HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
1-800-447-0460

Specified Disease - Organ & Tissue Transplant Policy

Administrative Office:
HCC Life Insurance Company
3600 Woodview Trace, Suite 180
Indianapolis, Indiana 46268
(888) 449-2377

POLICYHOLDER:	Rush County Employees (IN)
POLICYHOLDER ADDRESS:	Courthouse, 101 E. 2nd Street Rushville, IN 46173
POLICY NUMBER:	HCCLOT40904
POLICY EFFECTIVE DATE:	08/01/2019
POLICY ANNIVERSARY DATE:	August 1st of each succeeding year
PREMIUM DUE DATE:	First premium payment is due on the **Policy Effective Date** above. Thereafter, each premium payment is due on the first day of the month.
INITIAL ENROLLMENT:	81
MINIMUM ENROLLMENT:	50

PREMIUMS PER MONTH:
Single: $9.97   Family: $24.74

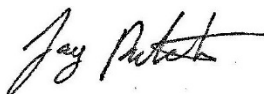
HCC Life Insurance Company will provide the Policy benefits to each **Participant** in consideration and acceptance of the **Policyholder's** signed **Application** and premium, and subject to all Policy provisions.

This Policy becomes effective at 12:01 a.m. at the **Policyholder's** address on the **Policy Effective Date** shown above, and replaces any previous agreement relating to transplant services between the **Policyholder** and the **Company** (or National Union Fire Insurance Company of Pittsburgh, Pa.). The first premium payment and all subsequent premium payments are due on the **Premium Due Date** shown above.

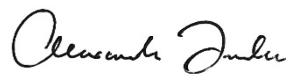
THIS IS A GROUP SPECIFIED DISEASE POLICY. IT IS NOT INTENDED TO BE A MAJOR MEDICAL HEALTH PLAN. THIS POLICY IS INTENDED TO QUALIFY AS AN "EXCEPTED BENEFIT" UNDER FEDERAL AND STATE LAW.

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

This Policy is issued by **Us** as of the **Policy Effective Date,** but is not valid unless countersigned by **Our** duly authorized representative.



President



Vice President and General Counsel

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POLICYHOLDER PROVISIONS

A. Defined Terms. Boldfaced terms have special meaning. Please refer to the Definitions, Schedule of Benefits, and/or Benefit Provisions of this Policy for a complete description of such terms.

B. Coverage. **Participants** are entitled to coverage for **Covered Transplant Services**, subject to the terms, conditions, limitations, and exclusions set forth in this Policy as further described in paragraph M below of this Provision.

C. Payment of Premiums. All premiums must be paid by the **Premium Due Date** shown on the Policy face page. Premiums shall be remitted to **Us** at the following address:

REGULAR MAIL (Lockbox):
HCC Life Insurance Company
P.O. Box 402032
Atlanta, GA 30384-2032

OVERNIGHT MAIL:
HCC Life Insurance Company
6000 Feldwood Road
Attn: Box 402032
College Park, GA 30349

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

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

E. Right to Amend Rates and Policy Terms. **We** may revise the premium rates or any other terms of this Policy on:
1. The date the **Policyholder** amends the **Medical Plan**.
2. The date a benefit change is made to this Policy at the **Policyholder's** request.
3. The date the **Policyholder** adds or deletes a subsidiary or affiliate.
4. The date an increase or decrease in the number of **Participants** exceeds 25% in any one month or 25% over any period of three consecutive months. The number of **Participants** will be derived from the **Policyholder's** monthly premium statements or any other reports obtained from the **Policyholder** or the **Policyholder's Medical Plan Administrator**.
5. The date **We** are notified by the state in which the **Policyholder** is located of any state imposed tax or assessment for which **We** are obligated to pay.
6. The date of any change in the **Policyholder's** business that materially affects **Our** risk.
7. The date it is discovered that there has been a material misrepresentation or nondisclosure of information that **We** could reasonably have expected to have been disclosed to **Us** by the **Policyholder** or the **Policyholder's Medical Plan Administrator**.

F. Incontestability. **We** may declare this Policy void back to the inception date of the **Policy Year** or cancel this Policy, if the **Application** contains a material misrepresentation. However, this provision will not apply once this Policy has been continuously in effect for two years.

G. Representations Not Warranties. A copy of the **Application** is attached to this Policy. All statements made by the **Policyholder** or by **Participants** applying for coverage will be considered representations and not warranties. No statement appearing on the **Application** will be used to contest the validity of the **Policyholder's** right to the benefits of this Policy, unless the **Policyholder** has been furnished a copy of the **Application**.

H. Evidence of Insurability. **We** may ask the **Policyholder** for verification that a **Participant** is covered under the **Policyholder's Medical Plan**.

POLICYHOLDER PROVISIONS
(Continued)

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

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

We may cancel this Policy at the end of the month in which the **Policyholder's** enrollment drops below the Minimum Enrollment shown on the Policy face page. However, **We** must provide written notification to the **Policyholder** of such cancellation not less than 10 days in advance of the termination date.

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

1. The date the **Medical Plan** is discontinued.
2. The date the **Policyholder's Medical Plan Administrator** listed in the Schedule of Benefits is changed to an administrator that **We** have not authorized.
3. The date it is determined that the **Policyholder's Medical Plan Administrator** is not properly licensed as required by state law.
4. The date the **Medical Plan** is found to be in violation of federal or state law. **We** reserve the right to allow the **Medical Plan** 90 calendar days within which to achieve compliance. Failure to comply by such date will result in termination of this Policy.
5. The date it is determined that the **Policyholder** is, or is affiliated with, a sanctioned entity, organization, or country.
6. Upon the **Policy Effective Date**, if the **Policyholder** fails to provide **Us** (within the first 90 days of the **Policy Effective Date**) with requested materials or information necessary for **Our** final review and approval of the premium rates. If this Policy is terminated under this provision, **We** will return the premium paid by the applicant for the current **Policy Year**, and **We** will have no liability under the terms of this Policy for the current **Policy Year**.
7. Upon the **Premium Due Date** if **We** do not receive premiums within the specified grace period.
8. The date the **Policyholder** becomes insolvent or files for bankruptcy, unless **We** and an appointed trustee in bankruptcy agree to continue the coverage during a period of reorganization.

J. Notice. When **We** provide written notice to the **Policyholder's** last known address regarding the administration of this Policy, it is deemed to be notice to all affected parties including all **Participants**. The **Policyholder** is responsible for giving notice to **Participants**, if applicable.

K. Legal Action. No legal action may be brought under this Policy within 60 days after **We** receive a claim. No action may be brought after 3 years from the date the claim is required to be furnished to **Us**.

L. Information Release and Data Confidentiality. The **Policyholder** and all **Participants** that need **Covered Transplant Services** must allow **Us** access to medical information from all appropriate **Providers**. Such information is necessary in order for **Us** to make proper benefit determinations. The information will not be used, disclosed, furnished, or made accessible to anyone other than **Our** authorized employees and vendors contracted by **Us** to carry out **Our** obligations under this Policy. In accordance with the applicable law, **We** and the **Policyholder** agree to establish and maintain administrative, technical and physical safeguards to protect the security, confidentiality and integrity of the medical information.

M. Entire Contract. This Policy (along with the Certificate) and the signed **Application** form the entire contract between the **Policyholder** and **Us**. No amendment to this Policy shall be effective unless confirmed by a written Endorsement agreed to and issued by **Us.** No agent or representative of the **Company**, other than an executive officer, may change this Policy or waive any of its provisions. No verbal statement by any executive officer or other employee of the **Company** is binding on **Us**.

POLICYHOLDER PROVISIONS
(Continued)

N. Audit. **We** shall have the right to inspect and audit all records and procedures of the: 1) **Policyholder**; 2) its **Medical Plan Administrator**; or 3) any other organization involved in the administration or adjudication of claims. In addition, **We** shall have the right to require premium records, proof of eligibility, and claim payment information in a manner that meets **Our** requirements.

O. Clerical Error. A clerical error made by the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or **Us** will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated. Any clerical error in data provided to **Us** must be corrected and promptly reported to **Us**. **We** will make appropriate adjustments to premiums due and/or benefit determinations. Any refund in premium due to **Policyholder** error is limited to the 12 month period prior to the date of the request for refund.

P. Conformity with Statutes. Any provision of this Policy that, on the **Policy Effective Date**, is in conflict with the requirements of state in which the Policy was delivered or federal statutes/regulations is hereby amended to conform to the minimum requirements of such statutes and regulations.

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

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

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

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

POLICYHOLDER PROVISIONS
(Continued)

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

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

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

The Certificate of Coverage is part of this Policy.

SCHEDULE OF BENEFITS

POLICY YEAR: 08/01/2019 through 07/31/2020

COVERED TRANSPLANTS: The following transplant procedures are covered as long as the transplant is the result of one of the **Covered Specified Diseases** set forth in the Appendix.

☒ Heart
☒ Lung/Double Lung
☒ Kidney (living or deceased donor)
☒ Pancreas
☒ Liver (living or deceased donor)
☒ Intestine

☒ Heart/ Lung
☒ Kidney/ Pancreas
☒ Kidney/Liver
☒ Liver/Intestine
☒ Pancreas/Intestine
☒ Liver/Pancreas/Intestine
☐ Other (specify):

☒ Autologous Bone Marrow Peripheral Stem Cell Including **High Dose Chemo**
☒ Allogeneic Bone Marrow - Peripheral Stem Cell – Cord Blood Including **High Dose Chemo** (related)
☒ Allogeneic Bone Marrow - Peripheral Stem Cell - Cord Blood Including **High Dose Chemo** (unrelated)

TRANSPLANT BENEFIT PERIOD:

The Transplant Benefit Period begins on the date of Transplant Evaluation for a Covered Transplant Procedure.

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

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

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

For a bone marrow/peripheral stem cell tissue transplant, the date the tissue is re-infused is deemed to be the date of the **Covered Transplant Procedure**.

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

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

SCHEDULE OF BENEFITS
(Continued)

LIFETIME LIMIT: Unlimited

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

1. All benefits paid on behalf of the **Participant** (including covered donor charges) under the Policy and any preceding or succeeding Organ & Tissue Transplant Policy or Specified Disease-Organ & Tissue Transplant Policy between the **Policyholder** and **Us** or National Union Fire Insurance Company of Pittsburgh, Pa.; and
2. All benefits paid by **Us** under the Travel Benefit provision.

REIMBURSEMENT AMOUNTS:

A. PARTICIPATING PROVIDER: ………… 100% of **Covered Charges** for **Covered Transplant Services** provided through a **Participating Transplant Provider**.

B. NONPARTICIPATING PROVIDER: ……80% of **Covered Charges** for **Covered Transplant Services** provided through a **Nonparticipating Transplant Provider** with respect to the type of **Covered Transplant Procedure** performed. Benefits for **Covered Transplant Services** provided through a **Nonparticipating Transplant Provider** will not exceed the Maximum Benefit stated below:

COVERED TRANSPLANT PROCEDURE	MAXIMUM BENEFIT FOR ALL COVERED TRANSPLANT SERVICES PROVIDED BY A NONPARTICIPATING TRANSPLANT PROVIDER
Heart	$488,000
Lung (Single)	$349,000
Lung (Double)	$442,000
Kidney (living or deceased donor)	$170,000
Pancreas	$162,000
Liver (living or deceased donor)	$332,000
Intestine	$517,000
Heart/Lung	$745,000
Kidney/Pancreas	$253,000
Kidney/Liver	$637,000
Liver/Intestine	$738,000
Pancreas/Intestine	$738,000
Liver/Pancreas/Intestine	$738,000
Autologous Bone Marrow/Peripheral Stem Cell Including **High Dose Chemotherapy**	$200,000
Allogeneic Bone Marrow/Peripheral Stem Cell/Cord Blood Including **High Dose Chemotherapy** - related	$334,000
Allogeneic Bone Marrow/Peripheral Stem Cell/Cord Blood Including **High Dose Chemotherapy** - unrelated	$394,000

C. SECONDARY PAYER: …..…………… If any other medical plan pays benefits as primary, benefits under the Policy will be considered secondary. Such secondary benefits will be the lesser of: a) **Covered Charges** minus charges paid by the primary payer; or b) the negotiated amount established between the primary payer and the **Provider**, minus charges paid by the primary payer.

SCHEDULE OF BENEFITS
(Continued)

ENDORSEMENTS: Yes ☐ No ☒

If yes, please specify:

POLICYHOLDER'S MEDICAL PLAN ADMINISTRATOR:

UMR, Inc.

Questions regarding Your coverage or this Policy should be directed to:

Tokio Marine HCC
3600 Woodview Trace, Suite 180
Indianapolis, Indiana 46268
Attention: Robby Kerr
(888) 449-2377

If **You** need the assistance of the governmental agency that regulates insurance; or if **You** have a compliant with **Us** that has been unresolved, **You** may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461 or (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

BENEFIT PROVISIONS

Capitalized, boldfaced terms have special meaning. Please refer to this section, the Schedule of Benefits, and/or Definitions of the Policy for a complete description of such terms.

INSURING AGREEMENT:

Subject to all terms, conditions, limitations, and exclusions, **We** will pay **Covered Charges** incurred by **You** for **Covered Transplant Services** performed by a **Transplant Provider** that are directly related to a **Covered Transplant Procedure** resulting from one of the **Covered Specified Diseases** set forth in the Appendix.

NOTIFICATION REQUIREMENTS FOR TRANSPLANTS AND POTENTIAL TRANSPLANTS:

We must be notified as soon as possible by **You**, the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or **Your Physician** that a **Covered Transplant Procedure** is being considered. Notification must occur before the referral is made to the **Transplant Provider** and services are rendered for any transplant consultation and/or **Initial Transplant Evaluation**. Notifications must be submitted to:

HCC Life Insurance Company
3600 Woodview Trace, Suite 180
Indianapolis, Indiana 46268
Attention: Transplant Nurse Advisor
(888) 449-2377

COVERED TRANSPLANT SERVICES:

The following services require Our prior approval and are eligible for coverage if they are provided to **You**, performed by a **Transplant Provider**, and directly related to a **Covered Transplant Procedure**. ***Complications of donation experienced by the living donor are not covered.***

1. Initial Transplant Evaluation. **Initial Transplant Evaluation** means screening tests, labs, x-rays, scans, procedures (including dental evaluations, x-rays, and examinations), and consultations for **You** (and any applicable living donor) to determine if **You** are an appropriate transplant candidate.

2. Ongoing Transplant Evaluation (after **You** have been approved for a transplant). **Ongoing Transplant Evaluation** means screening tests, labs, x-rays, scans, procedures, and consultations that occur in order for **You** to meet the listing requirements according to the United Network for Organ Sharing (UNOS) for solid organ transplantation.

3. Work-Up. **Work-Up** means screening tests, labs, x-rays, scans, procedures, and consultations to determine the appropriateness for **Your** transplantation just prior to: a) beginning **High Dose Chemotherapy** to be followed by bone marrow/stem cell transplantation; or b) admission for solid organ transplantation.

BENEFIT PROVISIONS
(Continued)

4. Clinical Trials. **Clinical Trials** means those services including and directly related to a **Covered Transplant Procedure** associated with **Your** participation in a clinical trial which includes coverage for all **Routine Patient Costs** associated with Phases I, II, III and IV clinical trials that are federally funded or approved by one or more of the following:
   a. The National Institutes of Health, including the National Cancer Institute (NCI).
   b. The Centers for Disease Control and Prevention.
   c. The Agency for Health Care Research and Quality.
   d. The Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in a. through d. or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. The Department of Energy.
   h. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
   i. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

   Clinical trial coverage is subject to either federal or state law, whichever provides the greater benefit level. If **You** are not participating in a clinical trial, the proposed treatment plan, protocol, supply, service or drug will be subject to the **Experimental and/or Investigational Treatment** definition. In either case, coverage is dependent on being **Medically Necessary**.

5. Solid Organ Procurement. **Solid Organ Procurement** means compatibility testing and procurement expenses for living and deceased donors; donor's surgical procedure to remove the organ or tissue; and inpatient and outpatient services for living donor.

6. Bone Marrow or Stem Cell Procurement. **Bone Marrow or Stem Cell Procurement** means expenses for:
   a. Procurement from **You** for autologous bone marrow/stem cell transplant;
   b. Procurement from a living donor for allogeneic bone marrow/stem cell transplant, including compatibility testing of relatives;
   c. Testing/typing of potential unrelated donors;
   d. Tests related to the procurement of bone marrow/stem cells, including human leukocyte antigen typing;
   e. Mobilization and collection of bone marrow and/or stem cells including prescription drugs used to mobilize stem cells; and
   f. Storage (for up to 6 months) of bone marrow/stem cells (autologous or allogeneic) for future use, as long as a bone marrow/stem cell transplant has been scheduled to occur within the same 6 months; and
   g. Bone marrow/stem cell registry search expenses such as from the National Marrow Donor program (NMDP).

7. Covered Transplant Procedure. **Covered Transplant Procedure** means a **Medically Necessary** adult or pediatric human organ and tissue transplant: a) resulting from one of the **Covered Specified Diseases** set forth in the Appendix; and b) listed as a **Covered Transplant** in the Schedule of Benefits that is not **Experimental and/or Investigational Treatment**.

8. Transplant Hospitalization. **Transplant Hospitalization** means the hospitalization for the **Covered Transplant Procedure** including inpatient **Hospital** services, **Physician** services and ancillary services. For solid organ transplantation, coverage begins 24 hours prior to the transplant procedure and includes **Work-Up**. Hospitalization of living solid organ donors is covered. For bone marrow/stem cell transplants, coverage begins with the **Work-Up** immediately prior to beginning **High Dose Chemotherapy** to include subsequent infusion of autologous or allogeneic bone marrow/stem cells. Bone marrow/stem cell transplantation may be performed as an inpatient or outpatient.

9. Follow-Up. **Follow-Up** means **Hospital** services (inpatient and outpatient), **Physician** services, labs, x-rays, procedures, and other diagnostic tests rendered by a **Transplant Provider** to determine the status of the transplanted organ or tissue after discharge from a **Transplant Hospitalization**.

10. Complications after Transplant for Recipient. **Complications after Transplant for Recipient** means services, supplies, and prescription drugs to treat complications experienced by the transplant recipient after transplant, such as:
    a. Rejection of a solid organ;
    b. Surgical complications; and
    c. Graft versus host disease of transplanted bone marrow or stem cells.

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

11. Acute Rehabilitation or Non-Acute Rehabilitation after Discharge from Transplant Hospitalization. **We** will pay for up to a total of 15 days/visits for physical rehabilitation, whether inpatient, outpatient, or in the home. In addition, for heart or lung transplant patients, **We** will pay for up to an additional 36 outpatient cardiac and/or pulmonary rehabilitation sessions.

12. Home Health Care after Discharge from Transplant Hospitalization. **We** will pay for up to a total of 15 home health care visits by a registered nurse to administer intravenous drugs, train the patient (and/or family) for self-administration of drugs, wound care, or similar procedures.

13. Durable Medical Equipment after Discharge from Transplant Hospitalization. **We** will pay for rental of durable medical equipment after discharge from the **Transplant Hospitalization**. This benefit is limited to the lesser of a total of 15 days of rental or the purchase price of such equipment.

14. Prescription Drugs. **We** will pay for immunosuppressants, prophylactic antibiotics, prophylactic antivirals and prophylactic antifungals that are **Medically Necessary** after discharge from the **Transplant Hospitalization** for up to 365 days after the date of transplantation. Drugs used to treat conditions not directly related to the **Covered Transplant Procedure** are not covered.

TRANSPLANT INDEMNITY PROVISION

In the event **You** obtain a **Covered Transplant Procedure**, **We** will pay $5,000 directly to **You** within days after receiving required proof that the **Covered Transplant Procedure** has occurred. **We** may pay benefits directly to any relative **We** deem appropriate if a benefit is payable and **You** are: 1) a minor; 2) legally incapable of giving valid receipt and discharge of payment; or 3) deceased.

PRE-EXISTING CONDITION WAITING PERIOD:

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

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

MULTIPLE TRANSPLANTS:

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

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

NON-PERFORMANCE OF COVERED TRANSPLANT PROCEDURES:

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

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

TRANSPLANT NURSE ADVISOR:

We will assign a transplant nurse advisor to facilitate the required prior authorization of all transplant related services, transplant coverage determinations, access to transplant facilities, and ongoing patient support related to transplantation during the **Transplant Benefit Period**. All **Covered Transplant Services** require pre-authorization through **Your** assigned Transplant Nurse Advisor. **We** may, in certain circumstances, provide benefits for **Medically Necessary** services, supplies or drugs that would otherwise be excluded from coverage. Such services, supplies or drugs may be covered as a result of changes in standards of care and/or emerging technology not addressed in the Policy. If **We** provide any benefit not covered under the Policy, this fact shall not be used against **Us** in any similar case and **We** shall not be required to extend this benefit to any other **Participant**.

BENEFIT PROVISIONS
(Continued)

TRAVEL BENEFIT (LODGING, MEALS AND TRANSPORTATION):

LODGING AND MEALS:

Your Benefit: $300 per day. This benefit is paid if **You** incur lodging and meals expenses during a **Transplant Benefit Period** for travel related to a **Covered Transplant Procedure**. This benefit is subject to the Maximum Travel Benefit shown below.

Living Donor Benefit: $300 per day. This benefit is paid if a living donor incurs lodging and meals expenses during a **Transplant Benefit Period** for travel related to a **Covered Transplant Procedure**. The benefit is subject to the Maximum Travel Benefit shown below.

TRANSPORTATION:

Your Benefit: **We** will reimburse reasonable and necessary transportation expenses incurred by **You** and one companion (two companions if **You** are a minor) during a **Transplant Benefit Period** for transportation related to a **Covered Transplant Procedure**. This benefit is subject to the Maximum Travel Benefit shown below.

Living Donor Benefit: **We** will reimburse reasonable and necessary transportation expenses incurred by a living donor and one companion during a **Transplant Benefit Period** for transportation related to a **Covered Transplant Procedure**. This benefit is subject to the Maximum Travel Benefit shown below.

Transportation includes: automobile; boat; airplane; and train. Automobile mileage reimbursement is based on current federal guidelines for mileage reimbursement.

Lodging, meals and transportation benefits will only be provided once **We** have received itemized receipts and a completed travel expense form (as supplied by **Us**).

Maximum Travel Benefit: The Maximum Travel Benefit for all eligible travel expenses (lodging, meals and transportation) incurred by **You**, a living donor, and all eligible companions are limited to a combined Maximum Travel Benefit of $15,000 per **Covered Transplant Procedure**. These travel, lodging, and meal benefits are included within and reduce **Your** Lifetime Limit, if applicable.

AMBULANCE BENEFIT:

In the event **You** require immediate, **Medically Necessary** ground or air (jet or helicopter) ambulance transportation to a **Transplant Provider** for treatment related to a **Covered Transplant Procedure, We** will pay the **Reasonable and Customary** travel expenses, as determined by **Us**, up to the Benefit Limit specified below, for services rendered within the United States by a licensed professional ambulance service, regularly scheduled airline, air ambulance, or railroad. Ambulance transportation (ground or air) requires **Our** prior approval.

Benefit Limit: Up to $25,000 per **Transplant Benefit Period**.

DISABILITY, LEAVE OF ABSENCE, OR LAYOFF:

If **You** are not actively at work as a result of a disability, leave of absence, Family Medical Leave (as defined by the Family Medical Leave Act of 1993), or layoff, eligibility for benefits provided under the Policy will only be extended to **You** through the earliest of:

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

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

CLAIMS PROVISIONS

A. Filing Claims.

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

B. Notice of Claim.

Written notice of a claim must be furnished to **Us** within 20 days following the **Date of Service**. Failure to furnish such notice shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such notice within such time, provided such notice is furnished as soon as reasonably possible.

C. Claim Forms.

We shall provide claim forms for filing proof of loss. If such forms are not furnished before the expiration of 15 days after **We** receive a notice of claims, **You** shall be deemed to have complied with the requirements for filing proof of loss. Claims must include:

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

D. Proof of Loss.

Written proof of loss must be furnished to **Us** within 90 days following the **Date of Service**. Failure to furnish such proof of loss shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the **Participant**, later than 12 months following the **Date of Service**.

E. Claim Payment.

We will pay benefits for all **Covered Charges** in accordance with the terms of the Policy within:

1. 45 days after receiving all necessary information, if filed by paper; and
2. 30 days after receiving all necessary information, if filed electronically.

Benefits are paid to **You** or to **Your** assignee or designee. **We** may pay benefits directly to the **Provider** or to any relative **We** deem appropriate if a benefit is payable and **You** are: 1) a minor; 2) legally incapable of giving valid receipt and discharge of payment; or 3) deceased.

APPEAL AND GRIEVANCE PROCEDURES

Appeals must be submitted for consideration within 180 days of the date of **Our** payment (if the appeal is based upon **Our** payment) within 180 days of the date of **Our** denial of coverage. Grievances regarding **Our** services or product may by submitted at any time during the **Policy Year**. Within 5 days of **Our** receipt of such Appeal or Grievance, **We** will provide **You** with a verbal or written acknowledgements of our receipt of the Appeal or Grievance.

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

1. Level 1 Review (Internal Review)

Standard Review: A Level 1 Standard Review of an appeal is available on a prospective or retrospective basis and may be requested verbally or in writing by **You** or **Your** designee. A Level 1 Standard Review will be performed in situations wherein the timeframe for the review does not jeopardize **Your** life or health. **We** will conduct the review and provide a written determination within 20 business days after receiving all necessary information to complete the review. If **We** are unable to provide a determination within 20 business days, **We** will notify **You** (before the 20th business day) of the reason for the delay and subsequently issue a written decision regarding the appeal within an additional 10 business days. **We** shall notify **You** in writing of the resolution of an appeal within 5 business days following the completion of an investigation.

Expedited Review: A Level 1 Expedited Review of an appeal is only available on a prospective basis and may be requested verbally or in writing by **You** or **Your** designee. A Level 1 Expedited Review is only available if the timeframe for the review could seriously jeopardize **Your** life or health. **We** will perform the review and communicate the determination verbally within 7 business days after receiving all necessary information to complete the review. **We** will also provide a written determination within 3 business days following **Our** verbal communication.

A Level 1 Review is required before any other appeal is available to **You**. All Level 1 Reviews are performed by an internal appeal committee that includes **Our** medical director. The results of a Level 1 Review are not binding on **You**. After the Level 1 Review has been completed, if **You** are not satisfied with the results, **You** may request a Level 2 Review or an Independent External Review, as set forth below.

2. Level 2 Review (External Peer Review)

Standard Review: A Level 2 Standard Review of an appeal is available on a prospective or retrospective basis and may be requested verbally or in writing by **You** or **Your** designee. A Level 2 Standard Review will be performed in situations wherein the timeframe for the review does not jeopardize **Your** life or health. **We** will coordinate the review with a **Peer Reviewer** and provide a written determination within 30 business days after having received the review results from the **Peer Reviewer**.

Expedited Review: A Level 2 Expedited Review of an appeal is available only on a prospective basis and may be requested verbally or in writing by **You** or **Your** designee. A Level 2 Expedited Review is available in situations wherein the timeframe for the review could seriously jeopardize **Your** life or health. **We** will coordinate the review with a **Peer Reviewer** and provide a verbal determination within 7 business days after having received the review results from the **Peer Reviewer.** **We** will also provide a written determination within 3 business days following **Our** verbal communication.

All Level 2 Reviews are conducted by a **Peer Reviewer** of **Our** choice.

Peer Reviewers are **Physicians** who:

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

The results of a Level 2 Review are binding on **Us**, but are not binding on **You**. After the Level 2 Review has been completed, if **You** are not satisfied with the results, **You** may request an Independent External Review, as set forth below.

3. **Independent External Review**

Standard Review: An Independent External Standard Review of an appeal is available on a prospective or retrospective basis and may be requested verbally or in writing by **You** or **Your** designee. An Independent External Standard Review will be performed in situations wherein the timeframe for the review does not jeopardize **Your** life or health. **We** will provide a written determination within 7 business days after having received the review results from the **Independent Review Organization.**

Expedited Review: An Independent External Expedited Review of an appeal is available only on a prospective basis and may be requested verbally or in writing by **You** or **Your** designee. An Independent External Expedited Review is available in situations wherein the timeframe for the review could jeopardize **Your** life or health. **We** will provide a written determination within 7 business days after having received the review results from the **Independent Review Organization**.

All Independent External Reviews are conducted by an **Independent Review Organization** according to applicable state regulations. In the absence of applicable state regulations, **We** will select an **Independent Review Organization** other than a Peer Reviewer used in a Level 2 Review. In either case, an **Independent Review Organization** will utilize **Physicians** to conduct the review who:

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

The results of an Independent External Review are binding. Once an Independent External Review has been completed, the appeal process is concluded. All costs are **Our** responsibility, except as otherwise set forth by state regulations.

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

COORDINATION OF BENEFITS

A. **Applicability.** This Section applies when **You** make a claim for reimbursement of **Covered Charges**, and **You** are covered by **Additional Medical Coverage**. If this provision applies, review the Order-of-Benefit-Determination Rules, under the heading of the same name, to determine whether the Policy's coverage is payable before or after **Additional Medical Coverage**. The Policy's coverage will not be reduced when its coverage is payable first, as determined under the Order-of-Benefit-Determination Rules; but may be reduced when another plan's benefits are payable first, as determined under the Order-of-Benefit-Determination Rules as set forth below.

B. **Order-of-Benefit-Determination Rules.** When there is a basis for a claim under the Policy and **Additional Medical Coverage**, the Policy is secondary if: (1) the **Additional Medical Coverage** does not have rules coordinating its benefits with the Policy; or (2) the **Additional Medical Coverage's** rules, the Policy's rules, or both, require the Policy's coverage be determined after those of the **Additional Medical Coverage**, except as may occur under the gender rule exception in Item C.2, below.

C. **Filing Guidelines.** The general guidelines which follow discuss the order in which **You** should file claims when **You** are covered under **Additional Medical Coverage**, using the first of the rules which applies:

1. The **Additional Medical Coverage** that covers **You** as a subscriber is obligated to pay before the Policy covering **You** as a dependent.

2. When the parents of a dependent child are neither separated nor divorced:
   a. **You** must file first under the Policy or **Additional Medical Coverage** covering the dependent child of the parent whose birthday falls earlier in the year; then file under the Policy or **Additional Medical Coverage** of the parent whose birthday falls later in the year; but
   b. If both parents have the same birthday, **You** must file first under the Policy or **Additional Medical Coverage** which has covered the parent for the longer period of time, and then under the Policy or **Additional Medical Coverage** of the other parent.

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

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

   EXCEPTION: If there is a court decree which establishes financial responsibility for medical, dental, or other health care expenses regarding the dependent child of parents who have separated or divorced:
   a. **You** must file first under the Policy or **Additional Medical Coverage** which covers the child as a dependent of the parent with such financial responsibility; then
   b. File under the Policy or **Additional Medical Coverage**, which covers the child as a dependent of the other parent.

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

COORDINATION OF BENEFITS
(Continued)

4. **You** must file first under the Policy or **Additional Medical Coverage** which covers **You** as a subscriber who is neither laid-off nor retired, or as a dependent of a subscriber; then file under the Policy or **Additional Medical Coverage** which covers **You** as a laid-off or retired subscriber or as a dependent of a laid-off or retired subscriber. Ignore this paragraph if the **Additional Medical Coverage** does not contain this paragraph and, as a result, the Policy and the **Additional Medical Coverage** do not agree on the order of benefit determination.

5. When the order of payment cannot be determined in accordance with these general guidelines, file first under the Policy or **Additional Medical Coverage** which has covered **You** for the longer period of time, then under the Policy or **Additional Medical Coverage** which has covered **You** for the shorter period of time.

D. Effect on the Policy's Coverage. When **You** are covered under two or more policies, which together pay more than the **Covered Charges** for **Covered Transplant Services**, **We** will pay the Policy's benefits according to the Order-of-Benefit-Determination Rules. The Policy's benefit payments will not be affected when this Policy is primary. ***However, when the Policy is secondary under the Order-of-Benefit-Determination Rules, benefits payable will be reduced (if necessary) so that combined benefits of all policies covering the Participant do not exceed the lesser of: 1) Covered Charges; or 2) the negotiated amount established between the primary insurer and the Provider.***

E. Right to Receive and to Release Information. To coordinate benefits, **We** will release or obtain information regarding a claim from any insurance company, organization, or person. **You** must furnish the **Company** with any information necessary to coordinate benefits.

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

EXCLUSIONS

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

A. Any service or supply not directly related to a **Covered Transplant Procedure**. This includes any service, supply, prescription drug, or altered or non-altered biological product rendered to monitor or treat the underlying disease and/or an unrelated disease before or after transplant (that is not part of the actual **Covered Transplant Procedure)**.

B. Services, supplies, and prescription drugs for treatment of complications related to a **Covered Transplant Procedure**, unless such complications are determined by **Us** to be the immediate and direct result of a **Covered Transplant Procedure**.

C. Services, supplies and prescription drugs required to meet **Transplant Provider's** patient transplant listing requirements including, but not limited to, programs for: chemical dependency; alcoholism; smoking cessation; and weight loss.

D. Nutritional supplements including, but not limited to, full or partial oral or intravenous nutrition after discharge from a transplant hospitalization or outpatient transplant procedure.

E. Charges for any transplant related services or supplies incurred prior to the **Policy Effective Date**.

F. Charges for any transplant related services or supplies related to a transplant that results from an accident or any disease not specified in the Appendix.

G. Charges for prescription drugs incurred prior to a **Covered Transplant Procedure**, except for prescription drugs used in mobilization and/or **High Dose Chemotherapy** that is part of a **Covered Transplant Service**.

H. Charges for prescription drugs incurred after discharge from a transplant hospitalization, except for immunosuppressants, prophylactic antibiotics, prophylactic antivirals, prophylactic antifungals, and/or prescription drugs used to treat complications directly related to a **Covered Transplant Procedure**.

I. Chemotherapy and/or surgery prior to beginning **High Dose Chemotherapy** (including bone marrow/stem cell transplantation).

J. Services provided for the removal of a transplanted solid organ, unless the removal is provided during a **Covered Transplant Procedure**.

K. Services, supplies, and/or drugs provided after: 1) a transplanted solid organ has been removed from the transplant recipient; 2) a transplanted solid organ ceases to function; 3) disease has returned in a solid organ or bone marrow/stem cell transplant recipient; or 4) prescription drugs, chemotherapy, radiation or other treatment has been rendered to treat the return of disease or as a prophylactic to the return of disease.

L. Services for human leukocyte antigen typing of **You** or **Your** relatives, compatibility testing, unrelated bone marrow/stem cell searches on registries, and harvest and/or storage of bone marrow/stem cells when bone marrow/stem cell transplant has not been reviewed and approved by **Us**.

M. Services and supplies for immunizations.

N. Animal organ or artificial organ transplants.

O. Charges for a stand-by **Physician**, unless otherwise approved by **Us**.

P. Services of a **Provider** who is a member of **Your Immediate Family**.

Q. Services, supplies, or **Hospital** care which **We** determine are not **Medically Necessary** for the treatment of illness, diseased condition, or impairment, except as specifically stated as covered.

R. **Custodial Care**.

S. Hospice care.

T. Charges for any **Experimental and/or Investigational Treatment**, except as specifically stated in the Policy.

U. Charges paid or payable under Workers' Compensation.

V. Preventive or routine care (including physicals, premarital examinations, any other routine or periodic examinations), dental services and supplies, education and training, except as specifically stated as covered.

W. Research studies or screening examinations.

X. Services or supplies to the extent **You** are not legally obligated to pay for them.

Y. Expenses incurred before the **Policy Year** begins or after it ends, except as stated in the Policy.

Z. Rest cures or sanitarium care.

AA. Services or supplies furnished by any **Provider** acting beyond the scope of such **Provider's** license.

BB. Any service or supply that is a **Medicare** Part A, Part B, or Part D liability.

CC. Services or supplies received from a dental or medical department maintained by or on behalf of the **Policyholder**.

DD. Services provided by any governmental agency to the extent that **You** are not charged for them, unless otherwise required by state or federal law.

EXCLUSIONS
(Continued)

EE. Services or supplies not specifically stated as covered.
FF. Telephone consultations, charges for failure to keep a scheduled visit, or charges for completing a claim form.
GG. Recreational or diversional therapy.
HH. Materials used in occupational therapy.
II. Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a **Provider** prescribes such items.
JJ. Services and supplies, which are eligible to be repaid under any private or public research fund whether or not such funding was applied for or received.
KK. Services and supplies for treatment of complications or diseases incurred by a living donor, including, but not limited to, increase length of hospitalization or the costs to treat any complication or disease.
LL. Services and supplies incurred by any COBRA continuee whose COBRA continuation coverage was not offered and/or elected, and premiums were not paid, within the time frames required by COBRA.
MM. **Prescription Drugs** for the treatment or prevention of a rejected organ or tissue following the end of the Transplant Benefit Period.
NN. Services and supplies of any **Provider** located outside the United States of America, except for organ or tissue procurement services, unless otherwise prohibited by United States federal law.
OO. Biological and/or mechanical devices used as a bridge to transplant unless specifically included in the Schedule of Benefits.
PP. Charges for any transplant-related services or supplies incurred during the current **Policy Year** when the transplant procedure occurred prior to the **Policy Effective Date**. However, **We** will make an exception to this Exclusion for **Covered Charges** related to a **Covered Transplant Procedure You** received under a previous Organ & Tissue Transplant Policy or Specified Disease-Organ & Tissue Transplant Policy issued by **Us** to the **Policyholder**, as long as:

1. There has been no break in coverage between the Transplant Policies issued by **Us**; and
2. The **Covered Charges** are for services or supplies incurred within the **Transplant Benefit Period** for the **Covered Transplant Procedure**.

TERMINATION PROVISIONS

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

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

We may cancel the Policy at the end of the month in which the **Policyholder's** enrollment drops below the Minimum Enrollment shown on the Policy face page. However, **We** must provide written notification to the **Policyholder** of such cancellation not less than 10 calendar days in advance of the termination date.

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

1. The date the **Medical Plan** is discontinued.
2. The date the **Policyholder's Medical Plan Administrator** listed in the Schedule of Benefits is changed to an administrator that **We** have not authorized.
3. The date it is determined that the **Policyholder's Medical Plan Administrator** is not properly licensed as required by state law.
4. The date the **Medical Plan** is found to be in violation of federal or state law. **We** reserve the right to allow the **Medical Plan** 90 calendar days within which to achieve compliance. Failure to comply by such date will result in termination of the Policy.
5. The date it is determined that the **Policyholder** is, or is affiliated with, a sanctioned entity, organization, or country.
6. Upon the **Policy Effective Date**, if the **Policyholder** fails to provide **Us** (within the first 90 calendar days of the **Policy Effective Date**) with requested materials or information necessary for **Our** final review and approval of the premium rates. If the Policy is terminated under this provision, **We** will return the premium paid by the applicant for the current **Policy Year**, and **We** will have no liability under the terms of the Policy for the current **Policy Year**.
7. Upon the **Premium Due Date** if **We** do not receive premiums within the specified grace period.
8. The date the **Policyholder** becomes insolvent or files for bankruptcy, unless **We** and an appointed trustee in bankruptcy agree to continue the coverage during a period of reorganization.

GENERAL PROVISIONS

A. Incontestability. **We** may declare the Policy null or cancel it, if the **Application** contains a material misrepresentation. However, this provision will not apply once the Policy has been in effect for two years.

B. Representations Not Warranties. A copy of the **Application** is attached to the Policy. All statements made by the **Policyholder** or by **Participants** applying for coverage will be considered representations and not warranties. No statement appearing on the **Application** will be used to contest the validity of the **Policyholder's** right to the benefits of the Policy, unless the **Policyholder** has been furnished a copy of the **Application**.

C. Evidence of Insurability. The **Policyholder** is required to provide **Us** with verification that **You** are covered by the **Policyholder's Medical Plan**.

D. Notice. When **We** provide written notice to the **Policyholder's** last known address regarding the administration of the Policy, it is deemed to be notice to all affected parties. The **Policyholder** is responsible for giving **You** notice, if applicable.

E. Legal Action. No legal action may be brought under the Policy within 60 days after **We** receive a claim. No action may be brought after 3 years from the date the claim is required to be furnished to **Us**.

F. Information Release and Data Confidentiality. The **Policyholder** and all **Participants** that need **Covered Transplant Services** must allow **Us** access to medical information from all appropriate **Providers**. Such information is necessary in order for **Us** to make proper benefit determinations. The information will not be used, disclosed, furnished, or made accessible to anyone other than **Our** authorized employees and vendors contracted by **Us** to carry out **Our** obligations under the Policy. **We** and the **Policyholder** agree to establish and maintain administrative, technical and physical safeguards to protect the security, confidentiality and integrity of the medical information.

G. Entire Contract. The Policy and the signed **Application** form the entire contract between the **Policyholder** and **Us**. No amendment to the Policy shall be effective unless confirmed by an Endorsement issued to form a part of the Policy. No agent or representative of the **Company**, other than an executive officer, may change the Policy or waive any of its provisions. No verbal statement by any executive officer or other employee of the **Company** is binding on **Us**.

H. Clerical Error. A clerical error made by the **Policyholder**, the **Policyholder's Medical Plan Administrator**, or **Us** will not void coverage that would otherwise be in force or continue coverage that would otherwise have terminated. Any clerical error in data provided to **Us** must be corrected and promptly reported to **Us**. **We** will make appropriate adjustments to premiums due and/or benefit determinations. Any refund in premium due to **Policyholder** error is limited to the 12-month period prior to the date of the request for refund.

I. 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 statues and regulations.

J. Not Liable for Provider Acts or Omissions. **We** are not responsible for the quality of care **You** receive from any **Provider**. The Policy does not give anyone any claim, right, or cause of action against **Us** based on what a **Provider** of health care or supplies does or does not do.

K. Right of Recovery. If **We** make any payment that according to the terms of the Policy should not have been made, including payment made in error, **We** may recover that incorrect payment from any appropriate party, whether or not it was due to **Our** error. If the incorrect payment was made directly to **You**, **We** may deduct it when making future payments directly to **You**.

GENERAL PROVISIONS
(Continued)

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

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

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

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

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

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

DEFINITIONS

A. Additional Medical Coverage – means any other insurance, other than the **Medical Plan**, that provides **You** with medical benefits covered under the Policy.

B. Application – means the **Policyholder's** completed Specified Disease - Organ & Tissue Transplant Application.

C. Company – means HCC Life Insurance Company.

D. Covered Charges – means charges incurred during a **Transplant Benefit Period** that are **Reasonable and Customary** in **Our** judgment, for **Covered Transplant Services**. With respect to **Providers**, a charge will not be considered **Reasonable and Customary** if it is not in conformity with one or a combination of the following:
1. A negotiated rate based on services provided;
2. A fixed rate per day; or
3. The **Reasonable and Customary** allowance for similar **Providers** who perform similar **Covered Transplant Services**.

E. Covered Specified Disease – means any of the diseases shown in the Appendix.

F. Covered Transplant – means any of the transplants listed as a **Covered Transplant** in the Schedule of Benefits.

G. Covered Transplant Procedure – means a **Medically Necessary** adult or pediatric human organ and tissue transplant: a) resulting from one of the **Covered Specified Diseases** set forth in the Appendix; and b) listed as a **Covered Transplant** in the Schedule of Benefits that is not **Experimental and/or Investigational Treatment**.

H. Covered Transplant Services – means the services shown as **Covered Transplant Services** in the Benefit Provisions.

I. Custodial Care – means care and services that assist in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, and using the toilet; feeding or preparation of special diets; and supervision of medication that usually can be self-administered. **Custodial Care** includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.

J. Date of Service – means the date when the service was actually provided or the date on which the purchase was made.

K. Diagnostic Services – means the following procedures that are directly related to a **Covered Transplant Procedure** and ordered by a **Provider Individual** because of specific symptoms in order to determine a definite condition or disease: (i) radiology, ultrasound, and nuclear medicine; (ii) laboratory and pathology; and (iii) EKGs, EEGs, and other electronic diagnostic medical procedures.

L. Experimental and/or Investigational Treatment – means any drug, device, procedure, facility, equipment, treatment plan, protocol, supply or service directly related to a **Covered Transplant Procedure** that is determined that, at the time it is used, one or more of the following conditions is present:
1. Its use requires approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to the Federal Drug Administration (FDA).
2. Its use is not yet recognized as acceptable medical practice throughout the United States to treat that illness; or is subject to either:
   a) A written investigational or research protocol or treatment plan; or
   b) A written informed consent or protocol used by a **Transplant Provider** in which reference is made to the drug, device, procedure, protocol, or treatment plan as being experimental, investigative, educational, for a research study, a pilot study, or posing an uncertain outcome, or having an unusual risk; or
   c) A written protocol, protocols or informed consent used by any other facility studying substantially the same drug, device, procedure or treatment which states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or
   d) An ongoing review by an Institutional Review Board.

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

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

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

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

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

N. **Immediate Family** – means **Your Spouse**, parent, child, sibling, grandparent, or grandchild.

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

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

P. **Medically Necessary** – means those prescription drugs, devices, procedures, treatments, services or supplies, provided by a **Provider**, which are required for treatment of the **Covered Specified Disease** set forth in the Appendix that requires the **Covered Transplant**, and are:

1. Consistent with **Your** diagnosis or symptoms and **You** are an appropriate candidate for the proposed treatment;
2. Appropriate treatment, according to generally accepted standards of medical practice;
3. Not provided only as a convenience to **You** or the **Provider**.
4. Not an **Experimental and/or Investigational Treatment**; and
5. Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment. Any service or supply provided by a **Provider** will not be considered **Medically Necessary** if **Your** symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

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

DEFINITIONS
(Continued)

Q. Medicare – means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

R. Member – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a member, or as a subscriber. **Member** does not include a dependent. Individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.

S. Participant – means an individual who is eligible for, and covered by, the **Policyholder's Medical Plan**, either as an employee, a retiree, a COBRA continuee, a **Member**, a subscriber, or a dependent who is also covered under the Policy (including adopted children, step children, disabled children, children subject to to legal guardianship, and children up to the age of 26, as required by law). If applicable, individuals that have exceeded their lifetime maximum benefit for medical benefits under the **Medical Plan** are not eligible for coverage under the Policy.

T. Premium Due Date – means the date the **Policyholder's** premium is due. The **Premium Due Date** is shown in the Policy face page.

U. Policy Effective Date – means the **Policy Effective Date** as shown on the Policy face page which is the date that coverage begins under the Policy.

V. Policy Year – means the period of time shown in the Schedule of Benefits during which the Policy is in effect. The **Policy Year** is subject to early termination as set forth in the Termination Provisions.

W. Pre-existing Condition – means any condition for which **You** have, within the 12 months prior to the **Policy Effective Date**:

1. Been advised by an attending **Physician** that a transplant evaluation or transplant may be needed (regardless of the timeframe to transplant evaluation or transplant, and regardless of the **Participant's** decision to move forward or not move forward with a **Transplant Consultation** or **Transplant Evaluation**;
2. Had a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of the outcome);
3. Been scheduled to have a **Transplant Consultation** and/or **Transplant Evaluation** (regardless of when the **Transplant Consultation** and/or **Transplant Evaluation** was to be done and regardless of the outcome); and/or
4. Received, or has been listed to receive, an organ or tissue transplant.

In addition, if **You** have, within the 12 months prior to the **Policy Effective Date** of the Policy, received dialysis treatments or been diagnosed with Chronic Kidney Disease or End Stage Renal Disease (ESRD), **You** will be deemed to have a **Pre-existing Condition**.

If **You** are added subsequent to the **Policy Effective Date** as a result of the acquisition of a new group, affiliate, division, and/or subsidiary, **Pre-existing Condition** will mean those conditions listed above that occurred within the 12 months prior to **Your** effective date of coverage under the Policy.

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

1. Provider Facility – means any of the following facilities:

a. Clinical Laboratory – means a laboratory that performs clinical procedures and is not affiliated or associated with a Hospital, **Physician**, or other **Provider**.

b. **Hospital** – means a facility which is a short-term general hospital and which: (1) is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **Physicians**, for compensation from its patients; (2) has organized departments of medicine and major surgery; and (3) provides 24-hour nursing service by or under the supervision of registered nurses. Surgical facilities may be either on premises or in facilities available to the hospital on a prearranged basis.

c. **Pharmacy** – means a facility licensed as a pharmacy by the state in which it operates.

d. **Transplant Provider** – means the following facilities:
   - i. **Nonparticipating Transplant Provider** – Any **Provider Facility** or **Provider Individual** that has not contracted with **Us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Provider Facility** or **Provider Individual** may be a **Nonparticipating Transplant Facility** with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.
   - ii. **Participating Transplant Provider** – Any **Provider Facility** or **Provider Individual** contracting with **Us** through an applicable transplant network to provide **Covered Transplant Procedures**. A **Provider Facility** or **Provider Individual** may be a **Participating Transplant Facility** with respect to: (1) certain **Covered Transplant Procedures**; or (2) all **Covered Transplant Procedures**.

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

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

Z. **Routine Patient Costs** – means those covered **Transplant Services** associated with participation in a clinical trial including and directly related to a **Covered Transplant Procedure**. **Routine Patient Costs** does not include:
1. The investigational item, device, drug(s), service, or altered or non-altered biological product, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis as established by **Us**.

AA. Skilled Care – means the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness. **Skilled Care** must be performed by or under the supervision of **Provider Individuals**.

BB. Spouse – means a person recognized as the **Member's Spouse** under the **Medical Plan**.

CC. Transplant Benefit Period – means the period of time shown in the Schedule of Benefits for which benefits are provided under the Policy.

DD. We, Us, Our – means HCC Life Insurance Company.

EE. You, Your – means the **Participant**, as defined in the Policy.

APPENDIX - COVERED SPECIFIED DISEASES

Heart - Adult or Pediatric
Congenital heart defects or disease
Cardiomyopathy
Severe coronary artery disease
Valvular disease

Heart/Lung - Adult or Pediatric
Eisenmenger syndrome
Cystic fibrosis with compromised cardiac function
Sarcoidosis involving only the heart and lungs
Irreversible right-heart failure secondary to pulmonary hypertension

Intestinal – Adult
Crohn disease
Superior mesenteric artery thrombosis
Superior mesenteric vein thrombosis
Short Bowel Syndrome
Desmoid tumor
Volvulus
Pseudo-obstruction
Massive resection secondary to tumor
Radiation enteritis

Intestinal - Pediatric
Intestinal atresia
Gastroschisis
Crohn disease
Microvillus involution disease
Necrotizing enterocolitis
Midgut Volvulus
Chronic intestinal pseudo-obstruction
Massive resection secondary to tumor
Hirschsprung disease
Short Bowel Syndrome

Kidney – Adult
Chronic Kidney Disease
End Stage Renal Disease
Glomerulonephritis
Polycystic Kidney Disease
Renal Cell Carcinoma

Kidney - Pediatric
Congenital Nephrotic Syndrome
Polycsystic Kidney Disease
Glomerulonephritis
Wilm's Tumor
Blocked urine flow and reflux
Alport Syndrome
Lupus and other autoimmune diseases

Kidney/Pancreas or Pancreas – Adult or Pediatric
Insulin dependent (type 1, juvenile)
End stage renal disease
Chronic Severe Pancreatitis

Liver - Adult
Chronic active hepatitis
Primary biliary hepatitis
Schlerosing cholangitis
Cryptogenic cirrhosis
Hemochromatosis
Hepatacellular cancer
Wilson's Disease
Alpha-One trypsin deficiency
Chronic Budd-Chiari Syndrome
Alcoholic cirrhosis
Glycogen storage disease
Fulminant liver failure

Liver - Pediatric
Biliary atresia and similar malformations
Glycogen storage disease
Familial cholestasis (Byler's Disease)
Intrahepatic bile duct paucity (Alagille's Syndrome)
Metabolic disease
Chronic active hepatitis
Alpha-One trypsin deficiency
Wilson's Disease
Tyrosinemia

APPENDIX - COVERED SPECIFIED DISEASES
(Continued)

Lung - Adult or Pediatric
Chronic obstructive pulmonary disease
Emphysema
Primary pulmonary fibrosis
Primary pulmonary hypertension
Cystic fibrosis
Infectious pulmonary disease with bronchiectasis
Eisenmenger's syndrome
Bronchiolitis obliterans

Multi-Organ (Other)
Combinations of disease types

Autologous Bone Marrow or Peripheral Stem Cell
Hodgkin's Lymphoma
Multiple Myeloma
Non-Hodgkin's Lymphoma
Testicular Cancer
Amyloidosis
Neuroblastoma

Allogeneic Bone Marrow or Peripheral Stem Cell (Related, Unrelated, Cord Blood)
Acute Myeloid Leukemia
Acute Lymphocytic Leukemia
Chronic Lymphocytic Leukemia
Chronic Myelogenous Leukemia
Hodgkin's Lymphoma
Non-Hodgkin's Lymphoma
Acquired Hematologic Diseases (non-malignant)
- Aplastic Anemia
- Fanconi's Anemia
- Diamond-Back Syndrome

Severe Aplastic Anemia
Genetic and Immunodeficiency Diseases
- Severe Combined Immunologic Deficiency Syndrome (SCIDS)
- Thalassemia
- Sickle Cell Disease
- Mucopolysaccharidosis
- Wiskott-Aldrich Syndrome
- Niemann-Pick Disease
- Osteopetrosis
- Other metabolic storage diseases

Myelodysplastic/Myeloproliferative Syndromes

HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
1-800 447-0460

Specified Disease – Organ & Tissue Transplant Application

Administrative Office:
HCC Life Insurance Company
3600 Woodview Trace, Suite 180
Indianapolis, Indiana 46268
(888) 449-2377

Policy Applicant: Rush County Employees (IN)	**Telephone:** 765-932-2077	**Tax ID:** 35-6000193
Street Address: Courthouse, 101 E. 2nd Street		
City: Rushville	**State:** IN	**Zip Code:** 46173
Name(s) of Affiliates to be Included: None	**Locations:** None	

The Applicant is: ☒ Single Employer ☐ Trust ☐ Other

Does the Applicant currently have major medical coverage in force? ☒ Yes ☐ No

Applicants that do not have major medical coverage in force, or that only have medical coverage provided through a limited benefit plan (such as a critical illness or "mini-med" plan) are not eligible for this Policy.

Agent of Record (Name of Entity):
Canyon Re LLC

Covered Transplants:

- ☒ Heart
- ☒ Lung/Double Lung
- ☒ Kidney (living/deceased donor)
- ☒ Pancreas
- ☒ Liver (living/deceased donor)
- ☒ Intestine
- ☒ Heart/Lung
- ☒ Kidney/Pancreas
- ☒ Kidney/Liver
- ☒ Liver/Intestine
- ☒ Pancreas/Intestine
- ☒ Liver/Pancreas/Intestine
- ☒ Autologous Bone Marrow-Peripheral Stem Cell Including High Dose Chemo
- ☒ Allogeneic Bone Marrow-Peripheral Stem Cell - Cord Blood Including High Dose Chemo (related)
- ☒ Allogeneic Bone Marrow-Peripheral Stem Cell - Cord Blood Including High Dose Chemo (non-related)

Benefit Period Start Date: ☒ Date of Evaluation ☐ 10 Days Before Transplant

Benefit Period End Date: ☒ 365 Days After Transplant

Lifetime Limit: ☐ $1,000,000 ☐ $2,000,000 ☒ Unlimited

Non-Participating Provider Reimbursement: ☒ 80%

Rates: Single: $9.97 Family: $24.74

Name of Medical Plan Administrator: UMR, Inc.	Name of PPO Network: UHC Choice Plus Network
Requested Policy Effective Date (subject to acceptance): 08/01/2019	Medical Plan Utilizes Reference Based Pricing? ☐ Yes ☒ No

Eligible Persons to be Covered Under the Policy: ☒ Employee ☐ Member ☐ Subscriber ☒ Spouse ☒ Dependents ☒ COBRA Continuee ☐ Retiree ☐ Other (Specify)

FRAUD WARNING

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

The Applicant hereby applies for insurance coverage for organ and/or tissue transplant resulting from a Specified Disease, and:

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

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

Applicant's Signature: Mark Bacon Date: 6-24-19
Individual authorized to sign as Applicant

Printed Name: Mark Bacon
Title: Commissioner

Licensed Agent's Signature: [signatures] Date: 6/25/2019

Printed Name: Brady Claxton Michael J Mecnik
Cannon PR 6/28/19