TOKIO MARINE HCC

HCC Life Insurance Company operating as Tokio Marine HCC - Stop Loss Group

Group Organ Transplant Insurance

A Specified Disease Policy for Self-Funded Groups

Questions and Answers

Value

What kinds of groups are good candidates for transplant insurance?

Self-funded groups of all industries, municipalities, unions, associations[1], government entities, and registered MEWAs, may all be good candidates for this coverage.

Why is it more practical to purchase stand-alone transplant policies rather than keeping transplant benefits within the existing medical plan?

There are several reasons to purchase stand-alone policies that insure transplants separately from the medical plan:

- Due to long wait times, solid organ transplants have a tendency to carry over plan contract years, causing unnecessary variabilities with deductibles and continuum of care, and are generally targets for "lasers" by stop loss carriers.
- Many plan documents have vague language regarding transplant coverage, which can lead to confusion and even litigation.
- Transplants are complicated exposures to manage and should be handled by experienced personnel who understand both the patient's needs as well as the clinical requirements to ensure the best outcomes.
- Transplant insurance promotes predictability rather than variability of cost in terms of budgeting, thus helping to stabilize a group's stop loss rates.

Which groups are the best candidates for transplant insurance?

Any group that has had a transplant exposure in the past has probably felt the financial pain either through their stop loss rates, or by funding the exposure through their deductible and/or laser. Groups that have never had a transplant may be facing odds that an exposure is due. Large groups that are totally self-funded (no stop loss) can benefit greatly in cash flow and budget predictability by purchasing transplant coverage. Smaller groups that either come from a fully insured arrangement or are already self funded are excellent candidates.

Does access to a transplant network mean my client does not need a separate transplant policy?

Access to a transplant network will certainly help mitigate the overall cost of a transplant procedure, but it won't change the plan's exposure. In addition, a network does not alleviate frequency issues in the group. Transplant insurance provides one single rate per employee per month regardless of the frequency or severity, and includes the cost of network access, transplant coordination and medical management.

How do I receive an organ transplant proposal?

RFPs should be sent to rfp.slot@tmhcc.com.

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Benefits

What transplant procedures are covered in the policy?

Covered transplant procedures include solid organs (heart, heart/lung, lung, liver, kidney, kidney/pancreas, pancreas and small intestine), as well as bone marrow stem cell and cord blood resulting from one of the covered specified diseases (see policy for a list of covered diseases).

What is a benefit period?

The transplant benefit period encompasses the period of time from patient evaluation up to 365 days post-transplant or the expenditure of the lifetime maximum, if applicable.

Is there a pre-existing condition clause?

Yes. Any plan participant will be excluded for 12 months from the effective date who: 1) has had a transplant or has been recommended or evaluated for a transplant within the past 24 months; 2) is currently on a transplant waiting list or dialysis; or 3) has been diagnosed with Chronic Kidney Disease/End-Stage Renal Disease (CKD/ESRD). The pre-existing condition clause does not apply: 1) to new hires and their dependents that enroll after the policy effective date or; 2) once the policy is renewed.[2]

Are there in and out-of-network benefits?

In-network benefits are 100% for covered transplant services with no co-pays, deductible or out of pocket expenses. Out-of-network benefits are 80% of charges for covered transplant services up to a maximum schedule per transplant type (see policy for specific caps).

What happens when the pre-existing period ends and a patient is excluded due to a pre-existing condition that is listed in a hospital outside of the transplant network?

If after the pre-existing waiting period the patient has not yet received a transplant and becomes eligible under the policy, we can attempt to arrange a special contract with the facility to consider the patient in-network, but this cannot be guaranteed. Otherwise, the transplant would be covered at the scheduled out-of-network maximum.

Are underlying medical conditions that lead to the need for a transplant covered?

No. Only covered transplant services as defined in the policy are covered, including complications directly related to the transplant procedure. For example, dialysis charges are not transplant-related and therefore not covered.

How is the 365 days "post-transplant" activated?

As long as the eligible candidate has their transplant during the contract period, then all covered transplant services will continue to be covered for up to 365 days thereafter, even if this period crosses over the renewal date and the policy is not renewed.

Are travel and lodging expenses included in the coverage?

Yes, up to a maximum of $15,000 for the patient and one companion at $300 per day. Patients are reimbursed directly upon submission of receipts.

Does the transplant policy supersede the transplant language in the plan document?

Yes, for eligible participants, the transplant policy language supersedes the transplant language in the plan document and is considered primary for the eligible employee and his/her dependents. However, those individuals that are subject to the 12 month pre-existing waiting period remain covered under the group's health plan and subject to its terms and benefits. Since the coverage includes network obligations and a requirement to pre-authorize transplant services, we will provide instructional language to insert into your plan document.

How does the policy get issued?

When the rate and benefit description are accepted by a group, we will require an application and disclosure statement to be filled out and signed by the employer. The employer is then issued an electronic version of the policy and certificate. Producers will need to be properly appointed by Tokio Marine HCC.

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Transplant Case Management

What is the notification requirement?

Full coverage is dependent upon notifying Tokio Marine HCC as soon as a participant is diagnosed as possibly needing a transplant evaluation, and before a referral to a transplant provider is made. In this manner, we can properly assess the participant's situation and take the necessary measures to assure proper care and full coverage.

How is medical necessity determined?

Our Medical Director has reviewed over 4,000 transplant cases and is very much in the forefront of the most recent medical reviews and technological advances in regard to transplants. This knowledge is invaluable in the review of the specific patient's situation in conjunction with the transplant benefit language in providing a determination.

Who sends determination letters out to patients, physicians and facilities?

Tokio Marine HCC sends all determination letters to patients, physicians and facilities.

What happens if Tokio Marine HCC is not notified before a referral is made?

Non-notification could result in a patient getting listed in a non-network facility, or receiving transplant-related care that is considered experimental or investigational. As a result, the medical facility may balance bill the patient for charges not covered under the policy.

Is Tokio Marine HCC transplant case management considered primary?

Self-funded groups that purchase the transplant policy will have the transplant policy considered primary to the self-funded plan for the purpose of a covered transplant for an eligible patient. We encourage the administrator to continue with case management to coordinate non-transplant issues so that the patient meets all non-transplant benefit requirements.

Does Tokio Marine HCC have its own transplant network?

Yes. We have a wholly owned transplant network, we maintain direct-to-provider contracts for transplant services, and we maintain access to other transplant networks to assure complete geographic coverage to facilities that provide the best transplant outcomes.

Underwriting

Are there any minimum enrollment or premium levels for self-funded groups?

Certain producers are assigned by Tokio Marine HCC as "pooled". These are producers (along with their administrators) that have agreed to enroll a significant number of employee lives into the transplant program and abide by certain guidelines established by Tokio Marine HCC. Pooling allows for a level of equalization and stabilization in premium rates regardless of the size of the group (minimum 50 employees) or whether there are possible transplant exposures. Group who are considered pooled will have access to pooled rates at policy inception and renewal, as long as the producer and administrator have met the pooling guidelines.

What information is necessary to issue a proposal?

For pooled groups, we require a physical address, a current census that includes single/family splits, the state in which the group is located, commission level desired, effective date and lifetime maximum requested ($1M, $2M or Unlimited). Non-pooled groups will be issued a more extensive list of required information.

Does the group have to have stop loss insurance through Tokio Marine HCC to purchase the transplant program?

No. A group can be eligible for this coverage regardless of their stop loss carrier, as long as they meet minimum enrollment requirements (see above).

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Underwriting Continued...

What kind of savings are realized in the employer's stop loss insurance for carving out transplants?

Most stop loss carriers will provide a small discount to their stop loss rates when an organ transplant policy is purchased, which can be used to defray some of the cost of the transplant coverage.

What is the benefit of purchasing a separate policy for transplant coverage?

The single largest benefit of purchasing a separate policy for transplant coverage is the leveling out effect of the costs associated with a transplant. For many small employers, the minimal premium cost of transplant insurance may be the best financial solution. Transplant insurance is a way to pay over time via premiums versus all at once when a transplant occurs. In addition, the coverage may help mitigate lasers and ongoing risk concerns from the stop loss carriers.

How does the group's transplant experience affect the rate at renewal?

In the "pooled" program, rates are not determined by individual group experience. As a result, the overall pool experience can lend stability at renewal for groups that experience transplant exposures. Non-pooled groups will have some credibility assessed to their transplant experience at renewal.

How is a rate determined for a group?

Rates are determined on a U.S. population basis, transplant utilization within any given state, and provider contracts with the hospitals in that territory. As a result, groups from different states may have different rates. Rates for non-pooled groups may be underwritten using known risk data on potential transplant patients.

Can a deductible be applied to the transplant coverage to help reduce the cost?

If the plan already has a specific stop loss deductible, it is impractical to introduce another deductible on the transplant coverage. By doing so, it splits the dollars that would normally apply to the stop loss deductible. Covered transplant services are charged against the lifetime maximum of the transplant policy, as they are not claims under the self-funded plan. In addition, first dollar coverage for transplants assures seamless management and care.

Claims

To whom are claims submitted?

Facilities and providers are directed to send all claims to Tokio Marine HCC for payment. Any non-covered expenses are forwarded to the administrator for adjudication and payment.

How is a transplant claim paid?

Payments of covered transplant services are made directly to providers, thus avoiding any cash flow issues for the employer. Eligible travel and lodging expenses are reimbursed directly to the employee upon presentation of receipts.

What constitutes a claim denial?

A transplant-related claim is denied when the service is determined to be experimental/investigational and/or not medically necessary. Transplant-related claims are also reviewed for duplicate or erroneous billing or not meeting other terms of coverage as defined in the policy.

To learn more, please contact:

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Disclaimer

Transplant benefits are those expenses that are transplant-related. Other non-transplant-related expenses may be considered for payment in accordance with the terms and conditions of your employer's health plan. Non-transplant-related expenses include, but are not limited to, the treatment of underlying disease or unrelated conditions. Transplant policy provisions are subject to eligibility and pre-existing condition limitations.

Exclusions

(state variations may apply)

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

- 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).
- 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.
- 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.
- Nutritional supplements including, but not limited to, full or partial oral or intravenous nutrition after discharge from a transplant hospitalization or outpatient transplant procedure.
- Charges for any transplant related services or supplies incurred prior to the Policy Effective Date.
- 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.
- 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.
- 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.
- Chemotherapy and/or surgery prior to beginning High Dose Chemotherapy (including bone marrow/stem cell transplantation).
- Services provided for the removal of a transplanted solid organ, unless the removal is provided during a Covered Transplant Procedure.
- 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.
- 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.
- Services and supplies for immunizations.
- Animal organ or artificial organ transplants.
- Charges for a stand-by Physician, unless otherwise approved by Us.
- Services of a Provider who is a member of Your Immediate Family.
- 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.
- Custodial Care.
- Hospice care.
- Charges for any Experimental and/or Investigational Treatment, except as specifically stated in the Policy.
- Charges paid or payable under Workers' Compensation.
- 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.
- Research studies or screening examinations.
- Services or supplies to the extent You are not legally obligated to pay for them.
- Expenses incurred before the Policy Year begins or after it ends, except as stated in the Policy.
- Rest cures or sanitarium care.
- Services or supplies furnished by any Provider acting beyond the scope of such Provider's license.
- Any service or supply that is a Medicare Part A, Part B, or Part D liability.
- Services or supplies received from a dental or medical department maintained by or on behalf of the Policyholder.
- Services provided by any governmental agency to the extent that You are not charged for them, unless otherwise required by state or federal law.
- Services or supplies not specifically stated as covered.
- Telephone consultations, charges for failure to keep a scheduled visit, or charges for completing a claim form.
- Recreational or diversional therapy.
- Materials used in occupational therapy.
- Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if a Provider prescribes such items.
- 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.
- Services and supplies for treatment of complications or diseases incurred by a living donor, including, but not limited to, increased length of hospitalization or the costs to treat any complication or disease.
- 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.
- Prescription Drugs for the treatment or prevention of a rejected organ or tissue following the end of the Transplant Benefit Period.
- 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.
- Biological and/or mechanical devices used as a bridge to transplant unless specifically included in the Schedule of Benefits.
- 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:
  - There has been no break in coverage between the Transplant Policies issued by Us; and
  - The Covered Charges are for services or supplies incurred within the Transplant Benefit Period for the Covered Transplant Procedure.

1. State variations apply.
2. Employees who come from acquisitions are subject to pre-existing requirements.

TOKIO MARINE HCC

Tokio Marine HCC - Stop Loss Group is a member of the Tokio Marine HCC group of companies.

Tokio Marine HCC - Stop Loss Group
operating as HCC Life Insurance Company
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