UnitedHealthcare Insurance Company

Limited Benefit Certificate of Coverage

Organ and Tissue Transplant

185 Asylum Street

Hartford, Connecticut 06103-3408

(Home Office)

Enrolling Group: The Alliance, CO

Policy Effective Date: January 1, 2020

Policy Number: 2004130

Covered Person: As on file with the Enrolling Group.

Certificate Number: As on file with the Enrolling Group.

Certificate Effective Date: As on file with the Enrolling Group.

The Policy to which this *Certificate of Coverage* refers is issued in Colorado.

UnitedHealthcare Insurance Company (“”we”, “us” or “our”) issues this *Certificate of Coverage (“Certificate”)* to the Covered Person as evidence of insurance under the Policy we issued to the Enrolling Group shown above. Financial benefits under the Policy are provided by us. Benefits administration may be furnished on our behalf by our affiliates, such as OptumHealth Care Solutions, LLC.

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 SUPPLEMENTAL POLICY THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

This is a legal contract between the Enrolling Group and us. If the Enrolling Group has any questions or problems with the Policy, we are ready to help the Enrolling Group. The Enrolling Group may call upon its agent or our Home Office for assistance at any time.

If the Enrolling Group or the Covered Person has questions, needs information about their insurance, or needs assistance in resolving complaints, the Enrolling Group or the Covered Person may call 1-800-367-4436.

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

Jeffrey Alter, President

Thomas J. McGuire, Secretary

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 13: Definitions*). All references to "Policy" throughout this *Certificate* shall mean the group Policy issued to the Enrolling Group along with the *Certificate of Coverage*, the Enrolling Group'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 Enrolling Group.

We agree with the Enrolling Group 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 Enrolling Group's application and payment of the required Premiums. The Enrolling Group's application is made a part of the Policy.

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

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

Introduction to Your Certificate

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 Enrolling Group 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 us. Any subsequent *Certificates* issued to you by us will in turn supersede this *Certificate*.

Important Note: 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.

How To Use This Certificate

This *Certificate* should be 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 understanding 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: Definitions*. By reviewing these definitions, you will have a clearer understanding of your *Certificate*.

When we use the words “we,” “us,” and “our” in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words “you” and “your” we are referring to people who are Covered Persons as the term is defined in *Section 14: Definitions*.

From time to time, the Policy may be amended. When that happens, a new *Certificate, Schedule of Benefits* or Amendment pages for this *Certificate* will be provided to you. Your *Certificate* should be kept in a safe place for your future reference.

However, this *Certificate* may be amended at any time by applicable state or Federal laws, rules and regulations. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede this *Certificate*.

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 us.

A Transplant provider’s participation status is his/her status as a Network or Out-of-Network provider. 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 us. If necessary, we 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.

We have sole authority to interpret 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. We may, from time to time, delegate this authority to other persons or entities providing services in regard to the Policy.

We reserve the right to change, interpret, modify, withdraw or add benefits or terminate the Policy, as permitted by law, without your approval. No person or entity has any authority to make any oral changes or amendments to the Policy.

We may, in certain circumstances for purposes of overall cost savings or efficiency, provide Coverage for services that would otherwise not be Covered. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

We may 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 and without prior notice to or approval by you. You must cooperate with those persons or entities in the performance of their responsibilities. We give due consideration to all available evidence. Our decisions are made in good faith.

Similarly, we 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 Note About Services

We do not provide Transplant Services or practice medicine. Rather, we arrange for providers of Transplant Services to participate in a Network. Network providers are independent practitioners and are not employees of ours. We, therefore, make payments 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 us. 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 us. 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.

We make decisions about benefit plan Coverage. These decisions are administrative decisions and are for payment purposes only. We are <u>not</u> liable for any act or omission of a provider of Transplant Services.

Transplant Identification Card

You will receive a Transplant identification card from us when you have notified us that you would like to be evaluated for a Transplant. You should show your Transplant identification card every time you request Transplant Services.

Contact Us

Throughout this *Certificate* you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding Transplant Services or any required procedure, please contact us at 1-800-367-4436.

TABLE OF CONTENTS

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/cadaveric, kidney/live donor, pancreas, simultaneous kidney/pancreas, pancreas after kidney, liver/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 us 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 Enrolling Group'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.

Policy Period: January 1, 2020 to December 31, 2020.

Benefit	Network Benefit	Out-of-Network
Maximum Benefit for Search & Registry Fees	100% of Eligible Expenses	Out-of-Network Benefits are not available.
Maximum Organ Procurement Benefit	100% of Eligible Expenses	60% of Eligible Expenses to a maximum as shown in the table below.
Maximum Hematopoietic Stem Cell Procurement Benefit	100% of Eligible Expenses if within 90 days of the Transplant.	60% of Eligible Expenses to a maximum as shown in the table below if within 90 days of the Transplant.
Maximum Bone Marrow Storage Benefit	100% of Eligible Expenses if within 90 days of the Transplant.	60% of Eligible Expenses if within 90 days of the Transplant.
Maximum Daily Benefit for Lodging and Transportation	100% of Eligible Expenses during any Transplant Benefit Period up to a daily maximum of $300 with a combined maximum of $15,000 for lodging and transportation.	Out-of-Network Benefits are not available.

Benefit	Network Benefit	Out-of-Network
Maximum Air Ambulance Benefit	100% of Eligible Expenses during any Transplant Benefit Period to a maximum of $25,000.	60% of Eligible Expenses during any Transplant Benefit Period to a maximum of $10,000.
Maximum Private Duty Nursing Benefit	100% of Eligible Expenses during any Transplant Benefit Period to a maximum of $10,000.	60% of Eligible Expenses during any Transplant Benefit Period to a maximum of $10,000.
Maximum Transplant Evaluation Benefit	100% of Eligible Expenses.	60% of Eligible Expenses to a maximum of $10,000.
Maximum Hospital Confinement and Physician Benefit	100% of Eligible Expenses.	**For Organ and Allogeneic Tissue Transplants:** 60% of Eligible Expenses to a maximum of $2,000 per day for each of the first 30 consecutive days of a Covered Person's Confinement and 60% of Eligible Expenses to a maximum of $1,700 per day for each day of a Covered Person's Confinement on or after the thirty-first day. **For Autologous Tissue Transplant:** 60% of Eligible Expenses to a maximum of $1,500 per day for each of the first 30 consecutive days of a Covered Person's Confinement and 60% of Eligible Expenses to a maximum of $850 per day for each day of a Covered Person's Confinement on or after the thirty-first day.
Maximum Skilled Nursing Facility Confinement Benefit	100% of Eligible Expenses.	60% of Eligible Expenses to a maximum of $10,000.
Maximum Acute Rehabilitation Facility Confinement Benefit	100% of Eligible Expenses.	60% of Eligible Expenses to a maximum of $10,000.
Maximum Home Health Benefit	100% of Eligible Expenses.	60% of Eligible Expenses to a maximum of $10,000.
Maximum Surgical Benefit for Organ or Tissue Transplant Benefit	100% of Eligible Expenses.	60% of Eligible Expenses to a maximum of $10,000.
Maximum Outpatient Treatment Benefit	100% of Eligible Expenses.	60% of Eligible Expenses to a maximum of $10,000.
Maximum Benefit for Prescription Drugs	100% of Eligible Expenses during the Transplant Benefit Period.	Out-of-Network Benefits are not available.

Benefit	Network Benefit	Out-of-Network
Maximum Benefit for Durable Medical Equipment	100% of Eligible Expenses during the Transplant Benefit Period	Out-of-Network Benefits are not available.
Maximum Policy Benefit per Covered Person per lifetime for all Transplants	Unlimited for all Transplant Services.	Unlimited for all Transplant Services.

Out-of-Network Organ and Tissue Procurement Table

Transplant	Maximum Benefit
Lung	$17,500
Double Lung	$25,000
Heart	$17,500
Liver	$22,500
Liver/Kidney	$25,000
Heart/Lung	$17,500
Heart/Kidney	$25,000
Pancreas	$25,000
Kidney	$17,500
Kidney/Pancreas	$25,000
Intestine, Liver/Intestine and Multivisceral Transplants	$00,000
Allogeneic BMT	$17,500
Autologous BMT	$12,500

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:

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.

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.

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.

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.

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.

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.

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.

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.

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.

Prescription Drugs

Prescription drugs medically necessary and directly related to a Covered Transplant procedure during the Transplant Benefit Period.

Durable Medical Equipment

Durable medical equipment is Covered following discharge of the Transplant procedure during the Transplant Benefit Period. Rental of durable medical equipment is limited to the lesser of a maximum of 15 days of rental or the purchase price.

Telemedicine

Covered services appropriately provided through Telemedicine in which no face-to-face contact is required between a health care provider and you (Please see the complete definition of Telemedicine in the Definitions, Section 14). Please call the number on your Transplant identification card to see if you are eligible for this service.

Travel 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. Lodging expenses for the Covered Person and one companion. If the Covered Person is a minor, reimbursement is payable for lodging expenses of the Covered Person and two companions.

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

Section 3: Procedures for Obtaining Benefits

Transplant Services

You are eligible for Coverage for Transplant Services listed in the *Schedule of Benefits* and *Section 2: Covered Transplant Services* of this *Certificate* if such Transplant Services are necessary and are provided by or under the direction of a Transplant provider or other provider. All Coverage is subject to the terms, conditions, exclusions or limitations of the Policy.

Network and Out-of-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. This section describes the procedures for obtaining Covered Transplant Services as Network Benefits. Network Benefits provide Coverage at a higher level than Out-of-Network Benefits.

Out-of-Network Benefits: These benefits apply when you decide to obtain Transplant Services from Out-of-Network providers. This section describes the procedures for obtaining Coverage of Transplant Services as Out-of-Network Benefits. Out-of-Network Benefits are generally paid at a lower level than Network Benefits. Out-of-Network Benefits require the payment of Coinsurance. In addition, when you obtain Transplant Services from Out-of-Network providers, you must file a claim with us to be reimbursed for Eligible Expenses. For information on our reimbursement policy guidelines used to determine Eligible Expenses, you should contact us at 1-800-367-4436 before obtaining Transplant Services from Out-of-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 Out-of-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* apply to all levels of benefits.

Procedure to Obtain Benefits

To obtain benefits for Transplant Services, you must:

A. notify us of your intent to receive such services; and

B. obtain prior approval from us for such services; and

C. allow us 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 our Member Services Department at 1-800-367-4436.

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

Emergency Transplant Services

We provide Coverage of Eligible Expenses for Emergency Transplant Services, subject to the terms, conditions, exclusions, and limitations of the Policy.

You must notify us 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 us, the situation is later determined not to be an Emergency.

At our 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 this section.

Non-transplant related emergency services are excluded from coverage. Please refer to your underlying medical plan for benefits of non-transplant related emergency services.

Prior Approval Does Not Guarantee Benefits

The fact that we authorize services or supplies does not guarantee that all charges will be Covered. We reserve 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

Eligibility

An Eligible Person is usually an employee or member of the Enrolling Group 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 13: Definitions* for complete definitions). The term Dependent generally refers to the Subscriber's spouse and children (see *Section 13: Definitions* for complete definitions).

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 completing a form provided or approved by the Enrolling Group. 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 Persons of the Enrolling Group, 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.

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*.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents shall take effect as set forth herein. Coverage is effective only if we receive any required Premium and a properly completed enrollment information within 31 calendar days of the date you first become eligible.

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 we receive any required Premium and are notified of the event within 31 calendar days.

Change in Family Status

You may make Coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption, as required by federal law. In such cases you must submit the required contribution of coverage and properly completed enrollment information within 31 calendar days of the marriage, birth, placement for adoption or adoption. Otherwise, you will need to wait until the next annual Open Enrollment Period.

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 us 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.

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 we receive any required Premium and properly completed enrollment information within 31 calendar 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 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 information within thirty-one (31) calendar 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 we receive 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 we receive 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

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

We 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. When your Coverage terminates, you may have continuation as described in *Section 10: Continuation of Coverage* or as provided under other applicable federal and/or state 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 Enrolling Group is responsible for notifying you of the termination of the Policy.

B. The date you cease to be eligible as a Subscriber or Enrolled Dependent or active member of the Enrolling Group.

C. The date we receive written notice from either the Subscriber or the Enrolling Group instructing us 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 Enrolling Group's pension or retirement plan, unless a specific coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, we will provide written notice of termination to the Subscriber.

E. The date specified by us that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided us with false material information, including, but not limited to, false, material information relating to residence, information relating to another person's eligibility for Coverage or status as a Dependent. We have the right to rescind Coverage back to the effective date.

F. The date specified by us that all Coverage will terminate because the Subscriber permitted the use of his or her ID card by any unauthorized person or used another person's card.

G. The date specified by us that Coverage will terminate due to material violation of the terms of the Policy.

H. The date specified by us that your Coverage will terminate because you failed to pay a required Premium.

I. The date specified by us that your Coverage will terminate because you have committed acts of physical or verbal abuse which pose a threat to our staff, a provider, or other Covered Persons.

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:

The Enrolled Dependent child is not able to be self-supporting because of mental or physical handicap or disability.

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.

We will ask you to furnish us 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, we may reasonably require that the Enrolled Dependent be examined at our expense by a Physician designated by us.

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

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*.

Section 6: Reimbursement

Reimbursement of Eligible Expenses from Network Providers

Network providers are responsible for submitting a request for payment of Eligible Expenses directly to us. We will pay properly submitted claims, for Eligible Expenses, within the time frames set forth in applicable state law. In the event a Network provider bills you for Eligible Expenses, you should contact us.

Reimbursement of Eligible Expenses from Out-of-Network Providers

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

Filing Claims for Reimbursement of Eligible Expenses from Out-of-Network Providers

You are responsible for submitting a request in writing for reimbursement to our office, on a form provided by or satisfactory to us, or in a manner satisfactory to us such as e-mail. Requests for reimbursement should be submitted within 90 calendar days after the date of service. Unless you are legally incapacitated, failure to provide this information to us within 365 days from 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 proof of loss that you submit to us must include all of the following information:

Your name and address;

Patient's name and age;

The name and address of the provider(s) of the service(s);

A diagnosis from the Physician;

Itemized bill that includes the CPT codes or description of each charge;

Date Transplant Services began;

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 us at 1-800-367-4436 and a claim form will be provided to you. If you do not receive the claim form within 15 calendar 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 us within 90 calendar days after the date of the loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 365 calendar days after the date of service.

Payment of Claims. Payment of claims for Out-of-Network Benefits are payable upon our receipt of acceptable proof of loss. Benefits will be paid to you unless:

A. the provider notifies us 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.

Section 7: Benefit Determinations

Pre-Service Benefit Determinations

Pre-service benefit determinations are made on those services that require notification or approval prior to receiving Transplant Services. For non-urgent services requiring a pre-service benefit determination, we will make a decision and notify you regarding whether the service is a Covered Transplant Service within 15 days of its receipt of a properly submitted pre-service benefit determination request from either you or your provider.

We may extend the review period for up to 15 days if the extension is necessary due to matters beyond our control, and if we notify you, prior to the expiration of the initial 15 day review period, of the circumstances requiring the extension and the date by which we expect to make a determination.

If you file a request for a pre-service benefit determination improperly, we will notify you of the improper filing and how to correct it within 5 business days of its receipt of the request. If additional information is needed to process the request for a pre-service benefit determination, we will notify you of: a) the information needed in order to make a determination; b) the time frames within which the information must be submitted; and c) the time frames within which a decision will be made after the additional information is received by us. You will have at least 45 days from the date you receive our notice to provide the additional information. If we issue a denial notice for the services for which you requested a pre-service benefit determination, it will explain the reason for the denial and provide the appeal procedures.

If your condition is urgent, please refer to the **Urgent Benefit Determinations that Require Immediate Attention** section below.

Concurrent Care Benefit Determinations

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your provider properly submit a request to extend the treatment or hospitalization, including all necessary information in the request, we will make a decision regarding the request within 5 business days of its receipt of the request. We will communicate our decision to you, and/or your provider, within 24 hours of its decision. If additional information is needed to process the concurrent care benefit determination request, we will notify you of: a) the information needed in order to make a determination; b) the time frames within which the information must be submitted; and c) the time frames within which a decision will be made after the additional information is received by us. If we issue a denial notice for the services for which you requested a concurrent care benefit determination, it will explain the reason for the denial and provide the appeal procedures.

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after Transplant Services have been received. If your post-service claim is denied, you, or your designee, will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30-day period if additional information is needed to process the claim. If additional information is needed to process the post-service claim, we will notify you of: a) the information needed in order to make a determination; b) the time frames within which the information must be submitted; and c) the time frames within which a decision will be made after the additional information is received by us. If we issue a denial notice for the post-service claim, it will explain the reason for the denial and provide the appeal procedures.

We may extend the review period for up to 15 days if the extension is necessary due to matters beyond our control, and if we notify you prior to the expiration of the initial 15 day review period of the circumstances requiring the extension and the date by which the we expect to make a determination.

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Urgent Benefit Determinations that Require Immediate Attention

Urgent benefit determinations are made on those services requiring immediate attention because your condition is such that you face an imminent and serious threat to your health, including the potential loss of life, limb or other major bodily function, or the normal review time frames set forth above would be detrimental to your life or health or could jeopardize your ability to regain maximum function. In such urgent cases, a request for Transplant Services, properly submitted by you or your provider, will be decided by us within 72 hours of our receipt of the necessary information. If additional information is needed to process the urgent benefit determination request, we will notify you, and/or your provider, of: a) the information needed in order to make a determination; b) the time frames within which the information must be submitted; and c) the time frames within which a decision will be made after the additional information is received by us. If we issue a denial notice for the services for which you requested an urgent benefit determination, it will explain the reason for the denial and provide the appeal procedures.

For concurrent reviews of urgent benefit determinations involving a request to extend the course of treatment beyond the initial period of time or number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, we will make a determination with respect to the request within 24 hours of our receipt of the request.

Section 8: Questions, Complaints and Appeals

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

What to Do if You Have a Question

You or your authorized representative should contact our Member Services Department at 1-800-367-4436. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

You or your authorized representative should contact our Member Services Department at 1-800-367-4436. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us 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. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

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 as described in Section 7, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

The patient's name and claim number.

The date(s) of medical service(s).

The provider's name.

The reason you believe the claim should be paid.

Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us 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. We 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 us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

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:

- 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 us 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.

- 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 us 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.

Please note that our decision is based only on whether or not benefits are available under the Policy for the proposed Transplant Services or procedures.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

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:

The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.

We 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.

If we need more information from your Physician to make a decision, we 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.

If you are dissatisfied with our decision, you may request an expedited external review as described in below.

External Review Program

If you are dissatisfied with an adverse determination after exhausting the procedures set forth above, you, or your authorized representative, may request an external review of our decision by submitting a written request, along with a completed application for an external review, to us within 60 days of the date of the upheld adverse determination. In order to be eligible for an external review, the adverse determination must involve a service that was denied on the basis that it is not medically necessary and the service must not be excluded from Coverage pursuant to Section 11. Your case will be assigned to an independent external review entity. The independent external review entity will make its decision within 30 business days of our receipt of your request for an external review; however, the 30 business day review period may be extended by the independent external review entity for up to an additional 10 business days, if needed, for the consideration of additional information related to your dispute.

You may be entitled to an expedited external review if the time frames required for a standard external review would seriously jeopardize your life or health or would jeopardize your ability to

regain maximum function or, for persons with a disability, create an imminent and substantial limitation of their existing ability to live independently. If an expedited external review is needed, you or your authorized representative must request such and provide a Physician's certification that your medical condition meets the criteria for an expedited external review. In the case of an expedited external review, the independent external review entity will make its decision within 7 business days of our receipt of your request for an expedited external review; however, the 7 business day review period may be extended by the independent external review entity for up to an additional 5 business days for the consideration of additional information related to your dispute.

The decision of the independent review organization shall be binding on the us and the Covered Person except to the extent we or the Covered Person have other remedies available under federal or state law.

Section 9: General Legal Provisions

Entire Policy

The Policy issued to the Enrolling Group, including the *Certificate of Coverage*, *Schedules of Benefits,* the Enrolling Group's application, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties.

Time Limit on Certain Defenses

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

Amendments and Alterations

Amendments to the Policy are effective upon 31 calendar days prior written notice to the Enrolling Group. Riders are effective on the date specified by us. 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 ours. No agent has authority to change the Policy or to waive any of its provisions.

Relationship Between Parties

The relationships between us and providers and relationships between us and Enrolling Groups, are **solely** contractual relationships between independent contractors. Providers and Enrolling Groups are not agents or employees of ours, nor are we or any employee of ours an agent or employee of providers or Enrolling Groups.

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

Information and Records

At times we may need additional information from you. You agree to furnish us with all information and proof that we may reasonably require regarding any matters pertaining to the Policy. If you do not provide this information when we request it, we may delay or deny payment of your Coverage.

By accepting Coverage under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have 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. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning Transplant Services which are necessary to implement and administer the terms of the Policy, for appropriate review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your Transplant records or billing statements, we recommend that you contact your provider. Transplant providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request Transplant forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

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

ERISA

When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Examination of Covered Persons

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

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 or Coverage.

Notice

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

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.

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.

Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Schedule of Benefits* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Schedule of Benefits*, or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate or Schedule of Benefits*.

Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Schedule of Benefits* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Schedule of Benefits*.

Unenforceable Provisions

If any provision of the Policy, *Certificate or Schedule of Benefits* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Schedule of Benefits* to the greatest extent legally permissible.

Subrogation and Reimbursement

The plan has a right to subrogation and reimbursement.

Subrogation applies when we have paid benefits on your behalf for a sickness or injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that we have paid that are related to the sickness or injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any benefits you received for that sickness or injury.

The following persons and entities are considered third parties:

A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.

Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.

The plan sponsor in a workers' compensation case or other matter alleging liability.

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.

Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.

Providing any relevant information requested by us.

Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.

Responding to requests for information about any accident or injuries.

Making court appearances.

Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits we have paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with us. If we incur attorneys'

fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.

We have a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

If you have been fully compensated or made whole, we 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, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.

Benefits paid by us may also be considered to be benefits advanced.

If you receive any payment from any party as a result of sickness or injury, and we allege some or all of those funds are due and owed to us, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the plan has paid.

The plan's rights to recovery will not be reduced due to your own negligence.

Upon our request, you will assign to us all rights of recovery against third parties, to the extent of the benefits we have paid for the sickness or injury.

We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits paid on your behalf out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the plan is governed by a six-year statute of limitations.

You may not accept any settlement that does not fully reimburse the plan, without its written approval.

We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.

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 sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this plan, the provisions of this section continue to apply, even after you are no longer covered.

The plan and all administrators administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

Refund of Overpayments

If we pay 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 us if any of the following apply:

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.

All or some of the payment made by us exceeded the benefits under the Policy.

All or some of the payment was made in error.

The refund equals the amount we 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 us 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, we 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. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 8: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Section 10: Coordination of Benefits

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.

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.

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, 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.

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.

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.

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. We may get the facts we need 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. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts it needs to apply those rules and determine benefits payable. If you do not provide us with the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we 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. We 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.

Right of Recovery

If the amount of the payments made by us 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.

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 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 Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group 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.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

Notifying you in a timely manner of the right to elect continuation coverage.

Notifying us in a timely manner of your election of continuation coverage.

Section 12: General Exclusions

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 provided in the United States of America.

2. not necessary to meet the health needs of the Covered Person; or

3. not rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Transplant Service; or

4. 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 us; or

5. not consistent with the diagnosis of the condition; or

6. are required only for the convenience of the Covered Person or his/her Physician; or

7. 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 dental exams 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 our 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 us.

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 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.

W. Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; acupuncture and other forms of alternative treatment.

X. 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.

Y. Services and associated expenses unrelated to the Covered Transplant Services.

Z. 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.

AA. Cardiac rehabilitation services and associated expenses which are not part of the Covered Transplant Service.

BB. Services and associated expenses related to pancreatic islet cell transplants.

CC. Services and associated expenses related to corneal transplants.

DD. Pain medication, mental health medication, over the counter medication, supplements, and prescription drugs used to treat a condition not directly related to the Covered Transplant procedure.

Section 13: Definitions

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 us, on behalf of us. 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: 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 - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

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

- A Dependent includes any child listed under 26 years of age.
- A Dependent includes an unmarried Dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26.

The Subscriber must reimburse us for any benefits that we pay for a child at a time when the child did not satisfy these conditions.

A 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 Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

Designated Beneficiary means a person who has entered into a Designated Beneficiary Agreement.

Designated Beneficiary Agreement means an agreement that is entered into by two people for the purpose of designating each person as the beneficiary of the other person and for the purpose of ensuring that each person has certain rights and financial protection based upon the designation. The right to be designated as a dependent in a health insurance policy must be granted under the Designated Beneficiary Agreement.

A Designated Beneficiary Agreement will be legally recognized if:

The parties to the Designated Beneficiary Agreement satisfy all of the following criteria:

Both are at least 18 years of age;

Both are competent to enter into a contract;

Neither party is married to another person;

Neither party is a party to a Civil Union.

Neither party is a party to another Designated Beneficiary Agreement; and

Both parties enter into the Designated Beneficiary Agreement without force, fraud or duress, and

The agreement is in substantial compliance with the statutory form that is considered the standard form for the Designated Beneficiary Agreement.

A Designated Beneficiary Agreement is legally sufficient if:

The wording of the Designated Beneficiary Agreement complies substantially with the standard form;

The Designated Beneficiary Agreement is properly completed and signed;

The Designated Beneficiary Agreement is acknowledged; and

The Designated Beneficiary Agreement is recorded with the county clerk and recorded in the county in which one of the parties resides. The Designated Beneficiary Agreement will be effective as of the date and time as received for recording by the county clerk and recorder.

Domestic Partner – a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership. In no event will a person's legal spouse be considered a Domestic Partner.

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 our contracted fee(s) for the Transplant Service with that provider;

2. When Covered Transplant Services are received from Out-of-Network providers as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are the fee(s) negotiated between us and the Out-of-Network provider.

B. For Out-of-Network Benefits:

1. When Covered Transplant Services are received from Out-of-Network providers, Eligible Expenses are the lesser of: 1) the fees that do not exceed our 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 an Out-of-Network provider routinely waives any Coinsurance and/or any annual deductible for Out-of-Network Benefits, Transplant Services for which the Coinsurance and/or the annual deductible are waived are not considered to be Eligible Expenses.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our 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 us.

Eligible Person. (1) An employee or member of the Enrolling Group; 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 Enrolling Group's major medical health benefit plan.

Enrolling Group. The employer or other defined or otherwise legally constituted group (Association, Union, etc.) to whom the Policy is issued.

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 we make 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) we may, in our 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 us 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*.

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 us and the Enrolling Group, 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 Out-of-Network Transplant Services during the entire period of time you are Covered under the Policy or any policy, issued by us to the Enrolling Group, 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 collective group of providers of Transplant Services (such as a Hospital, Physician, Alternate Facility, Home Health Agency, Skilled Nursing Facility or Inpatient Rehabilitation Facility) means that the providers, on behalf of a particular transplant program, have an agreement in effect with us as part of our Transplant Network.

Network Benefits will only be paid if Covered Transplant Services are provided by or arranged by the facility or provider designated by us.

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

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

Out-of-Network. A provider of Transplant Services that is not a participant in the Network as defined above.

Out-of-Network Benefits. Benefits available for Transplant Services obtained from Out-of-Network providers.

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 Enrolling Group, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between us and the Enrolling Group.

Policy Charge. The sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

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.

Rider - any attached description of Transplant Services Covered under the Policy. Transplant Services provided by a Rider may be subject to payment of additional Premiums and additional Coinsurance. Riders are effective only when signed by an officer and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

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 us 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 Enrolling Group'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 Enrolling Group.

Telemedicine. The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Telemedicine is Covered medical services that a Covered Person receives from a health care provider without face-to-face contact with the provider. Telemedicine does not include consultation by telephone or facsimile machine between health care providers or between a Covered Person and a health care provider.

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 prior to the date the Transplant is performed and ends three hundred sixty-five (365) days after the date of the Transplant.

B. For allogeneic Transplants, the **Transplant Benefit Period** begins 1 day prior to the date the Transplant is performed and ends three hundred sixty-five (365) days after the date of the Transplant.

C. For autologous Transplants, the **Transplant Benefit Period** begins 1 day prior to the date the Transplant is performed and ends three hundred sixty-five (365) days 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