UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103

(Home Office)

Policyholder: The Christian and Missionary Alliance

Policy Effective Date: January 1, 2017

Policy Number: 1001012

Covered Person: As on file with the Policyholder.

Certificate Number: As on file with the Policyholder.

Certificate Effective Date: As on file with the Policyholder.

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

UnitedHealthcare Insurance Company ("Company") issues this Certificate of Coverage ("Certificate") to the Covered Person as evidence of insurance under the Policy the Company issued to the Policyholder shown above. Financial benefits under the Policy are provided by the Company. Benefits administration may be furnished on the Company's behalf by the Company's affiliates, such as United Resource Networks, a division of the Company's affiliate United HealthCare Services, Inc., and the Company's affiliate Special Risk International, Inc.

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

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

Read the Certificate Carefully

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

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

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

Thomas J McShane — Deputy General Counsel

Neil B Cly — President

THIS IS A LIMITED BENEFIT POLICY

Critical Care Benefit
Certificate

Nonparticipating

Administrative Office:
11000 Optum Circle
MN103-0700
Eden Prairie, MN 55344

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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 15: Glossary). All references to "Policy" throughout this Certificate shall mean the group Policy issued to the Policyholder along with the Certificate of Coverage, the Policyholder's application and any amendments, endorsements or riders.

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

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

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

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

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

To the extent that state law applies, the Policy will be governed by the laws of the State of Colorado.

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

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

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

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

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

Many words used in this Certificate have special meanings. These words will appear capitalized and are defined for you in Section 15: Glossary. By reviewing these definitions, you will have a clearer understanding of your Certificate.

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

Network and Non-Network Benefits

This Certificate describes the benefit levels available under the Policy.

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

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

The information in Sections 4 through 12 applies to all levels of Coverage. Section 3 explains the procedures you must follow to obtain Coverage for Network Benefits and Non-Network Benefits, respectively. Section 2 describes which Transplant Services are Covered. Unless otherwise specified, the exclusions and limitations of Sections 13 and 14 apply to all levels of benefits.

Transplant Services Covered Under the Policy

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

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

Only Covered Transplant Services described in Section 2 and not specifically excluded in Section 13, are Covered under the Policy. The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for an injury or sickness does not mean that the procedure or treatment is Covered under the Policy.

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

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

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

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

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

Important Information Regarding Medicare

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

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

Important Note About Services

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

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

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

B. Your doctor is solely responsible for the quality of the care you receive.

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

Transplant Identification Card

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

Contact the Company

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

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Section 1: Schedule of Benefits

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

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

Digestive transplants are Covered only when Transplant Services are rendered by a Network provider.

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

Benefits are subject to the notice, prior approval and coordination requirements described in Section 3, 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 and such person has established a Transplant Benefit Period for which benefits are not exhausted, benefits will be paid for the remaining part of that Transplant Benefit Period as if such Coverage had not ended, as long as the Covered Person remains the liability of the Policyholder's medical health benefit plan, and such medical health benefit plan is in force. Benefits will be based on the plan in force for that person on the date that Transplant Benefit Period ends.

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

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

Policy Period: January 1, 2017 to December 31, 2017.

Benefit	Network	Non-Network
Maximum Benefit for Search & Registry Fees	100% up to $3,000 per search up to a maximum of $12,000.	Not covered.
Maximum Organ Procurement Benefit Donor	100% of Eligible Expenses during the Transplant Benefit Period.	60% of Eligible Expenses to a maximum as shown in the table below.
Maximum Bone Marrow Harvesting Benefit	100% of Eligible Expenses during any Transplant Benefit Period within 90 days of the Transplant.	60% of Eligible Expenses during any Transplant Benefit Period within 90 days of the transplant up to a maximum of $10,000.
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 Transportation Benefit	100% of Eligible Expenses during any Transplant Benefit Period with a combined maximum of $10,000 for lodging, transportation and meals.	No Benefit.
Maximum Daily Benefit for Lodging and Meals	100% of Eligible Expenses during any Transplant Benefit Period up to a daily maximum of $200 with a combined maximum of $10,000 for lodging, transportation and meals.	No Benefit.
Maximum Air Ambulance Benefit	100% of Eligible Expenses during any Transplant Benefit Period up to a maximum of $10,000.	60% of Eligible Expenses during any Transplant Benefit Period up to a maximum of $10,000.
Maximum Private Duty Nursing Benefit	100% of Eligible Expenses during any Transplant Benefit Period up to a maximum of $10,000.	60% of Eligible Expenses during any Transplant Benefit Period up to a maximum of $10,000.
Maximum Transplant Evaluation Benefit	100% of Eligible Expenses	60% of Eligible Expenses up to a maximum of $10,000.

Benefit	Network	Non-Network
Maximum Hospital Confinement and Physician Benefit	100% of Eligible Expenses.	For Organ and Allogeneic Tissue Transplants: 60% of Eligible Expenses up 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 up 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 up 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 up 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 up to a maximum of $10,000.
Maximum Home Health Benefit	100% of Eligible Expenses.	60% of Eligible Expenses up to a maximum of $10,000.
Maximum Surgical Benefit for Organ or Tissue Transplant Benefit	100% of Eligible Expenses.	60% of Eligible Expenses up to a maximum of $10,000.
Maximum Outpatient Treatment Benefit	100% of Eligible Expenses.	60% of Eligible Expenses up to a maximum of $10,000.
Maximum Policy Benefit per Covered Person per lifetime for all Transplants	Unlimited for all Transplant Services.	Unlimited for all Transplant Services.

Non-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
Digestive	$00,000
Allogeneic BMT	$17,500
Autologous BMT	$12,500

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

Transplant	Maximum Network or Non-Network Benefit
Lung	$00,000
Double Lung	$00,000
Heart	$00,000
Liver	$00,000
Liver/Kidney	$00,000
Heart/Lung	$00,000
Heart/Kidney	$00,000
Pancreas	$00,000
Kidney	$00,000
Kidney/Pancreas	$00,000
Digestive	$00,000
Allogeneic BMT	$00,000
Autologous BMT	$00,000

Section 2: Covered Transplant Services

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

A. provided by or under the direction of a Physician or other appropriate provider as specifically described;

B. not excluded as described in Section 13, General Exclusions;

C. received pursuant to the Procedures for Obtaining Benefits set forth in Section 3.

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

2.1 Evaluation

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

2.2 Organ and Tissue Procurement

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

2.3 Professional Fees for Surgical and Medical Services

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

2.4 Inpatient Hospital Services

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

2.5 Outpatient Emergency Transplant Services

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

2.6 Home Health Agency Services

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

2.7 Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Confinement (in a Semi-private Room), including medical services and supplies, when related to a Transplant and provided under the direction of a Physician. Transplant Services must be provided in a Skilled Nursing Facility or Inpatient Rehabilitation Facility and are Covered only for Transplant-related care and treatment which otherwise would require Confinement in a Hospital.

2.8 Ambulance Services

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

2.9 Outpatient Rehabilitation Services

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

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

2.10 Telemedicine

If you reside in a county with one hundred fifty thousand or fewer residents, you may be entitled to receive 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 Glossary, Section 15). Please call the number on your Transplant identification card to see if you are eligible for this service.

2.11 Travel, Meals, and Lodging Reimbursement

Subject to the limitations and conditions set forth in the Schedule of Benefits, the following expenses are reimbursable when Covered Transplant Services are provided by Network providers and incurred by a Covered Person who must travel outside a 50-mile radius from

his/her home to and/or from a Hospital where the Transplant and post-discharge follow-up care is provided:

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

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

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

Section 3: Procedures for Obtaining Benefits

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

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

B. obtain prior approval from the Company for such services; and

C. allow the Company to coordinate your receipt of such services.

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

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

3.2 Emergency Transplant Services

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

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

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

Coverage for continuation of care related to a Transplant and after the condition no longer is an Emergency requires compliance with the procedures described in Section 3.1.

3.3 Prior Approval Does Not Guarantee Benefits

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

Section 4: Eligibility, Enrollment and Effective Date of Coverage

4.1 Eligibility

An Eligible Person is usually an employee or member of the Policyholder who meets the eligibility requirements of the Policy. When an Eligible Person actually enrolls for Coverage under this

Policy, that Eligible Person is referred to as a Subscriber (see Section 15 for complete definitions). The term Dependent generally refers to the Subscriber's spouse and children (see Section 15 for complete definitions).

4.2 Enrollment

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

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

4.3 Effective Date of Coverage

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

4.4 Coverage for a New Eligible Person

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

4.5 Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage shall take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days.

4.6 Effective Date of Coverage for Confinement

If you are Confined on your effective date of Coverage and you do not have coverage for that Confinement under a prior benefit plan, Transplant Services related to the Confinement are Covered as long as: (a) you notify the Company of Confinement within 48 hours of the effective date or as soon as is reasonably possible; and (b) Transplant Services are received in accordance with the terms, conditions, exclusions and limitations of the Policy.

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

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

4.7 Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (a) The Eligible Person and/or Dependent had existing health coverage under another plan at the

time of the Initial Eligibility Period or Open Enrollment Period; and (b) Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted. A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date coverage under the prior plan terminated.

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

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

A. The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 60 days of the date of determination of subsidy eligibility.

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

Section 5: Termination of Coverage

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

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

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

A. The date the entire Policy is terminated, as specified in the Policy. The Policyholder is responsible for notifying you of the termination of the Policy.

B. The date you cease to be eligible as a Subscriber or Enrolled Dependent.

C. The date the Company receives written notice from either the Subscriber or the Policyholder instructing the Company to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.

D. The date the Subscriber is retired or pensioned, unless a specific Coverage classification is specified for retired or pensioned persons in the Policyholder's application and the Subscriber continues to meet any applicable eligibility requirements.

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

A. The date specified by the Company that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information, including, but not limited to, false, material information relating to residence and/or employment or information relating to another person's eligibility for Coverage or status as a Dependent. The Company has the right to rescind Coverage back to the Policy Effective Date.

B. The date specified by the Company that all Coverage will terminate because the Subscriber permitted the use of his or her Transplant identification card by any unauthorized person or used another person's identification card.

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

5.2 Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the limiting age specified in the Policy provided that:

A. the Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age, and

B. the Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance, and

C. proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company, and

D. payment of any required Premium for the Enrolled Dependent is continued.

Coverage will be continued so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a Physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the Company's request will result in the termination of the Enrolled Dependent's Coverage under the Policy.

5.3 Payment and Reimbursement Upon Termination

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

Section 6: Reimbursement

6.1 Reimbursement of Eligible Expenses from Network Providers

Network providers are responsible for submitting a request for payment of Eligible Expenses directly to the Company. The Company 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 the Company.

6.2 Reimbursement of Eligible Expenses from Non-Network Providers

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

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

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

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

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

A. Your name and address.

B. Patient's name and age.

C. Number stated on your Transplant identification card.

D. The name and address of the provider of the service(s).

E. A diagnosis from the Physician.

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

G. Date Transplant Services began.

H. A statement indicating that you are or you are not enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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

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

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

A. the provider notifies the Company that your signature is on file assigning benefits directly to that provider; or

B. you make a written request, that benefits be paid directly to the provider of services, at the time the claim is submitted.

6.4 Limitation of Action for Reimbursement

You do not have the right to bring any legal proceeding or action against the Company to recover reimbursement until 90 days after you have properly submitted a request for reimbursement, as described above. No action may be brought after 3 years from the time written proof of loss is required to be given under this Policy.

Section 7: 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, the Company 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.

The Company may extend the review period for up to 15 days if the extension is necessary due to matters beyond the Company's control, and if the Company notifies you, prior to the expiration of the initial 15 day review period, of the circumstances requiring the extension and the date by which the Company expects to make a determination.

If you file a request for a pre-service benefit determination improperly, the Company 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, the Company 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 the Company. You will have at least 45 days from the date you receive the Company's notice to provide the additional information. If the Company issues 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, the Company will make a decision regarding the request within 5 business days of its receipt of the request. The Company will communicate its 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, the Company 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 the Company. If the Company issues 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 the Company within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Company 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, the Company 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 the Company. If the Company issues a denial notice for the post-service claim, it will explain the reason for the denial and provide the appeal procedures.

The Company may extend the review period for up to 15 days if the extension is necessary due to matters beyond the Company's control, and if the Company notifies you prior to the expiration of the initial 15 day review period of the circumstances requiring the extension and the date by which the Company expects to make a determination.

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 the Company within 72 hours of the Company's receipt of the necessary information. If additional information is needed to process the urgent benefit determination request, the Company 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 the Company. If the Company issues 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, the Company will make a determination with respect to the request within 24 hours of the Company's receipt of the request.

Section 8: Questions, Complaints and Appeals

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

8.1 What to Do if You Have a Question

You or your authorized representative should contact the Company's Member Services Department at the telephone number shown on your Transplant ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

8.2 What to Do if You Have a Complaint

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

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

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

8.3 How to Appeal a Claim Decision

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

A. The patient's name and the identification number from the Transplant ID card.

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

C. The provider's name.

D. The reason you believe the claim should be paid.

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

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

Appeal Process

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

8.4 Appeals Determinations

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

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

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

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

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

Urgent Appeals that Require Immediate Action

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

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

B. The Company will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

C. If the Company needs more information from your Physician to make a decision, the Company will notify you of the decision by the end of the next business day following receipt of the required information.

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

If you are dissatisfied with the Company's decision, you may request an expedited external review as described in Section 8.5.

8.5 External Review

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 the Company's decision by submitting a written request, along with a completed application for an external review, to the Company 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 13. 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 the Company's 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 the Company's 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 Company and the Covered Person except to the extent the Company or the Covered Person have other remedies available under federal or state law.

Section 9: General Provisions

9.1 Entire Policy

The Policy issued to the Policyholder, including the Certificate of Coverage, the Policyholder's application, amendments and riders, constitute the entire Policy. All statements made by the

Policyholder or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties.

9.2 Limitation of Action

You do not have the right to bring any legal proceeding or action against the Company without first completing the complaint procedure specified in Section 8. If you do not bring such legal proceeding or action against the Company within 3 years of the date the Company notified you of its final decision as described in Section 8, you forfeit your rights to bring any action against the Company.

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

9.3 Time Limit on Certain Defenses

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

9.4 Amendments and Alterations

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

9.5 Relationship Between Parties

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

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

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

9.6 Records

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

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

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

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

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

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

9.7 ERISA

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

9.8 Examination of Covered Persons

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

9.9 Clerical Error

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

9.10 Notice

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

9.11 Workers' Compensation Not Affected

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

9.12 Conformity with Statutes

Any provision of the Policy that, on the Policy Effective Date, is in conflict with the requirements of state or federal statutes or regulations (in the applicable jurisdiction) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Section 10: Coordination of Benefits

10.1 Coordination of Benefits Applicability

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

The order of benefit determination rules below determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total Allowable Expense.

10.2 Definitions

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

A. A "Coverage Plan" is any of the following that provides benefits or services for medical or transplant care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

1. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

2. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

B. The order of benefit determination rules determine whether this Policy is a Primary Coverage Plan or Secondary Coverage Plan when compared to another Coverage Plan covering the person.

When this Policy is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Policy is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's benefits.

C. "Allowable Expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

1. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

2. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the

highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Coverage 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 Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

5. The amount a benefit is reduced by the Primary Coverage Plan because a covered individual does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

D. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Policy, or before the date this COB provision or a similar provision takes effect.

E. "Closed Panel Coverage Plan" is a Coverage Plan that provides health benefits to covered individuals primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

10.3 Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide non-Network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-dependent or dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is

secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child covered under more than one coverage plan. The order of benefits when a child is covered by more than one Coverage Plan is:

   a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

      1) The parents are married;

      2) The parents are not separated (whether or not they ever have been married); or

      3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

      1) The Coverage Plan of the custodial parent;

      2) The Coverage Plan of the spouse of the custodial parent;

      3) The Coverage Plan of the noncustodial parent; and then

      4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).

4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.

5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

6. Spouse as both subscriber and enrolled dependent. If a husband or wife is covered under this Policy as a Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Subscriber's benefits will pay first.

7. If preceding rules do not determine. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

10.4 Effect on the Benefits of This Policy

A. When this Policy is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Policy would have paid had it been the Primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Policy to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Policy will:

1. Determine its obligation to pay or provide benefits under its contract;

2. Determine whether a benefit reserve has been recorded for the Covered Person; and

3. Determine whether there are any unpaid Allowable Expenses during that claims determination period.

If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100% of total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

10.5 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 Policy and other Coverage Plans. The Company may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Policy and other Coverage Plans covering the person claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give the Company any facts it needs to apply those rules and determine benefits payable. If you do not provide the Company with the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

10.6 Payments Made

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

10.7 Right of Recovery

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

Section 11: Subrogation and Refund of Expenses

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

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

A. Third parties, including any person alleged to have caused you to suffer injuries or damages.

B. Your employer.

C. Any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

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

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

You agree as follows:

A. That you will cooperate with the Company in protecting the Company's legal and equitable rights to subrogation and reimbursement, including, but not limited to:

   1. providing any relevant information requested by the Company,

   2. signing and/or delivering such documents as the Company or its agents reasonably request to secure the subrogation and reimbursement claim,

   3. responding to requests for information about any accident or injuries,

   4. making court appearances, and

5. obtaining the Company's consent or its agents' consent before releasing any party from liability or payment of medical expenses.

B. That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.

C. That the Company has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

D. That no court costs or attorneys' fees may be deducted from the Company's recovery without the Company's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Company is not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

E. That regardless of whether you have been fully compensated or made whole, the Company may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.

F. That benefits paid by the Company may also be considered to be benefits advanced.

G. That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

H. That you or an authorized agent, such as your attorney, must hold any funds due and owing the Company, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.

I. That the Company may set off from any future benefits otherwise provided by the Company the value of benefits paid or advanced under this section to the extent not recovered by the Company.

J. That you will not accept any settlement that does not fully compensate or reimburse the Company without its written approval, nor will you do anything to prejudice the Company's rights under this provision.

K. That you will assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Company provided, plus reasonable costs of collection.

L. That the Company's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid.

M. That the Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name, which does not obligate the Company in any way to pay you part of any recovery the Company might obtain.

N. That the Company shall not be obligated in any way to pursue this right independently or on your behalf.

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

A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person, or

B. All or some of the payment made by the Company exceeded the benefits payable under the Policy.

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

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

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

Reimbursement of Benefits Paid. If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

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

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

Section 12: Continuation of Coverage Under Federal Law (COBRA)

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

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Policy, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

The Company is not the Policyholder's designated "plan administrator" as that term is used in federal law, and the Company does not assume any responsibilities of a "plan administrator" according to federal law. The Company is not obligated to provide continuation coverage to you if the Policyholder or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Policyholder or its plan administrator are:

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

B. Notifying the Company in a timely manner of your election of continuation coverage.

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Policyholder's plan administrator if you have questions about your right to continue coverage.

12.1 Qualified Beneficiaries for Continuation Coverage under Federal Law (COBRA)

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who was Covered under the Policy on the day before a qualifying event:

A. A Subscriber.

B. A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.

C. A Subscriber's former spouse.

12.2 Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the Coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue Coverage. The Qualified Beneficiary is entitled to elect the same Coverage that she or he had on the day before the qualifying event.

A. Termination of the Subscriber from employment with the Policyholder, for any reason other than gross misconduct or reduction of hours; or

B. Death of the Subscriber; or

C. Divorce or legal separation of the Subscriber; or

D. Loss of eligibility by an Enrolled Dependent who is a child; or

E. Entitlement of the Subscriber to Medicare benefits; or

F. The Policyholder filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

12.3 Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Subscriber or other Qualified Beneficiary must notify the Policyholder's designated plan administrator within 60 days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber or other Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period, the Policyholder and its plan administrator are not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under

federal law, the Subscriber must notify the Policyholder's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs, or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Policyholder's designated plan administrator.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial Premium due to the Policyholder's designated plan administrator must be paid on or before the 45th day after electing continuation.

12.4 Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event (A) as listed above).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event (A) above, then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events (B), (C), or (D) as listed above).

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, 18 months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.

D. The date coverage terminates under the Policy for failure to make timely payment of the Premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Policyholder filed for bankruptcy, (i.e. qualifying event (F)).

G. The date the entire Policy ends.

H. The date coverage would otherwise terminate as described in the Policy.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Policyholder filed for bankruptcy, (i.e. qualifying event (F)) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events (B) through (G) described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Policyholder's designated plan administrator for information regarding the continuation period.

Section 13: General Exclusions

Section 13.1 Exclusions.

Except as may be specifically provided in Section 2 or through a rider to the Policy, the following services are not covered:

A. Transplant-related health care services and supplies which are:

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

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

3. not consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; or

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

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

6. not demonstrated through prevailing peer-reviewed medical literature to be either:

   a. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or

   b. safe with promising efficacy:

      1) for treating a life-threatening sickness or condition;

      2) in a clinically controlled research setting; and

      3) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

      (For the purpose of this section, the term life-threatening is used to describe a condition which is more likely than not to cause death within one year of the date of the request for treatment).

B. Dental services, except those related to evaluation.

C. 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).

D. Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.

E. Health services and associated expenses for cosmetic procedures.

F. Health services and associated expenses for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for Transplant Services which are otherwise Experimental, Investigational or Unproven that are deemed to be, in the Company's judgment, Covered Transplant Services. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

G. 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.

H. Health services and associated expenses for organ or tissue transplants that are not specified as Covered in Section 2 of this Certificate.

I. Health services and associated expenses for megavitamin therapy; psychosurgery; or nutritional-based therapy.

J. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.

K. Growth hormone therapy.

L. Travel or transportation expenses beyond that which is set forth in Section 2.

M. Mental health and/or substance abuse services.

N. Any drugs that are investigative or which have not been approved for general sale by the United States Food and Drug Administration unless requested in writing by a Network provider and approved by the Company.

O. 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.

P. 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.

Q. 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.

R. 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.

S. 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.

T. Transplant Services provided in a foreign country, unless required as Emergency Transplant Services.

U. 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.

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

W. Health services and associated expenses relating to any artificial or mechanical device designed to supplement, assist, or replace organs either permanently or temporarily including but not limited to, a ventricular assist device (VAD, LVAD, RVAD, BIVAD) or similar device.

Section 14: Limited Benefits

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

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

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

Section 15: Glossary

This Section defines the terms used in this Certificate.

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

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

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

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

Coverage or **Covered.** The entitlement by a Covered Person to reimbursement for expenses incurred for Transplant Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Transplant Services must be provided: (1) when the Policy is in effect; and (2) prior to the date that any of the individual termination conditions of Section 5.1 occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

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

Dependent. (1) The Subscriber's legal spouse; or (2) a child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, or a child placed for adoption). The principal place of residence of the legal spouse must be with the Subscriber unless the Company approves other arrangements. The definition of Dependent is subject to the following conditions and limitations:

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

B. The term Dependent shall include an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber as described in Section 5.2 Extended Coverage for Handicapped Children.

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

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

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

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

A. For Network Benefits:

1. When Covered Transplant Services are received from Network providers, Eligible Expenses are the Company's contracted fee(s) for the Transplant Service with that provider;

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

B. For Non-Network Benefits:

1. When Covered Transplant Services are received from non-Network providers, Eligible Expenses are the lesser of: 1) the fees that do not exceed the Company's contracted fee(s) for Network providers; or 2) fees calculated based on available data resources of competitive fees.

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

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

A. As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Medical Association);

B. As reported by generally recognized professionals or publications;

C. As utilized for Medicare;

D. As determined by medical staff and outside medical consultants;

E. Pursuant to other appropriate sources or determinations accepted by the Company.

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

Emergency. A serious medical condition or symptom resulting from injury or sickness which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of a Covered Person.

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

Enrolled Dependent. A Dependent who is properly enrolled for Coverage under the Policy.

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, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

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; or

B. Subject to review and approval by any institutional review board for the proposed use; or

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; or

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.

The Company, in its judgment, may deem an Experimental, Investigational or Unproven Service a Covered Transplant Service for treating a life-threatening sickness or condition if it is determined by the Company that the Experimental, Investigational or Unproven Transplant Service at the time of the determination:

A. Is safe with promising efficacy;

B. Is provided in a clinically controlled research setting; and

C. Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life-threatening is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for a Transplant.)

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: (1) engaged in providing health care services in the home; and (2) authorized as required by the law of jurisdiction in which treatment is received.

Hospital. An institution, operated as required by law, which: (1) 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; (2) has 24 hour nursing services; and (3) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association. A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

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

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

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

A. Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;

B. Are ordered by a Physician; and

C. Are not excluded pursuant to the provisions of Section 13, General Exclusions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;

B. Are ordered by a Physician; and

C. Are not excluded pursuant to the provisions of Section 13, 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 the Policy. The Subscriber is the person who is not a Dependent on whose behalf the Policy is issued to the Policyholder.

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 one (1) day(s) prior to the date the Transplant is performed and ends twelve (12) months after the date of the Transplant.

B. For allogeneic Transplants, the **Transplant Benefit Period** begins on the first day of ablative therapy and ends twelve (12) months after the first date of ablative therapy.

C. For autologous Transplants, the **Transplant Benefit Period** begins on the first day of ablative therapy and ends twelve (12) months after the first date of ablative therapy.

D. For sub-myeloablative Transplants, the **Transplant Benefit Period** begins on the first day of ablative therapy and ends six (6) months after the first date of ablative therapy.

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

External Review Amendment

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103

(Home Office)

Policyholder: The Christian and Missionary Alliance **Policy Number:** 1001012

As described in this Amendment, the Policy is modified.

Because this Amendment reflects changes in requirements of insurance law of the State of Colorado, to the extent it may conflict with any Amendments issued to you previously, the provisions of this Amendment will govern.

Because this Amendment is part of a legal document (the Policy), the Company wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings and are defined in the *Certificate of Coverage* in *Section [14]: Glossary*.

Section 8.5 External Review in the *Certificate of Coverage* is replaced with the following:

8.5 External Review

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 the Company's decision by submitting a written request, along with a completed application for an external review, to the Company:

1. within four (4) months after the date you receive notice of an adverse determination following completion of the first level appeal process described above; or

2. within 60 days after the date you receive notice of the upheld adverse determination following completion of the voluntary second level appeal process described above.

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 13], except if you present evidence from a medical professional that there is a reasonable medical basis that the contractual exclusion does not apply. Your case will be assigned to an independent external review entity. The independent external review entity will make its decision, and provide notification, within 45 days after its receipt of the request for external review.

Expedited External Review

You may be entitled to an expedited external review if:

1. 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

2. for persons with a disability, the time frames for a standard external review would create an imminent and substantial limitation of their existing ability to live independently.

You may also have the right to request a concurrent expedited external review when a request for an expedited internal review (see *Urgent Appeals*, above) has been made.

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, and provide notification, within 72 hours after its receipt of the assignment of the request for external review.

The Company's failure to comply with any requirements related to the Company's internal appeals process will deem the internal appeals process exhausted and thereby permit you to request an external review.

The decision of the independent external review organization shall be binding on the Company and you except to the extent the Company or you have other remedies available under federal or state law.

Effective Date of this Amendment: October 31, 2011

Secretary President

Notices

Claims and Appeal Notice

Notice of Privacy Practices

Financial Information Privacy Notice

ERISA

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you 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, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a copayment and believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for benefits, and it was submitted properly with all needed information, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for benefits improperly, we will notify you of the improper filing and how to correct it within 5 days after the pre-service request for benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed

information within the 45 day period, your request for benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for benefits in accordance with the applicable claim filing procedure. When you have filed a request for benefits, your request will be treated under the same procedures for pre-service group health plan requests for benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent request for benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our customer service department before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a customer service representative. If you first informally contact our customer service department and later wish to request a formal appeal in writing, you should again contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our customer service department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for benefits determination or post-service claim determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- 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 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.

Appeals Determinations

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

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. 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. 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.

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

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.

Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in 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.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We* are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms “information” or “health information” in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our website www.myuhc.com.

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*For purposes of this Notice of Privacy Practices, “we” or “us” refers to the following UnitedHealthcare entities:

ACN Group of California, Inc.; All Savers Insurance Company; American Medical Security Life Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; IBA Health and Life Assurance Company; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Behavioral Health, Inc.; PacifiCare Behavioral Health of California, Inc.; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Behavioral Health of New Jersey, Inc.; PacifiCare Dental; PacifiCare Dental of Colorado, Inc.; PacifiCare Insurance Company, Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of California; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; PacifiCare of Oklahoma, Inc.; PacifiCare of Oregon, Inc.; PacifiCare of Texas, Inc.; PacifiCare of Washington, Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of Ohio;

UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Plan of the River Valley, Inc.; and U.S. Behavioral Health Plan, California.

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- ***For Payment*** of premiums due us and to process claims for health care services you receive.
- ***For Treatment***. We may disclose health information to your physicians or hospitals to help them provide medical care to you.
- ***For Health Care Operations***. We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health.
- ***To Provide Information on Health Related Programs or Products*** such as alternative medical treatments and programs or about health related products and services.
- ***To Plan Sponsors.*** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- ***For Appointment Reminders***. We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- ***To Persons Involved With Your Care.*** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- ***For Public Health Activities*** such as reporting disease outbreaks.
- ***For Reporting Victims of Abuse, Neglect or Domestic Violence*** to government authorities, including a social service or protective service agency.
- ***For Health Oversight Activities*** such as governmental audits and fraud and abuse investigations.
- ***For Judicial or Administrative Proceedings*** such as in response to a court order, search warrant or subpoena.
- ***For Law Enforcement Purposes*** such as providing limited information to locate a missing person.

- ***To Avoid a Serious Threat to Health or Safety*** by, for example, disclosing information to public health agencies.
- ***For Specialized Government Functions*** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- ***For Workers' Compensation*** including disclosures required by state workers' compensation laws of job-related injuries.
- ***For Research Purposes*** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- ***To Provide Information Regarding Decedents.*** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- ***For Organ Procurement Purposes.*** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

HIGHLY CONFIDENTIAL INFORMATION

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information*.

WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information.

- ***You have the right to ask to restrict*** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health

care. We may also have policies on dependent access that may authorize certain restrictions. ***Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.***

- ***You have the right to ask to receive confidential communications*** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address).
- ***You have the right to see and obtain a copy*** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- ***You have the right to ask to amend*** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- ***You have the right to receive an accounting*** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that Federal law does not require us to provide an accounting.
- ***You have the right to a paper copy of this notice***. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.myuhc.com.

EXERCISING YOUR RIGHTS

- ***Contacting your Health Plan***. If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- ***Filing a Complaint***. If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint**.**

FINANCIAL INFORMATION PRIVACY NOTICE

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with Federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthcare Service LLC; United Medical Resources, Inc.*

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the Federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY
HIV/AIDS	

Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

ERISA

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

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

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *COBRA* continuation rights. Review the Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the

latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

ERISA Statement

If the Enrolling Group is subject to ERISA, the following information applies to you.

Summary Plan Description

Name of Plan: The Christian and Missionary Alliance

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

The Christian and Missionary Alliance
8595 Explorer Drive
Colorado Springs, CO 80920
719-265-2128

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company

Employer Identification Number (EIN): 13-1623940

Effective Date of Plan: January 1, 2017

Type of Plan: Health care coverage plan

Name, business address, and business telephone number of Plan Administrator:

The Christian and Missionary Alliance
8595 Explorer Drive
Colorado Springs, CO 80920
719-265-2128

Type of Administration of the Plan:

Benefits are paid pursuant to the terms of a group health policy issued and insured by:

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, Connecticut 06103

The Plan is administered on behalf of the Plan Administrator by UnitedHealthcare Insurance Company pursuant to the terms of the group Policy. United Resource Networks, a division of OptumHealth Care Solutions, Inc., an affiliate of UnitedHealthcare Insurance Company, provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

Source of contributions and funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records:

Plan year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders. The plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.