UNITED STATES FIRE INSURANCE COMPANY
Administrative Office: 5 Christopher Way, Eatontown, New Jersey 07724

Organ Transplant
Certificate of Insurance

This certificate provided by United States Fire Insurance Company (herein called We, Our, or Us) describes the coverage that will be provided for all those persons called **Covered Persons** as defined in this certificate. Coverage will be provided for the losses described herein subject to the terms of the Group Policy. This certificate is issued to this Certificateholder named in the **Schedule**.

This certificate is not a contract of insurance. The complete terms and conditions governing each **Covered Person's** coverage are contained in the Group Policy issued to this Certificateholder named in the **Schedule**. The Group Policy may be changed or terminated without the consent of or notice to each **Covered Person**.

CONSIDERATION – TERM

Coverage under this Certificate is provided in consideration of the premium paid by this Certificateholder. The premium due is shown in the **Schedule**. The term of coverage for such Certificateholder will begin on the Effective Date specified under the Effective Dates section and end on the date as specified under the Renewal Provisions section. All periods of insurance will begin and end at 12:01 A.M. Standard Time or Daylight Time, as the case may be, at the address of this Certificateholder.

Signed for **United States Fire Insurance Company** By:

Douglas M. Libby
Chairman and CEO

James Kraus
Secretary

A Limited Benefit Health Coverage Form Providing Transplant Reimbursement Coverage.

A Limited Health Benefit coverage form. This is not major medical coverage nor does it meet the requirements for coverage required under a Worker's Compensation Act or similar legislation.

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SCHEDULE

Coverage Is Provided Under:	Group Policy Number AH27244-010
Issued To Group Policyholder:	The Group and Blanket Accident & Health Insurance Trust

Certificateholder: City of Fond du Lac

Term: 12 months

Certificate Number: US061034

Effective Date: January 1, 2014

Plan Administrator: Fairmont Specialty

Termination Date: December 31, 2014

Transplant Case Manager: Fairmont Specialty
5 Christopher Way, 3rd Floor
Eatontown, NJ 07724
1-877-810-9939 Option #2

SCHEDULE OF BENEFITS

Lifetime Maximum Transplant Benefit:	$1,000,000 per Covered Person for all Transplant Covered Charges
Annual Maximum Number of Covered Transplant Procedures of the same type:	2 per Policy year
Lifetime Maximum Number of Covered Transplant Procedures of the same type:	4 per Covered Person's lifetime
Policy Deductible:	-0- per Covered Transplant Procedure
Pre-Certification Penalty:	$5,000 per Covered Transplant Procedure
Transplant Benefit Period:	
1. For all organ transplants (other than bone marrow), the Transplant Benefit Period will commence:	5 days prior to the Covered Transplant Procedure,
and will terminate:	12months after the Covered Transplant Procedure
2. For all bone marrow transplants, the Transplant Benefit Period will commence:	30 days prior to the Covered Transplant Procedure,
and will terminate:	12 months after the Covered Transplant Procedure

BENEFIT DESCRIPTION	**MAXIMUM BENEFIT AMOUNT PER COVERED TRANSPLANT PROCEDURE**
Donor Organ or Tissue Procurement At a Participating Hospital	100% of Actual Network Cost for solid organs $30,000 for allogenic bone marrow
All Other Services At a Participating Hospital	100% of Actual Network Cost

MAXIMUM BENEFIT AMOUNT PER BENEFIT DESCRIPTION (Cont'd)	COVERED TRANSPLANT PROCEDURE
Donor Organ or Tissue Procurement At a Non-Participating Hospital	$15,000 for solid organs $30,000 for allogenic bone marrow
All Other Services At a Non-Participating Hospital	80% Network Cost in the Nearest Network Hospital where that Covered Transplant Procedure is performed.
Lodging and Meals Daily Maximum:	$200 per day
Transportation, Lodging, and Meals Maximum:	$10,000
Transportation Trip Maximum:	2 trips
Private Duty Nursing Care Daily Maximum:	$200 per day
Private Duty Nursing Care Maximum:	$10,000
All Other Services and Supplies Maximum:	$10,000
Assisting Physician Fees Covered Percentage:	20% of Covered Charges of the Primary Physician

DONOR BENEFITS (At a Participating or Non-Participating Hospital)	MAXIMUM BENEFIT AMOUNT PER COVERED TRANSPLANT PROCEDURE
Donor Transportation, Lodging, Meals, Medical Expenses, and Follow-up Care:	$10,000

DEFINITIONS

(Note: All masculine pronouns also include the feminine, unless context clearly states to the contrary.)

Ambulatory Surgical Center means a facility which is equipped and operated under the applicable laws of the state in which it is located and primarily performs outpatient surgical procedures.

Class means a grouping of **Covered Persons** based on one or more of the following: (1) age at issue; (2) sex; (3) Employee status; (4) dependent status; (5) current state of residence; or (6) any group of **Covered Persons** as agreed upon between this Certificateholder and us, as defined in the application for this Certificate.

Condition means a sickness or injury of a **Covered Person** which necessitates a **Covered Transplant Procedure**.

Covered Charge(s) means an expense actually incurred as a result of a **Covered Transplant Procedure** by or on behalf of a **Recipient** and which: (1) is necessary for the procedure; (2) has been recommended and prescribed by a **Physician**; (3) is not in excess of such charge that would have been made in the absence of this coverage; (4) is not excluded by the terms of this Certificate, and (5) does not exceed any amount payable under this Certificate. Expenses are incurred on the date a service is rendered or a supply is furnished.

Covered Person means each eligible person who is insured under this Certificate and for whom the required premium is paid.

Covered Transplant Procedure means the transfer of an organ(s) and associated tissue from a donor to a transplant Recipient in order to replace or restore function to a diseased structure. For the purpose of this Certificate, it includes only the following human to human organ transplants: (1) heart; (2) heart/kidney; (3) heart/lung(s); (4) lung(s); (5) liver; (6) liver/cadaveric; (7) liver/kidney; (8) liver/live donor; (9) pancreas; (10) kidney; (11) simultaneous kidney and pancreas; (12) pancreas after kidney; and (13) small bowel. A **Covered Transplant Procedure** will include only the following human to human transplant procedures when the procedure is used to treat leukemia, lymphoma, blood and genetic diseases and solid tumors: (1) allogeneic related; (2) allogeneic unrelated; (3) autologous; (4) synogeneic; (5) cord blood; (6) peripheral stem cells. All other transplants are excluded.

Employee means each person so described in the application whose employment status is the basis for eligibility for coverage under this Certificate.

Experimental or Investigational - A drug, device, procedure or treatment will be determined to be experimental or investigational, at the time it is used, if any of the following conditions occur: (1) approval is required, but not granted, by the appropriate federal or other governmental agency (such as, but not limited to, the Federal Drug Administration); or (2) it is not yet recognized as acceptable medical practice throughout the United States to treat that **Condition**; or (3) it is subject to either a written protocol or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment that states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk.

Patients in a Phase III randomized control trial sponsored by the National Cancer Institute or a jointly-sponsored national oncology cooperative group trial for the treatment of cancer will not be considered **Experimental or Investigational** for purposes of this Certificate.

Home Health Care means a program for continued care and treatment of a transplant **Recipient**. **Home Health Care** benefits must be **Pre-Certified** by the **Transplant Case Manager**. It must be established and approved in writing by the **Physician**. The attending **Physician** must certify that proper treatment of the **Condition** would require continued confinement in a **Hospital** in the absence of the services and supplies that are a part of the program.

Hospital means an institution which: (1) is continuously engaged primarily in providing medical care and treatment to sick or injured persons on an inpatient basis and at the patient's expense; (2) provides, either on its premises or in facilities available to it on a prearranged basis, diagnostic and therapeutic facilities for surgical and medical diagnoses by or under the control of one or more **Physicians**; (3) provides 24 hours a day, on premises, nursing service by or under the control of registered graduate **Nurses** (R.N.) on duty or on call; and (4) is not used, other

than incidentally, as a nursing home, a place for the aged, drug addicts, rest, alcoholics, convalescent care, rehabilitative purposes, or custodial care.

Medically Necessary means a service or supply which is determined to: (1) be appropriate and necessary for the symptoms, diagnosis or treatment of the **Condition**; (2) provide for the diagnosis or direct care and treatment of the **Condition**; (3) be within standards of good medical practice within the organized medical community; (4) not be **Experimental or Investigational**; (5) not be primarily for the convenience of the **Covered Person** or of any facility providing the covered services to the **Covered Person**; and (6) be an appropriate supply or level of service needed to provide safe and adequate care.

Nearest Network Hospital means the **Participating Hospital** which is closest in miles to the principal residence of the **Covered Person.**

Network Cost means the price negotiated by us with a **Participating Hospital.**

Nurse means a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.). A **Nurse** is not someone who is a member of the immediate family of the **Covered Person** whose loss is the basis for claim.

Participating Hospital means any **Hospital** contracting with us or the Case Manager named on the Schedule Page to provide Transplant Program Benefits related to specific **Covered Transplant Procedures** to **Covered Persons.**

Physician means a licensed practitioner of the healing arts acting within the scope of his license. He must be licensed to practice by the state in which he is a resident. A **Physician** is not someone who is a member of the immediate family of the **Covered Person** whose loss is the basis for claim.

Pre-Certification means a **Covered Person** is responsible for making sure the **Transplant Case Manager** is notified to obtain a plan of care for any **Covered Charges** associated with a **Covered Transplant Procedure.** The **Transplant Case Manager** will review the **Physician's** recommended course of treatment. Benefits will be paid only for authorized benefits, but the authorization does not guarantee that all charges are covered under this Certificate. Charges submitted for payment are subject to all other terms and conditions of this Certificate.

Pre-Certification Penalty means the amount of **Covered Charges**, as shown in the **Schedule**, for which a **Covered Person** must pay per **Covered Transplant Procedure** if **Covered Charges** are not **Pre-Certified** by the **Transplant Case Manager.**

Pre-Existing Condition means any **Condition** for which a **Covered Person** had received medical treatment, diagnosis or advice during the six months immediately prior to their effective date of coverage.

Recipient means a **Covered Person** who is the subject of a **Covered Transplant Procedure.**

Schedule means the Schedule of Benefits in this Certificate.

Transplant Benefit Period means the benefit period, stated in the **Schedule**, in which the **Transplant Benefit Period** will commence prior to the **Covered Transplant Procedure** and will terminate after the **Covered Transplant Procedure.** No **Transplant Benefit Period** can begin prior to a **Covered Person's** effective date of coverage under this Certificate. If a **Covered Person** undergoes two or more **Covered Transplant Procedures**, each of which is due to unrelated cause or causes, a **Transplant Benefit Period** will be established for each procedure. If a **Covered Person** undergoes two or more **Covered Transplant Procedures**, each or any of which is due to related cause or causes, separate **Transplant Benefit Periods** will be established only if: (1) in the case of an employed **Covered Person**, each period is separated by his return to active work for at least 3 months in a row; or (2) in the case of an unemployed **Covered Person**, each period is separated by his return to the normal activities of a person of like age and sex in good health for at least 3 months in a row.

Transplant Case Assistant means a person employed by the **Transplant Case Manager** to manage and coordinate all aspects of care with the **Hospitals**, **Physicians**, and the **Covered Person**.

Transplant Case Manager means the organization shown on the Cover Page who will manage and coordinate the transplant services for a **Covered Person**. Any **Covered Person** who establishes a **Transplant Benefit Period** will cooperate and work with the **Transplant Case Manager** in all aspects of the Organ or Tissue **Covered Transplant Procedure.**

ELIGIBLE PERSONS

Employees - All Employees who meet the eligibility requirements stated in the application for this Certificate are eligible for coverage under this Certificate. New Employees who meet these eligibility requirements may be added in accordance with the terms of this Certificate.

Dependents- Each eligible Employee's dependent(s) who meets the eligibility requirements stated in the application are eligible to apply for coverage under this Certificate. Eligible dependents can be the Employee's legal spouse and former spouse if a court of law has decreed that the Employee is responsible for that former spouse's medical insurance coverage, unmarried dependent child, step-child, legally adopted child, or unmarried grandchild, who is under 19 years of age and who the Employee contributes more than 50% towards his or her support. A dependent child's limiting age will be extended to 25 years of age if the child is a full-time student at an accredited college or university. A dependent child's limiting age will also be extended if the child is mentally or physically handicapped and incapable of self-support regardless of age. We can require periodic proof of qualification of dependent status and/or of handicap or disability, but such proof will not be required more than once a policy year.

We will cover newly-born, newly-adopted, or foster-placed children of the Employee or his covered spouse from the moment of birth, adoption, or placement for 31 days. Benefits will be those provided under this Certificate for dependent children. Coverage may be continued beyond that time if, within that 31 day period, we have received: (1) written notice of the child's birth, adoption, or placement; and (2) payment for any additional premium (including the premium for the 31-day period).

Evidence of Insurability - Except in the case of a newly-born, newly-adopted, or foster-placed child added within 31 days of birth, adoption, or placement, we reserve the right to require evidence of insurability satisfactory to us as a condition: (1) to being covered for this Certificate; or (2) to any change in benefits or coverage.

EFFECTIVE DATES

Insurance for a **Covered Person** will be effective as follows:

1. EMPLOYEES - If the Employee's insurance is noncontributory, an Employee's insurance will be effective on the date he becomes eligible. If the Employee's insurance is contributory, each Employee who applies for insurance on a form approved by us and agrees in writing to pay the required contributions, will become insured as follows:

   a. If the Employee applies within 31 days of the date he first becomes eligible, he will be insured on the later of the date he applies, or the date he becomes eligible.

   b. If the Employee applies after 31 days from the date he first becomes eligible, then the Employee must furnish evidence of insurability at his own expense to us before he may be considered for insurance. If approved, he will become insured on the date of such approval.

2. DEPENDENTS - If dependent insurance is noncontributory, a dependent's insurance will be effective on the date he becomes eligible. The Employee must be insured in order for his dependents to be insured. If the dependent insurance is contributory, the Employee who applies for dependent insurance on a form approved by us and agrees in writing to pay the required contributions for dependents will become insured for his dependents as follows:

a. For other than a newly-born, newly-adopted, or foster-placed child, if the Employee applies within 31 days after the date his dependents becomes eligible for insurance, his dependents will be insured on the later of the date the Employee applies for dependents' insurance or the date the Employee becomes insured.
b. For a newly-born, newly-adopted, or foster-placed child, if the Employee acquires this child while not insured for dependents' insurance, that child will be insured from the date of birth, adoption, or placement for 31 days. The Employee must apply for dependents' insurance within such 31 days in order for coverage to continue beyond 31 days. The dependents' insurance provided under this section will apply only to the newly born, newly adopted, or foster-placed child.

c. If the Employee applies after 31 days from the date his dependents became eligible for insurance, or for a newly-born, newly-adopted, or foster-placed child 31 days after the child was born, adopted, or placed in the home, his dependents will not be considered for insurance until the Employee furnishes to us evidence of insurability, at his own expense, for each dependent he wants to enroll. Insurance for those dependents must be approved by Us, and will become effective on the date of approval.

A benefit or coverage increase will take effect on the first premium due date after we accept the request for the increase. The required premium must be paid. A benefit or coverage decrease and its reduction in premium will take effect on the first premium due date after we receive the request. Any requested change must be made in writing and signed by the covered Employee. The Time Limit on Certain Defenses provision and any waiting periods in this Certificate will be applied on that increased portion of the benefit or coverage from the effective date of such increase in benefits or coverage.

RENEWAL PROVISIONS

Policy Renewal - We reserve the right to terminate this Certificate or any Class of **Covered Persons** by giving this Certificateholder at least 31 days written notice of our intent to do so. The Policyholder may elect to terminate this Certificate or any Class of **Covered Persons** by giving at least 31 days written notice to us.

Employee Coverage Renewal - Coverage under this Certificate for a covered Employee will be renewed unless terminated on the earlier of the dates that follow:

1. The date this Certificate terminates;
2. The date this Certificate is amended to terminate a Class of insureds to which he belongs;
3. The date his Lifetime Maximum Transplant benefit has been paid;
4. The date he fails to make a required premium payment, subject to the Grace Period provision;
5. The date he ceases to be eligible for coverage as defined in this Certificate; or
6. If contributory, the date the Employee requests cancellation of coverage.

Dependent Coverage Renewal - Coverage under this Certificate for a covered dependent will be renewed unless terminated on the earlier of the dates that follow:

1. The date this Certificate terminates;
2. The date this Certificate is amended to terminate a Class of **Covered Persons** to which he belongs;
3. The date the Employee's coverage terminates;
4. The date his Lifetime Maximum Transplant benefit has been paid;
5. The date the Employee fails to make a required premium payment, subject to the Grace Period provision;
6. With respect to the Employee's covered dependent children, the date there is no longer an Employee or spouse covered under this Certificate; or
7. The date he ceases to be eligible for coverage, as defined in this Certificate, except that coverage will not terminate for a covered child while he is:
   a. Mentally or physically handicapped; and
   b. Dependent on the covered Employee for support and maintenance; and
   c. The appropriate premiums are paid, when due.

Proof in writing of such handicap must be given to us within 31 days of the date he attains the limiting age. After this, we may not require such proof more often than once each year. His coverage under this Certificate will continue as long as:

- The Policy remains in force;
- The required premium for his coverage is paid; and
- The child is incapable of self-support.

Extended Benefits on Termination - If this Certificate terminates or if any Class of **Covered Persons** to which a **Recipient** belongs terminates, benefits will be extended subject to the following:

1. A **Transplant Benefit Period** must have been established prior to the date of termination; and
2. The Lifetime Maximum Transplant benefits have not been paid; then
3. To the extent benefits are available, we will pay benefits for **Covered Charges** for the remaining portion of the **Transplant Benefit Period**; and
4. All such payments will be based on the plan of coverage in force for the **Recipient** on the date of such termination; and
5. All such payments will be subject to all terms and conditions of this Certificate.

TRANSPLANT PROGRAM BENEFITS

Except as provided under EXCLUSIONS AND LIMITATIONS, when as a result of a **Condition** a **Covered Person** incurs **Covered Charges** for a **Covered Transplant Procedure**, we will pay benefits upon receipt of due proof of loss. The benefits described below will be paid for the services and supplies which are **Medically Necessary** during a **Transplant Benefit Period**. Payment of any benefits is subject to: (1) the Annual Maximum Number of **Covered Transplant Procedures** of the same type during any year for each **Covered Person** indicated in the **Schedule**; (2) the Lifetime Maximum Number of **Covered Transplant Procedures** of the same type during a **Covered Person's** lifetime indicated in the **Schedule**; (3) the Lifetime Maximum Transplant benefit; (4) approval of the **Transplant Case Manager**; and (5) all the terms and conditions of this Certificate.

Pre-Certification Requirement

IMPORTANT NOTICE: Any Covered Charges for which reimbursement is requested under this Certificate must be pre-certified by the Transplant Case Manager. This requirement applies to all Covered Persons. The Transplant Case Manager will assign a Transplant Case Assistant to coordinate the care necessary for the Covered Person's condition and to establish a Transplant Benefit Period.

The Covered Person is responsible for advising their Physician of the Pre-Certification requirement of this Certificate and for seeing that all procedures are followed. Pre-Certification does not guarantee that benefits will be paid. All of the standard terms and conditions of this Certificate apply.

Donor Organ and Tissue Procurement - Procurement includes evaluation, removal, preservation and transportation of donor organ and associated tissue. We will only pay **Covered Charges** for transportation of the donor organ to the location where the proposed surgical transplant procedure is to be performed that is within a 500 mile radius of the site at which the donor organ was procured. In the case of an emergency, when a suitable donor organ is not reasonably available within the 500 mile radius, benefits will be paid for transportation of the donor organ from outside the 500 mile radius. In no case, however, will benefits be provided for procurement of a donor organ from outside the United States (including its possessions) and Canada.

Transportation - If the **Recipient's Covered Transplant Procedure** is performed at a **Participating Hospital**, we will pay the **Covered Charges** incurred by the **Recipient** and a companion for transportation to and from the site of the **Participating Hospital** where the **Covered Transplant Procedure** is performed. If the **Recipient** is a minor, transportation benefits will be provided for up to two persons who travel with such **Recipient**. All trips and means of transportation must be approved by the **Transplant Case Manager**. Benefits will be limited to the number of trips and Transportation, Lodging, and Meals Maximum indicated in the Schedule. Itemized receipts are required to support all such expenses.

Lodging and Meals - If the **Recipient's Covered Transplant Procedure** is performed at a **Participating Hospital,** we will pay the **Covered Charges** incurred for lodging and meals incurred by the **Recipient's** companion(s) during the time the **Recipient** is confined to the **Participating Hospital** due to the **Covered Transplant**

Procedure. Benefits for lodging and meals will be limited to the Lodging and Meals Daily maximum amount shown in the **Schedule**. Benefits will not exceed the Transportation, Lodging, and Meals maximum shown in the **Schedule**. Itemized receipts are required to support all such expenses.

Hospital - The amount of daily room charge considered as **Covered Charges** will not exceed: (1) the average charge for a semi-private room; or (2) for each day a **Recipient** is in an intensive care unit of a **Hospital**, an amount not to exceed 3 times the average charge for a semi-private room. (If the **Hospital** provides private room accommodations only, the average semi-private room rate will be based on charges of **Hospitals** in the immediate area.)

Physician - Inpatient and outpatient **Hospital** medical services (including diagnosis and treatment) provided by a **Physician**.

Surgery - Surgical services performed by a **Physician**. This includes assisting **Physicians**, pre-operative care, surgery, and post-operative care. Assisting **Physician's** fees will be limited to the percentage of the **Covered Charge** allowed for the primary **Physician** as shown in the Schedule.

Private Duty Nursing Care - Services rendered by a licensed private duty **Nurse**, other than nursing services normally provided a patient who is **Hospital**-confined. Benefits for private duty **Nursing** will not exceed the Private Duty Nursing Daily maximum and benefit maximum shown in the **Schedule**.

Other Services and Supplies - The services and supplies that follow will be covered to the extent they are incurred during the **Covered Transplant Procedure** and do not duplicate any other **Covered Charge**:

1. X-ray exams and microscopic and laboratory tests and analysis;
2. Anesthesia, oxygen and their administration;
3. Surgical dressings and supplies;
4. Blood or blood derivatives and their administration;
5. Rental of wheelchairs, **Hospital** beds, mechanical equipment used to treat respiratory paralysis or equipment to administer oxygen. These will be covered only to the extent rental costs do not exceed the purchase price as determined by us;
6. Prescription drugs dispensed by a licensed pharmacy. Such drugs must be by written prescription of a **Physician** for the same **Condition** for which benefits are otherwise payable under this Certificate;
7. Local ambulance transportation of a **Recipient** to the nearest **Hospital** within 150 miles of a **Recipient's** location. Such transportation must be provided by a professional ambulance service;
8. Rehabilitative therapy provided by a licensed therapist, including but not limited to occupational and physical therapy service;
9. Emergency medical services performed in a **Hospital** outpatient department or **Physician's** office;
10. Medical care in an **Ambulatory Surgical Center**, only if the charges are made for a service that would normally require **Hospital** confinement;
11. **Home Health Care** services for a **Recipient** who: (a) is discharged from the **Hospital** sooner than would have been possible without such services; and (b) would otherwise have been required to be **Hospital** confined.

Transplant Procedure Not Performed - It may be that a **Covered Transplant Procedure** is not performed as scheduled due to the **Recipient's** medical condition or death. If this is the case, benefits will be paid only for those **Covered Charges** incurred for organ and tissue procurement and for transportation, lodging and meals as described in this Certificate.

Lifetime Maximum Transplant Benefit - The Lifetime Maximum Transplant Benefit amount is shown in the Schedule. It is the total amount that will be paid by us under this Certificate on behalf of a **Covered Person** during his lifetime.

Donor Expenses - Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Certificate or any other benefit plan covering the donor.

Medical expense benefits for a donor are limited to a maximum amount per **Transplant Benefit Period**, as shown in the **Schedule**, whether in a **Participating Hospital** or Non-**Participating Hospital.**

Donor "covered expenses" include the reasonable and customary expenses for services and supplies which are covered under this provision, and which are **Medically Necessary** and appropriate to the transplant.

Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving, and transporting the organ.

Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care.

For bone marrow transplants, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion.

For the donor, we will pay for "covered expenses" incurred for follow-up care. Charges for transportation to and from the site of the covered organ transplant procedure, including one other individual, or in the case the donor is a minor, two other individuals. In addition, all reasonable and necessary lodging and meal expense incurred during the **Transplant Benefit Period** will be covered up to a maximum shown in the **Schedule** per **Transplant Benefit Period.**

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for expenses incurred for:

1. Treatment while a **Covered Person** is not under the regular care of a **Physician** or for a service or supply which is not authorized by a **Physician**.
2. Treatment arising out of or in the course of a **Covered Person's** employment with an employer or self-employment.
3. Services arising out of, caused by, or in consequence of, war (whether declared or undeclared), invasion or civil war.
4. Treatment arising from **Pre-Existing Conditions**, unless coverage has been in force for 12 months after the effective date of coverage.
5. Any service received or supplies furnished outside the United States (including its possessions) and Canada.
6. Services or supplies for which: (a) there would be no payment required if this Certificate did not provide a benefit; or (b) benefits are available through any governmental program, which provides or pays for health services, whether or not such benefits are applied for, except this exclusion will not apply to medical assistance benefits received under Medicaid.
7. Services received or supplies furnished which are not directly related to the **Covered Transplant Procedure** performed or any complication of such procedure.
8. Cardiac rehabilitation services when not provided to a heart or heart and lung(s) transplant **Recipient.**
9. Air ambulance transportation, unless approved by **Transplant Case Manager.**
10. Travel time and related expenses charged by a provider of services.
11. Services and supplies which are not **Medically Necessary**.
12. Treatment of an emotional, mental or nervous disorder or disease resulting from a transplant procedure or a proposed **Covered Transplant Procedure**.
13. A **Covered Transplant Procedure** using fetal tissue.

PREMIUM PROVISIONS

Change in Premiums - We have the right to change the premium rates by Class for the plans of coverage under this Certificate. We may do this on any premium due date. We will give written notice to this Certificateholder at least 31 days in advance of any such rate change.

Premium Payments - Premiums are payable to us or to our authorized agent on the premium due date.

Grace Period - Subject to the RENEWAL PROVISIONS, a grace period of 31 days will be granted to pay each premium due after the first premium. During such grace period, the coverage under this Certificate to which those premiums apply will remain in force.

CLAIM PROVISIONS

Notice of Claim - Written notice of claim must be given to us within 30 days after a covered loss begins. If it cannot be given at that time, it must be given as soon as it is reasonably possible. Notice given to us by or on behalf of a **Covered Person** with enough information to identify him will be deemed notice to us.

Claim Forms - When we receive notice of claim, we will furnish claim forms for filing proof of loss. If we do not send the forms within 15 days, after we receive written notice, the **Covered Person** will be deemed to have met proof of loss requirements if he gives us written proof of the type and extent of his loss within the time stated in the Proof of Loss provision.

Proof of Loss - Written proof of loss must be given to us within 90 days after the date the covered loss began. If it was not reasonably possible to give timely proof, we will not reduce nor deny the claim for this reason if it is sent as soon as reasonably possible. In any event, the proof must be given no later than one year from the time specified, except in the absence of legal capacity.

Time Payment of Claims - Benefits payable under this Certificate will be paid immediately when we receive all information required to determine our liability.

Payment of Claims - We will, on receiving proof of a covered loss, pay the covered Employee the benefits due. Any accrued benefits, unpaid at his death, will be paid to his estate. If at the time of payment any benefit is payable to a person who is a minor or to a person who is not able to give a valid release, we may pay benefits up to $1,000 to someone related to the Employee by blood or by marriage. This will be a person we think is entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

On written direction of the covered Employee, all or a portion of any benefits payable under this Certificate may, at our option, be paid directly to the provider of such services. If the covered Employee requests otherwise in writing not later than the time of filing proof of such loss, we may not do this. It is not required that the service be rendered by a particular provider.

Physical Exam and Autopsy - We may, at our expense, have a **Covered Person** examined as often as reasonably necessary while a claim is pending. In the case of death, we may also have an autopsy made unless it is prohibited by law.

Legal Actions - No legal action may be brought to recover on this Certificate within 60 days after written proof of loss has been given as required in this Certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

GENERAL PROVISIONS

Entire Contract - The entire contract between the parties includes: (1) this Certificate; (2) the application of this Certificateholder, a copy of which is attached to and made a part of this Certificate, and (3) the Covered Persons' enrollment forms, if any.

In the absence of fraud, all statements made by this Certificateholder or the **Covered Persons** will be deemed representations and not warranties. No such statement will void coverage nor reduce benefits under this Certificate or be used in defense of a claim unless it is contained in a written instrument, a copy of which has been furnished to this Certificateholder or to the **Covered Person** or his beneficiary.

Changes - The Policy may be amended at any time without the consent of the **Covered Persons** or any other person. This may be done upon written agreement between this Certificateholder and us. A **Covered Person's** benefits will not be reduced for a loss which occurred prior to the date of any such amendment.

No change in this Certificate will be effective until approved by one of our officers. This approval must be noted on or attached to this Certificate. No agent may change this Certificate or waive any of its provisions.

Time Limit on Certain Defenses - Except for non-payment of premium, the validity of this Certificate will not be contested after it has been in force for two years from its Issue Date.

In the absence of fraud, no statement made by a **Covered Person** relating to his insurability will be used: (1) to contest his coverage under this Certificate after his coverage has been in force prior to the contest for a period of two years during his lifetime; nor (2) unless it is contained in a written instrument signed by the **Covered Person** and a copy given to him or his beneficiary.

Other Coverage With Us - At any one time each Covered Person may have only one certificate issued by us having coverage similar to that described in this Certificate. If we find he has more than one such certificate, coverage will be provided under the plan that has been in force for the longer period of time. We will refund premiums paid for all other certificates for concurrent periods of coverage.

Employee's Right to Examine Certificate - An Employee may return this certificate for any reason within 30 days of the effective date shown on this certificate schedule. We will refund any premiums paid for such coverage. The certificate will be deemed void from the start. No coverage will exist and no benefits will be paid for any loss.

Failure to Enforce - If we fail to enforce any provision or condition of this Certificate, such failure will not affect our right to do so at a later date. It will also not affect our right to enforce any other provision or condition of this Certificate.

Conformity with State Statutes - Any provision of this Certificate which, on its issue date, is in conflict with the statutes of the state in which this Certificate is issued is hereby amended to conform to the minimum requirements of such statutes.

UNITED STATES FIRE INSURANCE COMPANY

Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is attached to and made a part of your Policy/Certificate. The provisions of this Amendatory Endorsement are effective on the Effective Date of your Policy and will expire concurrently with your Policy/Certificate, unless otherwise terminated. In consideration of issuance, the Policy/Certificate is hereby amended and modified, as follows:

1. **Eligible Persons:**

   The **Dependents** provision is deleted and replaced with the following:

   Dependents - Each eligible Employee's dependent(s) who meets the eligibility requirements stated in the application are eligible to apply for coverage under this Policy. Eligible dependents can be the Employee's legal spouse and former spouse if a court of law has decreed that the Employee is responsible for that former spouse's medical insurance coverage, dependent child, step-child, legally adopted child, or unmarried grandchild, who is under 26 years of age. A dependent child's limiting age will be extended if the child is mentally or physically handicapped and incapable of self-support regardless of age. We can require periodic proof of qualification of dependent status and/or of handicap or disability, but such proof will not be required more than once a policy year.

   We will cover newly born, newly adopted, or foster-placed children of the Employee or his covered spouse from the moment of birth, adoption, or placement for 31 days. Benefits will be those provided under this Policy for dependent children. Coverage may be continued beyond that time if, within that 31 day period, we have received: (1) written notice of the child's birth, adoption, or placement; and (2) payment for any additional premium (including the premium for the 31-day period).

2. **Exclusions and Limitations**

   Exclusion number 4 regarding treatment arising from Pre-Existing Conditions is hereby deleted from the Policy/Certificate.

3. **General Provisions:**

   The **Conformity with Employer Plan** provision is added to the **General Provisions**:

   Conformity with Employer Plan - Any **Eligible Persons** or **Effective Dates** provisions in this Policy/Certificate which, on its issue date, are in conflict with any **Eligible Persons** or **Effective Dates** provisions of the Employer Plan are hereby amended to conform with such provisions. "Employer Plan" means the employee benefit plan, sponsored by the Employer, providing a program of health benefits to **Covered Persons**.

Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Certificate. If there is a conflict between the Certificate and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

Signed for **United States Fire Insurance Company** By:

Douglas M. Libby
Chairman and CEO

James Kraus
Secretary

UNITED STATES FIRE INSURANCE COMPANY

Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is attached to and made a part of your Policy/Certificate. The provisions of this Amendatory Endorsement are effective on the Effective Date of your Policy and will expire concurrently with your Policy/Certificate, unless otherwise terminated. In consideration of issuance, the Policy/Certificate is hereby amended and modified, as follows:

Definitions:

The **Covered Transplant Procedure** definition is deleted and replaced with the following:

Covered Transplant Procedure means the transfer of an organ(s) and associated tissue from a donor to a transplant Recipient in order to replace or restore function to a diseased structure. For the purpose of this Certificate, it includes only the following human to human organ transplants: (1) heart; (2) heart/kidney; (3) heart/lung(s); (4) lung(s); (5) liver; (6) liver/cadaveric; (7) liver/kidney; (8) liver/live donor; (9) pancreas; (10) kidney; (11) simultaneous kidney and pancreas; (12) pancreas after kidney; and (13) small bowel. A Covered Transplant Procedure will include only the following human to human transplant procedures when the procedure is used to treat leukemia, lymphoma, blood and genetic diseases and solid tumors: (1) allogeneic related; (2) allogeneic unrelated; (3) autologous; (4) synogeneic; (5) cord blood; (6) peripheral stem cells. All other transplants are excluded.

Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Certificate. If there is a conflict between the Certificate and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

Signed for **United States Fire Insurance Company** By:

Douglas M. Libby
Chairman and CEO

James Kraus
Secretary

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3rd Floor • Eatontown, NJ 07724

PRE-TRANSPLANT EVALUATION RIDER

Effective Date: January 1, 2014

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

PRE-TRANSPLANT EVALUATION BENEFIT

We will pay **Covered Charges** up to the **Maximum Benefit Amount** for services and supplies related to a **Pre-Transplant Evaluation** and provided to a **Covered Person** to determine if the **Covered Person** is an acceptable candidate for a transplant program.

Maximum Benefit Amount: $30,000

Pre-Transplant Evaluation means a series of interviews and tests for **Covered Persons** who are being considered for **Covered Transplant Procedures** prior to the transplant to ensure that the patient is physically capable of undergoing the transplant and to identify and treat any pre-existing conditions that may impact the transplant. Such test include, but are not limited to: Chest x-ray; EKG, Muga scan; Ultrasound with Doppler examination; CT Scan; MRI; Total body scan; Multiple blood tests; Upper or lower GI series; Renal function studies; Pulmonary functions studies; Hepatic angiograph; Cholangiogram; Gallium, colloidal gold, or technetium scan; Bone marrow biopsy; Dental assessment; Social worker evaluation; and Tissue typing.

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR **THE UNITED STATES FIRE INSURANCE COMPANY** BY:

Signature	Signature
Douglas M. Libby Chairman and CEO	James Kraus Secretary

UNITED STATES FIRE INSURANCE COMPANY

Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

Endorsement to the Group Policy/Certificate Providing Organ Transplant Insurance Issued in the State of Wisconsin

This endorsement is to be attached to and forms a part of the Policy/Certificate to which it is attached. It takes effect on the Effective Date of the Policy/Certificate.

In consideration of the premium charged and notwithstanding anything to the contrary, the Policy/Certificate to which this endorsement is attached is amended as follows:

- *The following Notice is hereby provided:*

  IMPORTANT NOTICE CONCERNING STATEMENTS IN THE ENROLLMENT FORM FOR YOUR INSURANCE

  Please read the copy of the enrollment form attached to this notice or to your certificate or which has been otherwise previously delivered to you by Us. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to Us within 10 days if any information shown on the form is not correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete

- *The **Change in Premiums** provision of the **PREMIUM PROVISIONS** section is deleted in its entirety and is replaced by the following:*

  Change in Premiums - We have the right to change the premium rates by Class for the plans of coverage under this Policy. We may do this on any premium due date. We will give written notice to the Policyholder at least 60 days in advance of any such rate change.

- *The definition of Experimental or Investigational is replaced with the following definition:*

  Experimental or Investigational - A drug, device, procedure or treatment will be determined to be experimental or investigational, at the time it is used, if any of the following conditions occur: (1) approval is required, but not granted, by the appropriate federal or other governmental agency (such as, but not limited to, the Federal Drug Administration); or (2) it is not yet recognized as acceptable medical practice throughout the United States to treat that **Condition**; or (3) it is subject to either a written protocol or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment that states it is experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk. Our claims department will determine what is considered as Experimental or Investigational, in conjunction with the Transplant Case Manager; and the decision will be based on the criteria above.

  Patients in a Phase III randomized control trial sponsored by the National Cancer Institute or a jointly sponsored national oncology cooperative group trial for the treatment of cancer will not be considered **Experimental or Investigational** for purposes of this Certificate.

- *The definition of Dependent is replaced with the following definition:*

  Dependents- Each eligible Employee's dependent(s) who meets the eligibility requirements stated in the application are eligible to apply for coverage under this Certificate. Eligible dependents can be the Employee's legal spouse and former spouse if a court of law has decreed that the Employee is responsible for that former spouse's medical insurance coverage, unmarried dependent child, step-child, legally adopted child, or unmarried grandchild, who is under 19 years of age.

  A dependent child's limiting age will be extended to 25 years of age if the child is a full-time student at an accredited college or university. A dependent child's limiting age will also be extended if the child is mentally or physically handicapped and incapable of self-support regardless of age. We can require

periodic proof of qualification of dependent status and/or of handicap or disability, but such proof will not be required more than once a policy year.

- *Paragraph 2 appearing under the Section entitled, EFFECTIVE DATES, is replaced with the following paragraph:*

  DEPENDENTS - If dependent insurance is noncontributory, a dependent's insurance will be effective on the date he becomes eligible. The Employee must be insured in order for his dependents to be insured. If the dependent insurance is contributory, the Employee who applies for dependent insurance on a form approved by us and agrees in writing to pay the required contributions for dependents will become insured for his dependents as follows:

  a. For other than a newly-born, newly-adopted, or foster-placed child, if the Employee applies within 31 days after the date his dependents becomes eligible for insurance, his dependents will be insured on the later of the date the Employee applies for dependents' insurance or the date the Employee becomes insured.

  b. For a newly-born, newly-adopted, or foster-placed child, if the Employee acquires this child while not insured for dependents' insurance, that child will be insured from the date of birth, adoption, or placement for adoption for 60 days. The Employee must apply for dependents' insurance within such 31 days in order for coverage to continue beyond 60 days. The dependents' insurance provided will apply only to the newly born, newly adopted, or foster-placed child.

  c. If the Employee applies after 60 days from the date his dependents became eligible for insurance, his dependents will not be considered for insurance until the Employee furnishes to us evidence of insurability, at his own expense, for each dependent he wants to enroll. Insurance for those dependents must be approved by Us, and will become effective on the date of approval. This item will not apply to a newly acquired child.

  d. For a newly acquired child, You must notify Us of the child, in writing and pay any requirement premium within 60 days after the date of birth. After 60 days, if notice and premium is not received, coverage for the child will end. If, however, within one year after the birth of the child, You make all past-due payments plus interest on such payments at the rate of 5 1/2% per year, coverage for the child will be reinstated.

  As used above, 'placed for adoption" or "placement for adoption" means any of the following:

  1. A county department or a child welfare agency places a child in Your home for adoption according to an agreement.

  2. A court orders a child to be placed in Your home for the purpose of adoption.

  3. A sending agency places a child in Your home and You take physical custody of the child at any location within the United States.

  4. A court of a foreign jurisdiction appoints You as guardian of a child who is a citizen of that jurisdiction, and the child arrives in Your home for the purpose of adoption.

  Coverage of a child shall begin on the date that a court makes a final order granting adoption of the child or on the date that the child is placed for adoption, whichever occurs first.

  All terms and conditions of the Policy/Certificate that are not in conflict with this Endorsement shall apply.

Douglas M. Libby
Chairman and CEO

When used throughout this document "Company", "Our", "We", or "Us" means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

Grievance

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.

Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) a statement of your rights, including the right to:
- attend the Second Level Review
- present his/her case to the review panel;
- submit supporting materials before and at the review meeting;
- ask questions of any member of the review panel;
- be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;
(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

When used throughout this document "The Company", "Our", "We", or "Us" means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Fairmont Speciality
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724