EXHIBIT B

THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS

DIALYSIS PATIENT CITIZENS, *et al*,)
)
Plaintiffs,)
)
v.) Civil Action No._______
)
SYLVIA MATHEWS BURWELL, Secretary,)
United States Department of Health and Human)
Services, *et al*.)
)
Defendants.)

AFFIDAVIT OF HRANT JAMGOCHIAN IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER

1. My name is Hrant Jamgochian. I am the Chief Executive Officer of Dialysis Patient Citizens ("DPC"). I have personal knowledge of the facts set forth herein or believe them to be true based on my experience at DPC or upon information provided to me by others. If asked to do so, I could testify truthfully about the matters contained herein.

2. DPC is a non-profit educational and social welfare organization operating under section 501(c)(4) of the Internal Revenue Code. Its purpose is to improve the quality of life of patients with kidney disease--both those with End Stage Renal Disease ("ESRD") and those with chronic kidney disease ("CKD")--through advocacy and education. We do this by empowering kidney disease patients and helping to elevate their voice with policymakers.

3. More than 500,000 people in the United States have ESRD. When someone has ESRD, his kidneys, which remove waste products and excess fluid from the blood, have stopped working. In order to survive, therefore, a person with ESRD must either obtain a new kidney through a kidney transplant or undergo dialysis, a mechanical process which cleans the blood, approximating the process of a functioning kidney. The standard dialysis treatment requires the

patient to be hooked up to a machine in a dialysis center for approximately four hours, three times a week, although more convenient methods of dialysis have been and are continuing to be developed.

4. CKD includes many different conditions that cause some loss of kidney function. CKD may or may not progress to ESRD. It usually gets worse slowly, and symptoms may not appear until the kidneys are badly damaged. There are approximately 26 million people with CKD in the U.S.--almost one in twelve Americans.

5. DPC's membership is restricted to kidney disease patients and their family members. We have more than 28,000 total members. Our 2016 Membership Survey found that 87% of our members with kidney disease are on dialysis, that 11% have had kidney transplants, and that 2% have CKD that is likely to progress to ESRD.

6. Our Membership Survey also found that the average DPC member with ESRD has been on dialysis for 6.7 years, and that 19% have been on dialysis for more than 10 years. One-third of our members who have not received transplants are on a transplant waiting list. The average waiting time for a transplant is between 3 and 7 years.

7. Fifty-three percent of our members are white, 30% are African-American, and 4% are Hispanic. Fifty-two percent are retired, and 26% are unemployed. That is to be expected, since although there have been advances in dialysis treatment in recent years, dialysis for most people remains a process that saps their energy and makes it very difficult to hold a full-time job. As a result, a large proportion of our members have very little income. Two-thirds have received some form of financial assistance to help make ends meet, including Social Security Disability payments, food stamps, pharmaceutical assistance programs, and charitable assistance.

8. Depending on their economic status, age, where they live and other factors, DPC members may have multiple insurance options to choose from, including Medicare--whether or not they're over 65--Medicaid and, since the guarantee-issue and non-discrimination provisions of the Affordable Care Act took effect in 2014, private coverage. Twenty-three percent of DPC members with ESRD--more than 6,000--have received funding to help pay their premiums, including premiums for both Medicare and private coverage, from the American Kidney Fund ("AKF").

9. DPC is a patient-led organization. Its by-laws require that the President, Vice President and 51% of the Board be current dialysis patients. For the past several years, the non-dialysis patients serving on the Board have been former dialysis patients with kidney transplants.

10. I have been the CEO of DPC since April 2011. I previously served as the Director of Health Policy for the United Way Worldwide, as Director of Congressional and State Relations for the American Pharmacists Association, and as Director of Field and State Operations for the American Psychological Association. I have a law degree (J.D.) from Catholic University, and a Master of Laws (LL.M) in Global Health Law from Georgetown.

11. While I have a family history of kidney disease, I never had any symptoms myself. However, a few months after joining DPC I was diagnosed with IgA Nephropathy, a form of CKD. I have had some recent troubling test results, which I discuss briefly below. I live in Bethesda, MD, with my wife Lenna and my three-year old son, Xander.

DPC's interest in and concern about CMS's Interim Final Rule ("IFR") regarding third-party payment

12. The Centers for Medicare and Medicaid Services ("CMS") is a component of the U.S. Department of Health and Human Services ("HHS"). On December 14, 2016 CMS published an Interim Final Rule (the "IFR"), to be made effective 30 days thereafter, that

contains two parts. The first part would require dialysis companies to explain to dialysis patients their various insurance options, the coverage each option provides, and what it will cost the patient; to explain whatever premium assistance may be available for private coverage; and to disclose the payment the company would receive from the insurer if the patient elects private coverage.

13. DPC believes that it is in the best interests of ESRD patients to receive comprehensive information about their insurance alternatives, and also about the compensation providers will receive if the patient elects each alternative. Notably, the rates the insurers negotiate with the dialysis companies are higher than those the government sets for Medicare and Medicaid. As a result, dialysis companies have an economic incentive to have dialysis patients covered by private insurance. Conversely, insurers have an economic incentive to disenroll dialysis patients, or to avoid insuring them in the first place, because dialysis patients cost them a great deal of money.

14. If the IFR stopped with the first part of the rule DPC would not be challenging it. But it does not stop there. Rather, it includes a second part that will cause low-income DPC members with ESRD who currently have AKF-funded private coverage to lose their insurance.

15. The second part of the IFR prohibits any dialysis company participating in Medicare or Medicaid--which as a practical matter is all dialysis companies--from paying the health insurance premiums of ESRD patients, or contributing to any organization that does so such as AKF, unless the patient's insurance company agrees to accept such payment. Because insurers have a strong economic incentive to avoid dialysis patients, and because the rule permits insurers to reject payment by dialysis-company-funded organizations like AKF on behalf of dialysis patients at any time and for any reason, the second part of the rule necessarily would result in the

elimination of AKF funding of private coverage for dialysis patients. If the IFR is permitted to take effect, therefore, DPC members who currently rely on AKF funding for private insurance and who cannot afford to pay their premiums themselves will lose their current health insurance.

16. DPC is vitally interested in and concerned about the IFR because it will adversely affect our members as well as more than 26 million other people with kidney disease--both CKD and ESRD--throughout the United States. Unfortunately, although CMS asserts in the IFR preamble that it is promulgating this rule without notice and the opportunity for the public to comment in order to prevent harm to patients, for the reasons discussed below the IFR will actually create harm to patients. CMS asserts that the IFR is necessary in order to protect patients seeking a transplant, to prevent unnecessary costs, and to prevent disruptions to patient care. In fact, however, as I explain below, the IFR will harm patients seeking a transplant, will create unnecessary costs, and will cause disruptions to patient care.

17. In this statement I first explain why CMS's promulgation of the IFR is unfair to dialysis patients in general and to DPC and its members in particular. I then explain the harm that this rule would cause to DPC members, both those with ESRD and those with CKD, if it is permitted to take effect.

The IFR v. HHS Guidance

18. The IFR directly contradicts guidance which CMS has published after the Affordable Care Act ("ACA") was enacted in March 2010, which DPC has relied on in advising its members. It is fundamentally unfair for CMS to now adopt a policy--and even more so to adopt it, as CMS has in the IFR, without notice and an opportunity for public comment--that penalizes DPC and its members for following exactly the advice CMS has given it. A few examples follow.

CMS guidance makes clear that ESRD patients who are eligible for Medicare also have the option of private insurance

19. In a publication intended for ESRD patients that was updated only a few months ago, CMS stated unequivocally that “Individuals with ESRD are not required to sign up for Medicare; it is voluntary.” CMS, “Medicare Coverage of Kidney Dialysis & Kidney Transplant Services” (rev. May 2016), available at https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf.

20. Further, CMS has made a point of reminding insurers that ESRD patients are not required to sign up for Medicare. CCIIO, Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 20, 2015), at 36, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015- R.pdf.

21. HHS has also made clear that ESRD patients can obtain both private coverage and Medicare, and that doing so can reduce the patient's costs: the booklet Financial Help for Treatment of Kidney Failure, published in June 2014 (NIH Publication No. 14-4765), at page 5 informs ESRD patients that "Having Medicare Part B plus another health plan can limit what a person pays out-of-pocket for health care."

22. Notwithstanding the above, by authorizing insurers to refuse to accept third-party payment and mandating disclosure of information that facilitates such refusals, the IFR would preclude ESRD patients who are eligible for both Medicare and private coverage but cannot afford to pay premiums themselves from obtaining private coverage. It would force them to rely exclusively on Medicare, even when private coverage would provide them with more extensive benefits than would Medicare.

<u>CMS guidance makes clear that Medicaid-eligible ESRD patients are also eligible for private coverage as long as they forego government subsidies</u>

23. In a Frequently Asked Question at the CMS website, CMS states that "qualified individuals who are Medicaid or CHIP eligible" are "not eligible to receive advance payments of premium tax credits or cost-sharing reductions" if they buy on the Exchange, but that they "are allowed to purchase qualified health plans instead of receiving coverage through the Medicaid or CHIP programs." See CMS, Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid (December 10, 2012), available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

24. Nevertheless, by authorizing insurers to refuse to accept third-party payment, the IFR would preclude ESRD patients who are eligible for both private coverage and Medicaid from obtaining private coverage. It would force them to rely exclusively on Medicaid, even when private coverage would provide them with more extensive benefits than would Medicaid alone.

<u>HHS has told ESRD patients who can not afford to pay private insurance premiums that the AKF may be able to pay those premiums for them, and has encouraged them to contact the AKF</u>

25. The National Institutes for Health (NIH), a component of HHS, tells insureds at its website that "The American Kidney Fund has grants to help pay health plan premiums. A social worker can help a person apply for assistance."

26. The NIH booklet Financial Help for Treatment of Kidney Failure is even more expansive and encouraging regarding AKF funding for ESRD patients. At page 9, it contains the following language:

> "What private organizations can help? Private organizations include charities and foundations. A few exist specifically to help people with kidney disease and kidney failure, such as the ***American Kidney Fund**. The American Kidney Fund gives small grants to U.S. dialysis and transplant patients based on need. The American Kidney Fund has grants to help pay health plan premiums. A social worker can help a person apply

> for assistance. The American Kidney Fund depends on donations, so there may be times when funds are low. More information can be found at www.kidneyfund.org."

27. The CMS Patient Rights documents also emphasize that patients must be told about any financial assistance available to them. CMS, "Dialysis Facility Patient Rights," available at https://www.medicare.gov/dialysisfacilitycompare/#resources/patients-rights.

28. The IFR would prevent dialysis patients from receiving assistance from AKF to pay their premiums even though HHS has consistently encouraged dialysis patients to obtain assistance from AKF to pay their premiums. That is fundamentally unfair.

How the IFR will injure DPC and its members

29. Of the more than 6000 DPC members who have AKF-funded health coverage, some have obtained private coverage through AKF assistance. Were the IFR to take effect, there is a significant risk that those members will face coverage disruptions. Some examples follow.

30. Medicare has no out-of-pocket limit, while private coverage does. The IFR will thus cause DPC's Medicare-eligible members with ESRD who have AKF-funded private coverage to lose that coverage, thus pushing them into Medicare with its lack of an out-of-pocket limit. In 23 states ESRD patients under the age of 65 do not have a right to purchase a Medigap policy--a policy paying some of the costs that Medicare does not cover--so in those states under-65 ESRD patients will have unlimited liability for the 20% of their costs that Medicare does not cover. Because ESRD patients not only must undergo dialysis but also often have such conditions as diabetes, anemia, hypertension, and congestive heart failure, under-65 ESRD patients on Medicare in states where they can not buy Medigap will likely be unable to afford to pay the 20% that Medicare does not cover. As a result both their finances and their health are likely to deteriorate.

31. I am aware of one member under 65 years of age in California, which is one of the states in which ESRD patients under 65 cannot buy Medigap coverage, who has been on dialysis since December 2014. She has had Blue Cross Blue Shield individual coverage since approximately 2012, and her premiums are currently paid by AKF. She is barely able to afford the costs of the $6,500 out-of-pocket limit on her policy, and is currently behind on her payments. Because she is unable to work full-time, she would be unable to cover both the out-of-pocket costs and premiums under her current policy. She would prefer to stay on her private coverage, but if AKF did not cover her premiums as a result of the IFR, she would struggle to do so. If she had Medicare instead of private insurance, she would likely have a 20% coinsurance requirement, which for a dialysis patient is likely to be many thousands of dollars more.

32. Even in the 27 states in which ESRD patients do have a right to purchase a Medigap policy, they typically have only a right to purchase the most basic Medigap Plan, which still leaves a substantial portion of their expenses uncovered. In those states, too, therefore, under-65 ESRD patients on Medicare would likely see both their finances and their health deteriorate.

33. The IFR will cause DPC's Medicaid-eligible members with ESRD who have AKF-funded private coverage to lose that coverage, thus leaving them with Medicaid exclusively. Less than half of all primary care physicians accept new Medicaid patients--44%, according to the Kaiser Family Foundation--and even fewer specialists accept new Medicaid patients, since Medicaid pays them so much less than either private insurance or Medicare. Dialysis patients often need multiple specialists, including nephrologists, vascular surgeons, and cardiologists. The IFR thus subjects DPC's Medicaid-eligible members with ESRD who now have AKF-funded private coverage to a substantial likelihood that they will have to find at least one and perhaps multiple new doctors, which could disrupt their care and adversely affect their health.

34. Medicare covers only the ESRD patient, not dependents. The IFR therefore will cause DPC's Medicare-eligible members with ESRD who have AKF-funded private coverage which also covers their dependents to lose that coverage. The IFR will thus result in the dependents of those DPC members losing their coverage (and will also force the ESRD patient himself to rely exclusively on Medicare and thus to suffer the injury described in paragraph 30, above).

35. Research shows that ESRD patients with private coverage are almost three times as likely to obtain a transplant as those on Medicare, and that African-American ESRD patients with private coverage are approximately 14 times as likely to obtain a transplant as those on Medicare. By preventing low-income ESRD patients, including low-income African-American patients, from obtaining private coverage, the IFR makes it substantially less likely that DPC's low-income members with ESRD who are seeking to receive transplants will receive them, and particularly less likely that DPC's low-income African-American members with ESRD who are seeking to receive transplants will receive them.

36. In some cases, private insurance covers drugs or devices that both Medicare and Medicaid do not cover. For example, a DPC member in Boynton Beach, FL who has AKF-funded private insurance is also a diabetic. She can control her blood sugar most effectively by using the Omnipod insulin pump along with the Dexcom continuous glucose monitoring system. Neither Medicare nor Medicaid cover either the Omnipod or Dexcom devices, but her private insurance covers both. Were the IFR to take effect, and thus eliminate her ability to maintain her private insurance coverage, she would lose coverage for both devices that enable her to most effectively control her blood sugar.

The perverse incentives the IFR creates for insurers

37. If the IFR takes effect insurers will have an incentive to accelerate the deterioration of the health of their low-income insureds with kidney disease rather than to prevent that adeterioration. That is because patients with ESRD, but not CKD before it progresses to ESRD, qualify for Medicare, and because under current law private insurers must continue to insure patients with ESRD for 30 months after they qualify for Medicare.[1] To avoid paying for 30 months of dialysis treatments, therefore, under current law the insurer has an incentive to keep its insureds with CKD as healthy as possible for as long as possible. Low-income patients on dialysis, however, can pay their premiums only through the assistance of the AKF. If the insurer can refuse to accept such payment--as the IFR authorizes it to do and essentially guarantees that it will do--the insurer can jettison any of its low-income patients as soon as they are diagnosed with ESRD, thus making Medicare solely responsible for the cost of 30 months of dialysis treatments. Were the IFR to take effect, therefore, it would be in the insurer's interest to have the health of its low-income patients with CKD decline to ESRD status as soon as possible, so that the insurer can get them and their costs off its books as soon as possible.

38. Moreover, the IFR would create an incentive for insurers to deny coverage for effective but expensive procedures not just to its low-income insureds but to potentially all its insureds. That is because even CKD patients who can today pay their premiums themselves because they work full time are likely not to be able to afford to do so if their health declines and

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[1] Under the Medicare Secondary Payer law, 42 U.S.C § 1395y, group health plans must continue to provide coverage to ESRD patients for 30 months after they become eligible for Medicare. § 1395y(b)(1)(C). In providing such coverage the insurer cannot take into account that its insureds with ESRD are entitled to or eligible for Medicare. § 1395y(b)(1)(C)(i). And the insurer cannot "differentiate in the benefits it provides" ESRD patients and other insureds on the basis of the existence of ESRD, the need for dialysis, or "in any other manner." § 1395y(b)(1)(C)(ii). Those requirements also apply to individual coverage sold on the Exchange operating in Texas, as well as in other states, because such coverage must include the same benefits as any of the state's three largest small group, state employee, or FEHBP plans, or of the state's leading HMO, and all those plans cover dialysis treatments for ESRD patients. See 45 C.F.R. § 156.100; https://www.cms.gov/cciio/resources/data-resources/ehb.html.

they are forced to go on dialysis and can no longer work full time. Data from our October 2016 Membership Survey bear this out: 55% of DPC members were employed when they started on dialysis, but only 8% of those now on dialysis are still employed full-time, with another 6% working part-time. Thus, an employed CKD patient with the means to pay his premiums himself may well become an unemployed ESRD patient without the means to pay his premiums once his kidneys fail. The IFR thus creates a system where insurers have an incentive to establish a two-track system of care: one for people who will be able to pay their own premiums after their kidneys fail, and one for those who won't.

39. Patients with kidney disease are particularly vulnerable when their insurer's economic interest conflicts with their own interest in maximizing their health status, because procedures are available that can minimize the adverse effects of dialysis or even avoid dialysis entirely, but they are very expensive. For example, the research clearly shows that patients with declining kidney function who receive pre-emptive kidney transplants--transplants before they need to go on dialysis--have better outcomes than those who receive post-dialysis transplants. They are less likely to reject the kidney; have a higher survival rate; are more likely to avoid infections; and can avoid the dietary restrictions and health complications of dialysis. It is clearly in such a patient's interest, therefore, to obtain a pre-emptive transplant. With the IFR in effect, however, the insurer would have a strong economic incentive not to approve such a transplant for a patient who is likely to need financial assistance to pay his premiums--which according to our Membership Survey includes the large majority of patients on dialysis. Instead, it would have an incentive to allow the patient's condition to deteriorate until he must go on dialysis, at which point he qualifies for Medicare. With the patient unable to pay his private

insurance premiums without financial assistance, Medicare would pay for the transplant and the private insurer would be absolved from doing so.

40. As I mentioned in para. 12 above, dialysis providers and insurers have opposite economic incentives regarding patients with kidney disease. Dialysis companies have an economic interest in getting paid as much as possible for treating dialysis patients, and insurers have an economic interest in avoiding dialysis patients entirely and in disenrolling them if they happen to end up with them. Dialysis providers and insurers also have opposite incentives regarding the longevity of dialysis patients: dialysis providers have an interest in keeping dialysis patients alive because they get paid as long as they're alive, whereas insurers have the opposite interest because they must make payments on behalf of the dialysis patients they insure for as long as they're alive. An insurer's incentive not to maximize the lifespan of its insured exists with respect to any patient on whose behalf the insurer pays out in claims more than it takes in in premium--that is an unavoidable effect of our health insurance system. But rather than seeking to minimize that incentive, the IFR exacerbates it. That doesn't mean than every insurer will seek to accelerate the decline of every patient with kidney disease who cannot afford to pay his own health insurance premium. But it does necessarily make that type of behavior more likely.

41. I am particularly concerned about the perverse incentives the IFR would create for insurers because as I noted in paragraph 11 above, I have CKD myself--in particular, a condition known as IgA Nephropathy, which reduces the ability of the kidneys to filter wastes from the blood. The test to determine the progression of IgA Nephropathy measures the level of the protein albumin, normally present in the blood, that has leaked into the urine. The normal level is between 0.0 and 17.0 micrograms per millileter (ug/mL). When I was first diagnosed, in

October 2012, my microalbumin test result was 248.1 ug/mL; my most recent test result, in July 2016, was 996.9.

42. I am hopeful that I can slow the progression of my kidney disease, as I have started to take medications (ACE inhibitors) to reduce some of the pressure on my kidneys. But if my kidney function continues to decline my wife has volunteered to donate her kidney to me so that I can obtain a pre-emptive transplant. I currently have a health insurance plan offered through the Washington DC Exchange by CareFirst, that covers me and my three-year old son. I am fortunate to be working at DPC, which pays for 90% of the employee premium and 75% of the dependent premium. Because of my current position with DPC, and because my wife and I have the means to pay unsubsidized health insurance premiums, I am hopeful that CareFirst would not resist authorizing a pre-emptive transplant for me. But for people who do not work for an organization dedicated to advocating for the rights of patients with kidney disease, and who don't have the luxury of another income and moderate savings as my wife and I do, the insurer's calculation would be different: it clearly would find it in its economic interest, if the IFR were in effect, to seek to avoid paying for a pre-emptive transplant for its insured and to push him into dialysis so that Medicare would pay for a post-dialysis transplant, even though the former option is better for the insured.

43. Notably, although HHS claims that third-party payment exposes ESRD patients to "a significant risk of a mid-year disruption in health care coverage," it is HHS which is creating the situation that produces that disruption, by authorizing the insurer to refuse to accept third-party payment. HHS could have prevented the disruption the IFR is creating and could have eliminated harm to ESRD patients by requiring the insurer to accept third-party payment. Moreover, HHS could have at least reduced disruption and harm to patients if it had permitted

insurers to reject third-party payment but had required them to make their decisions effective at the beginning of the next calendar year and had also required them to provide adequate notice to patients of their decisions and their effective dates. The patient would then at least have had time to try to make other arrangements to ensure that there would be no disruption in her care. The IFR, however, leaves ESRD patients in the worst possible position: it subjects them to the possibility that their care can be disrupted at any time, since it allows the insurer to refuse to accept third-party payment at any time and for any reason. The IFR thus does not eliminate an imminent hazard but rather creates one.

The effect of the IFR on insurer efforts to avoid or disenroll ESRD patients

44. Some insurers have sent private investigators to the homes of some DPC patients to ask them why they had private coverage.

45. Some insurers have stated in plan documents that policyholders are eligible to be covered only if they are "[n]ot eligible for or enrolled in Medicare at the time of application."

46. Some insurers have told DPC members that federal law requires them to enroll in Medicare four months after they've been diagnosed with ESRD.

47. Some insurers have demanded that ESRD patients sign an affidavit under penalty of perjury attesting that they have not and will not pay their premiums with money obtained from a third party, and threatening them with legal consequences without stating any legal basis for doing so. These letters appear to be designed to scare patients into dropping coverage they are satisfied with and are legally entitled to, and which they must maintain to be eligible for a kidney transplant. An example of such a letter is attached.

48. Because the IFR now mandates disclosure of information about a patient's use of third-party premium assistance, the IFR will inevitably embolden insurers to continue engaging

in the above-described conduct, which will inevitably have the effect of forcing some DPC members with AKF-funded private insurance into coverage that provides them less generous benefits than their current coverage.

49. It would also have the effect of forcing DPC to spend more time challenging insurance company efforts to have state insurance departments authorize insurers to blanketly reject third-party payments on behalf of ESRD patients, or even to authorize insurers to inquire into the source of the funds ESRD patients use when they pay their own premiums. And it would force DPC to spend more time and effort educating its members as to how to maximize their ability to obtain health coverage.

I, Hrant Jamgochian, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed this 6th day of January, 2017, in Washington, DC.

Hrant Jamgochian

Attachment A

UnitedHealthcare

May 24, 2016

via overnight delivery

Member:

Carrier Name: All Savers Insurance Company
Policy #:

Dear

Thank you for your payment in the amount of $777.45 on May 18, 2016, for the above medical policy.

Our records show that the American Kidney Fund may have improperly paid your premiums in the past. Your medical policy does not allow a party like the American Kidney Fund to pay your medical premium.

We need to make sure that you paid your premium with your own money. We also need to make sure you do not expect to be reimbursed for this payment from a party like the American Kidney Fund.

What do I need to do?

We want to ensure that you get the help you need. Please sign the attached document and send it back in the envelope we have provided by **June 3, 2016.**

What happens if I don't send back the document?

If you don't sign and return the document, we will not be able to accept your payment. We will return any payment received and you will not have coverage.

What happens if I did *receive* money from American Kidney F and to pay my premium?

Please call us right away. You will need to make your payment from your own money.

Do I have any other options?

- You may be eligible to enroll in Medicare if you have End-Stage Renal Disease. We have nurses available to talk to you about this option and other aspects of managing your care. Please call us toll-free at 866-561-7518, TTY 711. We will help you understand all of your options.

- You may be eligible to enroll in Texas Medicaid coverage. Please contact the Texas Medicaid Health and Human Services Commission to discuss whether you can access the care you need through their program. Call toll-free **1-800-252-8263**, TTY 711.

DECLARATION

Under penalty of perjury, I hereby state that the following information is true and correct to the best of my knowledge and belief, as of the date that I signed this document

1. I am over the age of majority, suffer from no legal disabilities, and have personal knowledge of the information contained in this Declaration.
2. I am the policyholder listed on Policy Number issued by All Savers Insurance Company (the "Policy").
3. I applied for the Policy of my own free will after considering available options.
4. I am aware that the Policy states that I must pay my own premium unless payment is made by one of the following parties:
   a. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
   b. Indian tribes, tribal organizations or urban Indian organizations; or
   c. State and Federal Government programs.
5. I hereby certify that the funds used to make the payment on May 18. 2016, in the amount of $777.45, were not supplied to me (and will not be reimbursed to me) by any third party entity other than one listed in 4 above. Further, I will not pay any future premium for the Policy with funds received front (or reimbursed by) a prohibited third party entity.

I declare under penalty of perjury under the laws of the United States of America and the state identified below that the foregoing is true and correct.

Executed , 2016, at

DATE CITY STATE

SIGNATURE