

<i>SERFF Tracking Number:</i>	<i>UHLC-126993975</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unimerica Insurance Company</i>	<i>State Tracking Number:</i>	<i>47767</i>
<i>Company Tracking Number:</i>	<i>MTP.POL.UIC.10.AR</i>		
<i>TOI:</i>	<i>H09G Group Health - Organ & Tissue Transplant - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H09G.000 Health - Organ & Tissue Transplant - Limited Benefit</i>
<i>Product Name:</i>	<i>Group Transplant</i>		
<i>Project Name/Number:</i>	<i>UIC Forms/</i>		

Filing at a Glance

Company: Unimerica Insurance Company

Product Name: Group Transplant

TOI: H09G Group Health - Organ & Tissue Transplant - Limited Benefit

Sub-TOI: H09G.000 Health - Organ & Tissue Transplant - Limited Benefit

Filing Type: Form

SERFF Tr Num: UHLC-126993975 State: Arkansas

SERFF Status: Closed-Approved-Closed State Tr Num: 47767

Co Tr Num: MTP.POL.UIC.10.AR State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Authors: Jayne Jackowski, Lynn Kaisershot

Date Submitted: 01/21/2011 Disposition Date: 02/16/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

General Information

Project Name: UIC Forms

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type:

Filing Status Changed: 02/16/2011

State Status Changed: 02/16/2011

Created By: Jayne Jackowski

Corresponding Filing Tracking Number:

Filing Description:

On behalf of Unimerica Insurance Company, I am submitting the enclosed group health forms for your Department's review and approval. These documents are new forms and are not being filed to replace any form previously approved in your state.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Overall Rate Impact:

Deemer Date:

Submitted By: Jayne Jackowski

Our intent is to use these forms for large employer groups only. Similar forms are part of a nationwide filing. Because the enclosed forms have been modified to reflect the laws and regulations of Arkansas, they will not be filed with

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Wisconsin, our State of Domicile.

These materials represent final printed format with the exception of variable text. Variable text is indicated by brackets. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and employees regarding access and alternatives to electronic issuance.

This is a large employer group, limited benefit product that provides transplant services. Transplant services include: kidney, pancreas, simultaneous kidney/pancreas, pancreas after kidney, liver and kidney, heart, single and double lung, heart/lung, heart/kidney, liver/cadaveric, liver/live donor, bone marrow, cord blood and peripheral stem cell transplants. Intestine, liver/intestine and multivisceral transplants are covered only when transplant services are rendered by a network provider.

This policy will be marketed solely as a fully-insured supplemental, limited benefit product offered to large employer groups as a "carve out" benefit to their underlying self-funded major medical plans. Sale of the product will be through properly licensed agents and brokers.

Company and Contact

Filing Contact Information

Jayne Jackowski, Senior Specialty Product Analyst	Jayne.Jackowski@eams.com
3100 AMS Blvd.	920-661-2234 [Phone]
	8002325432 [Ext]
Green Bay, WI 54313	920-661-9861 [FAX]

Filing Company Information

Unimerica Insurance Company	CoCode: 91529	State of Domicile: Wisconsin
PO Box 150450	Group Code: 707	Company Type: Life and Health
Hartford, CT 0606115-0450	Group Name:	State ID Number:
(860) 702-6017 ext. [Phone]	FEIN Number: 52-1996029	

Filing Fees

SERFF Tracking Number: UHLC-126993975 State: Arkansas
Filing Company: Unimerica Insurance Company State Tracking Number: 47767
Company Tracking Number: MTP.POL.UIC.10.AR
TOI: H09G Group Health - Organ & Tissue Sub-TOI: H09G.000 Health - Organ & Tissue Transplant -
Transplant - Limited Benefit Limited Benefit
Product Name: Group Transplant
Project Name/Number: UIC Forms/

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unimerica Insurance Company	\$150.00	01/21/2011	43988368

SERFF Tracking Number: UHLC-126993975 State: Arkansas
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 Product Name: Group Transplant
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/16/2011	02/16/2011

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	02/08/2011	02/08/2011	Jayne Jackowski	02/16/2011	02/16/2011

SERFF Tracking Number: UHLC-126993975 *State:* Arkansas
Filing Company: Unimerica Insurance Company *State Tracking Number:* 47767
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TOI: H09G Group Health - Organ & Tissue *Sub-TOI:* H09G.000 Health - Organ & Tissue Transplant -
Transplant - Limited Benefit Limited Benefit
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Disposition

Disposition Date: 02/16/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes
Form (revised)	Certificate of Coverage	Approved-Closed	Yes
Form	Certificate of Coverage	Replaced	Yes
Form	Application	Approved-Closed	Yes

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Product Name: Group Transplant
Project Name/Number: UIC Forms/

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 02/08/2011
Submitted Date 02/08/2011

Respond By Date

Dear Jayne Jackowski,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate of Coverage, MTP.COC.UIC.10.AR (Form)

Comment:

With respect to the schedule of benefits, there are some benefits that are not paid if received out of network. This does not comply with our Bulletin 9-85. Item 2 of the bulletin states in part that...."The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers. Please adjust those non-network benefits to comply with the bulletin.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 02/16/2011
 Submitted Date 02/16/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: The certificate has been revised to include out of network benefits for the services that previously didn't have benefits out of network.

Related Objection 1

Applies To:

- Certificate of Coverage, MTP.COC.UIC.10.AR (Form)

Comment:

With respect to the schedule of benefits, there are some benefits that are not paid if received out of network. This does not comply with our Bulletin 9-85. Item 2 of the bulletin states in part that..."The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers. Please adjust those non-network benefits to comply with the bulletin.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Certificate of Coverage	MTP.COC.UIC.10.A	R	Certificate	Initial			MTP.COC.UIC.10.A R.pdf

SERFF Tracking Number: UHLC-126993975 State: Arkansas
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TOI: H09G Group Health - Organ & Tissue Sub-TOI: H09G.000 Health - Organ & Tissue Transplant -
Transplant - Limited Benefit Limited Benefit
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Previous Version

Certificate of Coverage	MTP.COC	Certificate	Initial	MTP.COC
	.UIC.10.A			.UIC.10.A
	R			R.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Jayne Jackowski, Lynn Kaisershot

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 Transplant - Limited Benefit Limited Benefit
 Product Name: Group Transplant
 Project Name/Number: UIC Forms/

Form Schedule

Lead Form Number: MTP.POL.UIC.10.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/16/2011	MTP.POL.UIC.10.AR	Policy/Cont ract/Fratern al Certificate	Policy	Initial			MTP.POL.UIC.10.AR.pdf
Approved-Closed 02/16/2011	MTP.COC.UIC.10.AR	Certificate	Certificate of Coverage	Initial			MTP.COC.UIC.10.AR.pdf
Approved-Closed 02/16/2011	MTP.APP.UIC	Application/ Enrollment Form	Application	Initial			Unimerica Application_M TP_Final.pdf

Unimerica Insurance Company

[10701 W. Research Drive

Milwaukee, Wisconsin]

(Home Office)

Policyholder: [ABC Company]

Policy Number: [1234]

Policy Effective Date: [January 1, 2011]

Premium Due Date: [January 1 and the first day of each month thereafter]

Policy Anniversaries will be each [January 1].

This policy is issued in [_____].

Unimerica Insurance Company ("Company") agrees to provide, for eligible persons becoming insured under this Policy, benefits according to the terms, provisions, conditions, exclusions and limitations of this Policy, including the Certificate of Coverage. The following pages, including the Certificate of Coverage, any riders, endorsements or amendments, are part of the Policy.

The Policy is issued in consideration of the Policyholder's application, a copy of which is attached.

This Policy replaces and supersedes any previous agreements relating to Coverage for Transplant Services between the Policyholder and the Company.

The Company shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Policyholder's benefit plan. The Company shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Policyholder's benefit plan.

The Policy becomes effective at 12:01 A.M. Eastern Standard time on the Policy Effective Date shown above. The Policy will continue in force by the payment of Premiums when due. The Policy is subject to termination according to its terms.

Read the Policy Carefully

This is a legal contract between the Policyholder and the Company. If the Policyholder has any questions or problems with the Policy, the Company is ready to help the Policyholder. The Policyholder may call upon his agent or the Company's Home Office for assistance at any time.

The Company's President and Secretary have executed the Policy at Milwaukee, Wisconsin. If the Policyholder or the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, the Policyholder or the Covered Person may call [1-888-321-0881].

[Signature of authorized company officer]

[Title of authorized company officer]

THIS IS A LIMITED BENEFIT POLICY

**Group Limited Benefit Organ Transplant
Policy**

Nonparticipating

MTP.POL.UIC.10.AR

Administrative Office:

[MN010- S157

6300 Olson Memorial Highway

Golden Valley, MN 55427-4946]

[Group Policy: Transplant Services]

POLICY GENERAL PROVISIONS

Section 1: Glossary

The terms used in this Policy have the same meaning given those terms in [Section 14: Glossary] of the Certificate of Coverage ("Certificate").

Section 2: Coverage

Subscribers and their Enrolled Dependents are entitled to Coverage for Transplant Services subject to the terms, conditions, limitations and exclusions set forth in the Certificate included in this Policy. The Certificate describes the Transplant Services, including any optional riders and amendments, required copayments, and the terms, conditions, limitations and exclusions related to Coverage.

Section 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified on Exhibit 1 to this Policy entitled "Premiums." The Company reserves the right to change the schedule of rates for Premiums after a 31-day prior written notice on the first anniversary of the effective date of this Policy specified in the application or on any monthly due date thereafter, or on any date the provisions of this Policy are amended. The Company also reserves the right to change the schedule of rates for Premiums, retroactive to the effective date, if a material misrepresentation relating to health status has resulted in a lower schedule of rates.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each coverage classification that the Company shows in its records at the time of calculation. The Policy Charge will be calculated as follows using the Premium rates in effect at that time:

[A full calendar month's Premiums shall be charged for Covered Persons whose effective date of coverage falls on or before the 15th of that calendar month. No Premiums shall be charged for Covered Persons whose effective date of coverage falls after the 15th of that calendar month. A full calendar month's Premiums shall be charged for Covered Persons whose coverage is terminated after the 15th of that calendar month. No Premiums shall be charged for Covered Persons whose coverage is terminated on or before the 15th of that calendar month.]

[A pro rata Premium, calculated on the number of days Covered Persons are actually covered under this Policy, shall be charged for Covered Persons whose effective date of coverage falls on a date other than the first of the month or for Covered Persons whose coverage is terminated on a date other than the first of the month.]

[A full month's Premium shall be charged for any Covered Person who is covered under this Policy for any portion of a calendar month.]

3.3 Adjustments to the Policy Charge

The Company may make retroactive adjustments for any additions or terminations of Subscribers, or changes in coverage classification that are not reflected in the Company's records at the time the Company calculates the Policy Charge. The Company will not grant retroactive credit for any change occurring more than 60 days prior to the date the Company receives notification of the change from the Policyholder. The Company also will not grant retroactive credit for any calendar month in which a Subscriber has received Coverage.

The Policyholder must notify the Company in writing within 31 days of the effective date of enrollments, terminations or other changes. The Policyholder must notify the Company in writing each month, of any change in the coverage classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges shall be automatically added to the Premium. In addition, any change in law or regulation that significantly affects the Company's cost of operation shall result in an increase in Premium, in an amount the Company determines.

3.4 Payment of the Policy Charge

The Policy Charge is payable in advance by the Policyholder to the Company on a [monthly] [quarterly] [semi-annual] basis. The first Policy Charge is due and payable on the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each period thereafter that this Policy is in effect.

A late payment charge will be assessed for any Policy Charge not received within 10 calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments shall be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is made.

The Policyholder shall reimburse the Company for attorney's fees and any other costs related to collecting delinquent Policy Charges.

3.5 Grace Period

A grace period of [31] days shall be granted for the payment of any Policy Charge, during which time this Policy shall continue in force. The grace period will not extend beyond the date this Policy terminates.

The Policyholder is liable for payment of the Policy Charge during the grace period. If the Company receives written notice from the Policyholder to terminate the Policy during the grace period, the Company will adjust the Policy Charge so that it applies only to the number of days the Policy was in force during the grace period.

This Policy shall automatically terminate on the date the grace period expires if the Policy Charge remains unpaid.

Section 4: Policy Termination

4.1 Conditions for Termination of This Entire Policy

This Policy and all Coverage for Transplant Services under this Policy shall automatically terminate on the earliest of the dates specified below:

- A. On the last day of the grace period if the Policy Charge remains unpaid. The Policyholder remains liable for payment of the Policy Charge for the period of time the Policy remained in force during the grace period.
- B. On the date specified by the Policyholder, after at least 31 days prior written notice to the Company, that this Policy shall be terminated.
- C. On the date specified by the Company, after at least 31 days prior written notice to the Policyholder, that this Policy shall be terminated due to the Policyholder's violation of participation and/or contribution rules.

- D. On the date specified by the Company, after at least 31 days prior written notice to the Policyholder, that this Policy shall be terminated because the Policyholder performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, the Company has the right to rescind this Policy back to either:
 - 1. the effective date of this Policy.
 - 2. the date of the act, practice or omission, if later.
- E. On the date specified by the Company, after at least 90 days prior written notice to the Policyholder, that this Policy shall be terminated because the Company will no longer issue this particular type of limited group health benefit plan within the applicable market.
- F. On the date specified by the Company, after at least 180 days prior written notice to the applicable state authority and to the Policyholder, that this Policy shall be terminated because the Company will no longer issue any employer health benefit plan within the applicable market.
- G. At the Company's election on the Premium due date following the date the number of Covered Persons insured under this Policy is less than [[two (2)] - [fifty (50)]].

4.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Policyholder shall be and shall remain liable to the Company for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata fee for any period this Policy was in force during the grace period preceding the termination.

Section 5: General Provisions

5.1 Entire Policy

The group Policy, including the Certificate of Coverage, the application of the Policyholder, amendments and riders shall constitute the entire Policy between parties. All statements made by the Policyholder or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. No statement made by the Covered Person will be used to contest the insurance provided by the Policy; unless: 1) it is contained in a written statement signed by the Covered Person; and 2) a copy of the statement is furnished to the Covered Person or his/her beneficiary.

5.2 Dispute Resolution

No legal proceeding or action may be brought without first completing the complaint procedure specified in [*Section 7: Questions, Complaints and Appeals*] of the Certificate.

The parties acknowledge that because this Policy affects interstate commerce, the Federal Arbitration Act applies. If the Policyholder wishes to seek further review of the decision or the complaint or dispute, it shall submit the complaint or dispute to binding arbitration pursuant to the rules of the American Arbitration Association. Arbitration will take place in Milwaukee County, Wisconsin.

5.3 Time Limit on Certain Defenses

No statement made by the Policyholder, except a fraudulent statement, shall be used to void this Policy after it has been in force for a period of two years.

5.4 Amendments and Alterations

Amendments to this Policy are effective 31 days after the Company sends written notice to the Policyholder. Riders are effective on the date specified by the Company. No change will be made to this Policy unless made by an amendment or a rider that is signed by one of the Company's authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

5.5 Relationship Between Parties

The relationships between the Company and Network providers, and relationships between the Company and Policyholders, are **solely** contractual relationships between independent contractors. Network providers and Policyholders are not the Company's agents or employees, nor is the Company or any of its employees an agent or employee of Network providers or Policyholders. The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Policyholder and any Covered Person is that of employer and employee, Dependent, or other coverage classification as defined in this Policy. The Policyholder is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charge.

5.6 Records

The Policyholder shall furnish the Company with all information and proofs which the Company may reasonably require with regard to any matters pertaining to this Policy. The Company may at any reasonable time inspect all documents furnished to the Policyholder by an individual in connection with Coverage under this Policy, the Policyholder's payroll, and any other records pertinent to the Coverage under this Policy.

By accepting Coverage under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to them, to furnish the Company or its designees any and all information and records or copies of records relating to the services provided to the Covered Person. The Company has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

The Company agrees that such information and records will be considered confidential. The Company has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as the Company is required by law or regulation.

During and after the term of this Policy, the Company and its related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

5.7 Administrative Services

The services necessary to administer this Policy and the Coverage provided under it will be provided in accordance with the Company's standard administrative procedures or those standard administrative procedures of its designee. If the Policyholder requests that such administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Policyholder shall pay for such services or reports at the then-current charges for such services or reports.

5.8 ERISA

When this Policy is purchased by the Policyholder to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C., 1001 et seq., the Company shall not be named as, and shall not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA. The Policyholder agrees that the Policy constitutes the plan and plan document under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The Policyholder designates the Company as the claims fiduciary of this plan and gives the Company the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The Policyholder will comply with the disclosure and reporting requirements of ERISA regarding the plan and the Company's designation and authority as the claims fiduciary.

5.9 Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Transplant Services, the Company may reasonably require that a Physician, acceptable to the Company, examine the Covered Person at the Company's expense.

5.10 Clerical Error

Clerical error shall not deprive any individual of Coverage under this Policy or create a right to Coverage. Failure to report enrollments shall not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage shall not continue such coverage beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums shall be made. However, the Company shall not grant any such adjustment in Premiums or Coverage to the Policyholder for more than 60 days of Coverage prior to the date the Company received notification of such clerical error.

5.11 Workers' Compensation Not Affected

Coverage provided under this Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

5.12 Conformity with Statutes

Any provision of this Policy which, on its effective date, is in conflict with the requirements of any state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

5.13 Notice

When the Company provides written notice regarding administration of this Policy to an authorized representative of the Policyholder, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Policyholder is responsible for giving notice to Covered Persons.

5.14 Continuation Coverage

The Company agrees to provide Coverage under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in [*Section 11: Continuation of Coverage under Federal law (COBRA)*] of the Certificate.

The Company does not provide any administrative duties with respect to the Policyholder's compliance with federal or state law. All duties of the plan sponsor or plan administrator, including but not limited to notification of continuation of coverage under federal law (COBRA),

and state law continuation rights, and billing and collection of Premium, remain the sole responsibility of the Policyholder.

5.15 Subscriber's Individual Certificate

The Company will issue Certificates of Coverage and any attachments to the Policyholder for delivery to each covered Subscriber. The Certificate and any attachments will show all the benefits and provisions of the Policy.

EXHIBIT 1

Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified below:

Unimerica Insurance Company

[10701 W. Research Drive

Milwaukee, Wisconsin]

(Home Office)

Policyholder: [ABC Company]

Policy Effective Date: [January 1, 2011]

Policy Number: [1234]

Covered Person: As on file with the Policyholder.

Certificate Number: As on file with the Policyholder.

Certificate Effective Date: As on file with the Policyholder.

The Policy to which this Certificate of Coverage refers is issued in [_____].

Unimerica Insurance Company ("Company") issues this Certificate of Coverage ("Certificate") to the Covered Person as evidence of insurance under the Policy the Company issued to the Policyholder shown above. Financial benefits under the Policy are provided by the Company. Benefits administration may be furnished on the Company's behalf by the Company's affiliates[, such as OptumHealth Care Solutions, Inc.]

This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

Read the Certificate Carefully

This is a legal contract between the Policyholder and the Company. If the Policyholder has any questions or problems with the Policy, the Company is ready to help the Policyholder. The Policyholder may call upon his agent or the Company's Home Office for assistance at any time.

If the Policyholder or the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, the Policyholder or the Covered Person may call [1-888-321-0881].

It is signed at the Home Office of Unimerica Insurance Company as of the Policy Effective Date shown above.

[Signature of authorized company officer]

[Title of authorized company officer]

THIS IS A LIMITED BENEFIT POLICY

**Limited Benefit Organ Transplant
Certificate**

Nonparticipating

MTP.COC.UIC.10.AR

Administrative Office:

[MN010- S157

6300 Olson Memorial Highway

Golden Valley, MN 55427-4946]

[Certificate of Coverage: Transplant Services]

TRANSPLANT BENEFIT CERTIFICATE OF COVERAGE

Introduction

This Certificate of Coverage ("Certificate") sets forth the Covered Person's rights and obligations. References to "you" and "your" throughout this Certificate are references to a Covered Person (as defined in [Section 14: Glossary]). All references to "Policy" throughout this Certificate shall mean the group Policy issued to the Policyholder along with the Certificate of Coverage, the Policyholder's application and any amendments, endorsements or riders.

It is important that you READ YOUR CERTIFICATE CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Policyholder.

The Company agrees with the Policyholder to provide Coverage for Transplant Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Policyholder's application and payment of the required Premiums. The Policyholder's application is made a part of the Policy.

The Company shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Policyholder's benefit plan. The Company shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Policyholder's benefit plan.

The Policy shall take effect on the date specified and will be continued in force by the timely payment of the required Premiums when due, subject to the termination provisions set forth in the Policy. All Coverage under the Policy shall begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

[The Policy is delivered in the State of [_____] and is governed by ERISA.] [To the extent that state law applies, the Policy will be governed by the laws of the State of _____.]

You and any of your Enrolled Dependents, for whom the required Premiums have been paid, are eligible for Coverage under the Policy. The Policy is referred to in this Certificate as the Policy and is designated on the [Transplant] identification card.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a Certificate, this document describes the provisions of Coverage under the Policy but does not constitute the Policy. You may examine the entire Policy at the office of the Policyholder during regular business hours.

For Transplant Services rendered after the Policy Effective Date, this Certificate replaces and supersedes any Certificate that may have been previously issued to you by the Company. Any subsequent Certificates issued to you by the Company will in turn supersede this Certificate.

How To Use This Certificate

This Certificate should be read and re-read in its entirety. Many of the provisions of this Certificate are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your Coverage.

Your Certificate may be modified by the attachment of riders and/or amendments. Please read the provision described in these documents to determine the way in which provisions in this Certificate may have been changed.

Many words used in this Certificate have special meanings. These words will appear capitalized and are defined for you in [Section 14: Glossary]. By reviewing these definitions, you will have a clearer understanding of your Certificate.

From time to time, the Policy may be amended. When that happens, a new Certificate or amendment pages for this Certificate will be sent to you. Your Certificate should be kept in a safe place for your future reference.

Network and Non-Network Benefits

This Certificate describes the benefit levels available under the Policy.

Network Benefits: These benefits apply when you choose to obtain Transplant Services from a Network provider. [Section 3: Procedure for Obtaining Benefits] describes the procedures for obtaining Covered Transplant Services as Network Benefits. Network Benefits provide Coverage at a higher level than Non-Network Benefits.

Non-Network Benefits: These benefits apply when you decide to obtain Transplant Services from non-Network providers. [Section 3: Procedure for Obtaining Benefits] describes the procedures for obtaining Coverage of Transplant Services as Non-Network Benefits. Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits require the payment of Coinsurance. In addition, when you obtain Transplant Services from non-Network providers, you must file a claim with the Company to be reimbursed for Eligible Expenses. For information on the Company's reimbursement policy guidelines used to determine Eligible Expenses, you should contact the Company at [1-888-321-0881] before obtaining Transplant Services from non-Network providers.

The information in [Section 4: Eligibility, Enrollment and Effective Date of Coverage through Section 11: Continuation of Coverage under Federal law (COBRA)] applies to all levels of Coverage. [Section 3: Procedure for Obtaining Benefits] explains the procedures you must follow to obtain Coverage for Network Benefits and Non-Network Benefits, respectively. [Section 2: Covered Transplant Services] describes which Transplant Services are Covered. Unless otherwise specified, the exclusions and limitations of [Section 12: General Exclusions and Section 13: Limited Benefits] apply to all levels of benefits.

Transplant Services Covered Under the Policy

In order for Transplant Services to be Covered as Network Benefits, you must obtain all Transplant Services directly from or through a Network provider or provider agreed to by the Company.

So that you will not be required to pay bills for non-Covered services, you must always verify the participation status of a Physician, Hospital or other provider. From time to time, the participation status of a provider may change. You can verify the participation status by calling the Company. If necessary, the Company can provide assistance in referring you to Network providers.

Only Covered Transplant Services described in [Section 2: Covered Transplant Services] and not specifically excluded in [Section 12: General Exclusions], are Covered under the Policy. The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for an injury or sickness does not mean that the procedure or treatment is Covered under the Policy.

The Company has sole and exclusive discretion in interpreting the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its benefits. The Company may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Policy.

The Company reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Policy, in its sole discretion, as permitted by law, without the approval of Covered Persons. No person or entity has any authority to make any oral changes or amendments to the Policy.

The Company may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, provide Coverage for services that would otherwise not be Covered. The fact that the Company does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

The Company may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, including claims processing and utilization management services. The identity of the service providers and the nature of the services provided may be changed from time to time in the Company's sole discretion and without prior notice to or approval by Covered Persons. You must cooperate with those persons or entities in the performance of their responsibilities.

Similarly, the Company may, from time to time, require additional information from you to verify your eligibility or your right to receive Coverage for services under the Policy. You are obligated to provide this information. Failure to provide it may result in Coverage being delayed or denied.

Important Information Regarding Medicare

Coverage under the Policy is not intended to supplement any coverage provided by Medicare, but in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled for Coverage under the Policy. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If, in addition to being enrolled for Coverage under the Policy, you are enrolled in a *Medicare Advantage* (Medicare Part C) plan, you must follow all rules of that plan that require you to seek services from that plan's participating providers. When the Company is the secondary payer, the Company will pay any benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. If the Company is the secondary plan and you do not follow the rules of the *Medicare Advantage* plan, you may incur a larger out-of-pocket cost for Transplant Services.

Important Note About Services

The Company does not provide Transplant Services or practice medicine. Rather, the Company arranges for providers of Transplant Services to participate in a Network. Network providers are independent practitioners and are not employees of the Company. The Company, therefore, makes payment to Network providers through various types of contractual arrangements. These arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Covered Transplant Services.

The payment methods used to pay any specific Network provider vary. The method may also change at the time providers renew their participation contracts with the Company. The Physician-patient relationship is between you and your doctor.

- A. You must decide if any doctor treating you is right for you; this includes providers who you choose or providers to whom you have been referred to by the Company. You must decide with your doctor what care you should receive.
- B. Your doctor is solely responsible for the quality of the care you receive.

The Company makes decisions about benefit plan Coverage. These decisions are administrative decisions and are for payment purposes only. The Company is not liable for any act or omission of a provider of Transplant Services.

[Transplant] Identification Card

You will receive a [Transplant] identification card from the Company when you have notified the Company that you would like to be evaluated for a Transplant. You must show your [Transplant] identification card every time you request Transplant Services. If you do not show your card, the providers have no way of knowing that you are Covered under a Policy issued by the Company and you may receive a bill for Transplant Services, even if those services are rendered by a Network provider.

Contact the Company

Throughout this Certificate you will find statements that encourage you to contact the Company for further information. Whenever you have a question or concern regarding Transplant Services or any required procedure, please contact the Company at [1-888-321-0881] [or at the telephone number stated on your [Transplant] identification card].

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Section 1: Schedule of Benefits

This Schedule of Benefits outlines the Coverage provided by the Policy and described in this Certificate. Covered Transplant Services are described more completely in [*Section 2: Covered Transplant Services*].

Coverage is provided for Transplant Services for: kidney, pancreas, simultaneous kidney/pancreas, pancreas after kidney, liver and kidney, heart, single and double lung, heart/lung, heart/kidney, liver/cadaveric, liver/live donor, bone marrow, cord blood and peripheral stem cell transplants.

Intestine, liver/intestine and multivisceral transplants are Covered only when Transplant Services are rendered by a Network provider.

In addition, this Policy may cover other transplant procedures when determined appropriate by the Company in accordance with this Policy.

Benefits are subject to the notice, prior approval and coordination requirements described in [*Section 3: Procedures for Obtaining Benefits*], as well as the other terms and conditions described in this Certificate.

Two or more Transplant Benefit Periods will be treated as separate Transplant Benefit Periods if:

- A. They are due to unrelated causes; or
- B. They are due to related causes and the dates of transplantation are separated by [six (6)] consecutive months.

Continuation of Transplant: If at the time a Covered Person's coverage would otherwise terminate according to the terms of the Policy such person has established a Transplant Benefit Period for which benefits are not exhausted, benefits will be paid for the remaining part of that Transplant Benefit Period as if such Coverage had not ended, as long as the Covered Person remains the liability of the Policyholder's medical health benefit plan, and such medical health benefit plan is in force. Benefits will be based on the plan in force for that person on the date that Transplant Benefit Period ends.

[Deductible Amount (*applicable to High Deductible Health Plans only*):

Although this Policy does not impose a Deductible Amount, if a Subscriber selects a High Deductible Health Plan sponsored by the Policyholder, the Deductible Amount set forth in such Policyholder's High Deductible Health Plan must be satisfied by the Covered Person before benefits are payable under this Policy. This requirement is necessary in order for the Covered Person to remain eligible for the tax benefits afforded by the health savings account (HSA) associated with the Policyholder's High Deductible Health Plan (HDHP).]

[Deductible Amount	Network	Non-Network
Deductible Amount (<i>applicable to High Deductible Health Plan participants only</i>)	All Covered Persons subject to a HDHP Deductible Amount must first meet the Deductible Amount before Covered Transplant Services are eligible for reimbursement under this Policy.	All Covered Persons subject to a HDHP Deductible Amount must first meet the Deductible Amount before Covered Transplant Services are eligible for reimbursement under this Policy.]

Policy Period: [January 1, 2011 to December 31, 2011.]

Benefit	Network Benefit	Non-Network Benefit
Maximum Benefit for Search & Registry Fees	[80-100]% of Eligible Expenses[up to \$[1,000 - 10,000] per search to a maximum of \$[5,000 - 30,000]].	[60-80]% of Eligible Expenses[up to \$[1,000 - 10,000] per search to a maximum of \$[5,000 - 30,000]].
Maximum Organ Procurement Benefit Donor	[80-100]% of Eligible Expenses during the Transplant Benefit Period.	[60-80]% of Eligible Expenses to a maximum as shown in the table below.
Maximum Bone Marrow Harvesting Benefit	[80-100]% of Eligible Expenses during any Transplant Benefit Period if within [10 - 180] days of the Transplant.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000] during any Transplant Benefit Period if within [10 - 180] days of the Transplant.
Maximum Bone Marrow Storage Benefit	[80-100]% of Eligible Expenses if within [10 - 180] days of the Transplant.	[60-80]% of Eligible Expenses if within [10 - 180] days of the Transplant.
Maximum Transportation Benefit	[80-100]% of Eligible Expenses during any Transplant Benefit Period with a combined maximum of \$[5,000 - 30,000] for lodging, transportation and meals.	[60-80]% of Eligible Expenses during any Transplant Benefit Period with a combined maximum of \$[5,000 - 30,000] for lodging, transportation and meals.
Maximum Daily Benefit for Lodging and Meals	[80-100]% of Eligible Expenses during any Transplant Benefit Period up to a daily maximum of \$[50 - 500] with a combined maximum of \$[5,000 - 30,000] for lodging, transportation and meals.	[60-80]% of Eligible Expenses during any Transplant Benefit Period up to a daily maximum of \$[50 - 500] with a combined maximum of \$[5,000 - 30,000] for lodging, transportation and meals.
Maximum Air Ambulance Benefit	[80-100]% of Eligible Expenses during any Transplant Benefit Period to a maximum of \$[5,000 - 30,000].	[60-80]% of Eligible Expenses during any Transplant Benefit Period to a maximum of \$[5,000 - 30,000].
Maximum Private Duty Nursing Benefit	[80-100]% of Eligible Expenses during any Transplant Benefit Period to a maximum of \$[5,000 - 30,000].	[60-80]% of Eligible Expenses during any Transplant Benefit Period to a maximum of \$[5,000 - 30,000].
Maximum Transplant Evaluation Benefit	[80 -100]% of Eligible Expenses.	[60-80]% of Eligible Expenses [to a maximum of \$[5,000 - 30,000].

Benefit	Network Benefit	Non-Network Benefit
Maximum Hospital Confinement and Physician Benefit	[80-100]% of Eligible Expenses.	<p>For Organ and Allogeneic Tissue Transplants: [60-80]% of Eligible Expenses to a maximum of \$[500 - 5,000] per day for each of the first [10 - 180] consecutive days of a Covered Person's confinement and [60-80]% of Eligible Expenses to a maximum of \$[500 - 5,000] per day for each day of a Covered Person's confinement on or after the [thirty-first] day.</p> <p>For Autologous Tissue Transplant: [60-80]% of Eligible Expenses to a maximum of \$[500 - 5,000] per day for each of the first [10 - 180] consecutive days of a Covered Person's confinement and [60-80]% of Eligible Expenses to a maximum of \$[500 - 5,000] per day for each day of a Covered Person's confinement on or after the [thirty-first] day.</p>
Maximum Skilled Nursing Facility Confinement Benefit	[80-100]% of Eligible Expenses.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000].
Maximum Home Health Benefit	[80-100]% of Eligible Expenses.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000].
Maximum Surgical Benefit for Organ or Tissue Transplant Benefit	[80-100]% of Eligible Expenses.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000].
Maximum Outpatient Treatment Benefit	[80-100]% of Eligible Expenses.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000].
[Maximum Policy Benefit per Covered Person per lifetime for all Transplants]	[Unlimited for all Transplant Services.] [\$[1,000,000 - 5,000,000] for all Transplant Services.]	[Unlimited for all Transplant Services.] [\$[1,000,000 - 5,000,000] for all Transplant Services.]

Non-Network Organ and Tissue Procurement Table

Transplant	Maximum Benefit
Lung	[\$10,000 - 50,000]
Double Lung	[\$10,000 - 50,000]
Heart	[\$10,000 - 50,000]
Liver	[\$10,000 - 50,000]
Liver/Kidney	[\$10,000 - 50,000]
Heart/Lung	[\$10,000 - 50,000]
Heart/Kidney	[\$10,000 - 50,000]
Pancreas	[\$10,000 - 50,000]
Kidney	[\$10,000 - 50,000]
Kidney/Pancreas	[\$10,000 - 50,000]
Intestine, Liver/Intestine and Multivisceral Transplants	[\$0 - 5,000]
Allogeneic BMT	[\$10,000 - 50,000]
Autologous BMT	[\$10,000 - 50,000]

**Maximum Hospital/Physician Benefit
For Transplants Performed Prior to a
6 month Period Of Drug/Alcohol Sobriety**

Transplant	Maximum Network or Non-Network Benefit
Lung	[\$00,000]
Double Lung	[\$00,000]
Heart	[\$00,000]
Liver	[\$00,000]
Liver/Kidney	[\$00,000]
Heart/Lung	[\$00,000]
Heart/Kidney	[\$00,000]
Pancreas	[\$00,000]
Kidney	[\$00,000]
Kidney/Pancreas	[\$00,000]
Intestine, Liver/Intestine and Multivisceral Transplants	[\$00,000]
Allogeneic BMT	[\$00,000]
Autologous BMT	[\$00,000]

Section 2: Covered Transplant Services

Transplant Services described in this section are Covered when such services are:

- A. Provided by or under the direction of a Physician or other appropriate provider as specifically described;
- B. Not excluded as described in [*Section 12: General Exclusions*];
- C. Received pursuant to the procedures for obtaining benefits set forth in [*Section 3: Procedure for Obtaining Benefits*].

The Schedule of Benefits sets forth the amount of Coverage provided for Transplant Services. Subject to those benefit levels, and the other terms and conditions described in this Certificate, the Policy covers:

2.1 Evaluation

Services and supplies related to a Transplant and provided to a Covered Person to determine if the Covered Person is an acceptable candidate for a Hospital's transplant program. This includes Transplant-related services for outpatient surgery, laboratory, radiologic and other diagnostic tests and examinations provided by or through a Physician.

2.2 Organ and Tissue Procurement

Services and supplies provided for organ and tissue procurement, including removal, preservation and transportation. Where there is a live donor, this benefit includes donor screening, donor transportation to and from the Hospital where the donation occurs and health services associated with the removal of the organ and/or tissue. This benefit is only available when a Covered Person is the recipient of the Transplant.

2.3 Professional Fees for Surgical and Medical Services

Professional fees for surgical services and other medical care associated with a Transplant and provided by or through a Physician and rendered in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

2.4 Inpatient Hospital Services

Confinement related to a Transplant, including room and board, and services and supplies provided during Confinement (in a Semi-private Room) in a Hospital. Certain Transplant Services rendered during a Covered Person's Confinement are subject to separate benefit restrictions.

2.5 Outpatient Emergency Transplant Services

Services provided to stabilize and/or initiate treatment of Emergency conditions, related to a Transplant, and provided on an outpatient basis at either a Hospital or an Alternate Facility.

2.6 Home Health Agency Services

Part-time, intermittent services of a Home Health Agency, when related to a Transplant and provided under the direction of a Physician. Home Health Agency Services must be provided in your home, by or under the supervision of a registered nurse.

2.7 Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Confinement (in a Semi-private Room), including medical services and supplies, when related to a Transplant and provided under the direction of a Physician. Transplant Services must be

provided in a Skilled Nursing Facility or Inpatient Rehabilitation Facility and are Covered only for Transplant-related care and treatment which otherwise would require Confinement in a Hospital.

2.8 Ambulance Services

Emergency ambulance transportation for the Covered Person and one companion, via ground or air, by a licensed ambulance service to and/or from the treating Hospital where Transplant Services are to be rendered. If the Covered Person is a minor, benefits are payable for two companions.

2.9 Outpatient Rehabilitation Services

Short-term outpatient rehabilitation services. Coverage is provided only for physical therapy, occupational therapy and cardiac/pulmonary rehabilitation that are related to a Transplant.

Rehabilitation services must be performed in a Hospital or Skilled Nursing Facility or through a Home Health Agency or other provider.

2.10 Travel, Meals, and Lodging Reimbursement

Subject to the limitations and conditions set forth in the Schedule of Benefits, the following expenses are reimbursable when Covered Transplant Services are provided by Network providers and incurred by a Covered Person who must travel outside a 50-mile radius from his/her home to and/or from a Hospital where the Transplant and post-discharge follow-up care is provided:

- A. Transportation expenses for the Covered Person and one companion. If the Covered Person is a minor, reimbursement is payable for the transportation expenses of the Covered Person and two companions.
- B. Meal and lodging expenses for the Covered Person and one companion. If the Covered Person is a minor, reimbursement is payable for the meal and lodging expenses of the Covered Person and two companions.

The Company must receive valid receipts for such charges before reimbursement will be made.

Section 3: Procedures for Obtaining Benefits

3.1 Procedure to Obtain BenefitsTo obtain benefits for Transplant Services, you must:

- A. notify the Company of your intent to receive such services; and
- B. obtain prior approval from the Company for such services; and
- C. allow the Company to coordinate your receipt of such services.

You are responsible for assuring that required prior notification and approval is received before services are rendered. To start this process, call the Company's Member Services Department at [1-888-321-0881] [or at the telephone number shown on your [Transplant] identification card].

Failure to comply with these requirements may result in a lower level of Coverage or no Coverage of such Transplant Services.

3.2 Emergency Transplant Services

The Company provides Coverage of Eligible Expenses for Emergency Transplant Services, subject to the terms, conditions, exclusions, and limitations of the Policy.

You must notify the Company within [24 hours], or as soon as reasonably possible, if you are Confined for an issue related to a Transplant due to an Emergency. Transplant Services rendered on an Emergency basis are not Covered if, in the opinion of the Company, the situation is later determined not to be an Emergency.

At the Company's request, you must make available full details of the Emergency Transplant Services received in order for such Transplant Services to be Covered.

Coverage for continuation of care related to a Transplant and after the condition no longer is an Emergency requires compliance with the procedures described in [*Section 3.1: Procedure to Obtain Benefits*].

3.3 Prior Approval Does Not Guarantee Benefits

The fact that the Company authorizes services or supplies does not guarantee that all charges will be Covered. The Company reserves the right to review each claim. You will be notified in writing of any subsequent adjustment of benefits as a result of the claim review.

Section 4: Eligibility, Enrollment and Effective Date of Coverage

4.1 Eligibility

An Eligible Person is usually an employee or member of the Policyholder who meets the eligibility requirements of the Policy. When an Eligible Person actually enrolls for Coverage under this Policy, that Eligible Person is referred to as a Subscriber (see [Section 14: Glossary] for complete definitions). The term Dependent generally refers to the Subscriber's spouse and children (see [Section 14: Glossary] for complete definitions).

4.2 Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period [or during an Open Enrollment Period] by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

[If both spouses are eligible Employees of the Policyholder, each may enroll as a Subscriber or be Covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

[A.] [Dependent Child Special Open Enrollment Period]

[On or before the first day of the first plan year beginning on or after September 23, 2010, the Policyholder will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if the Company receives the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.]

4.3 Effective Date of Coverage

Coverage for you and any of your Dependents is effective on or after the date specified in the Policy. In no event is there Coverage for Transplant Services rendered or delivered before the Policy Effective Date, unless specifically stated in the Schedule of Benefits.

4.4 Coverage for a New Eligible Person

Coverage for you and any of your Dependents shall take effect as set forth herein. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within [31 days] of the date you first become eligible.

4.5 Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, legal guardianship, court or administrative order, [registration of a Domestic Partner,]or marriage shall take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 90 days (60 days for a newborn adopted child or a child placed for adoption).

4.6 Effective Date of Coverage for Confinement

If you are Confined on your effective date of Coverage and you do not have coverage for that Confinement under a prior benefit plan, Transplant Services related to the Confinement are Covered as long as:

- A. You notify the Company of Confinement within 48 hours of the effective date or as soon as is reasonably possible; and
- B. Transplant Services are received in accordance with the terms, conditions, exclusions and limitations of the Policy.

If you are Confined on your effective date of Coverage and the Confinement is covered under a prior benefit plan, Transplant Services for that Confinement are not Covered under the Policy. All other Transplant Services are Covered as of the effective date.

If you have prior coverage which has been required by state law to extend benefits for a particular condition or a disability as defined by state law, Transplant Services for the condition or disability will not be Covered under the Policy until your prior coverage is exhausted.

4.7 Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period [or Open Enrollment Period] may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met:

- A. The Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period [or Open Enrollment Period]; and
- B. Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted.

A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within [31 days] of the date coverage under the prior plan terminated.

A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by a birth, legal adoption, placement for adoption, [registration of a Domestic Partner,]or marriage, as required by federal law. In such cases you must submit the required Premium and a properly completed enrollment form within [thirty-one (31)] days of the marriage, birth, placement for adoption or adoption.

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period [or Open Enrollment Period] may also enroll for Coverage during a special enrollment period if:

- A. The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 60 days of the date of determination of subsidy eligibility.
- B. The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Eligibility Period [or Open Enrollment Period], and coverage under the prior plan was terminated as a result of the

Eligible Person and/or Dependent losing eligibility under Medicaid or Children's Health Insurance Program (CHIP). Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 60 days of the date coverage under the prior plan ended.

Section 5: Termination of Coverage

5.1 Conditions for Termination of a Covered Person's Coverage Under the Policy

The Company may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy, as permitted by law.

Your entitlement to Coverage, including coverage for Transplant Services rendered after the date of termination for Transplants that started prior to the date of termination, shall automatically terminate on the earliest of the dates specified below:

- A. The date the entire Policy is terminated, as specified in the Policy. The Policyholder is responsible for notifying you of the termination of the Policy.
- B. The [date][last day of the calendar month in which] you cease to be eligible as a Subscriber or Enrolled Dependent.
- C. The date the Company receives written notice from either the Subscriber or the Policyholder instructing the Company to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.
- D. The date the Subscriber is retired or receiving benefits under the Policyholder's pension or retirement plan, unless a specific coverage classification is specified for retired or pensioned persons in the Policyholder's application and the Subscriber continues to meet any applicable eligibility requirements.

When either of the following apply, the Company will provide advance written notice to the Subscriber that coverage will end on the date the Company identifies in the notice.

- A. **Fraud or Intentional Misrepresentation of a Material Fact.** You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, the Company has the right to demand that you pay back all benefits the Company paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, the Company can only demand that you pay back these benefits if the written application contained a fraudulent misstatement

- B. **Threatening Behavior.** You committed acts of physical or verbal abuse that pose a threat to our staff.

5.2 Extended Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. Coverage will be extended for that child beyond the limiting age specified in the Policy provided that both of the following are true regarding the Enrolled Dependent child:

- A. The Enrolled Dependent child is not able to be self-supporting because of mental or physical handicap or disability.
- B. The Enrolled Dependent child is chiefly dependent upon the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent and payment of any required Premium for the Enrolled Dependent is continued, unless coverage is otherwise terminated in accordance with the terms of the Policy.

The Company will ask you to furnish the Company with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before granting this extension of coverage for the child, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a Physician designated by the Company.

At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent child's continued disability and dependency, including medical examinations at the Company's expense. Such proof will not be required more than once a year. Failure to provide such satisfactory proof within 31 days of the Company's request will result in the termination of the Enrolled Dependent child's Coverage under the Policy.

5.3 Payment and Reimbursement Upon Termination

Termination of Coverage shall not affect any request for reimbursement of Eligible Expenses for Transplant Services rendered prior to the effective date of termination. Your request for reimbursement must be furnished as required in [Section 6: Reimbursement].

[[5.4] Extended Coverage for Full-Time Students

Coverage for an Enrolled Dependent child who is a Full-time Student [at a post-secondary school] and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- A. One year after the medically necessary leave of absence begins.
- B. The date coverage would otherwise terminate under the Policy.

Coverage will be extended only when the Enrolled Dependent is covered under the Policy because of Full-time Student status [at a post-secondary school] immediately before the medically necessary leave of absence begins and when the Enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- A. The Enrolled Dependent is suffering from a serious sickness or injury.
- B. The leave of absence [from the post-secondary school] is medically necessary, as determined by the Enrolled Dependent's treating Physician.
- C. The medically necessary leave of absence causes the Enrolled Dependent to lose Full-time Student status for purposes of coverage under the Policy.

A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious sickness or injury and that the leave of absence is medically necessary.

For purposes of this extended coverage provision, the term "leave of absence" shall include any change in enrollment [at the post-secondary school] that causes the loss of Full-time Student status.]

Section 6: Reimbursement

6.1 Reimbursement of Eligible Expenses from Network Providers

Network providers are responsible for submitting a request for payment of Eligible Expenses directly to the Company. In the event a Network provider bills you for Eligible Expenses, you should contact the Company.

6.2 Reimbursement of Eligible Expenses from Non-Network Providers

The Company shall reimburse you for Eligible Expenses from non-Network providers, subject to the terms, conditions, exclusions and limitations of the Policy.

6.3 Filing Claims for Reimbursement of Eligible Expenses from Non-Network Providers

You are responsible for sending a request for reimbursement to the Company's office, on a form provided by or satisfactory to the Company. Requests for reimbursement should be submitted within 90 days after the date of service. Unless you are legally incapacitated, failure to provide this information to the Company within 1 year of the date of service shall cancel or reduce Coverage for the Transplant Service.

Subject to written authorization from a Subscriber, all or a portion of any Eligible Expenses payable may be paid directly to the provider of the Transplant Services instead of being paid to the Subscriber.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the request must include all of the following information:

- A. Your name and address.
- B. Patient's name and age.
- C. Number stated on your [Transplant] identification card.
- D. The name and address of the provider of the service(s).
- E. A diagnosis from the Physician.
- F. Itemized bill that includes the CPT codes or description of each charge.
- G. Date Transplant Services began.
- H. A statement indicating that you are or you are not enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call the Company at the telephone number stated on your [Transplant] identification card and a claim form will be sent to you. If you do not receive the claim form within 15 days of your request, send in the proof of loss with the information stated above.

Proof of Loss. Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than one year after the date of service.

Payment of Claims. Payment of claims for non-Network Benefits are payable upon the Company's receipt of acceptable proof of loss. Benefits will be paid to you unless:

- A. the provider notifies the Company that your signature is on file assigning benefits directly to that provider; or
- B. you make a written request, that benefits be paid directly to the provider of services, at the time the claim is submitted.

6.4 Limitation of Action for Reimbursement

You do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 60 days after you have properly submitted a request for reimbursement, as described above. No action may be brought after 3 years from the time written proof of loss is required to be given under this Policy.

Section 7: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

7.1 What to Do if You Have a Question

Contact the Company's Member Services Department at the telephone number shown on your [Transplant] ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

7.2 What to Do if You Have a Complaint

Contact the Company's Member Services Department at the telephone number shown on your ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Company in writing, the Member Services representative can provide you with the appropriate address.

If the Member Services representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. The Company will notify you of the Company's decision regarding your complaint within 60 days of receiving it.

7.3 How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for benefits are those requests that require prior approval or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with either a pre-service request for benefits determination, a post-service claim determination or a rescission of coverage determination, you can contact the Company in writing to formally request an appeal.

Your request for an appeal should include:

- A. The patient's name and the identification number from the [Transplant] ID card.
- B. The date(s) of medical service(s).
- C. The provider's name.
- D. The reason you believe the claim should be paid.
- E. Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Company within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. The Company may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information

relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by the Company during the determination of the appeal, the Company will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

7.4 Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for benefits, see *Urgent Appeals That Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- A. For appeals of pre-service requests for benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- B. For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

The Company's decision is based on whether or not benefits are available under the Policy for the proposed Transplant Services or procedures.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in Transplant related treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- A. The appeal does not need to be submitted in writing. You or your Physician should call the Company as soon as possible.
- B. The Company will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- C. If the Company needs more information from your Physician to make a decision, the Company will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

[7.5 Federal External Review Program]

[The *Departments of Health and Human Services, Labor and Treasury (Departments)* will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been

established by the *Departments*, the Company will provide you with additional information concerning the process.

Contact the Company's Member Services Department at the telephone number shown on your [Transplant] ID card for more information on the Federal external review program.]

Section 8: General Provisions

8.1 Entire Policy

The Policy issued to the Policyholder, including the Certificate of Coverage, the Policyholder's application, amendments and riders, constitute the entire Policy. All statements made by the Policyholder or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties.

8.2 Limitation of Action

You do not have the right to bring any legal proceeding or action against the Company without first completing the complaint procedure specified in [Section 7: Questions, Complaints and Appeals]. If you do not bring such legal proceeding or action against the Company within 3 years of the date the Company notified you of its final decision as described in [Section 7: Questions, Complaints and Appeals], you forfeit your rights to bring any action against the Company.

The only exception to this limitation of action is that reimbursement of Eligible Expenses, as set forth in [Section 6: Reimbursement] of this Certificate, is subject to the limitation of action provision of that section.

8.3 Time Limit on Certain Defenses

No statement, except a fraudulent statement, made by the Policyholder shall be used to void the Policy after it has been in force for a period of two years.

8.4 Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Policyholder. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an amendment or a rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

8.5 Relationship Between Parties

The relationships between the Company and providers and relationships between the Company and Policyholders, are **solely** contractual relationships between independent contractors. Providers and Policyholders are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or Policyholders.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided to any Covered Person.

The relationship between the Policyholder and Covered Persons is that of employer and employee, Dependent or other coverage classification as defined in the Policy. The Policyholder is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's Coverage through the Company), for the timely payment of the Premiums to the Company, and for notifying Covered Persons of the termination of the Policy.

8.6 Records

You must furnish the Company with all information and proof that it may reasonably require regarding any matters pertaining to the Policy.

By accepting Coverage under the Policy, you authorize and direct any person or institution that has provided services to you, to furnish the Company any and all information and records or copies of records relating to the services provided to you. The Company has the right to request

this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

The Company agrees that such information and records will be considered confidential. The Company has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy or for appropriate medical review or quality assessment.

The Company is permitted to charge you reasonable fees to cover costs for completing medical abstracts or forms that you request.

In some cases, the Company will designate other persons or entities to request records or information from or related to you and to release those records as necessary. The Company's designees have the same rights to this information as does the Company.

During and after the term of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

8.7 ERISA

When the Policy is purchased by the Policyholder to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., the Company is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA. The Policyholder has agreed that the Policy constitutes the plan and plan document under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The Policyholder has designated the Company as the claims fiduciary of this plan and has given the Company the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The Policyholder will comply with the disclosure and reporting requirements of ERISA regarding the plan and the Company's designation and authority as the claims fiduciary.

8.8 Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Transplant Services, the Company may reasonably require that a Physician acceptable to the Company examine you at the Company's expense.

8.9 Clerical Error

If a clerical error or other mistake occurs, that error shall not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits.

8.10 Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Policyholder, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Policyholder is responsible for giving notice to Covered Persons.

8.11 Workers' Compensation Not Affected

The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

8.12 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.

Section 9: Coordination of Benefits

9.1 Benefits When You Have Coverage under More than One Plan

This section describes how benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

9.2 When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

9.3 Definitions

For purposes of this section, terms are defined as follows:

- A. A "Plan" is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. "Plan" includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. "Plan" does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. "This Plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any

other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. "Allowable Expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. "Closed Panel Plan" is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. "Custodial Parent" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

9.4 Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - 1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - 2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - 1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

- 2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
- 3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
- 4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
- c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a. or b. above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

9.5 Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

9.6 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts it needs to apply those rules and determine benefits payable. If you do not provide the Company with the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

9.7 Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

9.8 Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

[9.9 When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.]

Section 10: Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Company shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of any services and benefits provided by the Company to you from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Certificate, the Company shall also have an independent right to be reimbursed by you for the reasonable value of any services and benefits the Company provides to you, from any or all of the following listed below.

- A. Third parties, including any person alleged to have caused you to suffer injuries or damages.
- B. Your employer.
- C. Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- D. Any person or entity who is liable for payment to you on any equitable or legal liability theory.

All of the above listed third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- A. That you will cooperate with the Company in protecting the Company's legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - 1. Providing any relevant information requested by the Company.
 - 2. Signing and/or delivering such documents as the Company or its agents reasonably request to secure the subrogation and reimbursement claim.
 - 3. Responding to requests for information about any accident or injuries.
 - 4. Making court appearances.
 - 5. Obtaining the Company's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
- B. That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- C. That the Company has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- D. That no court costs or attorneys' fees may be deducted from the Company's recovery without the Company's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Company is not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- E. That regardless of whether you have been fully compensated or made whole, the Company may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- F. That benefits paid by the Company may also be considered to be benefits advanced.
- G. That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- H. That you or an authorized agent, such as your attorney, must hold any funds due and owing the Company, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- I. That the Company may set off from any future benefits otherwise provided by the Company the value of benefits paid or advanced under this section to the extent not recovered by the Company.
- J. That you will not accept any settlement that does not fully compensate or reimburse the Company without its written approval, nor will you do anything to prejudice the Company's rights under this provision.
- K. That you will assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Company provided, plus reasonable costs of collection.
- L. That the Company's rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- M. That the Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name, which does not obligate the Company in any way to pay you part of any recovery the Company might obtain.
- N. That the Company shall not be obligated in any way to pursue this right independently or on your behalf.
- O. That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- P. That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments. If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if any of the following apply:

- A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- B. All or some of the payment made by the Company exceeded the benefits under the Policy.
- C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 11: Continuation of Coverage Under Federal Law (COBRA)

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Policyholders that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Policyholder is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Company is not the Policyholder's designated "plan administrator" as that term is used in federal law, and the Company does not assume any responsibilities of a "plan administrator" according to federal law.

The Company is not obligated to provide continuation coverage to you if the Policyholder or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Policyholder or its plan administrator are:

- A. Notifying you in a timely manner of the right to elect continuation coverage.
- B. Notifying the Company in a timely manner of your election of continuation coverage.

Section 12: General Exclusions

Section 12.1 Exclusions.

Except as may be specifically provided in [Section 2: Covered Transplant Services] or through a rider to the Policy, the following services are not Covered:

- A. Transplant-related health care services and supplies which are:
1. not necessary to meet the health needs of the Covered Person; or
 2. not rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Transplant Service; or
 3. not consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; or
 4. not consistent with the diagnosis of the condition; or
 5. are required only for the convenience of the Covered Person or his or her Physician; or
 6. not demonstrated through prevailing peer-reviewed medical literature to be either:
 - a. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - b. safe with promising efficacy:
 - 1) for treating a life-threatening sickness or condition;
 - 2) in a clinically controlled research setting; and
 - 3) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
- (For the purpose of this section, the term life-threatening is used to describe a condition which is more likely than not to cause death within one year of the date of the request for treatment).
- B. Any form of renal dialysis, except dialysis performed immediately following a kidney Transplant procedure to promote organ functions.
- C. Dental services and associated expenses, except those related to evaluation.
- D. Custodial care; domiciliary care; private duty nursing; respite care; rest cures. (Custodial care means:
1. non-health related services, such as assistance in activities of daily living; or
 2. health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing; or
 3. services which do not require continued administration by trained medical personnel).

- E. Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
- F. Health services and associated expenses for cosmetic procedures.
- G. Health services and associated expenses for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for Transplant Services which are otherwise Experimental, Investigational or Unproven that are deemed to be, in the Company's judgment, Covered Transplant Services. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- H. Health services and associated expenses for removal of an organ from a Covered Person for purposes of transplantation into another person, except as may otherwise be Covered by the organ recipient's Coverage under the Policy. Health services and associated expenses for transplants involving mechanical or animal organs.
- I. Health services and associated expenses for organ or tissue transplants that are not specified as Covered in [*Section 2: Covered Transplant Services*] of this Certificate.
- J. Health services and associated expenses for megavitamin therapy; psychosurgery; or nutritional-based therapy.
- K. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.
- [L.] [Growth hormone therapy.]
- [M.] Travel or transportation expenses beyond that which is set forth in [*Section 2: Covered Transplant Services*].
- [N.] Mental health and/or substance use disorder services.
- [O.] Any drugs that are investigative or which have not been approved for general sale by the *United States Food and Drug Administration* unless requested in writing by a Network provider and approved by the Company.
- [P.] Outpatient prescribed or non-prescribed medical supplies including, but not limited to, elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; over-the-counter drugs and treatments.
- [Q.] Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- [R.] Transplant Services otherwise Covered under the Policy, but rendered after the date an individual's Coverage under the Policy terminates, including Transplant Services for medical conditions arising prior to the date the individual's Coverage under the Policy terminates.
- [S.] Transplant Services otherwise Covered under the Policy, but rendered prior to the date an individual's Coverage under the Policy is effective.
- [T.] Transplant Services for which the Covered Person has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Policy.

- [U.] [Coverage for an otherwise Eligible Person or a Dependent who is on active military duty; Transplant Services received as a result of war or terrorism, or any act of war or terrorism, whether declared or undeclared or caused during service in the armed forces of any country.]
- [V.] [Transplant Services provided in a foreign country, unless required as Emergency Transplant Services.]
- [W.] Transplant Services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation.
- [X.] Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; [acupuncture] and other forms of alternative treatment.
- [Y.] Health services and associated expenses involving mechanical organs and mechanical devices including but not limited to a Circulatory Assist Device (CAD) and any other artificial or mechanical device designed to supplement, assist or replace organs either permanently or temporarily.
- [Z.] Services and associated expenses related to islet cell transplants.
- [AA.] Services and associated expenses unrelated to the Covered Transplant Services.
- [BB.] Services and associated expenses unrelated to the diagnosis or treatment of a Covered Transplant Service including, without limitation, services and associated expenses related to a Covered Person's underlying disease or a relapse of a Covered Person's underlying disease. Specific to bone marrow transplants, a relapse of the Covered Person's underlying disease shall be deemed to have occurred upon the date following bone marrow transplant when the recurrence of the original disease is confirmed. This may occur retroactively depending upon receipt of appropriate clinical information.
- [CC.] Cardiac rehabilitation services and associated expenses which are not part of the Covered Transplant Service.

Section 13: Limited Benefits

There are certain benefit limitations that apply to Covered Persons who have used any drug, hallucinogen, controlled substance, or narcotic not prescribed by a Physician, or Covered Persons with a documented history of alcohol abuse. The limitations are as follows:

- [A.] Transplant Services and associated expenses for Transplants where the Covered Person has used any drug, hallucinogen, controlled substance, or narcotic not prescribed by a Physician are not Covered until after the Covered Person has abstained from use of all such substances for a period of at least six consecutive months immediately preceding the Transplant. (See [*Section 1: Schedule of Benefits*, Chart 2])

- [B.] Transplant Services and associated expenses for Transplants where the Covered Person has a documented history of alcohol abuse, are not Covered until after the Covered Person has abstained from any use of alcohol for a period of at least six consecutive months immediately preceding the Transplant. (See [*Section 1: Schedule of Benefits*, Chart 2])

Section 14: Glossary

This Section defines the terms used in this Certificate.

Alternate Facility. A non-Hospital health care facility, or an attached facility designated as such by a Hospital, which provides one or more of the following services on an outpatient basis as permitted under the law of jurisdiction in which treatment is received: prescheduled surgical, rehabilitative, laboratory or diagnostic services.

Amendment. Any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by an executive officer of the Company, on behalf of the Company. Amendments are subject to all terms, conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Coinsurance. The charge, in addition to the Premium, which you are required to pay for certain Transplant Services provided under the Policy. Coinsurance is expressed as the percentage of Eligible Expenses.

Confinement and Confined. An uninterrupted stay following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Coverage or Covered. The entitlement by a Covered Person to reimbursement for expenses incurred for Transplant Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Transplant Services must be provided:

- A. When the Policy is in effect; and
- B. Prior to the date that any of the individual termination conditions of [*Section 5.1: Conditions for Termination of a Covered Person's Coverage Under the Policy*] occur; and
- C. Only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

Covered Person. A Subscriber or an Enrolled Dependent; however, this term applies only while Coverage of such person under the Policy is in effect. References to "you" and "your" throughout this Certificate are references to a Covered Person.

Dependent. (1) The Subscriber's legal spouse; or (2) a child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, [a foster child,]a legally adopted child, a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse, or a child placed for adoption). [The term child also includes a grandchild of either the Subscriber or the Subscriber's spouse [when legal guardianship has been awarded to the Subscriber or the Subscriber's spouse].] [The principal place of residence of the legal spouse must be with the Subscriber unless the Company approves other arrangements.] [All references to the spouse of a Subscriber shall include a Domestic Partner.]

The definition of Dependent is subject to the following conditions and limitations:

- A. The term Dependent shall include any child listed above under [26] years of age.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age [26].]
- B. The term Dependent shall include an unmarried dependent child age [26] or older who is or becomes disabled and dependent upon the Subscriber as described in [*Section 5.2: Extended Coverage for a Disabled Dependent Child*].

[C. The term Dependent shall include [a][an unmarried] dependent child who is [26] years of age or older, but less than [29] years of age if evidence satisfactory to the Company of the following conditions is furnished upon request:

1. the child is not regularly employed on a full-time basis; and
2. the child is a Full-time Student; and
3. the child is primarily dependent upon the Subscriber for support and maintenance.]

[The definition of Dependent also includes such other sponsored Dependents as agreed upon by the Company and the Policyholder.]

The Subscriber must reimburse the Company for any Transplant Services provided to a child at a time when the child did not satisfy these conditions. The Policyholder and the Company may agree to increase these age limits, in which case the increased age limits will be stated in this Certificate or an Amendment to the Policy/Certificate.

The term Dependent also includes a child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order. The Policyholder is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

[The term Dependent does not include anyone who is also enrolled as a Subscriber[, nor can anyone be a Dependent of more than one Subscriber].]

[Domestic Partner - a person of the [opposite sex][same sex][opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. All of the following requirements apply to both persons:

- A. They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- B. They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- C. They must share the same permanent residence and the common necessities of life.
- D. They must be at least 18 years of age.
- E. They must be mentally competent to consent to contract.
- F. They must be financially interdependent [and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 1. [They have a single dedicated relationship of at least [6 - 18] months duration.]
 2. [They have joint ownership of a residence.]
 3. [They have at least two of the following:
 - a. A joint ownership of an automobile.
 - b. A joint checking, bank or investment account.

- c. A joint credit account.
- d. A lease for a residence identifying both partners as tenants.
- e. A will and/or life insurance policies which designates the other as primary beneficiary].]

[The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

Eligible Expenses. Eligible Expenses for Covered Transplant Services, incurred while the Policy is in effect, are determined as stated below:

- A. For Network Benefits:
 - 1. When Covered Transplant Services are received from Network providers, Eligible Expenses are the Company's contracted fee(s) for the Transplant Service with that provider;
 - 2. When Covered Transplant Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by the Company, Eligible Expenses are the fee(s) negotiated between the Company and the non-Network provider.
- B. For Non-Network Benefits:
 - 1. When Covered Transplant Services are received from non-Network providers, Eligible Expenses are the lesser of: 1) the fees that do not exceed the Company's contracted fee(s) for Network providers; or 2) fees calculated based on available data resources of competitive fees.

Eligible Expenses must not exceed the fees that the provider would charge any similarly situated payer for the same services. In the event a non-Network provider routinely waives any copayments and/or any annual deductible for Non-Network Benefits, Transplant Services for which the copayments and/or the annual deductible are waived are not considered to be Eligible Expenses.

Eligible Expenses are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- A. As indicated in the most recent edition of the Current Procedural Terminology (publication of the *American Medical Association*);
- B. As reported by generally recognized professionals or publications;
- C. As utilized for Medicare;
- D. As determined by medical staff and outside medical consultants;
- E. Pursuant to other appropriate sources or determinations accepted by the Company.

Eligible Person. (1) An employee of the Policyholder; or (2) other person who meets the eligibility requirements specified in both the application and the Policy.

Emergency. A serious medical condition or symptom resulting from injury or sickness which arises suddenly and, in the judgment of a reasonable person, requires immediate care and

treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of a Covered Person.

Emergency Transplant Services. Those health care services and supplies necessary for the treatment of an Emergency. Emergency Transplant Services are subject to the conditions and any Coinsurance described in this Certificate.

Enrolled Dependent. A Dependent who is properly enrolled for Coverage under both the Policy and the Policyholder's major medical health benefit plan.

Evaluation. Transplant Services rendered to the Covered Person to determine if the Covered Person is an acceptable candidate for a Transplant.

Experimental, Investigational or Unproven Services. Medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

- A. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- B. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental, Investigational or Unproven.)
- C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- D. Not demonstrated through prevailing peer reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Exceptions for a life-threatening sickness or condition:

If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the date of the request for a Transplant) the Company may, in its discretion, consider an otherwise Experimental, Investigational or Unproven Service to be a Covered Transplant Service for that sickness or condition if it is determined by the Company that the Experimental, Investigational or Unproven Transplant Service, at the time of the determination:

- A. Is safe with promising efficacy;
- B. Is provided in a clinically controlled research setting; and
- C. Uses a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

[Full-time Student. A person who is enrolled in and attending, full-time, a recognized course of study or training at:

- A. An accredited high school;
- B. An accredited college or university; or

- C. A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person ceases to be a Full-time Student [at the end of the calendar [month][year] during which][on the date] the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis.

A person continues to be a Full-time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on the [last day of the calendar [month] [year] in which][last day on which] the person was enrolled and in attendance at the institution on a full-time basis.]

Hematopoietic Stem Cell (HSC). Special cells derived from bone marrow, umbilical cord blood, peripheral blood, or certain fetal tissues.

Home Health Agency. A program or entity which is:

- A. Engaged in providing health care services in the home; and
- B. Authorized as required by the law of jurisdiction in which treatment is received.

Hospital. An institution, operated as required by law, which:

- A. Is primarily engaged in providing Transplant Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a staff of Physicians;
- B. Has 24 hour nursing services; and
- C. Is accredited as a Hospital by the *Joint Commission on Accreditation of Healthcare Organizations* [or by the *American Osteopathic Hospital Association*].

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Eligibility Period. The initial period of time, determined by the Company and the Policyholder, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Inpatient Rehabilitation Facility. A Hospital or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility which provides rehabilitation Transplant Services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis as permitted by the law of jurisdiction in which treatment is received.

Inpatient Rehabilitation Facility Services. Skilled rehabilitation services which meet all of the following criteria:

- A. Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- B. Are ordered by a Physician; and
- C. Are not excluded pursuant to the provisions of [*Section 12: General Exclusions*].

Determination of benefits for Inpatient Rehabilitation Facility Services is made based on both the skilled nature of the service and the need for Physician-directed medical management. Inpatient

Rehabilitation Facility Services are not determined by the availability of caregivers to perform them; the absence of a person to perform an unskilled service does not cause the service to become skilled.

[Maximum Policy Benefit. The maximum amount paid for Network and non-Network Transplant Services during the entire period of time the Covered Person is Covered under the Policy or any policy, issued by the Company to the Policyholder, that replaces the Policy. The Maximum Policy Benefit is stated in [Section 1], Schedule of Benefits.]

Medicare. Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq., and as later amended.

Mobilization. The harvesting of bone marrow, and/or the process of recruiting hematopoietic progenitor cells into the peripheral blood including, but not limited to, the placement of central venous catheters, the administration of chemotherapy and/or growth factors, and apheresis.

Network. When used to describe a provider of Transplant Services (such as a Hospital, Physician, Alternate Facility, Home Health Agency, Skilled Nursing Facility or Inpatient Rehabilitation Facility) means that the provider, on behalf of a particular transplant program, has a participation agreement in effect with the Company as part of the Company's Transplant Network to provide Transplant Services to Covered Persons.

The participation status of providers and their transplant programs will change from time to time.

The Company may direct Covered Persons to a facility that is not part of its Transplant Network to receive Transplant Services. Network Benefits will only be paid if Covered Transplant Services are provided by or arranged by the facility or provider designated by the Company.

Network Benefits. Benefits available for Covered Transplant Services when provided by a Network provider.

Non-Network Benefits. Benefits available for Transplant Services obtained from non-Network providers.

Open Enrollment Period. After the Initial Eligibility Period, a period of time determined by the Company and the Policyholder, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Physician. Any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Policy. The group Policy, the Certificate the application of the Policyholder, amendments and riders which constitute the agreement regarding the benefits, exclusions and other conditions between the Company and the Policyholder.

Policyholder. The employer or other defined or otherwise legally constituted group to whom the Policy is issued.

Premium. The periodic fee required for all Subscribers and Enrolled Dependents Covered under the Policy.

Preparative Therapy. The process by which the Covered Person is made physiologically ready to receive an HSC Transplant.

Semi-private Room. A room with 2 or more beds. The difference in cost between a Semi-private Room and a private room is Covered only when a private room is determined by the Company to be necessary or when a Semi-private Room is not available.

Skilled Nursing Facility. A Hospital or nursing facility which is licensed and operated in accordance with the law of jurisdiction in which treatment is received.

Skilled Nursing Facility Services. Skilled nursing, skilled teaching, and skilled rehabilitation services which meet all of the following criteria:

- A. Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- B. Are ordered by a Physician; and
- C. Are not excluded pursuant to the provisions of [*Section 12: General Exclusions*].

Determination of benefits for Skilled Nursing Facility Services is made based on both the skilled nature of the service and the need for Physician-directed medical management. Skilled Nursing Facility Services are not determined by the availability of caregivers to perform them; the absence of a person to perform an unskilled service does not cause the service to become skilled.

Subscriber. An Eligible Person who is properly enrolled for Coverage under both the Policy and the Policyholder's major medical health benefit plan. The Subscriber is the person [who is not a Dependent] on whose behalf the Policy is issued to the Policyholder.

Transplant. An authorized procedure for the implantation of organs, or infusion of HSC after Mobilization or Preparative Therapy.

Transplant Benefit Period. The periods, set forth below, during which Transplant Services for Covered Persons are Covered.

- A. For solid organs, the **Transplant Benefit Period** begins [1 day] [[2-10] days] prior to the date the Transplant is performed and ends [twelve (12)] months after the date of the Transplant.
- B. For allogeneic Transplants, the **Transplant Benefit Period** begins [1 day] [[2-10] days] prior to the date the Transplant is performed and ends [twelve (12)] months after the date of the Transplant.
- C. For autologous Transplants, the **Transplant Benefit Period** begins [1 day] [[2-10] days] prior to the date the Transplant is performed and ends [twelve(12)] months after the date of the Transplant.

Transplant Services. The health care services and supplies Covered under the Policy, except to the extent that such health care services and supplies are limited or excluded.

END OF CERTIFICATE

The undersigned Applicant requests the Transplant Insurance Benefits shown herein and provided by Unimerica Insurance Company, and agrees to be bound by the terms and provisions of the transplant Insurance Policy.

SECTION 1: APPLICANT INFORMATION

Full Legal Name of Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____ Tax ID No.: _____

Contact Person

Name: _____ Phone: _____ Fax: _____

E-mail Address: _____

Total Number of Eligible Persons: _____ Total Number of Covered Persons: _____

Requested Effective Date: _____ First Renewal Date: _____

Company is: Corporate Partnership Trust Association

Company is: ERISA ERISA Exempt Plan ERISA Health Plan No.: _____

SECTION 2: PLAN ADMINISTRATOR / TPA

Name of Plan Administrator / TPA: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Contact Person

Name: _____

Phone: _____ E-mail Address: _____

Financial / Accounts Payable Contact Person

Name: _____

Phone: _____ E-mail Address: _____

SECTION 3: CASE MANAGEMENT

Name of Plan Administrator / TPA: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Contact Person

Name: _____

Phone: _____ E-mail Address: _____

SECTION 4: ELIGIBILITY INFORMATION

Employee Waiting Period Options: First of the month following _____ days of employment

Other: _____

To be eligible, Employee must work _____ or more hours per week, and must be actively at work on the effective date of insurance. If not actively at work, insurance will be effective on the first day of the month following return to active employment.

Dependent Age Requirements: Full-time student beyond age 26? Yes No

If Yes, age limit: _____

Date Dependent attains age limit;

End of calendar year Dependent attains age limit

SECTION 5: PREMIUMS

Monthly Submitted Premium: \$ _____

Premium Rates: Employee Only: _____ Number covered: _____ =\$ _____

Employee + One: _____ Number covered: _____ =\$ _____

Employee + Spouse: _____ Number covered: _____ =\$ _____

Employee + Children: _____ Number covered: _____ =\$ _____

Employee + Family: _____ Number covered: _____ =\$ _____

Composite: _____ Number covered: _____ =\$ _____

It is understood and agreed that the Transplant Insurance will become effective on the date requested only if this Application is accepted. The Applicant agrees to transmit the total premiums for this insurance to Unimerica Insurance Company when due. The Applicant declares to the best of its knowledge and believes that statements and answers on this Application are complete and true.

[FRAUD WARNING NOTICE for applicants in [Florida]:

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.]

Full Legal Name of Authorized Person: _____

Print Name of Authorized Person: _____

Signature of Authorized Person: _____ Date: _____

Name of Broker Firm: _____

Print Agent Name: _____

Agent Address: _____

City: _____ State: _____ Zip: _____

Agent Phone: _____ Agent Fax: _____ License No.: _____

Signature of Agent or Broker: _____ Date: _____

All premiums are due on the first day of the calendar month of insurance.

Send Completed Application with the first month's premium to:

**OptumHealth
Managed Transplant Program
[6300 Olson Memorial Highway
MN010-S157
Golden Valley, MN 55427]**

FRAUD WARNING NOTICES: [(Please review notice that applies in your state)]

[For applicants in [Arkansas,] [Louisiana] [Rhode Island] [and] [West Virginia]:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For applicants in Colorado:

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.]

[For applicants in [District of Columbia]:

WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.]

[For applicants in [Kentucky,] [New Mexico,] [Ohio] [and] [Pennsylvania]:

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 insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[For applicants in [Maryland]:

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[For applicants in [all other states]:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]

<i>SERFF Tracking Number:</i>	<i>UHLC-126993975</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unimerica Insurance Company</i>	<i>State Tracking Number:</i>	<i>47767</i>
<i>Company Tracking Number:</i>	<i>MTP.POL.UIC.10.AR</i>		
<i>TOI:</i>	<i>H09G Group Health - Organ & Tissue Transplant - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H09G.000 Health - Organ & Tissue Transplant - Limited Benefit</i>
<i>Product Name:</i>	<i>Group Transplant</i>		
<i>Project Name/Number:</i>	<i>UIC Forms/</i>		

Supporting Document Schedules

		Item Status:	Status
Satisfied - Item:	Flesch Certification	Approved-Closed	Date: 02/16/2011
Comments:			
Attachment:			
Readability Certification.pdf			

		Item Status:	Status
Bypassed - Item:	Application	Approved-Closed	Date: 02/16/2011
Bypass Reason:	See Form Schedule		
Comments:			

**CERTIFICATION OF COMPLIANCE
FOR
READABILITY**

Unimerica Insurance Company		
Form number	Form Description	Flesch score
MTP.POL.UIC.10.AR & MTP.COC.UIC.10.AR	Group Policy & Certificate of Coverage	48.0
MTP.APP.UIC	Group Application	58.1

I hereby certify on behalf of **Unimerica Insurance Company** that the above Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores, and comply with the readability requirements in your state.

Signature



Print Name

Juanita B. Luis

Title

Assistant Secretary

Date

January 20, 2011

<i>SERFF Tracking Number:</i>	<i>UHLC-126993975</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unimerica Insurance Company</i>	<i>State Tracking Number:</i>	<i>47767</i>
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<i>Product Name:</i>	<i>Group Transplant</i>		
<i>Project Name/Number:</i>	<i>UIC Forms/</i>		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/21/2011	Form	Certificate of Coverage	02/16/2011	MTP.COC.UIC.10.AR.pdf (Superseded)

Unimerica Insurance Company

[10701 W. Research Drive

Milwaukee, Wisconsin]

(Home Office)

Policyholder: [ABC Company]

Policy Effective Date: [January 1, 2011]

Policy Number: [1234]

Covered Person: As on file with the Policyholder.

Certificate Number: As on file with the Policyholder.

Certificate Effective Date: As on file with the Policyholder.

The Policy to which this Certificate of Coverage refers is issued in [_____].

Unimerica Insurance Company ("Company") issues this Certificate of Coverage ("Certificate") to the Covered Person as evidence of insurance under the Policy the Company issued to the Policyholder shown above. Financial benefits under the Policy are provided by the Company. Benefits administration may be furnished on the Company's behalf by the Company's affiliates[, such as OptumHealth Care Solutions, Inc.]

This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

Read the Certificate Carefully

This is a legal contract between the Policyholder and the Company. If the Policyholder has any questions or problems with the Policy, the Company is ready to help the Policyholder. The Policyholder may call upon his agent or the Company's Home Office for assistance at any time.

If the Policyholder or the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, the Policyholder or the Covered Person may call [1-888-321-0881].

It is signed at the Home Office of Unimerica Insurance Company as of the Policy Effective Date shown above.

[Signature of authorized company officer]

[Title of authorized company officer]

THIS IS A LIMITED BENEFIT POLICY

**Limited Benefit Organ Transplant
Certificate**

Nonparticipating

MTP.COC.UIC.10.AR

Administrative Office:

[MN010- S157

6300 Olson Memorial Highway

Golden Valley, MN 55427-4946]

[Certificate of Coverage: Transplant Services]

TRANSPLANT BENEFIT CERTIFICATE OF COVERAGE

Introduction

This Certificate of Coverage ("Certificate") sets forth the Covered Person's rights and obligations. References to "you" and "your" throughout this Certificate are references to a Covered Person (as defined in [Section 14: Glossary]). All references to "Policy" throughout this Certificate shall mean the group Policy issued to the Policyholder along with the Certificate of Coverage, the Policyholder's application and any amendments, endorsements or riders.

It is important that you READ YOUR CERTIFICATE CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Policyholder.

The Company agrees with the Policyholder to provide Coverage for Transplant Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Policyholder's application and payment of the required Premiums. The Policyholder's application is made a part of the Policy.

The Company shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Policyholder's benefit plan. The Company shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Policyholder's benefit plan.

The Policy shall take effect on the date specified and will be continued in force by the timely payment of the required Premiums when due, subject to the termination provisions set forth in the Policy. All Coverage under the Policy shall begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

[The Policy is delivered in the State of [_____] and is governed by ERISA.] [To the extent that state law applies, the Policy will be governed by the laws of the State of _____.]

You and any of your Enrolled Dependents, for whom the required Premiums have been paid, are eligible for Coverage under the Policy. The Policy is referred to in this Certificate as the Policy and is designated on the [Transplant] identification card.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a Certificate, this document describes the provisions of Coverage under the Policy but does not constitute the Policy. You may examine the entire Policy at the office of the Policyholder during regular business hours.

For Transplant Services rendered after the Policy Effective Date, this Certificate replaces and supersedes any Certificate that may have been previously issued to you by the Company. Any subsequent Certificates issued to you by the Company will in turn supersede this Certificate.

How To Use This Certificate

This Certificate should be read and re-read in its entirety. Many of the provisions of this Certificate are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your Coverage.

Your Certificate may be modified by the attachment of riders and/or amendments. Please read the provision described in these documents to determine the way in which provisions in this Certificate may have been changed.

Many words used in this Certificate have special meanings. These words will appear capitalized and are defined for you in [Section 14: Glossary]. By reviewing these definitions, you will have a clearer understanding of your Certificate.

From time to time, the Policy may be amended. When that happens, a new Certificate or amendment pages for this Certificate will be sent to you. Your Certificate should be kept in a safe place for your future reference.

Network and Non-Network Benefits

This Certificate describes the benefit levels available under the Policy.

Network Benefits: These benefits apply when you choose to obtain Transplant Services from a Network provider. [Section 3: Procedure for Obtaining Benefits] describes the procedures for obtaining Covered Transplant Services as Network Benefits. Network Benefits provide Coverage at a higher level than Non-Network Benefits.

Non-Network Benefits: These benefits apply when you decide to obtain Transplant Services from non-Network providers. [Section 3: Procedure for Obtaining Benefits] describes the procedures for obtaining Coverage of Transplant Services as Non-Network Benefits. Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits require the payment of Coinsurance. In addition, when you obtain Transplant Services from non-Network providers, you must file a claim with the Company to be reimbursed for Eligible Expenses. For information on the Company's reimbursement policy guidelines used to determine Eligible Expenses, you should contact the Company at [1-888-321-0881] before obtaining Transplant Services from non-Network providers.

The information in [Section 4: Eligibility, Enrollment and Effective Date of Coverage through Section 11: Continuation of Coverage under Federal law (COBRA)] applies to all levels of Coverage. [Section 3: Procedure for Obtaining Benefits] explains the procedures you must follow to obtain Coverage for Network Benefits and Non-Network Benefits, respectively. [Section 2: Covered Transplant Services] describes which Transplant Services are Covered. Unless otherwise specified, the exclusions and limitations of [Section 12: General Exclusions and Section 13: Limited Benefits] apply to all levels of benefits.

Transplant Services Covered Under the Policy

In order for Transplant Services to be Covered as Network Benefits, you must obtain all Transplant Services directly from or through a Network provider or provider agreed to by the Company.

So that you will not be required to pay bills for non-Covered services, you must always verify the participation status of a Physician, Hospital or other provider. From time to time, the participation status of a provider may change. You can verify the participation status by calling the Company. If necessary, the Company can provide assistance in referring you to Network providers.

Only Covered Transplant Services described in [Section 2: Covered Transplant Services] and not specifically excluded in [Section 12: General Exclusions], are Covered under the Policy. The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for an injury or sickness does not mean that the procedure or treatment is Covered under the Policy.

The Company has sole and exclusive discretion in interpreting the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its benefits. The Company may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Policy.

The Company reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Policy, in its sole discretion, as permitted by law, without the approval of Covered Persons. No person or entity has any authority to make any oral changes or amendments to the Policy.

The Company may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, provide Coverage for services that would otherwise not be Covered. The fact that the Company does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

The Company may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, including claims processing and utilization management services. The identity of the service providers and the nature of the services provided may be changed from time to time in the Company's sole discretion and without prior notice to or approval by Covered Persons. You must cooperate with those persons or entities in the performance of their responsibilities.

Similarly, the Company may, from time to time, require additional information from you to verify your eligibility or your right to receive Coverage for services under the Policy. You are obligated to provide this information. Failure to provide it may result in Coverage being delayed or denied.

Important Information Regarding Medicare

Coverage under the Policy is not intended to supplement any coverage provided by Medicare, but in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled for Coverage under the Policy. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If, in addition to being enrolled for Coverage under the Policy, you are enrolled in a *Medicare Advantage* (Medicare Part C) plan, you must follow all rules of that plan that require you to seek services from that plan's participating providers. When the Company is the secondary payer, the Company will pay any benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. If the Company is the secondary plan and you do not follow the rules of the *Medicare Advantage* plan, you may incur a larger out-of-pocket cost for Transplant Services.

Important Note About Services

The Company does not provide Transplant Services or practice medicine. Rather, the Company arranges for providers of Transplant Services to participate in a Network. Network providers are independent practitioners and are not employees of the Company. The Company, therefore, makes payment to Network providers through various types of contractual arrangements. These arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Covered Transplant Services.

The payment methods used to pay any specific Network provider vary. The method may also change at the time providers renew their participation contracts with the Company. The Physician-patient relationship is between you and your doctor.

- A. You must decide if any doctor treating you is right for you; this includes providers who you choose or providers to whom you have been referred to by the Company. You must decide with your doctor what care you should receive.
- B. Your doctor is solely responsible for the quality of the care you receive.

The Company makes decisions about benefit plan Coverage. These decisions are administrative decisions and are for payment purposes only. The Company is not liable for any act or omission of a provider of Transplant Services.

[Transplant] Identification Card

You will receive a [Transplant] identification card from the Company when you have notified the Company that you would like to be evaluated for a Transplant. You must show your [Transplant] identification card every time you request Transplant Services. If you do not show your card, the providers have no way of knowing that you are Covered under a Policy issued by the Company and you may receive a bill for Transplant Services, even if those services are rendered by a Network provider.

Contact the Company

Throughout this Certificate you will find statements that encourage you to contact the Company for further information. Whenever you have a question or concern regarding Transplant Services or any required procedure, please contact the Company at [1-888-321-0881] [or at the telephone number stated on your [Transplant] identification card].

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Section 7: Questions, Complaints and Appeals

Section 8: General Provisions

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Section 10: Subrogation and Reimbursement

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Section 12: General Exclusions

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Section 14: Glossary

Section 1: Schedule of Benefits

This Schedule of Benefits outlines the Coverage provided by the Policy and described in this Certificate. Covered Transplant Services are described more completely in [*Section 2: Covered Transplant Services*].

Coverage is provided for Transplant Services for: kidney, pancreas, simultaneous kidney/pancreas, pancreas after kidney, liver and kidney, heart, single and double lung, heart/lung, heart/kidney, liver/cadaveric, liver/live donor, bone marrow, cord blood and peripheral stem cell transplants.

Intestine, liver/intestine and multivisceral transplants are Covered only when Transplant Services are rendered by a Network provider.

In addition, this Policy may cover other transplant procedures when determined appropriate by the Company in accordance with this Policy.

Benefits are subject to the notice, prior approval and coordination requirements described in [*Section 3: Procedures for Obtaining Benefits*], as well as the other terms and conditions described in this Certificate.

Two or more Transplant Benefit Periods will be treated as separate Transplant Benefit Periods if:

- A. They are due to unrelated causes; or
- B. They are due to related causes and the dates of transplantation are separated by [six (6)] consecutive months.

Continuation of Transplant: If at the time a Covered Person's coverage would otherwise terminate according to the terms of the Policy such person has established a Transplant Benefit Period for which benefits are not exhausted, benefits will be paid for the remaining part of that Transplant Benefit Period as if such Coverage had not ended, as long as the Covered Person remains the liability of the Policyholder's medical health benefit plan, and such medical health benefit plan is in force. Benefits will be based on the plan in force for that person on the date that Transplant Benefit Period ends.

[Deductible Amount (*applicable to High Deductible Health Plans only*):

Although this Policy does not impose a Deductible Amount, if a Subscriber selects a High Deductible Health Plan sponsored by the Policyholder, the Deductible Amount set forth in such Policyholder's High Deductible Health Plan must be satisfied by the Covered Person before benefits are payable under this Policy. This requirement is necessary in order for the Covered Person to remain eligible for the tax benefits afforded by the health savings account (HSA) associated with the Policyholder's High Deductible Health Plan (HDHP).]

[Deductible Amount	Network	Non-Network
Deductible Amount (<i>applicable to High Deductible Health Plan participants only</i>)	All Covered Persons subject to a HDHP Deductible Amount must first meet the Deductible Amount before Covered Transplant Services are eligible for reimbursement under this Policy.	All Covered Persons subject to a HDHP Deductible Amount must first meet the Deductible Amount before Covered Transplant Services are eligible for reimbursement under this Policy.]

Policy Period: [January 1, 2011 to December 31, 2011.]

Benefit	Network Benefit	Non-Network Benefit
Maximum Benefit for Search & Registry Fees	[80-100]% of Eligible Expenses [up to \$[1,000 - 10,000] per search to a maximum of \$[5,000 - 30,000]].	Non-Network Benefits are not available.
Maximum Organ Procurement Benefit Donor	[80-100]% of Eligible Expenses during the Transplant Benefit Period.	[60-80]% of Eligible Expenses to a maximum as shown in the table below.
Maximum Bone Marrow Harvesting Benefit	[80-100]% of Eligible Expenses during any Transplant Benefit Period if within [10 - 180] days of the Transplant.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000] during any Transplant Benefit Period if within [10 - 180] days of the Transplant.
Maximum Bone Marrow Storage Benefit	[80-100]% of Eligible Expenses if within [10 - 180] days of the Transplant.	[60-80]% of Eligible Expenses if within [10 - 180] days of the Transplant.
Maximum Transportation Benefit	[80-100]% of Eligible Expenses during any Transplant Benefit Period with a combined maximum of \$[5,000 - 30,000] for lodging, transportation and meals.	Non-Network Benefits are not available.
Maximum Daily Benefit for Lodging and Meals	[80-100]% of Eligible Expenses during any Transplant Benefit Period up to a daily maximum of \$[50 - 500] with a combined maximum of \$[5,000 - 30,000] for lodging, transportation and meals.	Non-Network Benefits are not available.
Maximum Air Ambulance Benefit	[80-100]% of Eligible Expenses during any Transplant Benefit Period to a maximum of \$[5,000 - 30,000].	[60-80]% of Eligible Expenses during any Transplant Benefit Period to a maximum of \$[5,000 - 30,000].
Maximum Private Duty Nursing Benefit	[80-100]% of Eligible Expenses during any Transplant Benefit Period to a maximum of \$[5,000 - 30,000].	[60-80]% of Eligible Expenses during any Transplant Benefit Period to a maximum of \$[5,000 - 30,000].
Maximum Transplant Evaluation Benefit	[80 -100]% of Eligible Expenses.	[60-80]% of Eligible Expenses [to a maximum of \$[5,000 - 30,000].

Benefit	Network Benefit	Non-Network Benefit
Maximum Hospital Confinement and Physician Benefit	[80-100]% of Eligible Expenses.	<p>For Organ and Allogeneic Tissue Transplants: [60-80]% of Eligible Expenses to a maximum of \$[500 - 5,000] per day for each of the first [10 - 180] consecutive days of a Covered Person's confinement and [60-80]% of Eligible Expenses to a maximum of \$[500 - 5,000] per day for each day of a Covered Person's confinement on or after the [thirty-first] day.</p> <p>For Autologous Tissue Transplant: [60-80]% of Eligible Expenses to a maximum of \$[500 - 5,000] per day for each of the first [10 - 180] consecutive days of a Covered Person's confinement and [60-80]% of Eligible Expenses to a maximum of \$[500 - 5,000] per day for each day of a Covered Person's confinement on or after the [thirty-first] day.</p>
Maximum Skilled Nursing Facility Confinement Benefit	[80-100]% of Eligible Expenses.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000].
Maximum Home Health Benefit	[80-100]% of Eligible Expenses.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000].
Maximum Surgical Benefit for Organ or Tissue Transplant Benefit	[80-100]% of Eligible Expenses.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000].
Maximum Outpatient Treatment Benefit	[80-100]% of Eligible Expenses.	[60-80]% of Eligible Expenses to a maximum of \$[5,000 - 30,000].
[Maximum Policy Benefit per Covered Person per lifetime for all Transplants]	[Unlimited for all Transplant Services.] [\$[1,000,000 - 5,000,000] for all Transplant Services.]	[Unlimited for all Transplant Services.] [\$[1,000,000 - 5,000,000] for all Transplant Services.]

Non-Network Organ and Tissue Procurement Table

Transplant	Maximum Benefit
Lung	[\$10,000 - 50,000]
Double Lung	[\$10,000 - 50,000]
Heart	[\$10,000 - 50,000]
Liver	[\$10,000 - 50,000]
Liver/Kidney	[\$10,000 - 50,000]
Heart/Lung	[\$10,000 - 50,000]
Heart/Kidney	[\$10,000 - 50,000]
Pancreas	[\$10,000 - 50,000]
Kidney	[\$10,000 - 50,000]
Kidney/Pancreas	[\$10,000 - 50,000]
Intestine, Liver/Intestine and Multivisceral Transplants	[\$0 - 5,000]
Allogeneic BMT	[\$10,000 - 50,000]
Autologous BMT	[\$10,000 - 50,000]

**Maximum Hospital/Physician Benefit
For Transplants Performed Prior to a
6 month Period Of Drug/Alcohol Sobriety**

Transplant	Maximum Network or Non-Network Benefit
Lung	[\$00,000]
Double Lung	[\$00,000]
Heart	[\$00,000]
Liver	[\$00,000]
Liver/Kidney	[\$00,000]
Heart/Lung	[\$00,000]
Heart/Kidney	[\$00,000]
Pancreas	[\$00,000]
Kidney	[\$00,000]
Kidney/Pancreas	[\$00,000]
Intestine, Liver/Intestine and Multivisceral Transplants	[\$00,000]
Allogeneic BMT	[\$00,000]
Autologous BMT	[\$00,000]

Section 2: Covered Transplant Services

Transplant Services described in this section are Covered when such services are:

- A. Provided by or under the direction of a Physician or other appropriate provider as specifically described;
- B. Not excluded as described in [*Section 12: General Exclusions*];
- C. Received pursuant to the procedures for obtaining benefits set forth in [*Section 3: Procedure for Obtaining Benefits*].

The Schedule of Benefits sets forth the amount of Coverage provided for Transplant Services. Subject to those benefit levels, and the other terms and conditions described in this Certificate, the Policy covers:

2.1 Evaluation

Services and supplies related to a Transplant and provided to a Covered Person to determine if the Covered Person is an acceptable candidate for a Hospital's transplant program. This includes Transplant-related services for outpatient surgery, laboratory, radiologic and other diagnostic tests and examinations provided by or through a Physician.

2.2 Organ and Tissue Procurement

Services and supplies provided for organ and tissue procurement, including removal, preservation and transportation. Where there is a live donor, this benefit includes donor screening, donor transportation to and from the Hospital where the donation occurs and health services associated with the removal of the organ and/or tissue. This benefit is only available when a Covered Person is the recipient of the Transplant.

2.3 Professional Fees for Surgical and Medical Services

Professional fees for surgical services and other medical care associated with a Transplant and provided by or through a Physician and rendered in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

2.4 Inpatient Hospital Services

Confinement related to a Transplant, including room and board, and services and supplies provided during Confinement (in a Semi-private Room) in a Hospital. Certain Transplant Services rendered during a Covered Person's Confinement are subject to separate benefit restrictions.

2.5 Outpatient Emergency Transplant Services

Services provided to stabilize and/or initiate treatment of Emergency conditions, related to a Transplant, and provided on an outpatient basis at either a Hospital or an Alternate Facility.

2.6 Home Health Agency Services

Part-time, intermittent services of a Home Health Agency, when related to a Transplant and provided under the direction of a Physician. Home Health Agency Services must be provided in your home, by or under the supervision of a registered nurse.

2.7 Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Confinement (in a Semi-private Room), including medical services and supplies, when related to a Transplant and provided under the direction of a Physician. Transplant Services must be

provided in a Skilled Nursing Facility or Inpatient Rehabilitation Facility and are Covered only for Transplant-related care and treatment which otherwise would require Confinement in a Hospital.

2.8 Ambulance Services

Emergency ambulance transportation for the Covered Person and one companion, via ground or air, by a licensed ambulance service to and/or from the treating Hospital where Transplant Services are to be rendered. If the Covered Person is a minor, benefits are payable for two companions.

2.9 Outpatient Rehabilitation Services

Short-term outpatient rehabilitation services. Coverage is provided only for physical therapy, occupational therapy and cardiac/pulmonary rehabilitation that are related to a Transplant.

Rehabilitation services must be performed in a Hospital or Skilled Nursing Facility or through a Home Health Agency or other provider.

2.10 Travel, Meals, and Lodging Reimbursement

Subject to the limitations and conditions set forth in the Schedule of Benefits, the following expenses are reimbursable when Covered Transplant Services are provided by Network providers and incurred by a Covered Person who must travel outside a 50-mile radius from his/her home to and/or from a Hospital where the Transplant and post-discharge follow-up care is provided:

- A. Transportation expenses for the Covered Person and one companion. If the Covered Person is a minor, reimbursement is payable for the transportation expenses of the Covered Person and two companions.
- B. Meal and lodging expenses for the Covered Person and one companion. If the Covered Person is a minor, reimbursement is payable for the meal and lodging expenses of the Covered Person and two companions.

The Company must receive valid receipts for such charges before reimbursement will be made.

Section 3: Procedures for Obtaining Benefits

3.1 Procedure to Obtain BenefitsTo obtain benefits for Transplant Services, you must:

- A. notify the Company of your intent to receive such services; and
- B. obtain prior approval from the Company for such services; and
- C. allow the Company to coordinate your receipt of such services.

You are responsible for assuring that required prior notification and approval is received before services are rendered. To start this process, call the Company's Member Services Department at [1-888-321-0881] [or at the telephone number shown on your [Transplant] identification card].

Failure to comply with these requirements may result in a lower level of Coverage or no Coverage of such Transplant Services.

3.2 Emergency Transplant Services

The Company provides Coverage of Eligible Expenses for Emergency Transplant Services, subject to the terms, conditions, exclusions, and limitations of the Policy.

You must notify the Company within [24 hours], or as soon as reasonably possible, if you are Confined for an issue related to a Transplant due to an Emergency. Transplant Services rendered on an Emergency basis are not Covered if, in the opinion of the Company, the situation is later determined not to be an Emergency.

At the Company's request, you must make available full details of the Emergency Transplant Services received in order for such Transplant Services to be Covered.

Coverage for continuation of care related to a Transplant and after the condition no longer is an Emergency requires compliance with the procedures described in [*Section 3.1: Procedure to Obtain Benefits*].

3.3 Prior Approval Does Not Guarantee Benefits

The fact that the Company authorizes services or supplies does not guarantee that all charges will be Covered. The Company reserves the right to review each claim. You will be notified in writing of any subsequent adjustment of benefits as a result of the claim review.

Section 4: Eligibility, Enrollment and Effective Date of Coverage

4.1 Eligibility

An Eligible Person is usually an employee or member of the Policyholder who meets the eligibility requirements of the Policy. When an Eligible Person actually enrolls for Coverage under this Policy, that Eligible Person is referred to as a Subscriber (see [Section 14: Glossary] for complete definitions). The term Dependent generally refers to the Subscriber's spouse and children (see [Section 14: Glossary] for complete definitions).

4.2 Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period [or during an Open Enrollment Period] by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

[If both spouses are eligible Employees of the Policyholder, each may enroll as a Subscriber or be Covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.]

[A.] [Dependent Child Special Open Enrollment Period]

[On or before the first day of the first plan year beginning on or after September 23, 2010, the Policyholder will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if the Company receives the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.]

4.3 Effective Date of Coverage

Coverage for you and any of your Dependents is effective on or after the date specified in the Policy. In no event is there Coverage for Transplant Services rendered or delivered before the Policy Effective Date, unless specifically stated in the Schedule of Benefits.

4.4 Coverage for a New Eligible Person

Coverage for you and any of your Dependents shall take effect as set forth herein. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within [31 days] of the date you first become eligible.

4.5 Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, legal guardianship, court or administrative order, [registration of a Domestic Partner,]or marriage shall take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 90 days (60 days for a newborn adopted child or a child placed for adoption).

4.6 Effective Date of Coverage for Confinement

If you are Confined on your effective date of Coverage and you do not have coverage for that Confinement under a prior benefit plan, Transplant Services related to the Confinement are Covered as long as:

- A. You notify the Company of Confinement within 48 hours of the effective date or as soon as is reasonably possible; and
- B. Transplant Services are received in accordance with the terms, conditions, exclusions and limitations of the Policy.

If you are Confined on your effective date of Coverage and the Confinement is covered under a prior benefit plan, Transplant Services for that Confinement are not Covered under the Policy. All other Transplant Services are Covered as of the effective date.

If you have prior coverage which has been required by state law to extend benefits for a particular condition or a disability as defined by state law, Transplant Services for the condition or disability will not be Covered under the Policy until your prior coverage is exhausted.

4.7 Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period [or Open Enrollment Period] may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met:

- A. The Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period [or Open Enrollment Period]; and
- B. Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted.

A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within [31 days] of the date coverage under the prior plan terminated.

A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by a birth, legal adoption, placement for adoption, [registration of a Domestic Partner,]or marriage, as required by federal law. In such cases you must submit the required Premium and a properly completed enrollment form within [thirty-one (31)] days of the marriage, birth, placement for adoption or adoption.

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period [or Open Enrollment Period] may also enroll for Coverage during a special enrollment period if:

- A. The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 60 days of the date of determination of subsidy eligibility.
- B. The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Eligibility Period [or Open Enrollment Period], and coverage under the prior plan was terminated as a result of the

Eligible Person and/or Dependent losing eligibility under Medicaid or Children's Health Insurance Program (CHIP). Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 60 days of the date coverage under the prior plan ended.

Section 5: Termination of Coverage

5.1 Conditions for Termination of a Covered Person's Coverage Under the Policy

The Company may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy, as permitted by law.

Your entitlement to Coverage, including coverage for Transplant Services rendered after the date of termination for Transplants that started prior to the date of termination, shall automatically terminate on the earliest of the dates specified below:

- A. The date the entire Policy is terminated, as specified in the Policy. The Policyholder is responsible for notifying you of the termination of the Policy.
- B. The [date][last day of the calendar month in which] you cease to be eligible as a Subscriber or Enrolled Dependent.
- C. The date the Company receives written notice from either the Subscriber or the Policyholder instructing the Company to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.
- D. The date the Subscriber is retired or receiving benefits under the Policyholder's pension or retirement plan, unless a specific coverage classification is specified for retired or pensioned persons in the Policyholder's application and the Subscriber continues to meet any applicable eligibility requirements.

When either of the following apply, the Company will provide advance written notice to the Subscriber that coverage will end on the date the Company identifies in the notice.

- A. **Fraud or Intentional Misrepresentation of a Material Fact.** You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, the Company has the right to demand that you pay back all benefits the Company paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, the Company can only demand that you pay back these benefits if the written application contained a fraudulent misstatement

- B. **Threatening Behavior.** You committed acts of physical or verbal abuse that pose a threat to our staff.

5.2 Extended Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. Coverage will be extended for that child beyond the limiting age specified in the Policy provided that both of the following are true regarding the Enrolled Dependent child:

- A. The Enrolled Dependent child is not able to be self-supporting because of mental or physical handicap or disability.
- B. The Enrolled Dependent child is chiefly dependent upon the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent and payment of any required Premium for the Enrolled Dependent is continued, unless coverage is otherwise terminated in accordance with the terms of the Policy.

The Company will ask you to furnish the Company with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before granting this extension of coverage for the child, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a Physician designated by the Company.

At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent child's continued disability and dependency, including medical examinations at the Company's expense. Such proof will not be required more than once a year. Failure to provide such satisfactory proof within 31 days of the Company's request will result in the termination of the Enrolled Dependent child's Coverage under the Policy.

5.3 Payment and Reimbursement Upon Termination

Termination of Coverage shall not affect any request for reimbursement of Eligible Expenses for Transplant Services rendered prior to the effective date of termination. Your request for reimbursement must be furnished as required in [Section 6: Reimbursement].

[[5.4] Extended Coverage for Full-Time Students

Coverage for an Enrolled Dependent child who is a Full-time Student [at a post-secondary school] and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- A. One year after the medically necessary leave of absence begins.
- B. The date coverage would otherwise terminate under the Policy.

Coverage will be extended only when the Enrolled Dependent is covered under the Policy because of Full-time Student status [at a post-secondary school] immediately before the medically necessary leave of absence begins and when the Enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- A. The Enrolled Dependent is suffering from a serious sickness or injury.
- B. The leave of absence [from the post-secondary school] is medically necessary, as determined by the Enrolled Dependent's treating Physician.
- C. The medically necessary leave of absence causes the Enrolled Dependent to lose Full-time Student status for purposes of coverage under the Policy.

A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious sickness or injury and that the leave of absence is medically necessary.

For purposes of this extended coverage provision, the term "leave of absence" shall include any change in enrollment [at the post-secondary school] that causes the loss of Full-time Student status.]

Section 6: Reimbursement

6.1 Reimbursement of Eligible Expenses from Network Providers

Network providers are responsible for submitting a request for payment of Eligible Expenses directly to the Company. In the event a Network provider bills you for Eligible Expenses, you should contact the Company.

6.2 Reimbursement of Eligible Expenses from Non-Network Providers

The Company shall reimburse you for Eligible Expenses from non-Network providers, subject to the terms, conditions, exclusions and limitations of the Policy.

6.3 Filing Claims for Reimbursement of Eligible Expenses from Non-Network Providers

You are responsible for sending a request for reimbursement to the Company's office, on a form provided by or satisfactory to the Company. Requests for reimbursement should be submitted within 90 days after the date of service. Unless you are legally incapacitated, failure to provide this information to the Company within 1 year of the date of service shall cancel or reduce Coverage for the Transplant Service.

Subject to written authorization from a Subscriber, all or a portion of any Eligible Expenses payable may be paid directly to the provider of the Transplant Services instead of being paid to the Subscriber.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the request must include all of the following information:

- A. Your name and address.
- B. Patient's name and age.
- C. Number stated on your [Transplant] identification card.
- D. The name and address of the provider of the service(s).
- E. A diagnosis from the Physician.
- F. Itemized bill that includes the CPT codes or description of each charge.
- G. Date Transplant Services began.
- H. A statement indicating that you are or you are not enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call the Company at the telephone number stated on your [Transplant] identification card and a claim form will be sent to you. If you do not receive the claim form within 15 days of your request, send in the proof of loss with the information stated above.

Proof of Loss. Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than one year after the date of service.

Payment of Claims. Payment of claims for non-Network Benefits are payable upon the Company's receipt of acceptable proof of loss. Benefits will be paid to you unless:

- A. the provider notifies the Company that your signature is on file assigning benefits directly to that provider; or
- B. you make a written request, that benefits be paid directly to the provider of services, at the time the claim is submitted.

6.4 Limitation of Action for Reimbursement

You do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 60 days after you have properly submitted a request for reimbursement, as described above. No action may be brought after 3 years from the time written proof of loss is required to be given under this Policy.

Section 7: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

7.1 What to Do if You Have a Question

Contact the Company's Member Services Department at the telephone number shown on your [Transplant] ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

7.2 What to Do if You Have a Complaint

Contact the Company's Member Services Department at the telephone number shown on your ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Company in writing, the Member Services representative can provide you with the appropriate address.

If the Member Services representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. The Company will notify you of the Company's decision regarding your complaint within 60 days of receiving it.

7.3 How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for benefits are those requests that require prior approval or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with either a pre-service request for benefits determination, a post-service claim determination or a rescission of coverage determination, you can contact the Company in writing to formally request an appeal.

Your request for an appeal should include:

- A. The patient's name and the identification number from the [Transplant] ID card.
- B. The date(s) of medical service(s).
- C. The provider's name.
- D. The reason you believe the claim should be paid.
- E. Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Company within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. The Company may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information

relevant to your claim for benefits. In addition, if any new or additional evidence is relied upon or generated by the Company during the determination of the appeal, the Company will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

7.4 Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for benefits, see *Urgent Appeals That Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- A. For appeals of pre-service requests for benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- B. For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

The Company's decision is based on whether or not benefits are available under the Policy for the proposed Transplant Services or procedures.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in Transplant related treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- A. The appeal does not need to be submitted in writing. You or your Physician should call the Company as soon as possible.
- B. The Company will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- C. If the Company needs more information from your Physician to make a decision, the Company will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

[7.5 Federal External Review Program]

[The *Departments of Health and Human Services, Labor and Treasury (Departments)* will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been

established by the *Departments*, the Company will provide you with additional information concerning the process.

Contact the Company's Member Services Department at the telephone number shown on your [Transplant] ID card for more information on the Federal external review program.]

Section 8: General Provisions

8.1 Entire Policy

The Policy issued to the Policyholder, including the Certificate of Coverage, the Policyholder's application, amendments and riders, constitute the entire Policy. All statements made by the Policyholder or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties.

8.2 Limitation of Action

You do not have the right to bring any legal proceeding or action against the Company without first completing the complaint procedure specified in [Section 7: Questions, Complaints and Appeals]. If you do not bring such legal proceeding or action against the Company within 3 years of the date the Company notified you of its final decision as described in [Section 7: Questions, Complaints and Appeals], you forfeit your rights to bring any action against the Company.

The only exception to this limitation of action is that reimbursement of Eligible Expenses, as set forth in [Section 6: Reimbursement] of this Certificate, is subject to the limitation of action provision of that section.

8.3 Time Limit on Certain Defenses

No statement, except a fraudulent statement, made by the Policyholder shall be used to void the Policy after it has been in force for a period of two years.

8.4 Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Policyholder. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an amendment or a rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

8.5 Relationship Between Parties

The relationships between the Company and providers and relationships between the Company and Policyholders, are **solely** contractual relationships between independent contractors. Providers and Policyholders are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or Policyholders.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided to any Covered Person.

The relationship between the Policyholder and Covered Persons is that of employer and employee, Dependent or other coverage classification as defined in the Policy. The Policyholder is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's Coverage through the Company), for the timely payment of the Premiums to the Company, and for notifying Covered Persons of the termination of the Policy.

8.6 Records

You must furnish the Company with all information and proof that it may reasonably require regarding any matters pertaining to the Policy.

By accepting Coverage under the Policy, you authorize and direct any person or institution that has provided services to you, to furnish the Company any and all information and records or copies of records relating to the services provided to you. The Company has the right to request

this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

The Company agrees that such information and records will be considered confidential. The Company has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy or for appropriate medical review or quality assessment.

The Company is permitted to charge you reasonable fees to cover costs for completing medical abstracts or forms that you request.

In some cases, the Company will designate other persons or entities to request records or information from or related to you and to release those records as necessary. The Company's designees have the same rights to this information as does the Company.

During and after the term of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

8.7 ERISA

When the Policy is purchased by the Policyholder to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., the Company is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA. The Policyholder has agreed that the Policy constitutes the plan and plan document under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The Policyholder has designated the Company as the claims fiduciary of this plan and has given the Company the discretionary authority to determine eligibility for benefits and to construe the terms of the plan. The Policyholder will comply with the disclosure and reporting requirements of ERISA regarding the plan and the Company's designation and authority as the claims fiduciary.

8.8 Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Transplant Services, the Company may reasonably require that a Physician acceptable to the Company examine you at the Company's expense.

8.9 Clerical Error

If a clerical error or other mistake occurs, that error shall not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits.

8.10 Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Policyholder, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Policyholder is responsible for giving notice to Covered Persons.

8.11 Workers' Compensation Not Affected

The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

8.12 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.

Section 9: Coordination of Benefits

9.1 Benefits When You Have Coverage under More than One Plan

This section describes how benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

9.2 When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

9.3 Definitions

For purposes of this section, terms are defined as follows:

- A. A "Plan" is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. "Plan" includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. "Plan" does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. "This Plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any

other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

- D. "Allowable Expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. "Closed Panel Plan" is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. "Custodial Parent" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

9.4 Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - 1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - 2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - 1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

- 2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
- 3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
- 4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
- c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a. or b. above as if those individuals were parents of the child.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

9.5 Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

9.6 Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts it needs to apply those rules and determine benefits payable. If you do not provide the Company with the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

9.7 Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

9.8 Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

[9.9 When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.]

Section 10: Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Company shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of any services and benefits provided by the Company to you from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Certificate, the Company shall also have an independent right to be reimbursed by you for the reasonable value of any services and benefits the Company provides to you, from any or all of the following listed below.

- A. Third parties, including any person alleged to have caused you to suffer injuries or damages.
- B. Your employer.
- C. Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- D. Any person or entity who is liable for payment to you on any equitable or legal liability theory.

All of the above listed third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- A. That you will cooperate with the Company in protecting the Company's legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - 1. Providing any relevant information requested by the Company.
 - 2. Signing and/or delivering such documents as the Company or its agents reasonably request to secure the subrogation and reimbursement claim.
 - 3. Responding to requests for information about any accident or injuries.
 - 4. Making court appearances.
 - 5. Obtaining the Company's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
- B. That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- C. That the Company has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- D. That no court costs or attorneys' fees may be deducted from the Company's recovery without the Company's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Company is not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- E. That regardless of whether you have been fully compensated or made whole, the Company may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- F. That benefits paid by the Company may also be considered to be benefits advanced.
- G. That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- H. That you or an authorized agent, such as your attorney, must hold any funds due and owing the Company, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- I. That the Company may set off from any future benefits otherwise provided by the Company the value of benefits paid or advanced under this section to the extent not recovered by the Company.
- J. That you will not accept any settlement that does not fully compensate or reimburse the Company without its written approval, nor will you do anything to prejudice the Company's rights under this provision.
- K. That you will assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Company provided, plus reasonable costs of collection.
- L. That the Company's rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- M. That the Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name, which does not obligate the Company in any way to pay you part of any recovery the Company might obtain.
- N. That the Company shall not be obligated in any way to pursue this right independently or on your behalf.
- O. That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- P. That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments. If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if any of the following apply:

- A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- B. All or some of the payment made by the Company exceeded the benefits under the Policy.
- C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 11: Continuation of Coverage Under Federal Law (COBRA)

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Policyholders that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Policyholder is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Company is not the Policyholder's designated "plan administrator" as that term is used in federal law, and the Company does not assume any responsibilities of a "plan administrator" according to federal law.

The Company is not obligated to provide continuation coverage to you if the Policyholder or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Policyholder or its plan administrator are:

- A. Notifying you in a timely manner of the right to elect continuation coverage.
- B. Notifying the Company in a timely manner of your election of continuation coverage.

Section 12: General Exclusions

Section 12.1 Exclusions.

Except as may be specifically provided in [Section 2: Covered Transplant Services] or through a rider to the Policy, the following services are not Covered:

- A. Transplant-related health care services and supplies which are:
1. not necessary to meet the health needs of the Covered Person; or
 2. not rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Transplant Service; or
 3. not consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; or
 4. not consistent with the diagnosis of the condition; or
 5. are required only for the convenience of the Covered Person or his or her Physician; or
 6. not demonstrated through prevailing peer-reviewed medical literature to be either:
 - a. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - b. safe with promising efficacy:
 - 1) for treating a life-threatening sickness or condition;
 - 2) in a clinically controlled research setting; and
 - 3) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
- (For the purpose of this section, the term life-threatening is used to describe a condition which is more likely than not to cause death within one year of the date of the request for treatment).
- B. Any form of renal dialysis, except dialysis performed immediately following a kidney Transplant procedure to promote organ functions.
- C. Dental services and associated expenses, except those related to evaluation.
- D. Custodial care; domiciliary care; private duty nursing; respite care; rest cures. (Custodial care means:
1. non-health related services, such as assistance in activities of daily living; or
 2. health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing; or
 3. services which do not require continued administration by trained medical personnel).

- E. Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
- F. Health services and associated expenses for cosmetic procedures.
- G. Health services and associated expenses for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for Transplant Services which are otherwise Experimental, Investigational or Unproven that are deemed to be, in the Company's judgment, Covered Transplant Services. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- H. Health services and associated expenses for removal of an organ from a Covered Person for purposes of transplantation into another person, except as may otherwise be Covered by the organ recipient's Coverage under the Policy. Health services and associated expenses for transplants involving mechanical or animal organs.
- I. Health services and associated expenses for organ or tissue transplants that are not specified as Covered in [*Section 2: Covered Transplant Services*] of this Certificate.
- J. Health services and associated expenses for megavitamin therapy; psychosurgery; or nutritional-based therapy.
- K. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.
- [L.] [Growth hormone therapy.]
- [M.] Travel or transportation expenses beyond that which is set forth in [*Section 2: Covered Transplant Services*].
- [N.] Mental health and/or substance use disorder services.
- [O.] Any drugs that are investigative or which have not been approved for general sale by the *United States Food and Drug Administration* unless requested in writing by a Network provider and approved by the Company.
- [P.] Outpatient prescribed or non-prescribed medical supplies including, but not limited to, elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; over-the-counter drugs and treatments.
- [Q.] Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- [R.] Transplant Services otherwise Covered under the Policy, but rendered after the date an individual's Coverage under the Policy terminates, including Transplant Services for medical conditions arising prior to the date the individual's Coverage under the Policy terminates.
- [S.] Transplant Services otherwise Covered under the Policy, but rendered prior to the date an individual's Coverage under the Policy is effective.
- [T.] Transplant Services for which the Covered Person has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Policy.

- [U.] [Coverage for an otherwise Eligible Person or a Dependent who is on active military duty; Transplant Services received as a result of war or terrorism, or any act of war or terrorism, whether declared or undeclared or caused during service in the armed forces of any country.]
- [V.] [Transplant Services provided in a foreign country, unless required as Emergency Transplant Services.]
- [W.] Transplant Services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation.
- [X.] Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; [acupuncture] and other forms of alternative treatment.
- [Y.] Health services and associated expenses involving mechanical organs and mechanical devices including but not limited to a Circulatory Assist Device (CAD) and any other artificial or mechanical device designed to supplement, assist or replace organs either permanently or temporarily.
- [Z.] Services and associated expenses related to islet cell transplants.
- [AA.] Services and associated expenses unrelated to the Covered Transplant Services.
- [BB.] Services and associated expenses unrelated to the diagnosis or treatment of a Covered Transplant Service including, without limitation, services and associated expenses related to a Covered Person's underlying disease or a relapse of a Covered Person's underlying disease. Specific to bone marrow transplants, a relapse of the Covered Person's underlying disease shall be deemed to have occurred upon the date following bone marrow transplant when the recurrence of the original disease is confirmed. This may occur retroactively depending upon receipt of appropriate clinical information.
- [CC.] Cardiac rehabilitation services and associated expenses which are not part of the Covered Transplant Service.

Section 13: Limited Benefits

There are certain benefit limitations that apply to Covered Persons who have used any drug, hallucinogen, controlled substance, or narcotic not prescribed by a Physician, or Covered Persons with a documented history of alcohol abuse. The limitations are as follows:

- [A.] Transplant Services and associated expenses for Transplants where the Covered Person has used any drug, hallucinogen, controlled substance, or narcotic not prescribed by a Physician are not Covered until after the Covered Person has abstained from use of all such substances for a period of at least six consecutive months immediately proceeding the Transplant. (See [*Section 1: Schedule of Benefits*, Chart 2])

- [B.] Transplant Services and associated expenses for Transplants where the Covered Person has a documented history of alcohol abuse, are not Covered until after the Covered Person has abstained from any use of alcohol for a period of at least six consecutive months immediately proceeding the Transplant. (See [*Section 1: Schedule of Benefits*, Chart 2])

Section 14: Glossary

This Section defines the terms used in this Certificate.

Alternate Facility. A non-Hospital health care facility, or an attached facility designated as such by a Hospital, which provides one or more of the following services on an outpatient basis as permitted under the law of jurisdiction in which treatment is received: prescheduled surgical, rehabilitative, laboratory or diagnostic services.

Amendment. Any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by an executive officer of the Company, on behalf of the Company. Amendments are subject to all terms, conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Coinsurance. The charge, in addition to the Premium, which you are required to pay for certain Transplant Services provided under the Policy. Coinsurance is expressed as the percentage of Eligible Expenses.

Confinement and Confined. An uninterrupted stay following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Coverage or Covered. The entitlement by a Covered Person to reimbursement for expenses incurred for Transplant Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Transplant Services must be provided:

- A. When the Policy is in effect; and
- B. Prior to the date that any of the individual termination conditions of [*Section 5.1: Conditions for Termination of a Covered Person's Coverage Under the Policy*] occur; and
- C. Only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

Covered Person. A Subscriber or an Enrolled Dependent; however, this term applies only while Coverage of such person under the Policy is in effect. References to "you" and "your" throughout this Certificate are references to a Covered Person.

Dependent. (1) The Subscriber's legal spouse; or (2) a child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, [a foster child,]a legally adopted child, a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse, or a child placed for adoption). [The term child also includes a grandchild of either the Subscriber or the Subscriber's spouse [when legal guardianship has been awarded to the Subscriber or the Subscriber's spouse].] [The principal place of residence of the legal spouse must be with the Subscriber unless the Company approves other arrangements.] [All references to the spouse of a Subscriber shall include a Domestic Partner.]

The definition of Dependent is subject to the following conditions and limitations:

- A. The term Dependent shall include any child listed above under [26] years of age.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age [26].]
- B. The term Dependent shall include an unmarried dependent child age [26] or older who is or becomes disabled and dependent upon the Subscriber as described in [*Section 5.2: Extended Coverage for a Disabled Dependent Child*].

[C. The term Dependent shall include [a][an unmarried] dependent child who is [26] years of age or older, but less than [29] years of age if evidence satisfactory to the Company of the following conditions is furnished upon request:

1. the child is not regularly employed on a full-time basis; and
2. the child is a Full-time Student; and
3. the child is primarily dependent upon the Subscriber for support and maintenance.]

[The definition of Dependent also includes such other sponsored Dependents as agreed upon by the Company and the Policyholder.]

The Subscriber must reimburse the Company for any Transplant Services provided to a child at a time when the child did not satisfy these conditions. The Policyholder and the Company may agree to increase these age limits, in which case the increased age limits will be stated in this Certificate or an Amendment to the Policy/Certificate.

The term Dependent also includes a child for whom health care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order. The Policyholder is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

[The term Dependent does not include anyone who is also enrolled as a Subscriber[, nor can anyone be a Dependent of more than one Subscriber].]

[Domestic Partner - a person of the [opposite sex][same sex][opposite or same sex] with whom the Subscriber has established a Domestic Partnership.]

[Domestic Partnership - a relationship between a Subscriber and one other person of the [opposite sex] [same sex] [opposite or same sex]. All of the following requirements apply to both persons:

- A. They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- B. They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- C. They must share the same permanent residence and the common necessities of life.
- D. They must be at least 18 years of age.
- E. They must be mentally competent to consent to contract.
- F. They must be financially interdependent [and they have furnished documents to support at least two of the following conditions of such financial interdependence:
 1. [They have a single dedicated relationship of at least [6 - 18] months duration.]
 2. [They have joint ownership of a residence.]
 3. [They have at least two of the following:
 - a. A joint ownership of an automobile.
 - b. A joint checking, bank or investment account.

- c. A joint credit account.
- d. A lease for a residence identifying both partners as tenants.
- e. A will and/or life insurance policies which designates the other as primary beneficiary].]

[The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]

Eligible Expenses. Eligible Expenses for Covered Transplant Services, incurred while the Policy is in effect, are determined as stated below:

- A. For Network Benefits:
 - 1. When Covered Transplant Services are received from Network providers, Eligible Expenses are the Company's contracted fee(s) for the Transplant Service with that provider;
 - 2. When Covered Transplant Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by the Company, Eligible Expenses are the fee(s) negotiated between the Company and the non-Network provider.
- B. For Non-Network Benefits:
 - 1. When Covered Transplant Services are received from non-Network providers, Eligible Expenses are the lesser of: 1) the fees that do not exceed the Company's contracted fee(s) for Network providers; or 2) fees calculated based on available data resources of competitive fees.

Eligible Expenses must not exceed the fees that the provider would charge any similarly situated payer for the same services. In the event a non-Network provider routinely waives any copayments and/or any annual deductible for Non-Network Benefits, Transplant Services for which the copayments and/or the annual deductible are waived are not considered to be Eligible Expenses.

Eligible Expenses are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- A. As indicated in the most recent edition of the Current Procedural Terminology (publication of the *American Medical Association*);
- B. As reported by generally recognized professionals or publications;
- C. As utilized for Medicare;
- D. As determined by medical staff and outside medical consultants;
- E. Pursuant to other appropriate sources or determinations accepted by the Company.

Eligible Person. (1) An employee of the Policyholder; or (2) other person who meets the eligibility requirements specified in both the application and the Policy.

Emergency. A serious medical condition or symptom resulting from injury or sickness which arises suddenly and, in the judgment of a reasonable person, requires immediate care and

treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of a Covered Person.

Emergency Transplant Services. Those health care services and supplies necessary for the treatment of an Emergency. Emergency Transplant Services are subject to the conditions and any Coinsurance described in this Certificate.

Enrolled Dependent. A Dependent who is properly enrolled for Coverage under both the Policy and the Policyholder's major medical health benefit plan.

Evaluation. Transplant Services rendered to the Covered Person to determine if the Covered Person is an acceptable candidate for a Transplant.

Experimental, Investigational or Unproven Services. Medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

- A. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- B. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental, Investigational or Unproven.)
- C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- D. Not demonstrated through prevailing peer reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Exceptions for a life-threatening sickness or condition:

If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the date of the request for a Transplant) the Company may, in its discretion, consider an otherwise Experimental, Investigational or Unproven Service to be a Covered Transplant Service for that sickness or condition if it is determined by the Company that the Experimental, Investigational or Unproven Transplant Service, at the time of the determination:

- A. Is safe with promising efficacy;
- B. Is provided in a clinically controlled research setting; and
- C. Uses a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

[Full-time Student. A person who is enrolled in and attending, full-time, a recognized course of study or training at:

- A. An accredited high school;
- B. An accredited college or university; or

- C. A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person ceases to be a Full-time Student [at the end of the calendar [month][year] during which][on the date] the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis.

A person continues to be a Full-time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on the [last day of the calendar [month] [year] in which][last day on which] the person was enrolled and in attendance at the institution on a full-time basis.]

Hematopoietic Stem Cell (HSC). Special cells derived from bone marrow, umbilical cord blood, peripheral blood, or certain fetal tissues.

Home Health Agency. A program or entity which is:

- A. Engaged in providing health care services in the home; and
- B. Authorized as required by the law of jurisdiction in which treatment is received.

Hospital. An institution, operated as required by law, which:

- A. Is primarily engaged in providing Transplant Services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a staff of Physicians;
- B. Has 24 hour nursing services; and
- C. Is accredited as a Hospital by the *Joint Commission on Accreditation of Healthcare Organizations* [or by the *American Osteopathic Hospital Association*].

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Eligibility Period. The initial period of time, determined by the Company and the Policyholder, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Inpatient Rehabilitation Facility. A Hospital or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility which provides rehabilitation Transplant Services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis as permitted by the law of jurisdiction in which treatment is received.

Inpatient Rehabilitation Facility Services. Skilled rehabilitation services which meet all of the following criteria:

- A. Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- B. Are ordered by a Physician; and
- C. Are not excluded pursuant to the provisions of [*Section 12: General Exclusions*].

Determination of benefits for Inpatient Rehabilitation Facility Services is made based on both the skilled nature of the service and the need for Physician-directed medical management. Inpatient

Rehabilitation Facility Services are not determined by the availability of caregivers to perform them; the absence of a person to perform an unskilled service does not cause the service to become skilled.

[Maximum Policy Benefit. The maximum amount paid for Network and non-Network Transplant Services during the entire period of time the Covered Person is Covered under the Policy or any policy, issued by the Company to the Policyholder, that replaces the Policy. The Maximum Policy Benefit is stated in [Section 1], Schedule of Benefits.]

Medicare. Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq., and as later amended.

Mobilization. The harvesting of bone marrow, and/or the process of recruiting hematopoietic progenitor cells into the peripheral blood including, but not limited to, the placement of central venous catheters, the administration of chemotherapy and/or growth factors, and apheresis.

Network. When used to describe a provider of Transplant Services (such as a Hospital, Physician, Alternate Facility, Home Health Agency, Skilled Nursing Facility or Inpatient Rehabilitation Facility) means that the provider, on behalf of a particular transplant program, has a participation agreement in effect with the Company as part of the Company's Transplant Network to provide Transplant Services to Covered Persons.

The participation status of providers and their transplant programs will change from time to time.

The Company may direct Covered Persons to a facility that is not part of its Transplant Network to receive Transplant Services. Network Benefits will only be paid if Covered Transplant Services are provided by or arranged by the facility or provider designated by the Company.

Network Benefits. Benefits available for Covered Transplant Services when provided by a Network provider.

Non-Network Benefits. Benefits available for Transplant Services obtained from non-Network providers.

Open Enrollment Period. After the Initial Eligibility Period, a period of time determined by the Company and the Policyholder, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Physician. Any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Policy. The group Policy, the Certificate the application of the Policyholder, amendments and riders which constitute the agreement regarding the benefits, exclusions and other conditions between the Company and the Policyholder.

Policyholder. The employer or other defined or otherwise legally constituted group to whom the Policy is issued.

Premium. The periodic fee required for all Subscribers and Enrolled Dependents Covered under the Policy.

Preparative Therapy. The process by which the Covered Person is made physiologically ready to receive an HSC Transplant.

Semi-private Room. A room with 2 or more beds. The difference in cost between a Semi-private Room and a private room is Covered only when a private room is determined by the Company to be necessary or when a Semi-private Room is not available.

Skilled Nursing Facility. A Hospital or nursing facility which is licensed and operated in accordance with the law of jurisdiction in which treatment is received.

Skilled Nursing Facility Services. Skilled nursing, skilled teaching, and skilled rehabilitation services which meet all of the following criteria:

- A. Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- B. Are ordered by a Physician; and
- C. Are not excluded pursuant to the provisions of [*Section 12: General Exclusions*].

Determination of benefits for Skilled Nursing Facility Services is made based on both the skilled nature of the service and the need for Physician-directed medical management. Skilled Nursing Facility Services are not determined by the availability of caregivers to perform them; the absence of a person to perform an unskilled service does not cause the service to become skilled.

Subscriber. An Eligible Person who is properly enrolled for Coverage under both the Policy and the Policyholder's major medical health benefit plan. The Subscriber is the person [who is not a Dependent] on whose behalf the Policy is issued to the Policyholder.

Transplant. An authorized procedure for the implantation of organs, or infusion of HSC after Mobilization or Preparative Therapy.

Transplant Benefit Period. The periods, set forth below, during which Transplant Services for Covered Persons are Covered.

- A. For solid organs, the **Transplant Benefit Period** begins [1 day] [[2-10] days] prior to the date the Transplant is performed and ends [twelve (12)] months after the date of the Transplant.
- B. For allogeneic Transplants, the **Transplant Benefit Period** begins [1 day] [[2-10] days] prior to the date the Transplant is performed and ends [twelve (12)] months after the date of the Transplant.
- C. For autologous Transplants, the **Transplant Benefit Period** begins [1 day] [[2-10] days] prior to the date the Transplant is performed and ends [twelve(12)] months after the date of the Transplant.

Transplant Services. The health care services and supplies Covered under the Policy, except to the extent that such health care services and supplies are limited or excluded.

END OF CERTIFICATE