied for or received.

## EXCLUSIONS

(Continued)

- II. Services and supplies for treatment of complications or diseases incurred by a living donor, including, but not limited to, increase length of hospitalization or the costs to treat any complication or disease.
- JJ. Services and supplies incurred by any COBRA continuee whose COBRA continuation coverage was not offered and/or elected, and premiums were not paid, within the time frames required by COBRA.
- KK. **Prescription Drugs** for the treatment or prevention of a rejected organ or tissue following the end of the Transplant Benefit Period.
- LL. Services and supplies of any **Provider** located outside the United States of America, except for organ or tissue procurement services, unless otherwise prohibited by United States federal law.
- MM. Biological and/or mechanical devices used as a bridge to transplant unless specifically included in the Schedule of Benefits.
- NN. Charges for any transplant-related services or supplies incurred during the current **Policy Year** when the transplant procedure occurred prior to the **Policy Effective Date**. However, we will make an exception to this Exclusion for **Covered Charges** related to a **Covered Transplant Procedure you** received under a previous Organ & Tissue Transplant Policy issued by **us** to the **Policyholder**, as long as:
  1. There has been no break in coverage between the Transplant Policies issued by **us**; and
  2. The **Covered Charges** are for services or supplies incurred within the Transplant Benefit Period for the **Covered Transplant Procedure**.]

[**We** may, in certain circumstances for purposes of overall cost savings or efficiency and in **our** sole discretion, provide benefits for services that would otherwise be excluded from coverage. If **we** provide any benefit not covered under the Policy, this fact shall not be used against **us** in any similar case and **we** shall not be required to extend this benefit to any other **Participant**.]

## RIGHT TO AMEND RATES AND POLICY TERMS

**We** may revise the premium rates or any other terms of the Policy on the occurrence of any of the following:

- A. [The date the **Policyholder** amends the **Medical Plan**.
- B. The date the **Policyholder** requests a benefit change in the Policy.
- C. The date the **Policyholder** adds or deletes a subsidiary or affiliate.
- D. The date an increase or decrease in the number of **Participants** exceeds [25%] in any [one] month or [XX,25%] over any period of [XXX,three] consecutive months. The number of **Participants** will be derived from the **Policyholder's** monthly premium statements or any other reports obtained from the **Policyholder** or the **Medical Plan's Administrator**.
- E. The date **we** are notified by the state in which the **Policyholder** is located of any state imposed tax or assessment for which **we** are obligated to pay.
- F. The date of any change in the **Policyholder's** business that materially affects **our** risk.
- G. The date it is discovered that there has been a material misrepresentation or nondisclosure of information that **we** could reasonably have expected to have been disclosed to **us** by the **Policyholder** or the **Policyholder's Medical Plan Administrator**.]

## TERMINATION PROVISIONS

**We** may, at any time, cancel benefits under the Policy for the reasons specified in the Policy.

In addition, **your** coverage shall automatically terminate on the earliest of the following dates:

- A. The date the Policy is terminated, as specified in the Policy. (The **Policyholder** is responsible for notifying **you** of the termination of the Policy.)
- B. The date **you** cease to be a covered **Participant**.
- C. The date **we** receive written notice from **you** or the **Policyholder** instructing **us** to terminate **your** coverage. (Coverage will terminate on the date specified in the notice, if provided.)

## GENERAL PROVISIONS

- A. Defined Terms.** The Policy contains certain defined terms that have been capitalized. Please refer to the Definitions section of the Policy for a complete description of such terms.
- B. Incontestability.** **We** may declare the Policy null or cancel it, if the **Application** contains a material misrepresentation. However, this provision will not apply once the Policy has been in effective for two years.
- C. Representations Not Warranties.** A copy of the **Application** is attached to the Policy. All statements made by the **Policyholder** or by **Participants** applying for coverage will be considered representations and not warranties. No statement appearing on the **Application** will be used to contest the validity of the **Policyholder's** right to the benefits of the Policy, unless the **Policyholder** has been furnished a copy of the **Application**.
- D. Evidence of Insurability.** The **Policyholder** is required to provide **us** with verification that **you** are covered by the **Policyholder's Medical Plan**.
- E. Notice.** When **we** provide written notice to the **Policyholder's** last known address regarding the administration of the Policy, it is deemed to be notice to all affected parties. The **Policyholder** is responsible for giving **you** notice, if applicable.
- F. Legal Action.** No legal action may be brought under the Policy within 60 days after **we** receive a claim. No action may be brought after 3 years from the date the claim is required to be furnished to **us**.
- G. Information Release and Data Confidentiality.** The **Policyholder** and all **Participants** that need **Covered Transplant Services** must allow **us** access to medical information from all appropriate **Providers**. Such information is necessary in order for **us** to make proper benefit determinations. The information will not be used, disclosed, furnished, or made accessible to anyone other than **our** authorized employees and vendors contracted by **us** to carry out **our** obligations under the Policy. **We** and the **Policyholder** agree to establish and maintain administrative, technical and physical safeguards to protect the security, confidentiality and integrity of the medical information.
- H. Entire Contract.** The Policy and the signed **Application** form the entire contract between the **Policyholder** and **us**. No amendment to the Policy shall be effective unless confirmed by an Endorsement issued to form a part of the Policy. No agent or representative of the **Company**, other than an executive officer, may change the Policy or waive any of its provisions. No verbal statement by any executive officer or other employee of the **Company** is binding on **us**.
- I. Clerical Error.** A clerical error made by the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or **us** will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated. Any clerical error in data provided to **us** must be corrected and promptly reported to **us**. **We** will make appropriate adjustments to premiums due and/or benefit determinations. Any refund in premium due to **Policyholder** error is limited to the 12-month period prior to the date of the request for refund.
- J. Conformity with Statutes.** Any provision of the Policy that, on the **Policy Effective Date**, is in conflict with the requirements of state or federal statutes or regulations (in the applicable jurisdiction) is hereby amended to conform to the minimum requirements of such statutes and regulations.
- K. Not Liable for Provider Acts or Omissions.** **We** are not responsible for the quality of care **you** receive from any **Provider**. The Policy does not give anyone any claim, right, or cause of action against **us** based on what a **Provider** of health care or supplies does or does not do.
- L. Right of Recovery.** If **we** make any payment that according to the terms of the Policy should not have been made, including payment made in error, **we** may recover that incorrect payment from any appropriate party, whether or not it was due to **our** error. If the incorrect payment was made directly to **you**, **we** may deduct it when making future payments directly to **you**.

## GENERAL PROVISIONS

(Continued)

**M. Subrogation and Right of Reimbursement.** Another party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to **Covered Transplant Services**. Such party may include, but is not limited to, any of the following: (a) the party or parties who caused the need for the **Covered Transplant Procedure**; (b) the insurer or other indemnifier of the party or parties who caused the **Covered Transplant Procedure**; (c) a guarantor of the party or parties who caused the **Covered Transplant Procedure**; (d) a worker's compensation insurer; (e) any other person, entity, policy or plan that is liable or legally responsible in relation to the **Covered Transplant Procedure**. When this happens, **we** may, at **our** option, (a) subrogate, that is, take over the **Participant's** right to receive payments from such party (the **Participant** or his or her legal representative must transfer to **us** any rights he or she may have to take legal action arising from the **Covered Transplant Procedure** to recover any sums paid under the Policy on behalf of the **Participant**), or (b) recover from the **Participant** or his or her legal representative any benefits paid under the Policy from any payment the **Participant** is entitled to receive from the other party. The **Participant** or his or her legal representative must cooperate fully with **us** in asserting its subrogation and recovery rights. The **Participant** or his or her legal representative will, within 5 days of receiving **our** request, provide all information and sign and return all documents necessary to exercise **our** rights under this provision.

**We** will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration that the **Participant** receives or is entitled to receive from any of the sources listed above. This lien will not exceed the greater of (a) the amount recovered from any other party, or (b) the amount of benefits paid by the Policy for **Covered Charges** plus the amount of all future benefits which may become payable under the Policy which result from the **Covered Transplant Services**. The **Company** will have the right to offset or recover such benefits from the amount received from any other party.

If the **Participant** or his or her legal representative makes any recovery from any other party and fails to reimburse **us** for any **Covered Charges**, then the **Participant** or his or her legal representative will be personally liable to **us** for the **Covered Charges** paid under the Policy. **We** may reduce future benefits payable under the Policy for any **Covered Charges** by the payment that the **Participant** or his or her legal representative has received from any other party.

Our first lien rights will not be reduced due to the **Participant's** own negligence; or due to the **Participant** not being made whole; or due to attorney's fees and costs. **We** are secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. **We** have the right to recover interest at the rate of 1/2% per month commencing on the date the **Participant** or his or her legal representative recovers any funds from any other party. **We** are not subject to any state law doctrines, including, but not limited to, the common fund doctrine, which would purport to require **us** to reduce **our** recovery by any portion of a **Participant's** attorney's fees and costs.

**We** will not pay for future **Covered Charges** until such **Covered Charges** have exceeded all amounts that were recovered or are to be recovered by or on behalf of a **Participant**. If the **Participant** resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the Policy takes secondary status. The Policy will reduce benefits for an amount equal to, but not less than, that state's mandatory minimum personal injury protection or medical payment requirement.

This provision also applies to any funds recovered from any other party by or on behalf of any dependent, the estate of any **Participant**; or on behalf of any incapacitated person.

## DEFINITIONS

- A. Additional Medical Coverage** – means any other insurance that provides **you** with medical benefits covered under the Policy.
- B. Application** – means the **Policyholder's** completed Organ & Tissue Transplant Application.
- C. Company** – means AIG Life Insurance Company.
- D. Covered Charges** – means charges incurred during a Transplant Benefit Period that are **Reasonable and Customary**, in **our** judgment, for **Covered Transplant Services**. With respect to **Providers**, a charge will not be considered **Reasonable and Customary** if it is not in conformity with one or a combination of the following:
1. A negotiated rate based on services provided;
  2. A fixed rate per day; or
  3. The **Reasonable and Customary** allowance for similar **Providers** who perform similar **Covered Transplant Services**.
- E. Covered Transplant Procedure** – means a **Medically Necessary** adult or pediatric human organ and tissue transplants listed as a Covered Transplant in the Schedule of Benefits.
- F. Covered Transplant Services** – means the services shown as Covered Transplant Services in the Benefit Provisions.
- G. Custodial Care** – means care and services that assist in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, and using the toilet; feeding or preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.
- H. Date of Service** – means the date when the service was actually provided or the date on which the purchase was made.
- I. Diagnostic Services** – means the following procedures that are directly related to a **Covered Transplant Procedure** and ordered by a **Provider Individual** because of specific symptoms in order to determine a definite condition or disease: (i) radiology, ultrasound, and nuclear medicine; (ii) laboratory and pathology; and (iii) EKGs, EEGs, and other electronic diagnostic medical procedures.
- J. [Experimental and/or Investigational Treatment** – means any drug, device, procedure, facility, equipment, treatment plan, protocol, supply or service directly related to a **Covered Transplant Procedure** (i) that is deemed to be experimental or investigational in nature by an appropriate technological assessment body established by any state or federal government, or (ii) where **we**, in **our** sole discretion, determine that, at the time it is used, one or more of the following conditions is present:
1. Its use requires approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to the Federal Drug Administration (FDA).
  2. Its use is not yet recognized as acceptable medical practice throughout the United States to treat that illness or injury; or is subject to either:
    - a) A written investigational or research protocol or treatment plan; or
    - b) A written informed consent or protocol used by the **Transplant Facility** in which reference is made to the drug, device, procedure, protocol, or treatment plan as being experimental, investigative, educational, for a research study, a pilot study, or posing an uncertain outcome, or having an unusual risk; or
    - c) A written protocol, protocols or informed consent used by any other facility studying substantially the same drug, device, procedure or treatment which states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or
    - d) An ongoing review by an Institutional Review Board.

## DEFINITIONS

(Continued)

For individuals participating or eligible to participate in clinical trials, the following will be considered Experimental and/or Investigational:

1. Clinical trials that are a single institution or investigator study. Clinical trials performed at a National Cancer Institute (NCI) designated Comprehensive Cancer Center are exempt from this requirement.
2. With regard to adult bone marrow/stem cell transplants:
  - a. All Phase I or II clinical trials; and
  - b. All Phase III clinical trials that are not sponsored by the NCI or similar national oncology cooperative body.
3. With regard to pediatric bone marrow/stem cell transplants:
  - a. All Phase I-IV clinical trials that are not sponsored by the Children's Oncology Group.
4. All "off protocol" treatment wherein **you** are not actually enrolled in a clinical trial.

Drugs, devices, procedures, facilities, equipment, treatment plans, supplies, and services that fall into the categories listed above **are not** considered Experimental and/or Investigational if their use is required by state law or recognized as acceptable medical practice throughout the United States to treat **your** illness as a result of:

1. The positive endorsement, recommendation, or publication of standards of care by national medical bodies or panels, including but not limited to, National Comprehensive Cancer Network (NCCN), NCI, or the National Institutes of Health; or
2. Multiple published peer review articles, in recognized professional medical journal(s), concerning such drug, device, procedure or treatment plan and reflecting its reproducibility by non-affiliated sources which **we** determine to be authoritative; or
3. Trial results (that adequately demonstrate safety and efficacy), which indicate the drug, device, procedure, protocol, or treatment plan is at least as clinically effective and cost effective as current standard therapy; or
4. Specific state mandated coverage requirements.]

**K. High Dose Chemotherapy** – means the use of a chemotherapeutic agent or agents to treat cancer or cancer-like illness (with or without irradiation) in doses which exceed the FDA approved or commonly recognized dosage range for the drug or drugs employed. In order to be considered as an eligible expense, High Dose Chemotherapy must:

1. Be part of a protocol or treatment plan that includes the reinfusion of autologous bone marrow or stem cells, or infusion of allogeneic bone marrow or stem cells, immediately after the High Dose Chemotherapy regimen is completed; and
2. Be expected to result in effects upon the bone marrow which would likely be lethal if left untreated.

All drugs and/or radiopharmaceuticals are subject to the **Experimental and/or Investigational Treatment** definition in the Policy.

**L. Immediate Family** – means **your** [spouse, parent, child, sibling, grandparent, or grandchild.]

**M. Medical Plan** – means a plan of major medical benefits maintained by the **Policyholder**. It includes, but is not limited to coverage provided under: group health insurance; health maintenance organizations; self-insured plans; preferred provider organizations; prepayment coverage; any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee plan, a union welfare plan, an employee organization plan, or an employee benefit organization; any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization; any government program except **Medicare** or Medicaid; the medical payments and/or no-fault provisions of automobile insurance; and any other group type coverage as permitted by law.

**Medical Plan** does not include benefits provided under [a limited health care benefit plan (such as a critical illness, specified disease, or "mini-med"), nor benefits provided under a: dental; vision; outpatient prescription drug; and/or short-term disability plan.]

## DEFINITIONS

(Continued)

- N. Medically Necessary or Medical Necessity** – means those drugs, devices, procedures, treatments, services or supplies, provided by a **Provider**, which are required for treatment of illness, injury, diseased condition, or impairment, and are:
1. consistent with **your** diagnosis or symptoms and **you** are an appropriate candidate for the proposed treatment;
  2. appropriate treatment, according to generally accepted standards of medical practice;
  3. not provided only as a convenience to **you** or the **Provider**;
  4. not an **Experimental and/or Investigational Treatment**; and
  5. not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment. Any service or supply provided at a **Provider Facility** will not be considered Medically Necessary if **your** symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The fact that a **Provider Individual** may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary or make the charge a **Covered Charge**.

- O. Medicare** – means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
- P. Member** – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a member, or as a subscriber. Member does not include a dependant. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.
- Q. Participant** – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a **Member**, a subscriber, or a dependent who is also covered under the Policy. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.
- R. Premium Due Date** – means the date the **Policyholder's** premium is due. The Premium Due Date is shown in the Policy Face Page.
- S. Policy Effective Date** – means the Policy Effective Date as shown on the Policy Face Page which is the date that coverage begins under the Policy.
- T. Policy Year** – means the period of time shown in the Schedule of Benefits during which the Policy is in effect. The Policy Year is subject to early termination as set forth in the Termination Provisions.
- U. Pre-existing Condition** – means any condition for which **you** have, within the 24 months prior to the Effective Date of the Policy:
1. Been advised by an attending **Physician** that a transplant may be needed (regardless of the timeframe to transplant and regardless of the **Participant's** decision to move forward or not move forward with a **Transplant Consultation** or **Transplant Evaluation**;
  2. Had a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of the outcome);
  3. Been scheduled to have a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of when the **Transplant Consultation** and/or **Transplant Evaluation** was to be done and regardless of the outcome); and/or
  4. Received, or has been listed to receive, an organ or tissue transplant.

[In addition, if **you** have, within the 24 months prior to the **Policy Effective Date** of the Policy, received dialysis treatments or been diagnosed with Chronic Kidney Disease or End Stage Renal Disease (ESRD), **you** will be deemed to have a Pre-existing Condition.]

## DEFINITIONS

(Continued)

If **you** are added subsequent to the **Policy Effective Date** as a result of the acquisition of a new group, affiliate, division, and/or subsidiary, Pre-existing Condition will mean those conditions listed above that occurred within the 24 months prior to **your** effective date of coverage under the Policy.

**V. Provider** – means any of the facilities and individuals listed below:

1. **Provider Facilities** – means any of the following facilities:

- a. **Clinical Laboratory** – means a laboratory that performs clinical procedures and is not affiliated or associated with a Hospital, **Physician**, or other **Provider**.
- b. **Hospital** – means a facility which is a short-term general hospital and which: (1) is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **Physicians**, for compensation from its patients; (2) has organized departments of medicine and major surgery; and (3) provides 24-hour nursing service by or under the supervision of registered nurses. Surgical facilities may be either on premises or in facilities available to the hospital on a prearranged basis.
- c. **Pharmacy** – means a facility licensed as a Pharmacy by the state in which it operates.
- d. **Transplant Facility** – means the following facilities:
  - i. **Nonparticipating Transplant Facility** – Any **Hospital** that has not contracted with **us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Hospital** may be a Nonparticipating Transplant Facility with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.
  - ii. **Participating Transplant Facility** – Any **Hospital** contracting with **us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Hospital** may be a Participating Transplant Facility with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.

2. **Provider Individuals** – means any of the following individuals:

- a. **Occupational Therapist** – means a person who is licensed as an Occupational Therapist by the state in which he or she practices. If that state does not issue such licenses, an Occupational Therapist is a person certified as an Occupational Therapist by an appropriate professional body.
- b. **Physical Therapist** – means a person who is licensed as a Physical Therapist by the state in which he or she practices. If that state does not issue such licenses, a Physical Therapist is a person certified as a Physical Therapist by an appropriate professional body.
- c. **Physician** – means a person performing services within the scope of his or her license, who is a duly licensed: (1) doctor of medicine (MD); (2) doctor of osteopathy (DO); (3) dentist; (4) optometrist; or (5) psychologist.
- d. **Respiratory/Inhalation Therapist** – means a person who is licensed as a Respiratory/Inhalation Therapist by the state in which he or she practices. If that state does not issue such licenses, a Respiratory/Inhalation Therapist is a person certified as a Respiratory/Inhalation Therapist by an appropriate professional body.
- e. **Speech Pathologist** and **Speech Therapist** – means a person licensed as a Speech Pathologist or Speech Therapist by the state in which he or she practices. If that state does not issue such licenses, a Speech Pathologist or Speech Therapist is a person certified as such by an appropriate professional body.

**W. Reasonable and Customary** – means with respect to the word customary, the amount charged by a majority of **Providers** in the same geographic region for similar services or supplies and/or is relative to the value and worth of similar services; and with respect to the word reasonable, a charge that meets the above criteria and, that in **our** judgment, is not an excessive amount for similar services or supplies; or a charge that merits special consideration due to complexity of treatment in the opinion of a peer review committee or consultant. Due to the lack of insurance, if a **Provider** accepts as full payment an amount less than **Reasonable and Customary**, the lesser amount will be determined to be the maximum **Reasonable and Customary** amount. Benefits will be based on the lesser of the actual billed charge or the **Reasonable and Customary** charge.

## DEFINITIONS

(Continued)

- X. **Skilled Care** – means the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury. Skilled care must be performed by or under the supervision of **Provider Individuals**.
- Y. **Spouse** – means a person recognized as the **Member's** spouse under the **Medical Plan**.
- Z. **We, Us, Our** – means AIG Life Insurance Company.
- AA. **You, Your** – means the **Participant**, as defined in the Policy.