SAMPLE EMPLOYER-GROUP MEDICAL INSURANCE BOOKLET-CERTIFICATE

Nippon Life Insurance Company of America® is providing prospective policyholders, members and dependents the opportunity to view sample employer group medical insurance Booklet-Certificates.

Please note that these Booklet-Certificates are only representative samples, and do not constitute an actual insurance policy or contract. Any Booklet-Certificates actually issued may significantly vary from the samples provided based upon final plan selection and other factors. If there is any conflict between the samples provided and your issued Booklet-Certificate, the issued Booklet-Certificate will control.

If you are already a member, please sign in or register to view your group-specific Booklet-Certificate.

IMPORTANT NOTE: NOTHING HEREIN IS A GUARANTEE OF BENEFITS OR ELIGIBILITY. ALL TERMS, PROVISIONS, CONDITIONS, LIMITATIONS AND EXCLUSIONS SHOWN IN YOUR ISSUED NIPPON LIFE INSURANCE COMPANY OF AMERICA BOOKLET-CERTIFICATE AND MASTER POLICY WILL GOVERN.

Nippon Life Benefits®

CA EVOLUTION WITH BUY UP

EFFECTIVE JANUARY 1, 2023

Group Plan Booklet Certificate

Medical Expense Coverage
Prescription Drugs Expense Coverage
Mail Service Prescription Drugs Expense Coverage

In any discrepancy between this on-line Group Plan Booklet Certificate and the master contract, the master contract will govern. This on-line Group Plan Booklet Certificate does not guarantee benefits or eligibility. All terms, provisions, conditions, limitations, and exclusions shown in the Group Plan Booklet Certificate and master policy (including any supplements) will apply. Copies of the Group Plan Booklet Certificate may be obtained from the Plan Administrator.

This Booklet-Certificate is issued by:

Nippon Life Insurance Company of America (Nippon Life Benefits)
P. O. Box 25951, Shawnee Mission, KS 66225-5951

(15-025)

Member's Signature

This insurance has been designed to provide financial help for a Member when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Nippon Life Insurance Company of America. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by the Company, as an insurer.

Member rights and benefits are determined by the provisions of the Group Policy. This booklet-certificate briefly describes those rights and benefits. It outlines what the Member must do to be insured. It explains how to file claims. It is the Member's booklet-certificate while they are insured.

If an Insured Person is undergoing a course of treatment from a Preferred Provider that terminates from the PPO network, completion of covered services may apply. Please call the toll-free number shown on the ID card for additional information.

THIS BOOKLET-CERTIFICATE REPLACES ANY PRIOR BOOKLET-CERTIFICATE THE MEMBER MAY HAVE RECEIVED. If the Member has any questions about this new booklet-certificate, please contact the Policyholder. In the event of future changes to the Member's coverage, he or she will be provided with a new booklet-certificate or a booklet-certificate rider.

If the Member has an electronic booklet-certificate, paper copies of this booklet-certificate are also available. Please contact the Policyholder to request a paper copy.

PLEASE READ THIS BOOKLET-CERTIFICATE CAREFULLY. The Company suggests starting with a review of the terms listed in the DEFINITIONS section. The meanings of these terms will help the Member understand the insurance.

The group insurance policy and the Member's coverage under the Group Policy may be discontinued or altered by the Policyholder or the Company at any time without the Member's consent.

MEDICAL BENEFITS MAY BE REDUCED IF THE UTILIZATION MANAGEMENT REQUIREMENTS DESCRIBED IN THIS BOOKLET-CERTIFICATE ARE NOT FOLLOWED. PLEASE CALL THE TOLL-FREE NUMBER SHOWN ON THE ID CARD ON ANY BUSINESS DAY OR SEE THE POLICYHOLDER FOR THE TOLL-FREE NUMBER WITH ANY QUESTIONS.

The insurance provided in this booklet-certificate is subject to the laws of the state of California.

NIPPON LIFE INSURANCE COMPANY OF AMERICA
P. O. Box 25951, Shawnee Mission, KS 66225-5951

CONTROLLING HEALTH CARE COSTS

Making choices about health care can sometimes be difficult. When seeking health care, take the same approach as for buying anything else. Ask questions. Make sure and get the most appropriate care for the condition. Use the following guidelines to be a wise health care consumer:

Practice Good Health Habits. Staying healthy is the best way to control medical costs. Eat a balanced diet, exercise regularly, and get enough sleep. Learn how to handle stress. Stop smoking and avoid excessive use of alcohol.

See a Doctor Early. Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

Make Sure Surgery is Needed. If a second opinion program is included, get one if unsure about the surgery. If surgery is needed, ask about same day surgery. Many procedures can be performed safely without a Hospital stay. Have these surgeries as an outpatient or at a place other than a Hospital and go home the same day.

Use Outpatient Services for X-ray or Laboratory Tests. Outpatient preadmission and diagnostic tests can save costly room and board charges.

Compare Prescription Drug Prices. Discuss the use of generic drugs with the doctor or pharmacist. Generic drugs are often cheaper than brand name drugs for the same quality.

Consider Hospital Stay Alternatives. Home Health Care, Skilled Nursing Facilities, and Hospice Care services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

Review Medical Bills Carefully. Make sure all charges are understood and bills received are only for services received. Keep medical records up-to-date.

Talk to the Doctor. Discuss the need for treatment with the doctor. To make wise health care decisions, understand the treatment and any risks or complications involved. Ask about treatment costs too. With today's health care costs, the doctor will understand concerns about medical expenses.

Be a wise health care consumer. Review benefits carefully so informed health care decisions can be made. Help control health care costs while getting the most this health care coverage has to offer.

No Cost Language Services

The Insured Person can request an interpreter and have documents read to him or her in his or her preferred language. For assistance, call the Company at one of the numbers shown below. These numbers are also shown on the Insured Person's ID card. For additional help, call the California Department of Insurance at 1-800-927-4357.

BENEFIT ADVICE

THE COMPANY WANTS TO HELP THE INSURED PERSON BE A WISE HEALTH CARE CONSUMER. PLEASE CALL WITH ANY QUESTIONS ABOUT THIS MEDICAL COVERAGE.

English and Non-English Toll-Free Telephone Number: 1-800-374-1835 during normal business hours.

Japanese Toll-Free Telephone Number: 1-800-971-0638 during normal business hours.

Korean Toll-Free Telephone Number: 1-877-827-8713 during normal business hours.

REFER TO THE CLAIM PROCEDURES SECTION (PAGE NBM 5146) OF THIS BOOKLET-CERTIFICATE FOR MORE DETAILED INFORMATION.

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SUMMARY OF BENEFITS
(Effective January 1, 2023)

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

This section highlights the benefits provided under this insurance. The purpose is to give the Insured Person quick access to the information he or she will most often want to review. **Please read the other sections of this booklet-certificate for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

If an Insured Person is sick or injured, Scheduled Benefits then in force will be payable for Covered Charges. Scheduled Benefits are based on the Member's class:

Class	**Scheduled Benefit**
All Members and their Dependents	Comprehensive Medical, Prescription Drugs and Mail Service Prescription Drugs

PREFERRED PROVIDER ORGANIZATION (PPO)

The Policyholder participates in a Preferred Provider Organization (PPO) network established and administered by the PPO shown on the Insured Person's identification card.

Preferred Provider Organization networks are arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for Members of participating Policyholders.

It is expected that the Policyholder's participation in the PPO will result in significant savings of funds needed to maintain the Member's coverage. These savings are to be passed on to the Member in the form of higher benefits payable for covered services received by Insured Persons from Preferred Providers.

Please note that the Policyholder's participation in the PPO network does not mean that the Insured Person's choice of provider will be restricted. The Insured Person may still seek needed medical care from any Hospital, Physician, or other provider. However, in order to avoid higher charges and reduced benefit payments, the Insured Person is urged to obtain such care from Preferred Providers whenever possible.

The Company has the right to terminate the PPO portion of this coverage if the Company or the PPO terminates the arrangement.

The Company also has the right to identify different Preferred Provider Organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

A current listing of the participating Hospitals, Physicians, and other providers is available through an on-line Preferred Provider directory. By accessing the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com, the Insured Person can review Preferred Provider directories for the PPO Network. If the Insured Person does not have internet access, the Insured Person can call the number on the Insured Person's ID card. The Company recommends that the Insured Person (1) verify his or her provider's participation in the network before seeking treatment; and (2) confirm the provider's PPO participation when making an appointment.

MEDICAL CARE COVERED CHARGES

Benefits payable will be based on four Categories of medical care services as described below. **See page NBM 5402 A PPO – Covered Charges for a full description of Covered Charges.**

BENEFITS PAYABLE

Benefits will be payable during a Calendar Year as shown below, and will vary depending upon whether or not needed care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization.

Service	PPO Providers	Non-PPO Providers
Hospital Services		
- Inpatient Hospital Services (including services for Medically Necessary Treatment of Mental Health and Substance Use Disorders)		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%
- Deductible	$1,000* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services - $1,000* per Calendar Year
Hospital Services Covered Charges for Birthing Center Services, Ambulatory Surgery Center Services, and freestanding dialysis center services will be subject to the applicable Calendar Year Deductible Amount.		
- Outpatient Hospital Services (including services for Medically Necessary Treatment of Mental Health and Substance Use Disorders)		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%
- Deductible	$1,000* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services – $1,000*per Calendar Year

Service	**PPO Providers**	**Non-PPO Providers**
- Emergency Room Visits (including MRIs, CATs, SPECTs, PETs and other similar imaging tests)		
- Coinsurance	100%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%
- Deductible	None	For Emergency Services – Same as PPO Providers. For other than Emergency Services -$1,000* per Calendar Year
- Copay	$150 per-visit (Waived if admitted.)	For Emergency Services – Same as PPO Providers. For other than Emergency Services - None
Physician Hospital Services (including services for Medically Necessary Treatment of Mental Health and Substance Use Disorders)		
- Physician Hospital Services (including surgery and Physician Visits on an inpatient or outpatient basis)		
- Coinsurance	80%	60%
- Deductible	$1,000* per Calendar Year	$1,000* per Calendar Year
Physician Office or Clinic Services (Including services for Medically Necessary Treatment of Mental Health and Substance Use Disorders)		
- Services at a Primary Care Physician's office or clinic (other than Urgent Care Center services, Preventive Health and Wellness Services and MRIs, CATs, SPECTs, PETs and other similar imaging tests), including both in-person and Telemedicine/Telehealth visits		
"Primary Care Physician" means a Physician who is a family or general practitioner, internist, obstetrician/gynecologist or pediatrician. For the purpose of Mental Health and Substance Use Disorders treatment, mental and behavioral health and substance use disorder providers, including psychiatrists, clinical psychologists, counselors, therapists, neuropsychologists, social workers, psychiatric nurses, and marriage and family therapists will be considered Primary Care Physicians.		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	$25 per visit	None

Service	**PPO Providers**	**Non-PPO Providers**
- Preventive Health and Wellness Services (including well woman visits and prenatal care) at a Primary Care Physician's office or clinic		
- Coinsurance	100%	Persons under age 19 – 60% Persons age 19 or older (adult) – No Benefits Payable
- Deductible	None	Persons under age 19 – $1,000* per Calendar Year Persons age 19 or older (adult) – No Benefits Payable
- Copay	None	Persons under age 19 – None Persons age 19 or older (adult) – No Benefits Payable
- Services at a Specialty Provider's office or clinic (other than Urgent Care Center services, Preventive Health and Wellness Services and MRIs, CATs, SPECTs, PETs and other similar imaging tests), including both in-person and Telemedicine/Telehealth visits		
"Specialty Provider" means any Physician other than a Primary Care Physician who is classified as a specialist by the American Boards of Medical Specialties; or who is designated by the Group Policy as a Specialty Provider.		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	$25 per visit	None
- Preventive Health and Wellness Services at a Specialty Provider's office or clinic		
- Coinsurance	100%	Persons under age 19 – 60% Persons age 19 or older (adult) – No Benefits Payable
- Deductible	None	Persons under age 19 – $1,000* per Calendar Year Persons age 19 or older (adult) – No Benefits Payable
- Copay	None	Persons under age 19 – None Persons age 19 or older (adult) – No Benefits Payable

Service	**PPO Providers**	**Non-PPO Providers**
- Services at an Urgent Care Center (other than MRIs, CATs, SPECTs, PETs and other similar imaging tests)		
"Urgent Care Center" means a facility that provides Treatment or Services for a sickness or injury that develops suddenly or unexpectedly outside of a Physician's normal business hours that requires immediate treatment, but is not of sufficient severity to be considered emergency treatment.		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	$25 per visit	None
- Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine)		
- Coinsurance	100%	No benefits payable
- Deductible	None	No benefits payable
- Copay	None	No benefits payable
All Other Covered Services		
- Ambulance Services		
- Coinsurance	80% (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%. (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)
- Deductible	$1,000* per Calendar Year (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)	For Emergency Services – Same as PPO Providers. For other than Emergency Services – $1,000* per Calendar Year. (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)
- Copay	None	None

Service	**PPO Providers**	**Non-PPO Providers**
- Home Infusion Therapy Services		
- Coinsurance	80%	60%
- Deductible	$1,000* per Calendar Year	$1,000* per Calendar Year
- Copay	None	None
- Other Medical Services (including MRIs, CATs, SPECTs, PETs and other similar imaging tests in any outpatient location)		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%.
- Deductible	$1,000* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services – $1,000* per Calendar Year.
- Copay	None	None
- Other Preventive Health and Wellness Services		
- Coinsurance	100%	Persons under age 19 – 60% Persons age 19 or older (adult) No Benefits Payable
- Deductible	None	Persons under age 19 – $1,000* per Calendar Year Persons age 19 or older (adult) – No Benefits Payable
- Copay	None	Persons under age 19 – None Persons age 19 or older (adult) – No Benefits Payable
- Intravenously Administered or Injected Medication (Includes the medication and administration of the medication)		
- Performed in a Primary Care Physician's Office		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year

Service	**PPO Providers**	**Non-PPO Providers**
- Copay	$25 per visit	None
- Performed in Specialist Office		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	$25 per visit	None
- Performed as Outpatient Hospital Services		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%
- Deductible	$1,000* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services – $1,000* per Calendar Year
- Copay	None	None

Non-emergency Services received from a Non-PPO Provider*

If an Insured Person receives covered Treatment or Services from a PPO facility at which, or as a result of which, the Treatment or Service is received from an individual Non-PPO Provider, the Insured Person will pay the same cost sharing that he or she would pay if the covered Treatment or Services would have been received from a PPO Provider.

Covered Charges used to satisfy the Out-of-Pocket Expense Limits that apply when such services are received from a Non-PPO Provider will be used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a PPO Provider.

The above benefits do not apply if the Insured Person has voluntarily chosen to receive such services from a Non-PPO Provider, has consented in writing, and the written consent demonstrates satisfaction of the following criteria:

(1) At least 24 hours in advance of care, the Insured Person must consent in Writing to receive services from the identified individual Non-PPO Provider.
(2) The consent must be obtained by the individual Non-PPO Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent must not be obtained by the facility or any representative of the facility. The consent must not be obtained at the time of admission or at any time when the Insured Person is being prepared for surgery or any other procedure
(3) At the time consent is provided the individual Non-PPO Provider must give the Insured Person a Written estimate of the Insured Person's total Out-of-Pocket cost of care. The Written estimate must be based on the individual Non-PPO Provider's billed charges for the Treatment or Service to be provided. The individual Non-PPO Provider must not attempt to collect more than the estimated amount without receiving separate Written consent from the Insured Person or the Insured Person's authorized representative, unless circumstances arise during delivery of the Treatment or Service that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.
(4) The consent must advise the Insured Person that he or she may elect to seek care from a PPO Provider or may contact the Company in order to arrange to receive the health service from a PPO Provider for lower Out-of-Pocket costs.
(5) The consent and estimate must be provided to the Insured Person in the language spoken by the Insured Person, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552 of the Health and Safety Code.
(6) The consent must also advise the Insured Person that any costs incurred as a result of the Insured Person's use of the Out-of-Network benefit will be in addition to in-network cost-sharing amounts and may not count toward the calendar year Out-of-Pocket maximum for in-network benefits or a Deductible, if any, for in-network benefits.

*Excludes services provided by a dentist.

COPAY AMOUNTS

Copays cannot be used to satisfy the individual or family Calendar Year Deductible maximums and will continue to apply after the Calendar Year Deductible has been satisfied.

In addition, no Copay will apply to charges incurred for MRIs, CATs, SPECTs, PETs and other similar imaging tests. These charges are subject to the Calendar Year Deductible.

DEDUCTIBLE AMOUNTS

* The Insured Person pays a single $1,000 per individual Deductible each Calendar Year (or $2,000 per family, but not counting more than $1,000 for any one Insured Person). After the Deductible is satisfied, the Company will pay Covered Charges at the rate of payment shown above.

Covered Charges used to satisfy the individual and family Calendar Year Deductibles that apply when care is received from PPO Providers will be used to satisfy the individual and family maximums that apply when care is received from Non-PPO Providers and vice versa.

OUT-OF-POCKET EXPENSE LIMITS (for each Calendar Year):

	PPO Providers	**Non-PPO Providers**
Per Person	$2,000	$4,000
Per Family	$4,000	$8,000

- Covered Charges used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a PPO Provider or Member Pharmacy will not be used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a Non-PPO Provider and vice versa.
- If the amount the Insured Person pays for Covered Charges in any one Calendar Year reaches the Out-of-Pocket Expense Limit shown above, the Company will pay 100% of additional Covered Charges.
- The Out-of-Pocket Expense Limit for PPO Providers applied to any individual Insured Person under family coverage will not exceed $9,100.

The following charges will not count toward satisfaction of the Comprehensive Medical Out-of-Pocket Expense Limits:

- Treatment or Service for which no benefits are payable because a medical necessity review determines the Treatment or Service in whole or in part is not a Covered Charge;
- If a generic equivalent is available and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price.

The following exceptions apply to the Benefits Payable provisions described above:

- For medical care received from PPO Providers and Non-PPO Providers: Hospital Inpatient Confinement Charges and charges for services provided in an inpatient confinement facility or selected outpatient procedures are subject to Utilization Management Requirements. **See page NBM 5407 CC for a complete description of the Utilization Management Program.**
- For outpatient injectable prescription drugs, benefits payable for a 30-day supply of medication will be 100% of Covered Charges in excess of $250 for cost sharing coinsurance amounts after satisfaction of the Deductible described in this section. If a generic equivalent is available and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price will not apply toward the $250 cost sharing limit.
- For all other outpatient prescription drugs, benefits for a 30-day supply of medication will be payable at 100% of Covered Charges in excess of $250 for any coinsurance amounts after satisfaction of the Deductible described in this section. If a generic equivalent is available and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price will not apply toward the $250 cost sharing limit.
- For Mental Health and Substance Use Disorders Treatment, **see page NBM 5402 B for a complete description of the benefits payable for these services.**
- For payment conditions applicable to Transplant Services, see page NBM 5402 C PPO.
- For payment conditions applicable to Emergency Services, see page NBM 5402 D.
- For payment conditions applicable to Gene-Based, Cellular And Other Innovative Therapies (GCIT), see page NBM 5402 F.
- For payment conditions applicable to Outpatient X-Ray Services and Outpatient Laboratory Services, see page NBM 5402 G PPO.
- For payment conditions applicable to Emergency Room Services, see page NBM 5402 H PPO.
- For payment conditions applicable to Home Health Care, see page NBM 5402 I.

If the Insured Person is referred to another provider, the Insured Person should verify with the Physician that the referral is for a PPO Provider. Examples of this would be an anesthesiologist, x-ray facilities, surgeons, radiologists etc. If that provider is not a PPO Provider, the level of benefits for Non-PPO Providers will apply.

Treatment or Service Not Available from a Preferred Provider

The Company will provide or arrange for an Insured Person to receive Treatment or Service for a listed Covered Charge from a Non-PPO Provider if medically appropriate care cannot be provided within the network. The Insured Person will pay the same cost sharing that he or she would pay if the covered Treatment or Services would have been received from a PPO Provider.

Covered Charges used to satisfy the Out-of-Pocket Expense Limits that apply when such services are received from a Non-PPO Provider will be used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a PPO-Provider.

Access to Treatment or Services from a PPO Provider will meet the following geographical standards:

- **Primary Care Physician:** within 15 miles or 30 minutes of an Insured Person's residence or workplace;
- **Specialist:** within 30 miles or 60 minutes of an Insured Person's residence or workplace;
- **Mental Health and Substance Use Disorder professionals:** within 15 miles or 30 minutes of an Insured Person's residence or workplace; and
- **Hospital:** within 15 miles or 30 minutes of an Insured Person's residence or workplace.

Timely Access to Care

The Company will provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the Insured Person's condition, consistent with good professional practices, and in compliance with state law.

Access to Treatment or Services from a PPO Provider will meet the following appointment availability standards:

- **Urgent care appointments for services that do not require Precertification:** within 48 hours of the request for appointment;
- **Urgent care appointments for services that require Precertification:** within 96 hours of the request for appointment;
- **Non-urgent appointments for primary care:** within ten business days of the request for appointment;
- **Non-urgent appointments with specialist physicians:** within fifteen business days of the request for appointment

- **Non-urgent appointments with a non-physician mental health care or substance use disorder provider:** within ten business days of the request for appointment;
- **Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider:** within ten business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. This does not limit coverage for non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider to once every 10 business days.
- **Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition:** within fifteen business days of the request for appointment;
- **Telephone triage or screening services:** in a timely manner appropriate for the Insured Person's condition. The triage or screening waiting time will not exceed 30 minutes.

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Insured Person.

Preventive care services and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or Mental Health and Substance Use Disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Continuity of Care and Completion of Covered Services by a Terminated Preferred Provider

Federal and California law provides protections to Insured Persons, who are Members of a health insurance plan which utilizes a network of Preferred Providers, when their treating provider is removed or terminated from the network. In many ways the federal Continuity of Care and the California Completion of Covered Services overlap or conflict with each other. In cases where an Insured Person is eligible for continued coverage under one provision but not the other, continuing coverage will be provided under the terms of the applicable provision subject to all provisions of this Group Policy. In cases where an Insured Person is eligible for continuing coverage under either or both provisions, the provision where the Insured Person would receive the greatest benefit or longest term of coverage will be applied.

Insured Persons seeking continuing coverage from a terminated provider under either provision must request the continuing coverage from the Company. All Insured Persons will be provided the opportunity to notify the plan and elect continuing coverage under either provision. An Insured Person who elects continuing coverage will be deemed to have elected continuing coverage under either the Continuity of Care or Completion of Covered Services Provision, and will receive continuing coverage pursuant to the provision where the Insured Person would receive the greatest benefit or longest term of coverage.

- **Completion of Covered Services**

  Applicability

  "Terminated Preferred Provider" means a Preferred Provider whose contract to provide services to Insured Persons is terminated or not renewed by the network or one of the network's contracting provider groups. A terminated Preferred Provider is not a provider who voluntarily leaves the network or contracting provider group or has been terminated due to reasons relating to medical disciplinary causes, fraud or other criminal activity. For providers who voluntarily leave the network see eligibility for continuing coverage under the Continuity of Care provisions below.

  Definitions

  - "Acute Condition" means a medical condition that involves a sudden onset of symptoms due to a sickness, injury, or other medical problem that requires prompt medical attention, and has a limited duration.

  - "Serious Chronic Condition" means a medical condition due to a disease, sickness, or other medical problem or medical disorder that is serious in nature and that:

    - persists without full cure or worsens over an extended period of time; or
    - requires ongoing treatment to maintain remission or prevent deterioration.

  - "Maternal Mental Health Condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

  - "Terminal Illness" means an incurable or irreversible condition that has a high probability of causing death within one year or less.

Coverage and Benefits Payable

Subject to all provisions of this Group Policy, at the Insured Person's request the Company will arrange for the completion of covered services provided by a Terminated Preferred Provider for:

- an Acute Condition: the duration of the condition; or
- a Serious Chronic Condition: the period of time necessary to complete the course of Treatment or Service and to arrange for a safe transfer to another provider, subject to a maximum of 12 months from the Terminated Preferred Provider contract termination date; or
- a pregnancy: through the course of the pregnancy and during the postpartum period. For purposes of an Insured Person who presents written documentation of being diagnosed with a Maternal Mental Health Condition from the Insured Person's treating Preferred Provider, completion of covered services for the Maternal Mental Health Condition will not exceed 12 months from the later of:
  - the date of the diagnosis; or
  - the end of pregnancy; or
- a terminal illness: the duration; or
- care of a newborn child between birth and 36 months: subject to a maximum of 12 months from the Terminated Preferred Provider contract termination date; or
- performance of surgery or other procedure recommended and documented by the Terminated Preferred Provider to occur within 180 days of the Terminated Preferred Provider contract termination date.

Benefits payable for Treatment or Service for Covered Charges received from that Terminated Preferred Provider will continue to be paid at the PPO level of benefits, subject to all provisions of the Group Policy.

- **Continuity of Care**

Applicability

"Terminated" or "Termination" means the expiration or non-renewal of a contract but does not apply to provider contracts terminated for failure to meet applicable quality standards or for fraud.

Definitions

"Continuing Care Patient" means an individual who is:

- undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of post-operative care;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is determined to be terminally ill and is receiving treatment for such illness from a provider or facility.

Coverage and Benefits Payable

If a contractual relationship between a health care provider or facility and the network is Terminated or the benefits being provided to an Insured Person under the Group Policy is Terminated because of either a change of terms in the participation of such a provider or a loss of benefits being provided under the Group Policy; the Company will permit the Insured Person to elect to continue to have benefits provided under the Group Policy, with the same terms and conditions, as would have applied and with respect to such Treatment or Service as would have been covered had such Termination not occurred, with respect to the course of treatment furnished by the provider or facility as related to the Insured Person's status as a Continuing Care Patient until the earlier of either:

a) the date the Insured Person is no longer a Continuing Care Patient; or
b) 90 calendar days after the provider has been Terminated.

Insured Persons, who are enrolled under the Group Policy, and are Continuing Care Patients, as defined above, will be notified on a timely basis of such Termination and the Insured Person's right to elect continued care from the provider or facility pursuant to the terms of this Group Policy and this provision.

BENEFIT MAXIMUMS

As described below, there are Maximum Payment Limits applicable to certain medical Treatments or Services, including, but not limited to the Treatments or Services listed below.

Home Health Care.....	100 visits per Insured Person/per Calendar Year
Skilled Nursing Facility Care.....	120 days for all confinements resulting from the same sickness or injury

The Insured Person's Responsibilities

The Insured Person's medical ID card includes a toll-free telephone number to call for Precertification. Follow all of the requirements described on page NBM 5407 CC -- Utilization Management Program or the Insured Person's benefits will be reduced.

See page NBM 5146 – Claim Procedures for important claim procedures information on filing medical claims.

Refer to the Description of Benefits section for specific details on the Precertification requirements for these services.

PRESCRIPTION DRUGS

Benefits Payable

Covered Charges will include charges for medically necessary prescription drugs including drugs that aren't shown on the Formulary list.

For each prescription and each refill:

- For generic and single source contraceptives for women ……...100% of Covered Charges.
- For outpatient prescription drugs……..100% of Covered Charges in excess of $250 for any Copay amounts.
- For all others .....100% of Covered Charges in excess of the Copay amount.

If the Insured Person uses a Nonmember Pharmacy, he or she must pay for the full cost of the Prescription Drugs when dispensed and then submit a claim form to the Company to request reimbursement. Benefits payable for Prescription Drugs dispensed at a Nonmember Pharmacy will be reimbursed up to an amount determined by the Company less the Copay amount.

Copay Amount

For each prescription and each refill:

For generic and single source contraceptives for women..... $0

For all others:

- For Tier 1 Generic Prescription Drugs (including selected Preferred Brand Name Prescription Drugs)..... $15
- For Tier 2 Preferred Brand Name Prescription Drugs..... $30
- For Tier 3 Non-Preferred Prescription Drugs $50

Copay amounts for prescriptions will apply toward satisfaction of the Comprehensive Medical Out-of-Pocket Expense Limits.

Each prescription and each refill will be filled with a Generic Prescription Drug if there is a generic equivalent available. If the Physician specifies that the medication must be a Preferred or non-Preferred Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Preferred or non-Preferred Brand Name Drug price after payment of the Preferred or non-Preferred Brand Name Drug Copay (whichever is applicable). If a generic equivalent is available, and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the Insured Person will pay the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price, in addition to the Generic Drug Copay. If a generic equivalent is available and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price will not apply toward satisfaction of the Out-of-Pocket Expense Limits or the $250 cost sharing limit for outpatient Prescription Drugs described above. If there is no generic equivalent available and a Preferred or non-Preferred Brand Name Drug is dispensed, the Preferred Brand Name Drug Copay or the non-Preferred Brand Name Drug Copay, whichever is applicable, will apply.

The Member and the Policyholder can locate the most current Drug Formularies (Preferred Drug List) at the following web address: www.NipponLifeBenefits.com.

See page NBM 5424 for a complete description of Prescription Drugs Expense Insurance.

MAIL SERVICE PRESCRIPTION DRUGS

Benefits Payable

For each prescription and each refill:

- For generic and single source contraceptives for women.....100% of Covered Charges.
- For outpatient prescription drugs .....100% of Covered Charges in excess of $250 for any Copay amount.
- For all others .....100% of Covered Charges in excess of the Copay amount.

If the Insured Person uses a Nonmember Pharmacy, he or she must pay for the full cost of the Prescription Drugs when dispensed and then submit a claim form to the Company to request reimbursement. Benefits payable for Prescription Drugs dispensed at a Nonmember Pharmacy will be reimbursed up to an amount determined by the Company less the Copay amount.

Copay Amount

For each prescription and each refill:

For generic and single source contraceptives for women..... $0

For all others:

- For Tier 1 Generic Prescription Drugs (including selected Preferred Brand Name Prescription Drugs)..... $30
- For Tier 2 Preferred Brand Name Prescription Drugs..... $60
- For Tier 3 Non-Preferred Prescription Drugs $100

Copay amounts for prescriptions will apply toward satisfaction of the Comprehensive Medical Out-of-Pocket Expense Limits.

Each prescription and each refill will be filled with a Generic Prescription Drug if there is a generic equivalent available. If the Physician specifies that the medication must be a Preferred or non-Preferred Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Preferred or non-Preferred Brand Name Drug price after payment of the Preferred or non-Preferred Brand Name Drug Copay (whichever is applicable). If a generic equivalent is available, and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the Insured Person will pay the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price, in addition to the Generic Drug Copay. If a generic equivalent is available and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price will not apply toward satisfaction of the Out-of-Pocket Expense Limits or the $250 cost sharing limit for outpatient Prescription Drugs described above. If there is no generic equivalent available and a Preferred or non-Preferred Brand Name Drug is dispensed, the Preferred Brand Name Drug Copay or the non-Preferred Brand Name Drug Copay, whichever is applicable, will apply.

The Member and the Policyholder can locate the most current Drug Formularies (Preferred Drug List) at the following web address: www.NipponLifeBenefits.com.

See page NBM 5425 for a complete description of Mail Service Prescription Drugs Expense Insurance.

BOOKLET-CERTIFICATE RIDER

This Nippon Life Insurance Company of America Rider complies with the 'No Surprises Act' (*42 U.S.C.A § 300gg-111* and its implementing regulations). Except as specifically provided herein, this Rider is subject to all of the terms, provisions, definitions, and limitations of the Group Policy.

Consolidated Appropriations Act
Nippon Life Insurance Company of America

As described in this Rider, the Group Policy is modified as stated below to comply with the applicable provisions of the *Consolidated Appropriations Act (the "Act") (P.L. 116-260).* This Rider reflects requirements of the Act; however, these requirements do not preempt applicable state law to the extent it is a "Specified State Law" as defined in 42 U.S.C.A. § 300gg-111(a)(3)(I).

Because this Rider is part of a legal document (the Group Policy), the Company wants to give Insured Persons information about the document that will help Insured Persons understand it. Certain capitalized words have special meanings. We have defined these words in booklet-certificate form NBM 5136 and in the Definitions section below.

I. No Surprises Act

Under the *No Surprises Act* Insured Persons are protected from surprise medical bills for Emergency Services, Air Ambulance Services furnished by Nonparticipating Providers, and Non-Emergency Services furnished by Nonparticipating Providers at Participating Facilities in certain circumstances. The accompanying regulations to the *No Surprises Act* require Emergency Services to be covered without any Precertification, without regard to whether the health care provider furnishing the Emergency Services is a Participating Provider or a Participating Emergency Facility with respect to the services, and without regard to any other term or condition of the Group Policy other than the exclusion or coordination of benefits, permitted affiliation, or Waiting Period.

Definitions Applicable to the No Surprises Act

Air Ambulance Service means medical transport by a rotary wing air ambulance or fixed wing air ambulance, as defined in 42 CFR 414.605 respectfully, for patients.

Ancillary Services mean Treatment or Services provided by out-of-network Physicians at a network facility that are any of the following:

- related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- provided by assistant surgeons, hospitalists, and intensivists;
- diagnostic services, including radiology and laboratory services, unless such Treatment or Services are excluded from the definition of Ancillary Services as determined by the Secretary (as that term is applied in the Act).

Cost-Sharing means the amount an Insured Person is responsible for paying for a Covered Charge under the terms of the Group Policy, including Copayments, coinsurance and amounts paid towards Deductibles, but does not include amounts paid towards premiums.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) a condition where the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy, b) a serious impairment to bodily functions, or c) a serious dysfunction of any bodily organ or part.

Emergency Services or **Emergency Health Care Services** mean the following Treatment or Service with respect to an emergency:

- A medical screening exam (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such emergency, and
- Such further medical exam and Treatment or Service, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to Stabilize the patient regardless of the department of the Hospital in which such further exam or Treatment or Service is provided.
- Services otherwise covered under the Group Policy when provided by an out-of-network provider or facility (regardless of the department of the Hospital in which the Treatment or Services are provided) after the patient is Stabilized and as part of outpatient observation, or an Hospital Inpatient Confinement or outpatient stay that is connected to the original emergency, unless:
  - The provider or facility, as described above, determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation.
  - The provider furnishing the additional Treatment or Service satisfies the notice and consent criteria in accordance with 45 CFR 149.410.
  - The patient is in such a condition to receive information as stated the preceding bullet above and to provide informed consent in accordance with applicable law.

Health Care Facility in the context of non-emergency services means:

- a Hospital as defined in section 1861(e) of the Social Security Act;
- a Hospital outpatient department;
- a critical access Hospital as defined in section 1861 of the Social Security Act; and
- an Ambulatory Surgery Center described in section 1833(i)(1)A of the Social Security Act.

Independent Freestanding Emergency Department means a Health Care Facility that:

- is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- provides Emergency Health Care Services.

Nonparticipating Emergency Facility means an emergency department of a Hospital, or an Independent Freestanding Emergency Department, that does not have a contractual relationship directly or indirectly with the network with respect to furnishing a Treatment or Service under the Group Policy.

Nonparticipating Provider means any Physician or other health care provider who does not have a contractual relationship directly or indirectly with the network with respect to furnishing a Treatment or Service under the Group Policy.

Out-of-Network Rate means, with respect to Surprise Medical Bills for Emergency Services, Surprise Medical Bills for Non-Emergency Services and Surprise Medical Bills for Air Ambulance Services, as defined herein, the total payment for Covered Charges furnished by a Nonparticipating Provider, Nonparticipating Emergency Facility, or Nonparticipating Provider of Air Ambulance Services. If a "Specified State Law" applies, the Out-of-Network Rate will be determined in accordance with such law. If no "Specified State Law" applies, the Out-of-Network Rate will be equal to:

- With respect to Surprise Medical Bills for Emergency Services and Surprise Medical Bills for Non-Emergency Services: the lesser of the billed amount or Qualifying Payment Amount reduced by the Insured Person's Cost-Sharing amount. The Insured Person's Cost-Sharing amount for this purpose is based on the Recognized Amount, as defined herein.
- With respect to Surprise Medical Bills for Air Ambulance Services: the lesser of the billed amount or Qualifying Payment Amount reduced by the Insured Person's Cost-Sharing amount. The Insured Person's Cost-Sharing amount, for this purpose, is as specified herein under the section captioned "Surprise Medical Bills for Air Ambulance Services".

Participating Emergency Facility means any emergency department of a Hospital, or an Independent Freestanding Emergency Department, that has a contractual relationship directly or indirectly with the network setting forth the terms and condition on which a relevant Treatment or Service is provided to an Insured Person under the Group Policy. A single case agreement between an emergency facility to address unique situation in which an Insured Person requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating Health Care Facility means any Health Care Facility that has a contractual relationship directly or indirectly with the network of the Group Policy setting forth the terms and condition on which a relevant Treatment or Service is provided to an Insured Person under the Group Policy. A single case agreement between an emergency facility to address unique situation in which an Insured Person requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating Provider means any Physician or other health care provider who has a contractual relationship directly or indirectly with the network of the Group Policy setting forth the terms and condition on which a relevant Treatment or Service is provided to an Insured Person under the Group Policy.

Qualifying Payment Amount has the meaning prescribed by 45 CFR 149.140.

Recognized Amount means the amount which an Insured Person's Cost-Sharing is based on for the below Treatment or Service when provided by out-of-network providers:

- Out-of-network Emergency Health Care Services.
  - The recognized amount is based on the lesser of:
    - the amount that is the Qualifying Payment Amount as determined under applicable law. The Qualifying Payment Amount has the meaning given the term in 45 CFR § 149.140(a)(16); or
    - the amount billed by the provider or facility.

- Non-emergency health care services received at certain network facilities by out-of-network Physicians, when such services are either Ancillary Services, or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain network facilities" are limited to a Hospital (as defined in 1861(e) of the Social Security Act), a Hospital outpatient department, a critical access Hospital (as defined in 1861(mm)(1) of the Social Security Act), an Ambulatory Surgery Center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.
  - The recognized amount is based on California Specified State Law CIC 10112.82 which is the greater of:
    - the average contracted rate; or
    - 125 percent of the amount Medicare reimburses for the same or similar treatment or service in the general geographic region in which the services were rendered.

Specified State Law has the meaning prescribed by 42 U.S.C.A § 300gg-111(a)(3)(I).

Surprise Medical Bills for Emergency Services

Coverage for Emergency Services will be provided without the need for Precertification, even if the Treatment or Services are provided on an out-of-network basis. Coverage will also be provided without regard to whether the health care provider furnishing the Emergency Services is a Participating Provider or a Participating Emergency Facility, as applicable, with respect to the Treatment or Service.

Emergency Services provided by a Nonparticipating Provider or a Nonparticipating Facility will be covered in the following manner:

- without imposing any administrative requirement, limitation on coverage or Cost-Sharing requirements which are greater or more restrictive than those imposed on a Participating Provider or Participating Emergency Facility;
- by calculating the Cost-Sharing requirement as if the total amount that would have been charged for the Treatment or Service by such participating entity were equal to the Recognized Amount for such Treatment or Service; and
- by counting any Cost-Sharing payments made by the Insured Person with respect to the Emergency Services toward any in-network Deductible or in-network out of pocket maximums applied under the Group Policy in the same manner as if the Cost-Sharing payment were made by a Participating Provider or Participating Emergency Facility.

The total payment under the Group Policy will be equal to the Out-of-Network Rate, as defined herein.

Surprise Medical Bills for Non-Emergency Services

Coverage for Treatment or Service furnished to an Insured Person by a Nonparticipating Provider with respect to a visit to a Participating Health Care Facility will be covered as follows:

- there will be no imposition of a Cost-Sharing requirement for the Treatment or Service which are greater than the Cost-Sharing requirement that would have been applied if the Treatment or Service had been furnished by a Participating Provider;
- Cost-Sharing requirements will be calculated as if the total amount that would have been charged for the Treatment or Service by such Participating Provider were equal to the Recognized Amount for the Treatment or Service;
- a determination no later than 30 calendar days after the bill is transmitted by the provider whether the Treatment or Services are covered under the Group Policy and if the Treatment or Services are Covered Charges, send to the provider an initial payment or denial notice.
- any Cost-Sharing payment made by the Insured Person will be counted toward any in-network Deductible and in-network out-of-pocket maximums under the Group Policy in the same manner as if such Cost-Sharing payments were made with respect to the Treatment or Service furnished by a Participating Provider.

The total payment under the Group Policy will be equal to the Out-of-Network Rate, as defined herein.

Surprise Medical Bills for Air Ambulance Services

Coverage for Insured Persons from Treatment or Service furnished by a Nonparticipating Provider of Air Ambulance Services will be covered as follows:

- the Cost-Sharing requirements with respect to the Treatment or Service will be the same requirement that would apply if the Treatment or Service was provided by a Participating Provider of Air Ambulance Services.
- the Cost-Sharing requirement will be calculated as if the total amount that would have been charged for the Treatment or Service by a Participating Provider of Air Ambulance Services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the Treatment or Service.
- the Cost-Sharing amounts will be counted towards any in-network Deductible and in-network out-of-pocket maximums applied under the Group Policy in the same manner as if the Cost-Sharing payments were made with respect to Treatment or Service furnished by a Participating Provider of Air Ambulance Services.

The total payment under the Group Policy will be equal to the Out-of-Network Rate, as defined herein.

II. Dispute Resolution

Any dispute that arises as to the provision of payment for Treatment or Service as described above will be considered an Adverse Benefit Determination. Any dispute that arises regarding the provision of payment between the Company and a provider, facility or Air Ambulance Service will be resolved pursuant to the independent dispute resolution process articulated in 29 CFR §§ 2590.716-8 and 2590.717-2.

III. Provider Directories

The Act provides that if an Insured Person receives a Treatment or Service from an out-of-network provider and was informed incorrectly by the Company prior to receipt of the Treatment or Service that the provider was an in-network provider, either through the Company's database, the provider directory, or in the Company's response to an Insured Person's request for such information (via telephone, electronic, web-based or internet-based means), the Insured Person may be eligible for Cost-Sharing that would be no greater than if the Treatment or Service had been provided from an in-network provider.

All other terms, provisions, conditions, limitations, and exclusions of the Group Policy remain in full force and effect with respect to benefits and all other aspects of the insurance of the Group Policy, and are controlling with respect to this Rider unless expressly modified herein.

Nothing in this Rider will vary, alter, or extend any provision or condition of the Group Policy(ies) other than as stated in this Rider.

NIPPON LIFE INSURANCE COMPANY OF AMERICA

Aimee Averill
Senior Vice President, Service, IT Strategy & Project Management

Takashi Nakayama
President and Chief Executive Officer

HOW TO BE INSURED – MEMBERS

MEDICAL EXPENSE INSURANCE

Eligibility

Persons enrolling for insurance must be a Member (as defined in page NBM 5136 - Definitions) who Resides in the United States.

If the person is a Member on January 1, 2023, the person will be eligible on that date.

If the person is not a Member until later, the person will be eligible on the first of the Insurance Month coinciding with or next following the date the person becomes a Member.

A person will not be eligible for insurance under the Group Policy while he or she is covered under an HMO offered by the Policyholder as an alternative insurance to the Group Policy.

Individual Incontestability and Eligibility

All statements made by any Member or Dependent will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the Insured Person's insurance unless:

- the insurance has been in force for less than two years during the Insured Person's lifetime; and
- the statement is in Written form Signed by the Insured Person; and
- the Company can demonstrate that the Insured Person has constituted fraud or made an intentional misrepresentation of material fact; and
- a copy of the form which contains the statement is given to the Insured Person or the Insured Person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, the Company may, at any time, adjust premiums and benefits to reflect the correct age.

The Company may at any time terminate an Insured Person's eligibility under the Group Policy:

- in Writing and with 31 day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law;
- in Writing and with 31 day notice, upon finding in a civil or criminal case that an Insured Person has submitted claims that contain false or fraudulent elements under state or federal law;
- in Writing and with 31 day notice, when an Insured Person has submitted a claim which, in good faith judgment and investigation, an Insured Person knew or should have known, contains false or fraudulent elements under state or federal law.

Effective Date for Non-Contributory Insurance

Unless the Member waives coverage in Writing and is covered under another group medical policy, insurance for which the Member contributes no part of the premium will become effective on the date the Member is eligible. The Member must enroll for initial insurance in a form provided by the Company.

If enrollment for non-contributory insurance is made more than 31 days after the date a Member is eligible and other than during an Annual Open Enrollment Period or Special Enrollment Period described below, insurance for such Member will become effective as described below for Late Enrollees.

If enrollment for non-contributory insurance is made more than 31 days after the date a Member is eligible but during an Annual Open Enrollment Period described below, insurance for such Member will become effective as described below under "Annual Open Enrollment Period".

If enrollment for non-contributory insurance is made more than 31 days after the date a Member is eligible but during a Special Enrollment Period described below, insurance for such Member will become effective as described below under "Special Enrollment Periods" (other than a "Medicaid or Child Health Insurance Program (CHIP) Special Enrollment Period").

If enrollment for non-contributory insurance is made more than 60 days after the date a Member is eligible but during a Special Enrollment Period described below, insurance for such Member will become effective as described below under "Medicaid or Child Health Insurance Program (CHIP) Special Enrollment Period".

Effective Date for Contributory Insurance

If the Member is required to contribute towards the cost of his or her insurance, the Member must enroll for initial insurance in a form provided by the Company. The insurance will become effective on:

- the date the Member is eligible, if the Member's enrollment is made within 31 days after the date he or she is eligible; or
- the first of the Insurance Month coinciding with or next following the date of the Member's enrollment, if the Member's enrollment is made within 31 days after the date he or she is eligible.

If enrollment for contributory insurance is made more than 31 days after the date a Member is eligible and other than during an Annual Open Enrollment Period or Special Enrollment Period described below, insurance for such Member will become effective as described below for Late Enrollees.

If enrollment for contributory insurance is made more than 31 days after the date a Member is eligible but during an Annual Open Enrollment Period described below, insurance for such Member will become effective as described below under "Annual Open Enrollment Period".

If enrollment for contributory insurance is made more than 31 days after the date a Member is eligible but during a Special Enrollment Period described below, insurance for such Member will become effective as described below under "Special Enrollment Periods" (other than a "Medicaid or Child Health Insurance Program (CHIP) Special Enrollment Period").

If enrollment for contributory insurance is made more than 60 days after the date a Member is eligible but during a Special Enrollment Period described below, insurance for such Member will become effective as described below under "Medicaid or Child Health Insurance Program (CHIP) Special Enrollment Period".

Statement of Health Requirements

A statement of health, in a form provided by the Company, may be required from a Member. The statement of health will be used for rating the group, case management or reinsurance purposes. In no event will a person be declined for insurance, or charged an additional premium, due to his or her health status.

Late Enrollment Provisions

- **Definition**

Late Enrollee. Late Enrollee means, with respect to insurance under a Policyholder's Group Health Plan, a Member or Dependent who enrolls under such plan other than during:

(1) the first period in which the individual is eligible to enroll under the Group Health Plan; or
(2) a Special Enrollment Period described below.

For the purpose of (1) above, only the most recent period of eligibility will be considered in determining whether an individual is a Late Enrollee if:

(1) the individual loses eligibility under the Group Health Plan or due to a general suspension of the Group Health Plan; and
(2) the individual later becomes eligible again under the Group Health Plan or due to resumption of the Group Health Plan's insurance.

The term "Late Enrollee" also means a Member or Dependent who:

(1) was previously insured under the Group Policy but elected to terminate the coverage; and
(2) reapplies for insurance more than 31 days after the termination date; and
(3) does not qualify for one of the Special Enrollment Periods described below.

- **Effective Date for Late Enrollees**

If a Late Enrollee enrolls for insurance other than during an Annual Open Enrollment Period or Special Enrollment Period, the effective date of insurance for the Late Enrollee will be the next Policy Anniversary date, provided on such date:

(1) the Member continues to meet the Group Policy's definition of a Member; and
(2) for Dependent insurance, the Dependents continue to meet the Group Policy's definition of Dependent.

- **Annual Open Enrollment Period**

An Annual Open Enrollment Period will be available for any Member or Dependent who failed to enroll:

(1) during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period as described below; or
(2) during any previous Annual Open Enrollment Period; or
(3) within 31 days after the termination date, if the individual was previously insured under the Group Policy but elected to terminate the insurance.

To qualify for enrollment during the Annual Open Enrollment Period, the Member or Dependent:

(1) must meet the eligibility requirements described in the Group Policy, including satisfaction of any applicable Waiting Period; and
(2) may not be covered under an alternate medical expense coverage offered by the Policyholder, unless the Annual Open Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Open Enrollment period is the one-month period immediately prior to the Policy Anniversary date. The Policy Anniversary date is January 1.

The effective date for any qualified individual enrolling for insurance during the Annual Open Enrollment Period will be the day immediately following completion of the Annual Open Enrollment Period.

- **Special Enrollment Periods**

If the Member or Dependent enrolls after the first period in which the Member or Dependent were eligible to enroll but during a Special Enrollment Period as described below, the Member or Dependent will be a Special Enrollee and will not be considered a Late Enrollee.

The Special Enrollment Periods are:

(1) Loss of Other Coverage. A Special Enrollment Period will apply to a Member or Dependent if all of the following conditions are met:

(i) the Member or Dependent was covered under another Group Health Plan or had other Health Insurance Coverage at the time of his or her initial eligibility, and declined enrollment; and

(ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, termination of a Domestic Partner relationship, death, cessation of Dependent status, termination of employment or reduction in work hours, when the individual no longer resides, lives or works in a service area and there is no other benefit package available under the other Group Health Plan, or when the other Group Health Plan no longer offers any benefits to a class of similarly situated individuals), or due to termination of employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation); and

(iii) enrollment is made within 31 days after the other coverage terminates.

The effective date of insurance will be the first day of the Insurance Month coinciding with or next following the date of the enrollment.

NOTE: For the purpose of (1) (ii) above:

(i) "loss of eligibility" does not include a loss due to failure of the individual to pay premiums on a timely basis or termination of insurance for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health insurance); and

(ii) "employer contributions" include contributions by any current or former employer (of the individual or another person) that was contributing to the insurance of the individual.

(2) Newly Acquired Dependents. A Special Enrollment Period will apply to the Member or Dependent if:

(i) the Member is enrolled (or is eligible to be enrolled but failed to enroll during a previous enrollment period); and

(ii) a person becomes the Member's Dependent through marriage, or declaration of a Domestic Partner relationship, birth, adoption or Placement for Adoption; and

(iii) enrollment is made within 31 days after the date of the marriage, or declaration of a Domestic Partner relationship, birth, adoption or Placement for Adoption, or the date Dependent Medical Expense Insurance is available to the Member under the Group Policy.

The effective date of the Member's or Dependent's insurance will be:

(i) in the event of marriage, or declaration of a Domestic Partner relationship, the date of marriage or declaration of a Domestic Partner relationship; or
(ii) in the event of a Dependent Child's birth, the date of such birth; or
(iii) in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

(3) Court-Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): A Special Enrollment Period will apply to the Member or Dependent Child if:

(i) the Member is enrolled (or eligible to be enrolled but failed to enroll during a previous enrollment period); and
(ii) the Member failed to enroll his or her Dependent Child during a previous enrollment period; and
(iii) the Member is required by a QMCSO or NMSN as defined by federal law and state insurance laws to provide health coverage for his or her Dependent Child.

The enrollment:

(i) may be made at any time after the issue date of the QMCSO or NMSN; and
(ii) will apply only to the Member and/or Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date of the Member's or Dependent Child's insurance will be the first of the Insurance Month coinciding with or next following the date of the enrollment.

An enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of the Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

(4) All Other Court-Ordered Coverage. A Special Enrollment Period will apply to the Member, the Member's spouse or Domestic Partner or Dependent Child if:

(i) the Member is enrolled (or is eligible but has failed to enroll during a previous enrollment period); and
(ii) the Member failed to enroll the spouse or Domestic Partner or Dependent Child during a previous enrollment period; and
(iii) the Member is required by a court or administrative order to provide health insurance for the spouse or Domestic Partner or Dependent Child; and
(iv) enrollment is made for the spouse or Domestic Partner within 31 days after the issue date of the court or administrative order. A request for enrollment for a minor Dependent Child may be made at any time after the issue date of the court or administrative order.

The effective date of the Member's, the spouse's or Domestic Partner's or Dependent Child's insurance will be the first of the Insurance Month coinciding with or next following the date of the enrollment.

(5) Election to Transfer Coverage. A Special Enrollment Period will apply to a Member and Dependents if:

(i) the Policyholder offers employees a choice among health benefit coverages; and
(ii) the Policyholder notifies the Company in Writing of the Policyholder's open enrollment period prior to the effective date of the Group Policy; and
(iii) the Member elects to transfer from another of the offered coverages to coverage under the Group Policy; and
(iv) enrollment is made during an open enrollment period designated by the Policyholder for such transfer.

The effective date of the Member's and Dependent's insurance under the Group Policy will be the day immediately following the last day of the designated open enrollment period described above.

(6) Medicaid or Child Health Insurance Program (CHIP) Plan. A Special Enrollment Period will apply to a Member and Dependents if either of the following conditions is met:

(i) the Member or Dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage and request for enrollment is made within 60 days after the date coverage is terminated; or

(ii) the Member or Dependent becomes eligible for premium assistance under Medicaid or CHIP to purchase coverage under the Group Policy and request for enrollment is made within 60 days after the date eligibility for premium assistance is determined.

The effective date of insurance will be the first of the Insurance Month coinciding with or next following the day after the other coverage terminates or the date of eligibility for premium assistance.

Effective Date for Benefit Changes

A change in the Member's Scheduled Benefit amount because of a change in his or her status (insurance class) will be effective on the first of the Insurance Month coinciding with or next following the date of change in status.

A change in the Scheduled Benefits because of a change in the schedule of insurance elected by the Policyholder will be effective on the date of change.

Termination

Unless continued as provided below or on page NBM 5117 A - Continuation – State Required, NBM 5117 B - COBRA Continuation, NBM 5117 C - Federal Family and Medical Leave Act (FMLA), and NBM 5117 D - Uniformed Services Employment and Reemployment Act of 1994 (USERRA), a Member's insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- for contributory insurance, the end of the Insurance Month, if requested by the Member before that date; or
- the end of the Insurance Month in which the Member ceases to belong to a class for which insurance is provided; or

- the end of the Insurance Month in which the Member ceases to be a Member; or
- the end of the Insurance Month in which the Member ceases to be actively employed; or
- the date the Member transfers to an HMO offered by the Policyholder as an alternative to coverage under the Group Policy.

Termination of Insurance While Outside of the United States

If the Member is outside the United States for more than six consecutive months, his or her insurance will automatically terminate. However, the Member will continue to be eligible for benefits provided under the Group Policy if the Member is temporarily outside of the United States for a period of six months or less.

Continuation

If the Member ceases to be actively employed because of his or her sickness or injury, the Member's Medical Expense Insurance may be continued until the earlier of the date the Member returns to active employment, or the date insurance would otherwise terminate as described above, but in no event longer than six consecutive months.

If the Member ceases to be actively employed because of layoff or leave of absence, insurance may be continued on a limited basis, but in no event longer than one month.

If coverage under the Group Policy is continued under either COBRA or a state continuation mandate, this continuation coverage provided will run concurrently with the COBRA or state continuation.

The Member's coverage may also be continued by paying the required contribution, if any, under the continuation provisions described on page NBM 5117 A - Continuation – State Required, NBM 5117 B - COBRA Continuation , NBM 5117 C - Federal Family and Medical Leave Act (FMLA) and NBM 5117 D - Uniformed Services Employment and Reemployment Act of 1994 (USERRA).

All continuation provisions may run concurrently.

If the Member is interested in continuing his or her insurance beyond the date it would normally terminate, the Member should consult with the Policyholder before his or her insurance terminates.

Contact the Policyholder with reinstatement questions.

MEDICAL EXPENSE INSURANCE

Eligibility

A Member's spouse must Reside in the United States to be eligible for Dependent Medical Expense Insurance.

A Member will be eligible for Dependent insurance on the latest of:

- the date the Member is eligible for Member insurance; or
- the date the Member enters a class for which Dependent insurance is provided; or
- the date the Member first acquires a Dependent.

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member insurance. If a Member is eligible for Dependent insurance, such insurance will become effective under the same terms as described earlier for Member insurance, except any required statement of health will be with respect to the health of the Member's Dependents.

If Dependent insurance is then in effect for any other Dependent, a new Dependent will be insured on the date acquired. Enrollment for insurance is not required provided the Company is notified of the new Dependent within 31 days after the date the Dependent is acquired. With respect to medical benefits for a newborn or newly adopted Dependent Child, effective date provisions are modified as described below.

Insurance for a Newborn or Newly Adopted Child

A newborn child will be insured for medical benefits from the moment of birth provided the child meets the Group Policy's definition of a Dependent Child. A newly adopted child will be covered for medical benefits on the date of adoption or Placement for Adoption (whichever is earlier), provided the child meets the Group Policy's definition of a Dependent Child. Any applicable prior application or first of the Insurance Month provisions will be waived with respect to such child.

However, if the Member is required to contribute toward the cost of Dependent insurance, the Member must notify the Company within 31 days after the date of birth, adoption or Placement for Adoption, in order to continue the child's insurance beyond the 31-day period. If such notice is not given to the Company within the 31-day period, the child will be subject to the Late Enrollment provisions. If the Member's enrollment is a result of a QMCSO or NMSN, the child will not be a Late Enrollee and is eligible for a Special Enrollment Period as described on page NBM 5115 O - How To Be Insured – Members.

If the child's insurance terminates because the Member fails to enroll for insurance (or pay the required contribution) within the 31-day period following the child's date of birth, adoption or Placement for Adoption, benefits will be payable only for covered expenses incurred by the child during the 31-day period in which insurance was in force. The Extended Benefits (after termination of insurance) will not apply to the child.

Individual Incontestability and Eligibility

A Member's Dependents will be subject to the Individual Incontestability and Eligibility as described earlier for Member insurance.

Termination

Unless continued as provided on page NBM 5117 A - Continuation – State Required, NBM 5117 B - COBRA Continuation, NBM 5117 C - Federal Family and Medical Leave Act (FMLA), and NBM 5117 D - Uniformed Services Employment and Reemployment Act of 1994 (USERRA):

- Insurance for all of the Member's Dependents will terminate on the earliest of:
  - the end of the Insurance Month in which the Member ceases to belong to a class for which Dependent insurance is provided; or
  - the date Dependent coverage is removed from the Group Policy; or
  - the date the Member's insurance ceases; or
  - the end of the Insurance Month in which the last premium is paid for the Member's Dependent Medical Expense Insurance.
- Insurance for any one Dependent will terminate on the earlier of:
  - the last day of the Insurance Month in which he or she ceases to be the Member's Dependent; or
  - for contributory insurance, the end of the Insurance Month, if requested by the Member before that date; or

- for each Domestic Partner or Domestic Partner's Dependent Child, on the last day of the Insurance Month in which that Domestic Partner or Domestic Partner's Dependent Child ceases to be a Dependent. However, a Domestic Partner who no longer resides with the Member will not cease to be a Dependent until termination of the Domestic Partner partnership has been filed with the State of California if required, provided the Domestic Partner otherwise continues to be a Dependent.

Notwithstanding the above, insurance will terminate on the last day of the calendar month in which the Member's Dependent Child turns age 26.

However, insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on the Member for primary support.

- The Company will notify the Insured that the Dependent Child's coverage will terminate upon attainment of the limiting age unless the Insured submits proof of the criteria described above to the Company within 60 days of the date of receipt of the notification. The Company will send this notification to the Insured at least 90 days prior to the date the Dependent Child attains the limiting age. Upon receipt of a request by the Insured for continued coverage of the Dependent Child and proof of the criteria described above, the Company will determine whether the Dependent Child meets such criteria before the child attains the limiting age. If the Company fails to make the determination by that date, the Company will continue coverage of the Dependent Child pending the Company's determination.

- The Company may subsequently request information about a Dependent child whose coverage is continued beyond the limiting age as described above, but not more frequently than annually after the two-year period following the Dependent Child's attainment of the limiting age.

Insurance will also be continued for a Dependent Child who is over age 26 and enrolled as a Full-Time Student while on a medical leave of absence.

- If a Dependent Child takes a medical leave of absence, and the nature of the Dependent Child's injury, illness, or condition would render the Dependent Child incapable of self-support, the provisions for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap above will apply if the Dependent Child is chiefly dependent on the Member for primary support.

- If a Dependent Child takes a medical leave of absence from school, but the nature of the Dependent Child's injury, illness, or condition does not meet the requirements for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap above, the Dependent Child's coverage will continue until the earlier of:

  - a period not to exceed 12 months; or
  - the date the coverage is scheduled to terminate pursuant to the terms and conditions of the policy.

The period of coverage under this paragraph will begin on the earlier of:

- the first day of the medical leave of absence from the school; or
- the date the Physician determines the illness prevented the Dependent Child from attending school.

Any break in the school calendar will not disqualify the Dependent Child from coverage under this paragraph.

Documentation or certification of the medical necessity for a leave of absence from school must be submitted to the Company at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school if the medical reason for the absence and the absence are not foreseeable, and will be considered evidence of entitlement to coverage under this paragraph.

Termination of Insurance While Outside of the United States

A Member's Dependents will be terminated under the same terms in the Termination of Insurance While Outside of the United States provisions as described on page NBM 5115 O - How To Be Insured – Members for the Member's insurance.

Continuation

In addition, under certain conditions, the Member's Dependent Medical Expense Insurance may be continued after the date it would normally terminate.

See the continuation provisions described on page NBM 5117 A - Continuation – State Required, NBM 5117 B - COBRA Continuation, NBM 5117 C - Federal Family and Medical Leave Act (FMLA), and NBM 5117 D - Uniformed Services Employment and Reemployment Act of 1994 (USERRA).

Contact the Policyholder with reinstatement questions.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

GENERAL PROVISIONS

Payment Conditions

If an Insured Person receives Treatment or Service for a sickness or injury, the Company will pay Comprehensive Medical benefits for Covered Charges:

- in excess of the Deductible or Copay amount; and
- at the payment percentages indicated; and
- to the applicable Maximum Payment Limit;

as described in Summary of Benefits section, page NBM 5102 PPO – Summary of Benefits.

Benefit Qualification

To qualify for payment of the benefits provided, for an insured class, the Insured Person must:

- be insured in that class on the date medical Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES section, page NBM 5146.

Benefits Payable

Benefits payable will be as described in this booklet-certificate, subject to:

- all listed terms, conditions and limitations; and
- the terms, conditions and limitations of Utilization Management Program, Coordination With Other Benefits, Integration With Medicare and Subrogation and Reimbursement.

Benefits Payable – Required by Federal Law

Subject to the benefits payable provisions as described above, benefits will be payable for:

- **Newborns' and Mothers' Health Protection Act of 1996**

  Under Federal Law, Group Health Plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a Group Health Plan may not, under Federal law, require that a provider obtain authorization from the Group Health Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

  See "Maternity Coverage" under Benefits Payable - State-Required California - below for description of how benefits will be payable under the Group Policy.

- **Pediatric Vaccines**

  Covered Charges will include the cost of Pediatric Vaccines administered to a Dependent Child from birth through 18 years of age.

  Pediatric Vaccines mean those vaccines shown on the list established and periodically reviewed by the Advisory Committee on Immunization Practices as referenced by Section 1928 of Title 19 of the Social Security Act or such other list of vaccines as mandated by other Federal or State laws that are applicable to the Group Policy.

  Benefits for Pediatric Vaccines will be paid at 100% of Prevailing Charges and no Deductible or Copay will be applied.

  NOTE: The benefit will be coordinated with the Children's Preventive Pediatric Care Services provision as described below in Benefits Payable – State Required - California.

- **Women's Health and Cancer Rights Act of 1998**

Under Federal law, group health plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the Insured Person is receiving benefits, coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed, including nipple and areola reconstruction as well as nipple and areola repigmentation to restore the physical appearance of the breast;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation between the attending Physician and the Insured Person.

Also see "Breast Cancer Treatment" under Benefits Payable – State Required - California below.

- **Preventive Health and Wellness Health Services**

Preventive Health and Wellness Services from PPO Providers will be covered in accordance with guidelines from the following organizations:

- U.S. Preventive Services Task Force;
- Health Resources and Services Administration Women's Preventive Services Guidelines; and
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Preventive Health and Wellness Services can be found at: www.healthcare.gov/ and include:

Covered Preventive Services for Adults:

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin preventive medication for adults aged 50 to 59 years with a $\geq$ 10% 10-year cardiovascular risk
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk

- Colorectal Cancer screening for adults over 45
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Prediabetes and Type 2 Diabetes screening in adults aged 35 to 70 who have overweight or obesity
- Diet and physical activity counseling for adults at higher risk for chronic disease
- Falls prevention in community-dwelling adults age 65 and older who are at increased risk for falls. This includes vitamin D supplementation and exercise or physical therapy
- Hepatitis B screening for adults at high risk for infection
- Hepatitis C screening for adults aged 18 to 79 years
- HIV screening for all adults at higher risk
- Hypertension screening in adults 18 years or older without known hypertension, with office blood pressure measurement
- Immunization vaccines for adults - doses, recommended ages, and recommended populations vary:
  - Hepatitis A;
  - Hepatitis B;
  - Herpes Zoster;
  - Human Papillomavirus;
  - Influenza (Flu Shot);
  - Measles, Mumps, Rubella;
  - Meningococcal;
  - Pneumococcal;
  - Tetanus, Diphtheria, Pertussis;
  - Varicella.
- Lung cancer screening for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
- Obesity screening and counseling for all adults
- Prostate specific antigen screening for men
- Screening for unhealthy drug use – questions only, not testing biological specimens
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Skin cancer behavioral counseling for fair skinned individuals ages 6 months-24 years
- Statin preventive medication for adults ages 40-75 with no history of cardiovascular disease
- Syphilis screening for all adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for latent tuberculosis infection in populations at high risk.

Covered Preventive Services for Women, including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Aspirin use as preventive medication after 12 weeks gestation in women who are at high risk for preeclampsia
- Bacteriuria urinary tract or other infection screening for pregnant women
- Behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight in pregnancy
- BRCA risk assessment for women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with BRCA 1/2 gene mutation. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.
- Breast Cancer Mammography screening every 1 to 2 years for women over 40
- Breast cancer preventive medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and Interpersonal Violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational Diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for younger women and other women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Hepatitis C virus screening for women at high risk for infection
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) NDA Test: high risk HPV DNA testing every 3 years for women with normal cytology results who are 30 or older
- Perinatal depression: counseling and interventions.
- Osteoporosis screening for women over age 60 depending on risk factors
- RH Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Well-Women Visits to obtain recommended preventive services.

Covered Preventive Services for Children:

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages (Ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
- Blood Pressure screening for children (Ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Dental caries in children from birth through age 5 years – application of fluoride varnish to the primary teeth of all infants and children starting at age of primary tooth eruption and prescribed oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders (Ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight, and Body Mass Index measurements for children (Ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at high risk for infection
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary:
  - Diptheria, Tetanus, Pertussis;
  - Haemophilus influenza type b;
  - Hepatitis A;
  - Hepatitis B;
  - Human Papillomavirus;
  - Inactivated Poliovirus;
  - Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal;
  - Rotavirus;
  - Varicella.
- Iron supplements for children ages 6 to 12 months at risk for anemia

- Lead screening for children at risk of exposure
- Medical History for all children throughout development disorders (Ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
- Obesity screening and counseling
- Oral Health risk assessment for your children disorders (Ages 0-11 months; 1-4 years; 5-10 years)
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Skin cancer behavioral counseling for fair skinned individuals ages 10-24
- Tobacco Use counseling for adolescents and school-aged children
- Tuberculin testing for children at higher risk of tuberculosis disorders (Ages 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years)
- Vision screening for all children

Preventive Health and Wellness Services from PPO Providers will be payable at 100% and no Deductible or Copay will apply. Preventive Health and Wellness Services from Non-PPO Providers for a Dependent Child under age 19 will be subject to Deductible and coinsurance. Benefits for Preventive Health and Wellness Services for an adult are not payable when received from Non-PPO Providers.

Note: This benefit will be coordinated with the Children's Preventive Pediatric Care Services provision as described below in Benefits Payable – State Required – California.

- **Contraceptive Methods and Counseling for Women**

Covered Charges from a Member Pharmacy or PPO Provider will include charges incurred by a woman for all of the following services and contraceptive methods for women:

- Except as provided below, all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the insured's provider.
- Voluntary sterilization procedures.
- Patient education and counseling on contraception.
- Follow-up services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, the Company is not required to cover all of those therapeutically equivalent versions, as long as at least one is covered without cost sharing.

If a covered therapeutic equivalent of a drug, device, or product is not available, or is deemed medically inadvisable by the Insured Person's Physician, the Company will provide coverage, subject to the Company's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost sharing.

If an Insured Person's Physician determines that none of the methods designated by the Company are medically appropriate for the Insured Person, the Company will cover some other FDA-approved prescription contraceptive method prescribed by the Insured Person's Physician.

Benefits will be payable for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an Insured by a Member Pharmacy or PPO Provider or at a location licensed or otherwise authorized to dispense drugs or supplies.

Benefits for Covered Charges from a Member Pharmacy or PPO Provider for generic and single source contraceptive drugs will be payable at 100%. Benefits for Covered Charges from a Member Pharmacy or PPO Provider for brand name contraceptive drugs will be payable the same as any other covered Treatment or Service and will be subject to cost-sharing. Benefits for Covered Charges from a Member Pharmacy or PPO Provider for brand name contraceptive drugs will be payable at 100% if there is no generic equivalent available. Some or all of the above services may not be payable when received from a Non-Member Pharmacy or Non-PPO Providers. The above services from Non-PPO Providers will be subject to Deductible and coinsurance.

- **Clinical Trials - (These benefits will be coordinated with the state mandated Clinical Trials benefit described further down in this section.)**

Covered Charges will include charges incurred for routine patient care costs in connection with an Approved Clinical Trial. Benefits will be payable the same as any other covered Treatment or Service.

For the purposes of this section, routine patient costs include medically necessary Treatment or Service provided to a Qualified Individual in relation to cancer or other Life-Threatening Condition that are considered Covered Charges consistent with benefits provided under the Group Policy for an Insured Person not enrolled in an Approved Clinical Trial. Routine patient costs do not include:

- Experimental or Investigational Measures (the investigational item, device, or service, itself);
- Treatment or Service provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Qualified Individual; or
- Treatment or Service that is clearly inconsistent with Generally Accepted and established standards of care for a particular diagnosis.

The Company may require a Qualified Individual to participate in an Approved Clinical Trial conducted in-network through a PPO Provider, if the PPO Provider participates in the trial and will accept the Qualified Individual in the trial. This does not preclude a Qualified Individual from participating in an Approved Clinical Trial conducted out-of-network through a Non-PPO Provider; however, in that circumstance, benefits will be paid at the non-PPO level.

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition; and

- the study or investigation is federally approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - the National Institutes of Health;
  - the Centers for Disease Control and Prevention;
  - the Agency for Health Care Research and Quality;
  - the Centers for Medicare & Medicaid Services;
  - a cooperative group or center of any of the above named entities or the Department of Defense or the Department of Veterans Affairs;
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - the Department of Veterans Affairs, the Department of Defense, or the Department of Energy provided the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:
    - to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and

- assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or

- the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

"Life-Threatening Condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Qualified Individual" means an Insured Person who meets the following conditions:

- is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Condition; and

- either:

  - the referring health care professional participates in the trial and has concluded that the Insured Person's participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in the first bullet above; or
  - the Insured Person provides medical and scientific information establishing that the Insured Person's participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in the first bullet above.

Benefits Payable - State Required - California

Subject to the provisions as described above, including any required under federal law, benefits will be payable under the Group Policy for:

- **Abortions and Abortion Related Services**

  Covered Charges will include charges for all abortions, including medication and surgical abortions, and abortion related services, including pre-abortion and follow-up services.

  Benefits will be payable at 100% of Covered Charges and no Deductible or Copay will apply.

- **AIDS Vaccine**

  Covered Charges will include the cost of a vaccine administered for acquired Immune Deficiency Syndrome (AIDS). The vaccine must be approved for marketing by the federal Food and Drug Administration and recommended by the United Public Health Services.

  Benefits will be payable the same as any other covered Treatment or Service.

- **Blood Lead Levels Screening**

  Benefits payable for a Dependent Child will include Covered Charges incurred for screening for blood lead levels in Dependent Children who are at risk for Lead Poisoning, as determined by a health care provider.

  For these purposes, a health care provider is any of the following:

  - a person licensed to practice medicine in California;
  - a nurse practitioner licensed to practice in California; or
  - a physician assistant licensed to practice in California.

"Lead Poisoning" means: the disease present when:

- the concentration of lead in whole venous, arterial, or cord blood reaches or exceeds levels constituting a health risk, as specified in the most recent United States Centers for Disease Control and Prevention guidelines for lead poisoning as determined by the California Department of Public Health; or
- the concentration of lead in whole venous, arterial, or cord blood reaches or exceeds levels constituting a health risk as determined by the Department.

Benefits will be payable as described below under Children's Preventive Pediatric Care Services.

- **Breast Cancer Screening and Treatment**

Covered Charges will include charges incurred for breast cancer screening, diagnosis, and treatment. The charges will include, but are not limited to:

- prosthetic devices or reconstructive surgery for the diseased breast on which the mastectomy was performed, and prosthetic devices or reconstructive surgery for a healthy breast if, in the opinion of the attending Physician and surgeon, the surgery is necessary to achieve normal symmetrical appearance; and
- complications from a mastectomy, including lymphedema.

As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

Preventive breast cancer screening tests from PPO Providers will be payable at 100% and no Deductible or Copay will apply. (See Mammographies as described below in this Benefits Payable - State Required - California.)

Preventive breast cancer screening tests from Non-PPO Providers will be subject to the Deductible and coinsurance.

Coverage for prosthetic devices and reconstructive surgery will be subject to the Deductible and coinsurance.

Note: This benefit will be coordinated with the Women's Health and Cancer Rights Act of 1998 benefit as described under Benefits Payable – Required by Federal Law above.

- **California Prenatal Screening Program**

Covered Charges will include charges incurred while participating in the California Prenatal Screening Program which is a statewide prenatal testing program administered by the State Department of Health Services.

Benefits will be payable at 100% of Covered Charges and no Deductible or Copay will apply.

- **Cancer Screening Tests**

Covered Charges will include charges incurred for all generally medically accepted cancer screening tests including biomarker testing.

Preventive cancer screening tests from PPO Providers will be covered in accordance with guidelines from the following organizations:

- U.S. Preventive Services Task Force; and
- Health Resources and Services Administration.

Preventive cancer screening tests meeting the guidelines from the above organizations, received from PPO Providers, will be payable at 100% and no Deductible or Copay will apply.

Preventive cancer screening tests from Non-PPO Providers will be subject to Deductible and coinsurance.

All other cancer screening tests will be payable the same as for any other Physician Office or Clinic Visit.

- **Cervical Cancer Screening Test**

Covered Charges will include charges incurred for an annual cervical cancer screening test upon the referral by a Physician and surgeon, nurse practitioner or certified nurse midwife, providing care to the Insured Person and operating within the scope of his/her license. Coverage for an annual cervical cancer screening test includes the conventional Pap smear, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration, and any cervical screening test approved by the federal Food and Drug Administration, upon the referral of the Insured Person's health care provider.

Preventive cervical cancer screening tests from PPO Providers will be payable at 100% and no Deductible or Copay will apply.

Preventive cervical cancer screening tests from Non-PPO Providers will be subject to Deductible and coinsurance.

All other cervical cancer screening tests will be payable the same as for any other covered Treatment or Service.

- **Children's Preventive Pediatric Care Services**

Benefits payable for a Dependent Child will include Covered Charges incurred for Children's Preventive Pediatric Care Services from the moment of birth through age 18 as described below.

- **Covered Services**

Benefits for Children's Preventive Pediatric Care Services will be consistent with the most recent Bright Futures Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics and will include:

- periodic physical examinations; and
- immunizations; and
- laboratory services in connection with the periodic physical examinations. and
- screening for blood lead levels in children who are at risk for lead poisoning, as determined by a health care provider in accordance with the applicable state law; and
- screenings for Adverse Childhood Experiences (ACEs).

- **Definitions**

For purposes of this section, “Adverse Childhood Experiences,” or “ACEs,” means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being.

- **Rate of Payment**

  If Children's Preventive Pediatric Care Services are provided by a PPO Provider, benefits will be payable at 100% of Covered Services and no Deductible or Copay will be applied.

  If services are provided by a Non-PPO Provider, benefits will be payable the same as any other covered Treatment or Service.

  Note: This benefit will be coordinated with the Pediatric Vaccine benefit and Preventive and Wellness Health Services as described in Benefits Payable – Required by Federal Law above and the Blood Lead Levels Screening benefit above.

- **Clinical Trials - (These benefits will be coordinated with the federal Clinical Trials benefit described above.)**

Covered Charges will include charges incurred for Routine Patient Care Costs related to an approved clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life threatening disease or condition for a Qualified Insured:

Treatment or Service must be provided in a clinical trial:

- is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration; or
- is a drug trial that is exempt from a new drug application reviewed by the United States Food and Drug Administration; or
- is approved or funded by one or more of the following:

  - one of the National Institutes of Health; or
  - the federal Centers for Disease Control and Prevention; or
  - the Agency for Healthcare Research and Quality; or
  - the federal Centers for Medicare and Medicaid Services; or
  - the federal Food and Drug Administration, in the form of an investigational new drug application; or
  - a cooperative group or center of any of the entities described above, the United States Department of Defense, or the United States Department of Veteran Affairs; or

- a qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for Center Support Grants; or
- one of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
  - the United States Department of Veterans Affairs.
  - the United States Department of Defense.
  - the United States Department of Energy

For the purpose of this benefit:

"Life-threatening Disease or Condition" means a disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

"Qualified Insured" means an insured who meets both of the following conditions:

- the insured is eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition; and
- either of the following applies:
  - the referring health care professional is a participating provider and has concluded that the insured's participation in the clinical trial would be appropriate because the insured meets the above conditions; or
  - the insured provides medical and scientific information establishing that the insured's participation in the clinical trial would be appropriate because the insured meets the above conditions.

"Routine Patient Care Costs" include drugs, items, devices, and services provided consistent with coverage under the policy for an insured who is not enrolled in an approved clinical trial, including the following:

- Drugs, items, devices, and services typically covered absent a clinical trial;
- Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service;
- Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service;

- Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service; and
- Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

"Routine Patient Care Costs" does not include the following:

- The investigational drug, item, device, or service itself;
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the insured;
- Drugs, items, devices, and services specifically excluded from coverage in the policy, except for drugs, items, devices, and services required to be covered pursuant to this Update or other applicable law; or
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

Benefits will be payable for Treatment or Service provided: (a) by a PPO Provider at the agreed-upon rate and (b) by a Non-PPO Provider at the negotiated rate the Company would otherwise pay to a PPO Provider for the same services, less applicable Copays and Deductibles.

- **Colorectal Cancer Screening Tests**

Covered Charges will include charges incurred for a colorectal cancer screening test assigned either an A or B grade by the United States Preventive Services Task Force, including screening examinations or laboratory tests that aren't colonoscopies. For positive results from such tests or procedures, the resulting required colonoscopy must also be covered.

Preventive colorectal cancer screening tests from PPO Providers will be payable at 100% and no Deductible or Copay will apply.

Benefits for preventive colorectal cancer screening tests are not payable when received from Non-PPO Providers.

All other colorectal cancer screening tests will be payable the same as for any other covered Treatment or Service.

- **Contraceptive Supplies for Other than Contraceptive Purposes**

Covered Charges will include charges incurred for contraceptive supplies ordered by a Physician for reasons other than for contraceptive purposes such as:

- decreasing the risk of ovarian cancer; or
- eliminating symptom of menopause; or
- for prescription contraception that is necessary to preserve the life or health of the Insured Person.

If medical care is received from Preferred Providers, benefits will be payable at 100% of Covered Charges and no Deductible or Copay will be applied.

If medical care is received from Non-Preferred Providers, benefits will be payable the same as any other Treatment or Service.

- **Dental Services – General Anesthesia and Hospital Charges**

Covered Charges will include charges incurred for general anesthesia and for associated Hospital or Ambulatory Surgery Center charges when the clinical status, or underlying medical condition of the Insured Person requires dental treatment to be rendered in a hospital setting. Benefits are payable when incurred by:

- Insured Persons who are under the age of seven; or
- Insured Persons who are severely disabled; or
- Insured Persons, regardless of age, whose health is compromised and for whom general anesthesia is medically necessary.

Benefits payable will not include charges for the dental procedures, including the professional fee of the dentist.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Diabetes**

  - **Diabetic Equipment, Supplies and Prescriptions**

    - **Benefits Payable**

      Covered Charges will include charges incurred for diabetic equipment, and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary even if the items are available without a prescription.

      Covered Charges will also include diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable the Insured Person to properly use the equipment, supplies, and medications and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the Insured Person's Physician.

      Benefits will be payable the same as for any other covered Treatment or Service.

    - **Covered Charges**

      - **Equipment and Supplies**

        Coverage for medically necessary equipment and supplies will include the following:

        - Blood glucose monitors and blood glucose testing strips;
        - Blood glucose monitors designed to assist the visually impaired;
        - Insulin pumps and all related necessary supplies;
        - Ketone urine testing strips;
        - Lancets and lancet puncture devices;
        - Pen delivery systems for the administration of insulin;
        - Podiatric devices to prevent or treat diabetes-related complications;
        - Insulin syringes;
        - Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

- **Prescriptions**

In addition, Covered Charges will include the following prescription items if the items are determined to be medically necessary:

- Insulin;
- Prescriptive medications for the treatment of diabetes;
- Glucagon.

NOTE: For the purpose of these state-required benefits, the following diabetic supplies will be payable under Prescription Drug Expense Covered Charges or Mail Service Prescription Drug Expense Covered Charges: insulin; disposable insulin needles/syringes; disposable blood/urine glucose acetone testing agents (e.g. Chemstrips, Acetest tablets, and Clinitest tablets); lancets; glucometers (limited to no more than one each Calendar Year); glucagon, prescriptive medications for the treatment of diabetes; and alcohol swabs.

All other diabetic supplies will be payable the same as any other covered Treatment or Service as described in this section.

- **Diabetic Daycare Self-Management Education Programs**

Covered Charges will include charges for Diabetic Daycare Self-Management Education as described below:

- **Definition**

Diabetic Self-Management Education Program means instruction which will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy thereby avoiding frequent hospitalizations and complications. The program must be state-certified and must be provided by healthcare professionals, including but not limited to Physicians, licensed registered nurses (R.N.s) and licensed pharmacists who are knowledgeable about the treatment of diabetic patients. Programs whose sole or primary purpose is weight reduction are not covered.

- **Benefits Payable**

Covered Charges will include professional fees, laboratory services and prescription drugs. Benefits will be payable the same as for any other covered Treatment or Service; however, Physician Visits are limited to one per day. Benefits are payable only if the covered person enrolled in the program has been diagnosed as a diabetic. Benefits are not payable for nutritional components or books, or for any charges incurred by the Insured Person's family members.

- **FDA Approved Drugs**

Covered Charges will include charges for federal Food and Drug Administration (FDA) approved drugs prescribed for conditions not specifically noted in the approval provided all of the following conditions have been met:

- the drug is approved by the FDA; and
- the drug is prescribed by a contracting licensed health care professional for the treatment of a life-threatening condition; or
- the drug is prescribed by a contracting licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition; and
- the drug has been recognized for treatment of that condition by any of the following:
    - the American Hospital Formulary Service Drug Information; and
    - one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
        - The Elsevier Gold Standard's Clinical Pharmacology; or
        - The National Comprehensive Cancer Network Drug and Biologics Compendium; or
        - The Thomson Micromedex DrugDex; or
    - two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Any prescription drug coverage required by the provision must also include medically necessary services associated with the administration of the drug.

"Life-threatening" means either or both of the following:

- diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
- diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Footwear for Foot Disfigurement**

  Covered Charges will include charges special footwear for foot disfigurement necessary for persons who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.

  Benefits will be payable the same as for any other covered Treatment or Service subject to a Calendar Year maximum payment of $500. These benefits must be prescribed by a Physician and will be subject to the Covered Charges requirements of the Group Policy.

- **Home Test Kits for Sexually Transmitted Diseases**

  Covered Charges will include charges for Home Test Kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by a PPO Provider, or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

  For purposes of this section, "Home Test Kit" means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow Insured Persons to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

  Benefits for an FDA-approved combination antigen/antibody HIV self-test for periodic HIV screening will be payable at 100% of Covered Charges when deemed medically necessary or appropriate and ordered directly by an in-network clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

  Benefits for all other Home Test Kits will be payable the same as for any other covered Treatment or Service.

- **Human Immunodeficiency Virus (HIV) Testing**

Covered Charges will include charges for Human Immunodeficiency Virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

Benefits will be payable the same as for any other covered Treatment or Service except as described above under Preventive Health and Wellness Services or Home Test Kits for Sexually Transmitted Diseases.

- **Infertility Treatment**

Covered Charges will include charges incurred for covered services for the diagnosis and treatment of infertility including, but not limited to, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer, regardless of experimental status.

- **Definitions**

"Infertility" means either:

- the presence of a demonstrated condition recognized by a licensed medical physician as a cause of infertility, or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

"Treatment of infertility" means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer (GIFT).

"In vitro fertilization" means the laboratory medical procedures involving the actual in vitro fertilization process.

- **Rate of Payment**

Benefits for these covered services will be payable the same as for any other covered Treatment or Service up to a lifetime maximum benefit of $1,000 for each Insured Person.

- **Covered Services**

Coverage for procedures for gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer will be provided if:

- the Insured Person has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments for which coverage is available under the Group Policy; and
- the Insured Person has not undergone four completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals will be covered; and
- the procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or the American Fertility Society minimal standards for programs of in-vitro fertilization.

- **Covered Services Limitations**

For purposes of these state-required benefits, covered services will not include and no benefits will be paid for:

- in vitro fertilization; or
- reversal of voluntary sterilization; or
- payment for medical services rendered to a surrogate for purposes of childbirth; or
- costs associated with cryopreservation and storage of sperm, eggs, and embryos; provided, however, subsequent procedures of a medical nature necessary to make use of the cryopreserved substance will not be similarly excluded if deemed non-experimental and non-investigational; or
- selected termination of an embryo; provided, however, that where the life of the mother would be in danger, were all embryos to be carried to full term, said termination shall be covered; or
- non-medical costs of an egg or sperm donor; or
- travel costs for travel within 100 miles of the Insured Person’s home address as filed with the Company and travel costs not medically necessary and not mandated or required by the Company; or
- infertility treatments, other than those described above, deemed experimental in nature, however, where infertility treatment includes elements which are not experimental in nature along with those which are, to the extent services may be delineated and separately charged, those services which are not experimental in nature will be covered.

- **Jawbone Surgical Procedures**

  Covered Charges will include coverage for medically necessary surgical procedures directly affecting the upper and lower jawbone or associated joints.

  Benefits will be payable the same as for any other covered Treatment or Service.

- **Laryngectomy – Prosthetic Devices**

  Benefits Payable

  Covered Charges will include charges for prosthetic devices to restore a method of speaking.

  Benefits will be payable the same as for any other covered Treatment or Service.

  Definitions

  "Laryngectomy" means the removal of the larynx for medically necessary reasons, as determined by a licensed physician and surgeon.

  "Prosthetic devices" mean and include the provision of initial and subsequent prosthetic devices, including installation accessories, pursuant to an order of the patient's physician and surgeon. "Prosthetic devices" do not include electronic voice producing machines.

- **Mammographies**

  Covered Charges will include charges incurred for mammography for screening or diagnosis.

  - If services are provided by a PPO Provider, benefits for screening mammograms will be payable the same as the Preventive Health and Wellness Services benefits as described above under Benefits Payable – Required by Federal Law.
  - All other mammograms will be payable the same as for any other covered Treatment or Service.

- **Non-Preventive Maternity Services**

Covered Charges will include coverage for ambulatory care maternity services, involuntary complication of pregnancy, neonatal care and inpatient hospital maternity care, including labor, delivery, and postpartum care. Benefits will be payable the same as for any other covered Treatment or Service.

Benefits for Hospital Inpatient Confinement charges will be payable for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean section. Benefits will be payable the same as for any other covered Treatment or Service; however, the 48-hour and 96-hour minimum will not be subject to the Precertification or Covered Charges requirements of the Group Policy. Any benefits payable in excess of the 48-hour or 96-hour minimum will be subject to all terms and conditions of the Group Policy that apply to any other covered Treatment or Service.

Covered Charges for inpatient hospital care may be for a time period less than 48 or 96 hours if:

- the decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating Physicians in consultation with the mother; and
- the Covered Charges include a post discharge follow up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating Physician. The visit will be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit will include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating Physician will disclose to the mother the availability of a post discharge visit, including an in-home visit, physician office visit, or a visit to a facility under contract with the Company. The treating Physician, in consultation with the mother, will determine whether the post discharge visit will occur at home, the contracted facility, or the treating Physician's office after assessment of certain factors. These factors will include, but not be limited to, the transportation needs of the family, and environmental and social risks.

Preventive Maternity Services such as well-woman visits include prenatal and postnatal care. Benefits will be payable the same as any other Adult Wellness as described on page NBM 5102 PPO – Summary of Benefits.

- **Orally Administered Anti-Cancer Medication**

Covered Charges for the treatment of cancer will include prescribed orally administered anticancer medication that is used to kill or slow the growth of cancerous cells.

The level of benefits provided for orally administered cancer medication will not be less than the level of benefits provided for intravenously administered or injected cancer medication i.e., the insurance cannot be subject to any preauthorization, dollar limit, Copayment (Copay) Deductible, or Coinsurance that does not apply to intravenously administered or injected anticancer medication. Benefits for orally administered anticancer medication will be payable at 100% and no Deductible or Copay will apply. Benefits for intravenously administered or injected cancer medication will be payable as described in the Schedule of Benefits section of this booklet-certificate.

- **Orthotic and Prosthetic Devices**

Covered Charges will include original and replacement orthotic devices as prescribed by a Physician or as ordered by a licensed health care provider acting within the scope of his or her limited license. Covered Charges will also include original and replacement prosthetic devices as prescribed by a Physician.

Benefits will be payable the same as for any other covered Treatment of Service.

- **Osteoporosis Services**

Covered Charges will include charges for services related to diagnosis, treatment and appropriate management of osteoporosis. Such services will include, but are not limited to, all Food and Drug Administration approved technologies including bone mass measurement when medically necessary.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Phenylketonuria (PKU)**

Covered Charges will include charges for the testing and treatment of Phenylketonuria (PKU) for those Formulas and Special Food Products that are a part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Company, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

- **Definitions**

"Formula" means an enteral product or enteral products for use at home that are prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribed dietary treatments, as medically necessary for the treatment of PKU.

"Special Food Product" means a food product that is both of the following:

- prescribed by a Physician or nurse practitioner for the treatment of PKU and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and
- used in place of normal food products, such as grocery store foods, used by the general population.

- **Rate of Payment**

Benefits will be payable the same as for any other covered Treatment or Service.

- **Prenatal Diagnosis of Genetic Disorders**

Covered Charges will include charges for Prenatal Diagnosis of Genetic Disorders of the fetus by diagnostic procedures in instances of high risk pregnancy.

Benefits will be payable at the PPO level for Treatment or Service received from either a PPO or a Non-PPO Provider.

- **Preventive Health Services for HIV Preexposure Prophylaxis (PrEP)**

Covered Charges will include charges incurred for preventive health services for HIV Preexposure Prophylaxis (PrEP) for:

- Insured Persons, including adolescent Dependents, who are high risk of HIV infection, as determined by the Insured Person's attending Physician;
- prescription drugs approved by the U.S. Food and Drug Administration for HIV PrEP and recommended for HIV PrEP by the Centers for Disease Control and Prevention (CDC) in its most recently updated clinical practice guidelines and official publications. No preauthorization is required for these drugs;

- services needed for HIV PrEP initiation and follow-up care recommended by the USPSTF, as specified in the CDC's most recently updated clinical guidance and determined by a person's attending health care provider, including but not limited to:

  - Provider office and telehealth visits for prescribing and medication management;
  - HIV testing;
  - Kidney function testing;
  - Serologic testing for hepatitis B and C viruses;
  - Hepatitis B vaccination;
  - Testing for other sexually transmitted infections, including 3-site testing for gonorrhea and chlamydia;
  - Pregnancy testing; and
  - Ongoing follow-up and monitoring every 3 months.

Benefits will be payable at 100% of Covered Charges and no Deductible or Copay will apply.

- **Prostate Cancer Screening**

Covered Charges will include charges incurred for the screening and diagnosis of prostate cancer. Benefits will include prostate-specific antigen testing and digital rectal examinations when medically necessary.

Benefits will be payable the same as any other covered Treatment or Service.

- **Reconstructive Surgery**

Covered Charges will include coverage for Reconstructive surgery.

"Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if the surgery is to do either of the following:

- improve function; or
- create a normal appearance, to the extent possible.

Reconstructive surgery also includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

"Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Second Opinion**

When requested by an Insured Person or contracting health professional who is treating an Insured Person, Covered Charges will include charges incurred for a second opinion by an appropriately qualified health care professional.

An appropriately qualified health care professional is a primary care physician or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Telehealth**

Covered Charges will include charges for Telehealth. Prior to the delivery of health care via Telehealth, the Insured Person's health care provider at the originating site must verbally inform him or her that Telehealth may be used and obtain verbal consent from the Insured Person for this use. The verbal consent must be documented in the Insured Person's medical record.

The use of Telehealth cannot be required if the Insured Person's health care provider has determined that it is not appropriate.

- Definitions

"Asynchronous store and forward" means the transmission of the Insured Person's medical information from an originating site to the health care provider at a distant site without the presence of the Insured Person.

"Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

"Health care provider" means a person who is licensed under this division.

"Originating site" means a site where the Insured Person is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

"Synchronous interaction" means a real-time interaction between the Insured Person and a health care provider located at a distant site.

"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of the Insured Person's health care while he or she is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for the Insured Person and includes synchronous interactions and asynchronous store and forward transfers.

- Rate of Payment

Benefits will be payable the same as if the covered Treatment or Service is received on an in-person basis.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

Benefits Payable

Benefits payable will be as described in the following NBM 5402 sections, subject to:

- all listed terms, conditions and limitations; and
- all Payment Provisions as described in page NBM 5400; and
- the terms, conditions and limitations of Utilization Management Program, Coordination With Other Benefits, Integration With Medicare and Subrogation and Reimbursement.

COVERED CHARGES

Covered Charges will be the actual cost charged to the Insured Person but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Covered Charges for Comprehensive Medical benefits payable will be based on four categories of medical care services as described below.

Payment of Covered Charges not listed shall be determined by the Company based on the amount payable for a Covered Charge of a comparable nature.

- **Hospital Services** include:

  - charges by a Hospital for room and board (but not more than the Hospital Room Maximum if confinement is in a private room); and
  - Hospital services other than room and board; and
  - charges by a Physician for pathology, radiology, or the administration of anesthesia while receiving treatment in a Hospital (on an inpatient or outpatient basis); and
  - the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), but only when such services are provided while receiving treatment during a Hospital Inpatient Confinement or as otherwise required by state law; and
  - physical, occupational, and speech therapy, but only when such services are provided while receiving treatment during a Hospital Inpatient Confinement; and
  - charges for blood and blood plasma when provided while the Insured Person is receiving treatment during a Hospital Inpatient Confinement; and
  - Birthing Center services; and
  - Ambulatory Surgery Center services; and
  - Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described in page NBM 5402 F; and
  - freestanding dialysis center services.

- **Physician's Hospital Services** include charges for:

  - the services of a Physician while receiving treatment at a Hospital, on an inpatient or outpatient basis (including surgery and Physician Visits); and
  - outpatient physical, occupational and speech therapy, performed in an outpatient Hospital setting, not to exceed 30 visits per Calendar Year, except that outpatient physical, occupational, and speech therapy will not be subject to any visit limits for Medically Necessary Treatment of a Mental Health and Substance Use Disorder, less any therapy visits payable for the Calendar Year under Physician's Office or Clinic Services; and
  - Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described in page NBM 5402 F; and
  - the services of a Physician for surgery received in a Physician's office, clinic or Ambulatory Care Center or an Urgent Care Center.

- **Physician's Office or Clinic Services** include:

  - charges for Treatment or Service furnished at the Physician's office or clinic or an Urgent Care Center. Such services include charges for a Physician Visit, injections, take-home drugs, blood, blood plasma, x-ray and laboratory examinations, x-ray, radium, and radioactive isotope therapy, removal of impacted teeth; and
  - dressings, supplies, equipment not considered to be Durable Medical Equipment as described in page NBM 5402 J, anesthesia; and
  - the services of a Health Care Extender; and
  - outpatient physical, occupational, and speech therapy not to exceed 30 visits per Calendar Year for each Insured Person, except that outpatient physical, occupational, and speech therapy will not be subject to any visit limits for Medically Necessary Treatment of a Mental Health and Substance Use Disorder; and
  - Traditional East Asian Medicine as described in page NBM 5402 N; and
  - Telemedicine or Telehealth Treatment or Service; and
  - Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine); and
  - Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described in page NBM 5402 F; and
  - Dental Services to repair damages to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within twelve months after the accident. Covered Charges are limited to the least expensive procedure that would provide professionally acceptable results; and
  - the services of a certified respiratory care practitioner when performing pulmonary rehabilitation and respiratory home care services, if such services are furnished according to a method of treatment prescribed by a Physician; and
  - the services of a licensed speech pathologist or audiologist for treatment of speech or hearing impairments.

- **All Other Covered Services** include:

  - drugs and medicines: (i) requiring a Physician's prescription; and (ii) approved by the Food and Drug Administration for general marketing; and (iii) which are not otherwise considered Covered Charges under the Comprehensive Medical Expense portion of the Group Policy; and (iv) so long as said drugs or medicines are not subject to the limitations as described in page NBM 5402 Q - Limitations and excluding those charges paid under Prescription Drugs Expense Insurance as described in page NBM 5424 and Mail Service Prescription Drugs Expense Insurance as described in page NBM 5425; and
  - charges for ambulance or ambulance transport services (including air ambulance services) provided by a Hospital or a licensed service or through the "911" emergency response system, for emergency medical transportation services to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) or to and from a Hospital when needed to transition to a more cost effective level of care as determined by the Company; and
  - covered orthotics, casts, splints, braces, crutches; and
  - Skilled Nursing Facility Care as described in page NBM 5402 M; and
  - Hospice Care as described in page NBM 5402 L; and
  - Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described in page NBM 5402 F; and
  - Home Health Care as described in page NBM 5402 I; and
  - Home Infusion Therapy Services as described in page NBM 5402 I; and
  - Durable Medical Equipment as described in page NBM 5402 J; and
  - Prosthetics as described in page NBM 5402 K; and
  - the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), but only when such services are provided as part of Home Health Care, Home Infusion Therapy Services or Hospice Care as required by state law; and
  - cornea or skin transplants; and
  - oxygen (including rental of equipment for its administration) and nebulizers and related charges; and
  - the following services performed while the Insured Person is not Hospital Inpatient Confined, or is not in a Hospital emergency room: magnetic resonance imaging (MRIs), computerized axial tomography (CATs), positron emission tomography (PETs), and single photon emission computerized tomography (SPECTs), or other similar imaging tests and all related services (other than evaluation and management services) including but not limited to drugs and supplies; and
  - unattended (home) sleep studies.

Drug and Medicine Management

For certain drugs or classes of drugs designated by the Company, the Company reserves the right to:

- require preauthorization for dispensing; and
- limit the quantity of drugs for which benefits will be paid; and
- require the dispensing of certain drugs before paying benefits for another drug within a given class, as established by the Company; and
- require the dispensing of a single daily dose of certain drugs.

For drugs requiring preauthorization, the Pharmacy Benefit Manager must notify the prescribing provider within 72 hours of receipt of a non-urgent request or 24 hours if exigent circumstances exist, whether the request is approved or disapproved. If the Pharmacy Benefit Manager fails to respond within the respective timeframes, the request is deemed approved for the duration of the prescription, including refills. If the request for preauthorization is incomplete or clinically relevant material information necessary to make a coverage determination is not included, the Pharmacy Benefit Manager must notify the prescribing provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or clinically relevant material information is needed to approve or deny the preauthorization or to appeal the denial thereof. Once the requested information is received, the applicable time period to approve or deny a preauthorization or to appeal, will begin to elapse. If a coverage determination or request for additional or clinically relevant material information by the Pharmacy Benefit Manager is not received by the prescribing provider within the time allotted, the preauthorization or appeal of a denial thereof, shall be deemed approved for the duration of the prescription, including refills. In the event of a denial, the Pharmacy Benefit Manager must inform the prescribing provider and insured of the external appeal process below.

Cosmetic Treatment or Service

Covered Charges will include Cosmetic Treatment or Service resulting from a sickness or an accidental injury (except as described under Reconstructive Surgery on page NBM 5400 – Payment Provisions), and rendered within 18 months after the date the sickness or accidental injury was first diagnosed. Benefits will be payable the same as for any other covered Treatment or Service.

Smoking Cessation

Covered Charges will include charges incurred for Smoking Cessation. For each tobacco cessation attempt, benefits will be payable without Precertification for:

- Screening for tobacco use; and
- A minimum of four (4) in-person tobacco cessation counseling sessions (including group counseling and individual counseling), as well as three (3) telephone counseling sessions, all of which are at least 10 minutes each; and
- Self-help materials that are tailored to the individual patient; and
- All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications, and including combining multiple medications) for a minimum of the length of time specified in the Agency for Healthcare Research and Quality's (AHRQ) "Suggestions for the Clinical Use of Medications for Tobacco Dependence Treatment."

If medical care is received from Preferred Providers, benefits will be payable at 100% of Covered Charges and no Deductible or Copay will apply.

If medical care is received from Non-Preferred Providers, no benefits will be payable.

Covered Charges for Multiple Surgical Procedures

If an Insured Person undergoes two or more procedures during the same anesthesia period, Covered Charges for the services of the Physician, facility, or other covered provider for each procedure that is clearly identified and defined as a separate procedure will be based on:

- 100% of Prevailing Charges for the first or primary procedure; and
- 50% of Prevailing Charges for the second procedure; and
- 25% of Prevailing Charges for each of the other procedures.

Covered Charges for an Assistant during Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if the skill level of a Medical Doctor or Doctor of Osteopathy would be required to assist the primary surgeon. Covered Charges for such services will be paid up to 20% of the Prevailing Charge of the covered surgical procedure if the procedure is performed by a Physician or Health Care Extender.

In addition, the multiple surgical procedures percentages, as described above will be applied.

Covered Charges Carried Forward

To determine Deductible satisfaction, Treatment or Service received by an Insured Person during the last three months of a Calendar Year may be counted as if received in either:

- the Calendar Year in which actually received; or
- the next following Calendar Year;

whichever would result in the greater benefit payment.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

MENTAL HEALTH AND SUBSTANCE USE DISORDERS TREATMENT

Coverage will be provided for the Medically Necessary Treatment of Mental Health and Substance Use Disorders.

All medical necessity determinations made by the Company concerning service intensity, level of care placement, continued stay, and transfer or discharge of Insured Persons diagnosed with Mental Health and Substance Use Disorders will be made using the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

If Treatment or Services for the medically necessary treatment of a Mental Health or Substance Use Disorder are not available in-network within the geographic and timely access standards set by law or regulation, the Company will arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow up services that, to the maximum extent possible, meet those geographic and timely access standards. For more details regarding timely access standards please see "Timely Access to Care" located in Summary of Benefits section of this booklet-certificate. As used in this section, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the Insured Person within geographic and timely access standards. The Insured Person will pay the same cost sharing that he or she would pay if the covered Treatment or Services would have been received from a PPO Provider.

- **Inpatient Hospital Services**

  If an Insured Person is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Substance Use Disorder Treatment Facility, a psychiatric or an alcohol/drug unit of a general Hospital, or a residential treatment center or facility, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

  Benefits are payable the same as for any other Hospital Inpatient Confinement. Hospital Inpatient Confinements are subject to the Utilization Management Program, including Precertification requirements, as described on NBM 5407 CC.

- **Outpatient Office Visits**

Covered Charges for Treatment or Service received by a Physician at an outpatient office visit will include, but not be limited to:

- mental health evaluations and treatment;
- drug therapy monitoring for Mental Health and Substance Use Disorder treatment;
- treatment for substance abuse withdrawal symptoms;
- diagnostic assessment and surgical consultations for gender dysphoria;
- hormone therapy or medication management for gender dysphoria; and
- Behavioral health treatment for pervasive developmental disorder or autism delivered in an office setting.

Benefits will be payable the same as for any other Physician Visit, except that outpatient physical, occupational, and speech therapy will not be subject to any visit limits.

- **Outpatient Services other than Office Visits**

Covered Charges for Outpatient Services other than Office Visits include the following services:

- Partial Hospitalization or Day Treatment Services;
- crisis intervention or stabilization;
- psychological testing;
- individual psychotherapy;
- family therapy, if the patient is present;
- group therapy;
- electroconvulsive therapy;
- psychiatric, alcohol or drug abuse medication management;
- biofeedback;
- behavior modification treatment;
- substance use abuse rehabilitation or counseling services;
- hypnotherapy;
- recreational therapy;
- art therapy;
- music therapy;
- dance therapy;
- wilderness therapy;
- psychoanalysis and aversion therapy;
- Social Detoxification;
- after-care treatment programs for alcohol or drug abuse;
- narcosynthesis;

- fertility preservation, speech therapy and surgical services to change primary and/or secondary sex characteristics (breast, genital, gonadectomy, facial features, hair removal, etc.) in connection with gender dysphoria; and
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism delivered in other than an office setting.

If an Insured Person receives any Outpatient Services by a Hospital, Community Mental Health Center, or Outpatient Substance Abuse Treatment Facility, benefits will be payable the same as for any other Outpatient Services.

Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service.

If an Insured Person receives any Mental Health and Substance Use Disorders treatment by a Physician or Health Care Extender, benefits will be payable the same as for any other Physician Visit, except that outpatient physical, occupational, and speech therapy will not be subject to any visit limits.

- **Pervasive Developmental Disorder or Autism**

Covered Charges will also include charges for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism.

- **Covered Services**

Coverage for Behavioral Health Treatment will be provided if:

- The treatment is prescribed by a Physician and surgeon or is developed by a psychologist, both of which must be licensed according to the laws of this state; and
- The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by:

  - A Qualified Autism Service Provider; or
  - A Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider; or
  - A Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider or a Qualified Autism Service Professional.

- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with state laws which require the Qualified Autism Service Provider to do all of the following:
  - Describe the Insured Person's behavioral health impairments to be treated; and
  - Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Insured Person's progress is evaluated and reported; and
  - Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism; and
  - Discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing, or for the reimbursement of respite, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

- **Rate of Payment**

Benefits will be payable the same as for any other covered Treatment or Service; however, benefits will not be payable for Treatment or Service that exceeds the federal requirements for Essential Health Benefits.

- **Definitions**

"Behavioral Health Treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism and that meet all of the following requirements:

- The treatment is prescribed by a Physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
- The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
    - A Qualified Autism Service Provider.
    - A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
    - A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the Qualified Autism Service Provider does all of the following:
    - Describes the Insured Person's behavioral health impairments or developmental challenges that are to be treated.
    - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Insured Person's progress is evaluated and reported.
    - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Development Disorder or Autism.
    - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

"Generally Accepted Standards of Mental Health and Substance Use Disorder Care" means standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment under state law.

Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Health Care Provider" means any of the following:

- a person who is licensed under Cal Bus & Prof Code § 500 et seq. (Healing Arts).
- an associate marriage and family therapist or marriage and family therapist trainee.
- a Qualified Autism Service Provider or Qualified Autism Service Professional certified by a national entity.
- an associate clinical social worker.
- an associate professional clinical counselor or professional clinical counselor trainee.
- a registered psychologist.
- a registered psychological assistant.
- a psychology trainee or person supervised.

"Medically Necessary Treatment of a Mental Health or Substance Use Disorder" means a service or product addressing the specific needs of that Insured Person, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- Conforming to the Generally Accepted Standards of Mental Health and Substance Use Disorder Care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other Health Care Provider.

"Mental Health and Substance Use Disorders" means a mental health condition or substance use disorder:

- falling under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems; or
- that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health and Substance Use Disorders Treatment in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

"Pervasive Developmental Disorder or Autism" will be as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

"Qualified Autism Service Provider" means either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist according to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the licensee.

"Qualified Autism Service Professional" means an individual who meets all of the following criteria:

- Provides Behavioral Health Treatment; and
- Is employed and supervised by a Qualified Autism Service Provider; and
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider; and
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined by state law; and
- Has training and experience in providing services for Pervasive Developmental Disorder or Autism according to the laws of this state.

"Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

- Is employed and supervised by a Qualified Autism Service Provider or a Qualified Autism Service Professional; and
- Provides treatment and implements services according to a treatment plan developed and approved by the Qualified Autism Service Provider; and
- Meets the criteria required in the regulations for this state; and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

- **Limitations**

The general Comprehensive Medical limitations as described in page NBM 5402 Q will apply to Mental Health and Substance Use Disorder treatment.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

- **TRANSPLANT SERVICES**

Transplant Services means Covered Charges incurred in connection with the Covered Transplants listed below that are a Covered Charge and not considered to be an Experimental or Investigational Measure. The following benefits will be payable for Treatment or Service for Transplant Services. These benefits will be payable instead of any other benefits described in the Group Policy, except as otherwise provided in this section.

- **Covered Transplants**

The following human-to-human organ or bone marrow transplant procedures (including charges for organ or tissue procurement) will be considered Covered Charges, subject to all limitations and maximums described in this section, for an Insured Person.

- Heart;
- Heart/lung (simultaneous);
- Lung;
- Liver;
- Kidney;
- Kidney-Pancreas;
- Pancreas;
- Small Bowel;
- Bone marrow transplant or peripheral stem cell infusion for the following conditions when a positive response to standard medical treatment or chemotherapy has been documented. Unless otherwise indicated, coverage is for one transplant or infusion only per lifetime.
    - Acute Lymphoblastic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
    - Acute Myelogenous Leukemia - Autologous bone marrow transplant or peripheral stem cell infusion;
    - Acute Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
    - Chronic Lymphocytic Leukemia – Allogeneic bone marrow transplant or peripheral stem cell infusion;
    - Chronic Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
    - Aplastic Anemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
    - Hodgkin's Disease - Autologous bone marrow transplant or peripheral stem cell infusion;

- Hodgkin's Disease - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Non-Hodgkin's Lymphoma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Non-Hodgkin's Lymphoma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Multiple Myeloma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Multiple Myeloma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Pediatric Neuroblastoma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Pediatric Neuroblastoma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Primary Amyloidosis – Autologous bone marrow transplant or peripheral stem cell infusion;
- Myelodyplastic Syndrome - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Pediatric Monosomy 7 – Allogeneic bone marrow transplant or peripheral stem cell infusion;
- SCID (Severe Combined Immunodeficiency Disease) – Allogeneic bone marrow transplant or stem cell infusion;
- Thalassemia – Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Myelofibrosis - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Testicular cancer – Autologous bone marrow transplant or peripheral stem cell infusion;
- Wiscott-Aldrich Syndrome – Allogeneic bone marrow transplant or peripheral stem cell infusion.

The following non-myeloablative regimens are considered Covered Charges, subject to all limitations and maximums described in this section, for the Insured Person:

- Multiple Myeloma – Allogeneic bone marrow transplant or stem cell infusion;
- Non-Hodgkin’s Lymphoma – Allogeneic bone marrow transplant or stem cell infusion;
- Chronic B-Cell Lymphocytic Leukemia – Allogeneic bone marrow transplant or peripheral stem cell infusion.

Up to three (3) donor leukocyte infusions will be considered a Covered Charge following an allogeneic bone marrow transplant or peripheral stem cell infusion. Any infusions in excess of three (3) will not be covered.

As technology changes, the above referenced Covered Transplants will be subject to modifications when appropriate.

Cornea and skin transplants are not Covered Transplants for the purpose of this section. Instead, cornea and skin transplants are covered under the normal provisions of this Comprehensive Medical section, and are not subject to any conditions set forth in this section.

- **Covered Charges**

For the purpose of this section, Transplant Services Covered Charges will include all services listed in the general Comprehensive Medical Covered Charges section, including, but not limited to, services by a Home Health Care Agency, Skilled Nursing Facility, Hospice, and services for Home Infusion Therapy Services and Durable Medical Equipment.

Covered Charges will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage.

- **Benefits Payable: Within the Transplant Network**

For Transplant Services provided by a provider in the Transplant Network, benefits payable for Treatment or Service received each Calendar Year will be paid at the PPO level of benefits, subject to the Calendar Year Deductible.

If transplant related services are provided by a provider in the Transplant Network, travel and lodging expenses for the Insured Person and the Insured Person's accompanying person will be covered if the treating facility is greater than 100 miles one way from the Insured Person's home (excluding travel or lodging provided by a family member or friend). This would include ambulance expenses that would otherwise be excluded under the Comprehensive Medical ambulance benefit, if such expenses are incurred solely to meet timing requirements imposed by the transplant. Benefits payable cannot be used to satisfy any Deductible or coinsurance amount under the ambulance benefit in the normal provisions of the Comprehensive Medical section.

Travel and lodging benefits will be payable at 100%, without application of any Deductible Amount up to a lifetime maximum benefit of $5,000 for each transplant recipient.

All travel and lodging benefits must be approved in advance by the Company.

As used in this section, "Transplant Network" means any network of providers that the Company determines to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule.

- **Benefits Payable: Outside the Transplant Network**

No benefits will be payable for Transplant Services provided by other than a Transplant Network provider or for travel and lodging expenses.

- **Limitations: Applicable Within the Transplant Network**

The general Comprehensive Medical limitations listed in page NBM 5402 Q - Limitations will apply to Transplant Services. In addition, limitations specific to Home Health Care Services, Home Infusion Therapy Services, Durable Medical Equipment, Hospice Care, and Skilled Nursing Facility provisions will apply to Transplant Services if those benefits are used in connection with a Covered Transplant.

For each transplant episode Covered Charges will include:

- Transplant evaluations from no more than two transplant providers; and
- No more than one listing with the United Network of Organ Sharing (UNOS).

If the transplant is not a Covered Transplant under the Group Policy, all charges related to the transplant and all related complications will be excluded from payment under the Group Policy, including, but not limited to, dose-intensive chemotherapy.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

EMERGENCY SERVICES

If an Insured Person requires Emergency Services, either within the PPO Service Area or outside the PPO Service Area, benefits for such treatment received for these Emergency Services will be paid at the PPO level, subject to the provisions described in page NBM 5198 NS. Treatment or Service from a Non-PPO Provider for conditions that are not Emergency Services will be paid at the Non-PPO level.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

GENE-BASED, CELLULAR AND OTHER INNOVATIVE THERAPIES (GCIT)

- **Covered Charges**

Covered Charges will include benefits for Gene-Based, Cellular And Other Innovative Therapies (GCIT) as follows:

- cellular immunotherapies;
- genetically modified oncolytic viral therapy;
- other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain Therapeutic conditions;
- all human Gene-based therapy that seeks to change the usual function of a Gene or alter the biologic properties of living cells for Therapeutic use, including for example therapies using:

    - Luxturna® (Voretigene neparvovec);
    - Zolgensma® (Onasemnogene abeparvovec-xioi);
    - Spinraza® (Nusinersen);

- products derived from Gene editing technologies, including CRISPR-Cas9;
- oligonucleotide-based therapies, including for example therapies using:

    - Antisense (an example is Spinraza);
    - siRNA;
    - mRNA; and
    - microRNA therapies.

As used in this section, the following are defined terms:

"Gene" means a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

"Molecular" means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

"Therapeutic" means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

"Gene-Based, Cellular And Other Innovative Therapies (GCIT)" means any Treatment or Service that is Gene-based, cellular, and innovative Therapeutics. The services have a basis in genetic/Molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs.

- **Benefits Payable by a GCIT-Designated Facility/Provider**

For Gene-Based, Cellular And Other Innovative Therapies (GCIT) Treatment or Services provided by a GCIT-Designated Facility/Provider, benefits payable for Treatment or Service received each Calendar Year will be paid at the PPO level of benefits, subject to the Calendar Year Deductible.

If GCIT Treatment or Services are provided by a GCIT-Designated Facility/Provider, travel and lodging expenses for the Insured Person and the Insured Person's accompanying person will be covered if the GCIT-Designated Facility/Provider is greater than 100 miles one way from the Insured Person's home (excluding travel or lodging provided by a family member or friend). This would include ambulance expenses that would otherwise be excluded under the Comprehensive Medical ambulance benefit, if such expenses are incurred solely to meet timing requirements imposed by the GCIT Treatment or Service. Benefits payable cannot be used to satisfy any Deductible or coinsurance amount under the ambulance benefit in the normal provisions of the Comprehensive Medical section.

Travel and lodging benefits will be payable at 100%, without application of any Deductible Amount up to a lifetime maximum benefit of $5,000 for each GCIT Treatment or Service recipient.

All travel and lodging benefits must be approved in advance by the Company.

As used in this section, "GCIT-Designated Facility/Provider" means any network of providers that the Company determines to be an appropriate GCIT network and that has contracted to provide GCIT Treatment or Services subject to a negotiated fee schedule.

- **Benefits Payable: Outside a GCIT-Designated Facility/Provider**

For GCIT Treatment or Services provided by other than a GCIT-Designated Facility/Provider, benefits will be payable the same as any other covered Treatment or Service and subject to the Calendar Year Deductible and the applicable coinsurance rate.

No benefits will be payable for travel and lodging expenses if services are provided outside the GCIT-Designated Facility/Provider.

- **Limitations**

The general Comprehensive Medical limitations listed in page NBM 5402 Q – Limitations will apply to Gene-Based, Cellular And Other Innovative Therapies (GCIT). In addition, GCIT Covered Charges will not include charges for:

- any Gene-Based, Cellular And Other Innovative Therapies (GCIT) not approved by the Company.

GCIT Treatment or Service is subject to Precertification. Please see the Utilization Management Program described on page NBM 5407 CC.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

OUTPATIENT X-RAY SERVICES AND OUTPATIENT LABORATORY SERVICES

- OUTPATIENT X-RAY SERVICES

Payment of outpatient x-ray services will be made as follows:

- The PPO level of benefits will be paid only to Preferred Providers.
- If the Insured Person goes to a PPO or non-PPO Physician's office or clinic and the Physician sends the x-ray(s) to a PPO facility for interpretation, the PPO level of benefits will be paid. If the Insured Person is not seen within that facility, the Physician Office or Clinic Service Copay if any, will not apply, but the PPO level of benefits will be paid.
- If the Insured Person goes to a PPO or non-PPO Physician's office or clinic and the Physician sends the x-ray(s) to a non-PPO facility, the level of benefits for Non-Preferred Providers will apply.
- If the Insured Person goes to a PPO freestanding x-ray facility, the Physician Office or Clinic Service Copay, if any, will apply and the PPO level of benefits will be paid. If the x-ray facility is not a Preferred Provider, the level of benefits for Non-Preferred Providers will apply.

- OUTPATIENT LABORATORY SERVICES

Quest Diagnostics, Inc. is a laboratory provider that conducts outpatient testing. QuestSelect™, a service of Quest Diagnostics has entered into an agreement with the Company to provide outpatient Laboratory Services for which benefits are payable under the Group Policy. The following section describes benefits payable for Laboratory Services when the QuestSelect™ program is chosen. If the QuestSelect™ program is not used, regular plan benefits will apply.

When the Insured Person needs outpatient Laboratory Services, the Insured Person or his or her Physician may choose any laboratory they wish. However, the benefits will be more favorable if the QuestSelect™ program is chosen.

The Insured Person must show the QuestSelect™ identification at the Physician's office or clinic and request that the laboratory work be sent through the QuestSelect™ program to a participating Quest Diagnostics laboratory for processing. The Physician's office or clinic must call the QuestSelect™ program to have specimens picked up by courier. The paperwork accompanying the specimens must indicate the Insured Person participates in the QuestSelect™ program.

"Laboratory Services" means Covered Charges for testing of materials, fluids or tissues obtained from patients for the purpose of screening, diagnosing or monitoring a condition and for determining appropriate treatment.

If the Insured Person goes to a Physician's office or clinic and the Physician sends the laboratory work through the QuestSelect™ program to a participating Quest Diagnostics laboratory for processing, the Company will pay 100% of Covered Charges for the Laboratory Services.

If the Insured Person goes to a Physician's office or clinic and the Physician sends the laboratory work to a Quest Diagnostics laboratory which does not participate in the QuestSelect™ program, regular benefits will apply, including any applicable Deductibles, Copays and coinsurance.

If the Insured Person goes to an approved QuestSelect™ collection site with a Physician's directive and presents his or her medical or QuestSelect™ identification card and verbally requests that the QuestSelect™ program be used, the Company will pay 100% of Covered Charges for the Laboratory Services. If the collection site is not an approved QuestSelect™ collection site, regular benefits will apply, including any applicable Deductibles, Copays and coinsurance.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

EMERGENCY ROOM SERVICES

Benefits payable for Emergency Services will be subject to Copays, Deductibles and coinsurance in the following order:

- If medical care is received from PPO Providers:
  - first, the emergency room Copay, if any, will be applied; and
  - then, the applicable coinsurance percentage will be applied.

- If medical care is received from Non-PPO Providers:
  - first, the Calendar Year Deductible will be applied; and
  - then, the applicable coinsurance percentage will be applied.

The emergency room Copay amount, if any:

- will be waived if the Insured Person is admitted to the Hospital immediately following emergency room treatment; and
- will not count toward satisfaction of the Calendar Year Deductible

If an Insured Person requires Emergency Services, either within the PPO Service Area or outside the PPO Service Area, benefits for such treatment received for these Emergency Services will be paid at the PPO level, subject to the provisions described in page NBM 5198 NS. Treatment or Service from a Non-PPO Provider for conditions that are not Emergency Services will be paid at the Non-PPO level.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

HOME HEALTH CARE AND HOME INFUSION THERAPY SERVICES

- HOME HEALTH CARE SERVICES

- Covered Charges

In order to be considered a Covered Charge, Home Health Care Services must be rendered in accordance with a prescribed Home Health Care Plan. The Home Health Care Plan must be:

- prescribed by the attending Physician; and
- established prior to the initiation of the Home Health Care Services.

In addition, the attending Physician must certify that Home Health Care Services are necessary to prevent, delay or shorten Hospital Inpatient Confinement o Skilled Nursing Facility Confinement.

Covered Charges will include charges by a Home Health Care Agency for:

- part-time or intermittent home nursing care by or under the supervision of a licensed registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.); and
- part-time or intermittent home care by a Home Health Aide; and
- the services of a physical therapist, occupational therapist, speech therapist, or respiratory therapist; and
- intermittent services of a registered dietician or social worker; and
- drugs and medicines which require a Physician's prescription, (unless a Covered Charge under Home Infusion Therapy Services), as well as other supplies prescribed by the attending Physician; and
- laboratory services (unless a Covered Charge under Home Infusion Therapy Services).

- Benefits Payable

Benefits will be payable the same as for any other covered Treatment or Service except that:

- benefits will never be payable at less than 80%; and
- the Home Health Care Deductible Amount for an Insured Person will be $50 of Comprehensive Medical Covered Charges each Calendar Year. (This Deductible Amount will be applied with the Comprehensive Medical Deductible(s) for all other Covered Charges.)

The maximum benefit is 100 Home Health Care visits per Calendar Year for each Insured Person. For each covered provider, up to four hours of continuous service will be counted as one visit. Covered providers include a: Home Health Aide, licensed registered nurse (R.N.), licensed practical nurse (L.P.N.), registered dietician, social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, or any other member of the Home Health Care team.

- **Limitations**

The general Comprehensive Medical limitations listed in page NBM 5402 Q – Limitations will apply to Home Health Care. In addition, Home Health Care Covered Charges will not include charges for:

- more than 100 Home Health Care visits in a Calendar Year for each Insured Person; or
- nursing, laboratory or therapy services rendered as part of Home Infusion Therapy Services; or
- services provided by an Insured Person's Immediate Family or any other person residing in the home; or
- Custodial Care.

- **HOME INFUSION THERAPY SERVICES**

- **Covered Charges**

Covered Charges will include charges by a Home Health Care Agency, home infusion company or infusion suite for the following services:

- intravenous chemotherapy;
- intravenous antibiotic therapy;
- intravenous steroidal therapy;
- intravenous pain management;
- intravenous hydration therapy;
- intravenous antiretroviral and antifungal therapy;
- intravenous inotropic therapy;
- total parenteral nutrition;
- intravenous gamma globulin.;
- intrathecal and epidural;
- blood and blood products;
- injectable antiemetics;
- injectable diuretics; and
- injectable anticoagulants

Home Infusion Therapy Services must be rendered in accordance with a prescribed treatment plan. The treatment plan must be:

- set up prior to the initiation of the Home Infusion Therapy Service; and
- reviewed and certified as necessary by the attending Physician at least once every 30 days; and
- prescribed by the attending Physician.

In addition, the attending Physician must certify that Home Infusion Therapy Services are necessary to prevent, delay or shorten Hospital Inpatient Confinement or Skilled Nursing Facility confinement.

Covered Charges will be limited to: drugs; intravenous solutions; equipment associated with Home Infusion Therapy; pharmacy compounding and dispensing services; fees associated with drawing blood for the purpose of monitoring response to therapy; ancillary medical supplies; nursing services for intravenous restarts and dressing changes; and nursing services required due to Emergency Services or for skilled teaching.

- **Benefits Payable**

Benefits will be payable the same as for any other covered Treatment or Service.

- **Limitations**

The general Comprehensive Medical limitations listed in page NBM 5402 Q - Limitations will apply to Home Infusion Therapy Services. In addition, Home Infusion Therapy Service Covered Charges will not include charges for:

- services, drugs, equipment, or supplies used in Home Infusion Therapy Services which are covered under any other section of the Group Policy, except as specifically provided for in this section; or
- services or supplies for any Home Infusion Therapy Services not specifically provided for in this section; or
- services or supplies for any nursing visits, care or services associated with Home Infusion Therapy Services other than those identified in this section; or
- services or supplies for other services required to administer therapy in the home setting, but which do not involve direct patient contact, including, but not limited to, delivery charges and record keeping; or
- services provided by an Insured Person's Immediate Family or any other person residing in the home.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

DURABLE MEDICAL EQUIPMENT

- **Covered Charges**

Covered Charges will include charges for rental or purchase of Durable Medical Equipment on behalf of the Insured Person. Durable Medical Equipment means non-disposable equipment that:

- can withstand repeated use; and
- is primarily and customarily used to serve a medical purpose; and
- is generally not useful to a person who is not sick or injured, or used by other family members; and
- is appropriate for home use; and
- improves bodily function caused by sickness or injury, or further prevents deterioration of the medical condition.

Covered Charges will include repair, adjustment or replacement of purchased Durable Medical Equipment, unless damage results from the Insured Person's negligence or abuse of such equipment.

- **Benefits Payable**

Benefits for Durable Medical Equipment will be payable the same as for any other covered Treatment or Service. In addition, Covered Charges for rental of Durable Medical Equipment will be limited to the purchase price of the piece of equipment. If a purchase price cannot be determined, the purchase price will be deemed to equal 1.5 times the manufacturer's invoice price. The determination as to whether to purchase or rent the equipment is at the Company's sole discretion. In the event, the Company elects to purchase equipment on the Insured Person's behalf, the Insured Person will be the owner of the equipment and the Company will have no right or title to the equipment. Regardless of whether the Company elects to rent or purchase equipment, the Company will not have any responsibility, obligation or liability in connection with the equipment, its operation or maintenance.

Claims submitted for Durable Medical Equipment must be accompanied by the Physician's Written prescription of necessity. However, this prescription does not by itself entitle the Insured Person to benefits.

- **Limitations**

The general Comprehensive Medical limitations listed in page NBM 5402 Q - Limitations will apply to Durable Medical Equipment charges. In addition, Durable Medical Equipment Covered Charges will not include Durable Medical Equipment charges which:

- are in excess of the purchase price of the equipment; or
- are for Durable Medical Equipment used in Home Infusion Therapy Services, except as provided under this section above; or
- are provided during rental for repair, adjustment, or replacement of components and accessories necessary for the functioning and maintenance of covered equipment; or
- are for motorized carts or scooters and strollers, except for wheelchairs; or
- are for non-hospital type beds; or
- are for lift chairs.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

- **PROSTHETICS**

  - **Covered Charges**

    Covered Charges will include charges for prosthetic devices (including external electronic voice boxes and similar hand held communication devices after laryngectomy) and supplies which replace all or part of:

    - an absent body part (including contiguous tissue) resulting from sickness, injury, or congenital anomalies; or
    - the function of a permanently inoperative or malfunctioning body part.

    Covered Charges will include the purchase, fitting, and necessary adjustment or replacement of the prosthetic device. In addition, Covered Charges will include cleaning and repairs, unless damage results from an Insured Person's negligence or abuse of the prosthetic device.

  - **Benefits Payable**

    Benefits for Prosthetics will be payable the same as for any other covered Treatment or Service.

  - **Limitations**

    The general Comprehensive Medical limitations listed in page NBM 5402 Q - Limitations will apply to prosthetic charges. In addition, Prosthetic Covered Charges will not include charges which are:

    - for prosthetic charges that are not prescribed by the attending Physician; or
    - for dental implants.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

- **HOSPICE CARE**

  - **Covered Charges**

    Covered Charges will include charges for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Skilled Nursing Facility for:

    - any terminally ill Insured Person who chooses to participate in a Hospice Care Program rather than receive medical treatment to promote cure, and who, in the opinion of the attending Physician, is not expected to live longer than six months; and
    - the family of such Insured Person;

    but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care Program.

    Hospice Care Services consist of:

    - inpatient and outpatient hospice care, home care, nursing care, homemaking services, dietary services, social counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual; and
    - medical equipment, drugs and medicines (requiring a Physician's prescription) prescribed for the dying individual by any Physician who is a part of the Hospice Care Team; and
    - instructions for care of the patient, social counseling, and other supportive services for the family of the dying individual.

  - **Benefits Payable**

    Benefits will be payable the same as for any other covered Treatment or Service.

- **Limitations**

The general Comprehensive Medical limitations listed in page NBM 5402 Q - Limitations will apply to Hospice Care. In addition, Hospice Care Covered Charges will not include Hospice Care charges that:

- are for Hospice Care Services not approved by the attending Physician and the Company; or
- are for transportation services; or
- are for Hospice Care Services provided at a time other than while participating in a Hospice Care Program.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

SKILLED NURSING FACILITY CARE

- **Covered Charges**

If an Insured Person is confined in a Skilled Nursing Facility, Covered Charges will include any charges incurred for room, board, and other services required for treatment, provided:

- the Insured Person requires daily Skilled Nursing or skilled rehabilitation care on an inpatient basis as determined by the Company; and
- the Skilled Nursing Facility confinement results from the sickness or injury that was the cause of the Hospital Inpatient Confinement; and
- inpatient Skilled Nursing Facility confinement is certified by a Physician as necessary to treat a sickness or injury; and

either

- the Skilled Nursing Facility confinement immediately follows a Hospital Inpatient Confinement for which benefits were payable under the Group Policy; or
- the Skilled Nursing Facility confinement begins not later than 14 days after the end of Hospital Inpatient Confinement or begins not later than 14 days after the end of a prior Skilled Nursing Facility confinement for which benefits were payable under the Group Policy.

The requirements for prior Hospital Inpatient Confinement will be waived if pre-approved by the Company. If not pre-approved, and the Skilled Nursing Facility care does not follow Hospital Inpatient Confinement as described, benefits will be reduced as shown in page NBM 5407 CC - Utilization Management Program.

- **Benefits Payable**

Benefits will be payable the same as for any other covered Treatment or Service, except that:

Covered Charges for each day will not be more than 50% of:

- the actual room charge (if the Hospital Inpatient Confinement was in a semiprivate room); or
- the Hospital Room Maximum (if the Hospital Inpatient Confinement was in a private room);

of the Hospital in which the Insured Person was confined before the Skilled Nursing Facility confinement. Also, Covered Charges will not include charges for more than 120 days for all Skilled Nursing Facility confinements that result from the same or a related sickness or injury. In addition, Covered Charges will not include any charges after the date the attending Physician stops treatment or withdraws certification.

The following services will not be subject to the Skilled Nursing Facility confinement maximums as stated above:

- drugs and medicines (requiring a Physician's prescription) that are not billed by the Skilled Nursing Facility; and
- Durable Medical Equipment as that term is defined in this section that are not billed by the Skilled Nursing Facility; and
- x-ray or laboratory services that are not billed by the Skilled Nursing Facility; or
- visits by a Doctor of Medicine (M.D.) or Doctor of Osteopathy.

- **Limitations**

The general Comprehensive Medical limitations listed in page NBM 5402 Q - Limitations will apply to Skilled Nursing Facility confinements. In addition, Skilled Nursing Facility Covered Charges will not include Skilled Nursing Facility confinement charges billed by the Skilled Nursing Facility that:

- are in excess of the limits and maximums described in this section; or
- are incurred on or after the date the attending Physician stops treatment or ceases to prescribe skilled care.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

- TRADITIONAL EAST ASIAN MEDICINE

- Covered Charges

Covered Charges will include charges for:

- acupuncture;
- acupressure.

Covered charges will include charges for the following herbal supplements where the listed herb is the only ingredient or the primary Active Ingredient in the supplement when the supplement has been indicated by a Certified Professional for the treatment of a medical condition:

- Ginseng;
- Fucoidan;
- White Flower Oil;
- Se Ci Yu Medicated Oil;
- Pei Pa Koa;
- Cordyceps;
- Tiger Balm;
- Eagle Brand;
- Fufang Ejiao Jiang;
- Yunnan Baiyao;
- Weitai 999; and
- Bu Xin Wan.

- Definitions

Active Ingredient means any component that provides a direct effect in the diagnosis, cure, mitigation, treatment, or prevention of the indicated disease.

Certified Professional means any licensed Physician, Acupuncturist, Massage Therapist or any holder of a certificate in a traditional East Asian discipline from a reputable institution.

East Asian, for the purposes of this section, East Asian is geographically defined to include Japan, Korea (South and North), and China (including the People's Republic of China, Taiwan, Hong Kong and Macau).

- **Benefits Payable**

Benefits will be payable the same as for any other covered Treatment or Service, not to exceed a maximum benefit of $500 each Calendar Year for each Insured Person. Benefits will be payable for these services when they are provided by a Physician, an Acupuncturist, or Doctor of Traditional East Asian Medicine for services provided within the scope of their license.

- **Limitations**

The general Comprehensive Medical limitations listed in page NBM 5402 Q - Limitations will apply to Traditional East Asian Medicine charges. In addition, Traditional East Asian Medicine Covered Charges will not include charges which are:

- in excess of the limits and maximums described in this section; or
- for ancillary supplies, including, but not limited to tapes and videos; or
- for ancillary supplies, including but not limited to drinking vessels, cookware, mortar and pestle, or any other object or method to mix or combine covered supplements; or
- any supplement obtained illegally or which is combined with, or used in combination with any other compound to create, an illegal substance.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

LIMITATIONS

Covered Charges will not include and no benefits will be paid for the following Treatment or Service unless provided otherwise in page NBM 5400 - General Provisions. The following exclusions and limitations will apply only to the extent permitted by the Patient Protection and Affordable Care Act of 2010 and corresponding regulations:

- Treatment or Service that is not a Covered Charge; or
- Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure prescribed in the notice of that claim decision); or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- Treatment or Service due to any form of temporomandibular joint disorder (malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), except that benefits are payable for medically necessary surgical procedures directly affecting the upper or lower jawbone or associated joints; or
- the services of any person who is in an Insured Person's Immediate Family; or
- Dental Services or materials, including dental implants, except as described under Covered Charges; or
- eye examinations for the correction of vision or the fitting of glasses, eye refractions; vision materials including but not limited to frames or lenses; or
- hearing aids; or
- acupressure treatment; acupuncture treatment, except as described under Traditional East Asian Medicine; or
- drugs or medicines that do not require a Physician's prescription or have not been approved by the Food and Drug Administration for general marketing. This does not apply to over the counter contraceptives for women when prescribed by a Physician; or
- vitamins, minerals (except prescription potassium supplements) and herbal supplements, except as provided under Traditional East Asian Medicine whether or not they require a Physician's prescription; or
- nutritional supplements (even if the only source of nutrition), or special diets (whether or not they require a Physician's prescription); or
- wigs or hair prostheses; or
- Cosmetic Treatment or Service which does not qualify for coverage as described in page NBM 5402 A PPO – Covered Charges, and any complications arising therefrom; or
- personal hygiene, comfort, or convenience items, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, hoyer lift, gait belts, bedpans, physical fitness equipment, stair glides, elevators or lift, adaptive equipment for the purpose of aiding in the performance of Activities of Daily Living including, but not limited to dressing, bathing, preparation or feeding of meals; or

- "barrier free" home modifications, whether or not recommended by a Physician, including, but not limited to ramps, grab bars, railings or standing frames; or
- non-implantable communication-assist devices, including, but not limited to, communication boards, and computers; or
- Treatment or Service for work-hardening programs or vocational rehabilitation services; or
- cryopreservation or storage; or
- Treatment or Service for education or training; or
- Treatment or Service for learning disorders except for disorders listed as mental health conditions in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or ICD-10 lists; or
- Treatment or Service for developmental delay except for disorders listed as mental health conditions in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or ICD-10 lists. This limitation does not include outpatient occupation, speech and physical therapy services; or
- marital counseling; or
- Treatment or Service for which the Insured Person has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from participation in criminal activities; or
- Treatment or Service for and complications related to:
  - human-to-human organ or bone marrow transplants, except as described under Transplant Services or Covered Charges; or
  - animal-to-human organ or tissue transplants; or
  - implantation within the human body of artificial or mechanical devices designed to replace human organs; or
- behavior modification or group therapy, except as provided for under Mental Health and Substance Use Disorders Treatment; or
- Treatment or Service for insertion, removal, or revision of breast implants, unless provided post-mastectomy or during or after medically necessary gender reassignment surgery; or
- Treatment or Service for any sickness or condition for which the insertion of breast implants, or the fact of having breast implants within the body, was a contributing factor, unless the sickness or condition occurs post-mastectomy or during or after medically necessary gender reassignment surgery; or
- Treatment or Service for Kerato-Refractive Eye Surgery for myopia (nearsightedness), hyperopia (farsightedness), or astigmatism; or
- charges for telephone calls or telephone consultations or missed appointments; or
- any nursing services (except as described under Covered Charges and as required by state law); or

- Treatment or Service for infertility (including testing other than initial diagnostic testing), or Treatment or Service related to the restoration of fertility or the promotion of conception (including reversal of voluntary sterilization); or for the collection or purchase of donor semen (sperm) or oocytes (eggs); the services of a surrogate parent; or the freezing or storage of sperm, oocytes, or embryos; or
- Treatment or Service performed for the purpose of reversal of voluntary sterilization; or
- Treatment or Service for routine foot care including the removal of corns and calluses or trimming of toenails, flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary; or
- dietetic counseling, unless provided while the Insured Person is Hospital Inpatient Confined except as covered under Preventive Health and Wellness Services, or as provided under Home Health Care, or Hospice Care; or
- Treatment or Service by any type of health care practitioner not otherwise provided for in this booklet-certificate, unless recognition is state mandated; or
- Treatment or Service for moxibustion, herbology, dietary and nutritional counseling (except that benefits will be payable for medical nutritional counseling as described in page NBM 5400 – Diabetes – Diabetic Equipment, Supplies and Prescriptions), body work, and breathing and exercise techniques; or
- Treatment or Service provided for weight loss or reduction of obesity, except for the following intensive behavioral interventions: Diabetes screening; Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors; and Obesity screening: children and adolescents; or
- Treatment or Service for Custodial Care; or
- Treatment or Service for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained; or
- Treatment or Service for vision therapy or orthoptic therapy; or
- Treatment or Service that is paid for by a Medicare Supplement Insurance Plan; or
- charges for e-mail communication or e-mail consultation; or
- charges that are billed incorrectly or separately for Treatment or Service that are an integral part of another billed Treatment or Service as determined by the Company; or
- charges for venipuncture when billed with other laboratory services; or
- charges for lab specimen handling fees when billed with other laboratory services; or
- charges for Physician overhead, including but not limited to surgical suites or rooms, or equipment used to perform the particular Treatment or Service (i.e. laser equipment); or
- Treatment for non-synostotic plagiocephaly (positional head deformity) except that this limitation will not apply to cranial helmets for such deformities if more conservative treatment has been tried but has failed; or
- additional charges incurred because care was provided after hours, on a Sunday, holidays or week-end; or
- charges for heating pads, heating and cooling units, ice bags or cold therapy units; or
- Sleep studies using devices that do not provide a measurement of Apnea Hypopnea Index (AHI) and oxygen saturation; or
- charges for DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or

- charges for devices used specifically as safety items or to affect performance in sports-related activities; or
- Treatment or Service for gynecomastia (abnormal breast enlargement in males) except that benefits will be payable for reconstructive surgery when gynecomastia is caused by disease; or
- charges for physicals, health examinations, immunizations or screening procedures which are performed solely for school, sports, employment, insurance, licensing or travel if such physicals, examinations, immunizations, or screenings exceed the threshold recommended by the United States Preventive Services Task Force (USPSTF) for preventive services; or
- Treatment or Service for complications of a non-covered Treatment or Service; or
- Treatment or Service incurred after termination of coverage under this booklet-certificate, except as provided under Extended Benefits; or
- charges for travel and lodging except as indicated under Transplant Services; or
- molecular genetic testing (specific gene identification) for the purposes of health screening or if not part of a treatment regimen for a specific sickness, except as covered under Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described on page NBM 5402 F; or
- charges for transportation services except as described for ambulance services under All Other Covered Services; or
- Treatment or Services for standby services; or
- charges for more than one anesthesia provider during the same anesthesia period. Anesthesia provider includes a certified nurse anesthetist or a Physician; or
- Treatment or Service for reduction mammoplasty (except when following a mastectomy or when medically necessary for gender reassignment surgery); or
- comprehensive physical examinations or medical diagnostic procedures required by, paid by or reimbursed by the Policyholder; or
- Hospital overhead; or
- cosmetic surgery for personal reasons beyond sickness, injury, or medically necessary gender reassignment surgery; or
- routine immunizations and inoculations given as preventive measures against disease to Insured Persons age 19 and older when received from Non-PPO Providers; or
- drugs or medicines which are eligible for coverage under the Prescription Drugs Expense Insurance section of this booklet-certificate, including those for which benefits are not payable under that section of this booklet-certificate, for whatever reason; or
- recreational therapy, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; or
- art therapy, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services and, unless provided while the Insured Person is Hospital Inpatient Confined; or
- relaxation techniques; or
- massage; or
- spiritual healing; or
- imagery; or
- energy healing; or
- homeopathy.

MEDICAL EXPENSE INSURANCE

UTILIZATION MANAGEMENT PROGRAM

In order to monitor the use of inpatient health care services, services within specialized facilities, and other kinds of medical treatment, this plan has a Utilization Management program which will promote efficiency and cost containment. Utilization Review procedures are used to evaluate the necessity and appropriateness of services while maintaining quality of care.

- **Utilization Management Requirements - Applicable to medical care received from a PPO Provider or a Non-PPO Provider**

  - For Hospital Inpatient Confinement Charges and charges for services provided in an inpatient confinement facility, a Precertification is requested from the Company by the Insured Person or a designated patient representative as soon as a Hospital Inpatient Confinement or confinement in an inpatient confinement facility is scheduled, but no later than the day of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility, for other than Emergency Services. Precertification is not a guarantee that benefits will be payable.

    For the purpose of these requirements, "Precertification" means notification to the Company by the Insured Person or his or her designated representative prior to a non-emergency Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

    Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges or inpatient confinement facility charges that the Company determines to be a Covered Charge.

    An inpatient confinement facility includes:

    - Hospital;
    - Skilled Nursing Facility;
    - Rehabilitation hospital;
    - Hospice;
    - Long term acute care facility;
    - Gene-Based, Cellular And Other Innovative Therapies (GCIT) facility/provider;
    - Psychiatric Hospital or psychiatric unit of a general hospital for Mental Health treatment;
    - Inpatient Alcohol or Drug Abuse Treatment Facility or drug or alcohol unit of a general hospital or any other facility required by state law to be recognized as a treatment facility under the Group Policy for Substance Use Disorders treatment; or
    - Residential treatment center or facility.

Certain exceptions apply to Hospital Inpatient Confinement for childbirth as described below.

- For Emergency Services admissions, the Insured Person or a designated patient representative must contact the Company within two business days of a Hospital Inpatient Confinement or of a confinement in an inpatient confinement facility. Precertification is not a guarantee that benefits will be payable.

- For selected outpatient non-emergency medical services, the Insured Person or a designated patient representative must contact the Company 15 calendar days before the care is provided, or the Treatment or Service is scheduled. Precertification is not required when the selected outpatient non-emergency medical services are for Mental Health and Substance Use Disorder treatment. Precertification is not a guarantee that benefits will be payable.

Outpatient services requiring Precertification are as follows:

Diagnostics
CT Head or Brain
CT Maxillofacial
CT Orbit, Sella or Posterior Fossa or Outer, Middle or Inner Ear
CT Soft Tissue Neck
MRA Head
MRA Neck
MRI Lower Extremity
PET Scan Limited, and Whole Body
IMRT

Bariatrics Procedures
Bariatric Surgery
Lap Band, Gastric Sleeve
Gastric Bypass - Lap Band

Breast Related Procedures
Breast- Mastectomy
Breast- Reduction Mammaplasty
Breast- Removal of Mammary Implant or Delayed Insertion
Breast- Reconstruction

Selected Procedures
Hysterectomy
Laparoscopic Hysterectomy
Abdominoplasty, Panniculectomy
Blepharoplasty
Blepharoplasty - Repair of Blepharoptosis
Septoplasty - Nasal
Rhinoplasty - If Secondary to Septoplasty

Orthopedic Procedures

Artificial Disc Lumbar
Artificial Disc Cervical
Back Surgery - Spinal Cath with Lami
Back Surgery - Laminectomy Cerv Decomp
Back Surgery - Laminectomy Thor Decomp
Laser Discectomy, Radiofrequency Decomp
Back Surgery - Laminectomy
Back Surgery - Laminectomy Dec of Cord
Back Surgery - Spine Disk Surgery
Back Surgery - Removal of Vertebral Body
Back Surgery - Lami Myelotomy
Back Surgery - Lami excision Lesion Tumor
Back Surgery - Lami excision Lesion
Back Surgery - Laminectomy Implnt Neurst
Percutaneous Intradiscal Electrothermal Annuloplasty
Back Surgery - Lateral discectomy Thoracic
Back Surgery - Lateral discectomy Lumbar
Back Surgery - Cervical transoral- C1-2
Back Surgery - Ant Cervical below C2
Back Surgery - Anterior Thoracic
Back Surgery - Anterior Lumbar Fusion
Back Surgery - Post or postlat Cervical Fusion
Back Surgery - Post or Thoracic Fusion
Back Surgery - Post Lumbar Fusion
Back Surgery - Post Laminectomy/discect
Back Surgery - Exploration of Spinal Fusion
Facet Joint Injection

Radiosurgery Procedures

Cranial Stereotactic
Sterotactic Radiosurgery

Vericose Vein Procedures

Sclerotherapy
Venous Ablation
Venous Ligation
Gene-Based Cellular And Other Innovative Therapies (GCIT) facility/provider

The above list is also available on the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com. Precertification is not required when the outpatient services in the above list are for Mental Health and Substance Use Disorder treatment. Please be aware that some outpatient services while not requiring Precertification may nevertheless be subject to medical necessity reviews to determine whether it is a Covered Charge.

- **Precertification - Applicable to medical care received from PPO Providers or Non-Preferred Providers**

A Precertification by the Company is required for all Hospital Inpatient Confinements or inpatient facility confinements and selected outpatient procedures. Precertification is not required when the outpatient procedures are for Mental Health and Substance Use Disorder treatment. Precertification is not a guarantee that benefits will be payable.

Precertification requires a review by the Company of a Physician's report of the need for selected outpatient procedures or a Hospital Inpatient Confinement or confinement in an inpatient confinement facility, (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth).

The report (verbal or Written) must include the:

- reason(s) for the Hospital Inpatient Confinement or confinement in an inpatient confinement facility or outpatient procedure; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed on an outpatient basis or during the Hospital Inpatient Confinement or confinement in an inpatient confinement facility; and
- estimated length of the Hospital Inpatient Confinement or confinement in an inpatient confinement facility, if applicable.

If a Hospital Inpatient Confinement or confinement in an inpatient confinement facility will exceed the approved number of days, the Company will initiate a Continued Stay Review. For the purpose of these requirements, **Continued Stay Review** means a review by the Company of a Physician's report of the need for continued Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

The report (verbal or Written) must include the:

- reason(s) for requesting continued Hospital Inpatient Confinement or confinement in an inpatient confinement facility; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed during the Hospital Inpatient Confinement or confinement in an inpatient confinement facility; and
- estimated length of the continued Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by the Company for Inpatient Hospital Confinement or confinement in an inpatient confinement facility will not be considered Covered Charges.

The following exception applies to Hospital Inpatient Confinement for childbirth.

Covered Charge requirements are waived and a Precertification is not required for mother and baby, for:

- A 48-hour Hospital Inpatient Confinement following vaginal delivery; or
- A 96-hour Hospital Inpatient Confinement following cesarean section.

A request for review by the Company of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated above must be made by the Insured Person or a designated patient representative before the end of that time period.

Except as waived above, no benefits will be payable for any Treatment or Service that is not a Covered Charge.

If Precertification is denied the Insured Person or a designated patient representative has the right to request an appeal review.

When an Insured Person has health care insurance under more than one plan, the Precertification requirements do not apply when the Company will pay as a secondary plan as described in page NBM 5156 Coordination With Other Benefits.

- **Definitions Applicable to the Utilization Management Program**

Concurrent Review

Utilization Review conducted during an Insured Person’s Hospital stay or course of treatment.

Continued Stay Review

A review by the Company of a Physician's report of the need for continued Hospital Inpatient Confinement or confinement in an inpatient confinement facility to determine if the continued stay is a Covered Charge.

Health Professional

An individual who:

- has undergone formal training in a health care field;
- holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and
- has professional experience in providing direct patient care.

Initial Clinical Review(er)

Clinical review conducted by appropriate licensed or certified Health Professionals. Initial Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Adverse Benefit Determination.

Notification of Utilization Review Services

Receipt of necessary information to initiate review of a request for Utilization Review services to include the Insured Person's name and the Member's name (if different from Insured Person's name), attending Physician's name, treatment facility's name, diagnosis, and date of service.

Ordering Provider

The Physician or other provider who specifically prescribes the health care service being reviewed.

Peer Clinical Review(er)

Clinical review conducted by a Physician or other Health Professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal review, the Peer Clinical Reviewer is a Physician or other Health Professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the Ordering Provider.

Precertification

A review by the Company of a Physician's report before certain services are provided, such as a Hospital Inpatient Confinement or a confinement in an inpatient confinement facility (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth) or selected outpatient procedures to determine whether the services being recommended are considered Coverage Charges. Precertification is not a guarantee that benefits will be payable.

Prospective Review

Utilization Review conducted prior to an Insured Person's stay in a Hospital or other health care facility or course of treatment, including any required preauthorization or Precertification.

Retrospective Review

Utilization Review conducted after the Insured Person is discharged from a Hospital or other health care facility or has completed a course of treatment.

Urgent Review

Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to an Insured Person's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the Company's determination using the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An Insured Person's provider should not request an Urgent Review for a situation in which the provider or Insured Person has had adequate time to request standard Precertification.

Utilization Management

The administration of Utilization Review procedures, such as Precertification of hospital admissions and inpatient confinements, monitoring services during a course of treatment, discharge planning, peer reviews, case management and appeals.

Utilization Review

The evaluation of the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities according to a set of formal techniques and guidelines.

- **Utilization Review Program**

  - **Prospective Review**

    For an initial Prospective Review, a decision and notification of the decision will be made within five (5) calendar days of the date the Company receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Company will either immediately upon the expiration of the five (5) calendar days or as soon as the insurer becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the Insured Person, in writing, that the Company cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Company will also notify the provider and Insured Person of the anticipated date on which a decision may be rendered. The Company will render a decision within five (5) calendar days of receiving the necessary information. For certifications, the Company will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person. Upon request, the Company will provide Written notification of the certification. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

  - **Urgent Prospective Review**

    For Urgent Review of a Prospective Review, a decision and notification of the decision will be made within 72 hours of the date the Company receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Company will either issue an Adverse Benefit Determination or send an explanation of the information needed to complete the review within 24 hours of receipt of Notification of Utilization Review Services. If the Company does not issue an Adverse Benefit Determination and requests additional information to complete the review, the Insured Person, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 48 hours to provide the necessary information. The Company will render a decision within 48 hours of either receiving the necessary information or if no additional information is received, the expiration of the 48 hours to provide the specified additional information. For certifications, the Company will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person. Upon request, the Company will provide Written notification of the certification. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

- **Concurrent Review**

For a Concurrent Review that does not involve an Urgent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Company will be decided within the timeframes and according to the requirements for Prospective Review.

- **Urgent Concurrent Review**

For an Urgent Review of a Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Company will be decided and notification of the decision will be made within 24 hours of receipt of the Notification of Utilization Review Services if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. If a request is made less than 24 hours prior to the expiration of the previously approved period or number of treatments, a decision and notification of the decision will be made within 72 hours of receipt of the Notification of Utilization Review Services.

- **Retrospective Review**

For a Retrospective Review, a decision and notification of the decision will be made within 30 calendar days after the Company receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Company will either issue an Adverse Benefit Determination or send an explanation of the information needed to complete the review prior to the expiration of the 30 calendar days. If the Company does not issue an Adverse Benefit Determination and requests additional information to complete the review, the Insured Person, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Company will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, the Company will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person. Upon request, the Company will provide Written notification of the certification. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

- **Request for Reconsideration**

When an initial decision is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision will be made available within one (1) business day to discuss the Adverse Benefit Determination decision with the attending Physician or other Ordering Provider upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician or other Ordering Provider will be informed of the right to initiate an appeal and the procedure to do so. For certifications, the Company will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person. Upon request, the Company will provide Written notification of the certification. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

- **Appeal of Adverse Benefit Determinations**

The Insured Person, a designated patient representative, Physician, or other health care provider has the right to request an appeal review of any Utilization Management decision by fax or in Writing. The Company will make a full and fair review of the Adverse Benefit Determination.

The Company will allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeal process.

The Company will provide the claimant, free of any charge, with any new or additional evidence considered, relied upon, or generated by the Company in connection with the claim. The evidence will be provided in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided. If it is impossible to provide the new or additional evidence in time for the Insured Person to have a reasonable opportunity to respond, the timing for appeal determinations will be tolled until the earlier of:

- the date the claimant responds to the new or additional evidence; or
- three weeks from the date the new or additional evidence was mailed to the claimant.

Before the Company issues a final internal Adverse Benefit Determination based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale. The rationale will be provided in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided. If it is impossible to provide the new or additional rationale in time for the Insured Person to have a reasonable opportunity to respond, the timing for appeal determinations will be tolled until the earlier of:

- the date the claimant responds to the new or additional rationale; or
- three weeks from the date the new or additional rationale was mailed to the claimant.

- **Expedited Appeal Review and Voluntary Appeal Review**

An expedited appeal review is a request, usually by telephone but can be Written, for a review of a decision not to certify an Urgent Review. An expedited appeal review must be requested within 180 calendar days of the receipt of an Adverse Benefit Determination.

A decision and notification of the decision on the expedited appeal of an Urgent Review decision will be made within 72 hours from request of an expedited appeal review. Written or electronic notification of the appeal review outcome will be made to the attending Physician or other Ordering Provider and the Insured Person.

If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, attending Physician, or other Ordering Provider can request an external review or a voluntary appeal review. The voluntary appeal review may be requested by telephone, fax or in Writing. The Insured Person, attending Physician or other Ordering Provider may submit Written comments, documents, records and other information relating to the request for the voluntary appeal review. The Company will make a decision within 30 calendar days of request for a voluntary appeal review. However, if the voluntary appeal review cannot be processed due to incomplete information, the Company will send a Written explanation of the additional information that is required, or an authorization for the Insured Person's Signature, so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to the Company within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the voluntary appeal review. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the voluntary appeal review request or as required by state law.

Election of a second appeal is voluntary and does not negate the Insured Person's right to an external review, nor does it have any effect on the Member or the Insured Person's rights to any other benefit under the Group Policy. The Company offers the voluntary appeal review process in an effort that the claim may be resolved in good faith without legal intervention. At any time during the second appeal process, the Insured Person may request an external review.

Note: The expedited appeal process does not apply to Retrospective Reviews.

- **Standard Appeal Review and Voluntary Appeal Review**

A standard appeal may be requested in Writing. It must be requested within 180 calendar days of the receipt of an Adverse Benefit Determination. A final internal Adverse Benefit Determination will be made in Writing to the Insured Person, the attending Physician or other Ordering Provider within 30 calendar days of receiving the request for an appeal.

If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, attending Physician, or other Ordering Provider can request an external review or a voluntary appeal review. The voluntary appeal review may be requested by telephone, fax or in Writing. The Insured Person, attending Physician or other Ordering Provider may submit Written comments, documents, records and other information relating to the request for voluntary appeal review. The Company will make a decision within 30 calendar days of request for a voluntary appeal review. However, if the voluntary appeal review cannot be processed due to incomplete information, the Company will send a Written explanation of the additional information that is required, or an authorization for the Insured Person's Signature, so information can be obtained from the attending Physician or other Ordering Provider. This information must be sent to the Company within 45 calendar days of the date of the Written request for the information or as required by state law. Failure to comply with the request for additional information could result in declination of the voluntary appeal review. A decision will be made and notification of the outcome will be provided within 30 calendar days of the receipt of all necessary information to properly review the voluntary appeal review request or as required by state law.

Election of a second appeal is voluntary and does not negate the Insured Person's right to external review, nor does it have any effect on the Member or the Insured Person's rights to any other benefit under the Group Policy. The Company offers the voluntary appeal review process in an effort that the claim may be resolved in good faith without legal intervention. At any time during the second appeal process, the Insured Person may request an external review.

- **Notice of Utilization Review**

For purposes of satisfying the claims processing requirements, receipt of claim will be considered to be met when the Company receives Notification of Utilization Review Services.

If an Insured Person or designated patient representative fails to follow the Company's procedures for filing a claim for a Precertification, a Prospective Review, or an Urgent Review, the Company will notify the Insured Person or designated patient representative of the failure and the proper procedures to be followed.

SEE CLAIM PROCEDURES IN PAGE NBM 5146 FOR IMPORTANT CLAIM PROCEDURES INFORMATION ON FILING MEDICAL CLAIMS.

COMPLAINT AND GRIEVANCE PROCEDURES

First-Level Appeal Review

The Insured Person or a designated patient representative acting on behalf of the Insured Person may request an appeal of an Adverse Benefit Determination by Written request to the Company within 180 calendar days of receipt of the notice of Adverse Benefit Determination. The Written request should be sent to the local service center (the address is shown on the Insured Person's ID card).

The Insured Person or a designated patient representative acting on behalf of the Insured Person should submit written comments, documents, records, and any other information relating to the claim for benefits.

The Insured Person or a designated patient representative acting on behalf of the Insured Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Insured Person's claim for benefits.

The Company will make a full and fair review of the claim. The review will take into account all comments, documents, records, and other information submitted by the Insured Person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. It will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The review will identify the medical or vocation experts whose advice was obtained on behalf of the plan in connection with an Insured Person's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

Additionally, the health care professional engaged for purposes of a consultation under the paragraph above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

In the case of a claim involving urgent care, for an expedited review process:

- A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

- All necessary information, including the Company's benefit determination on review, will be transmitted between the Company and the Insured Person by telephone, facsimile, or other available similarly expeditious method.

The Company may require additional information to make the review. The Company will notify the Insured Person in Writing of the appeal decision as follows:

- In the case of a claim involving urgent care, the Company will notify the Insured Person of the Company's benefit determination on review as soon as possible, but not later than 72 hours after receipt of the Insured Person's request for review of an Adverse Benefit Determination by the Company.

- In the case of a pre-service claim, the Company will notify the Insured Person of the Company's benefit determination not later than 15 days after receipt by the Company of the Insured Person's request for review of an Adverse Benefit Determination.

- In the case of a post-service claim, the Company will notify the Insured Person of the Company's benefit determination not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

If the appeal remains unresolved for more than 30 calendar days, the Insured Person has the right to file an external appeal.

Election of a second appeal review is voluntary and does not negate the Insured Person's right to an external review, nor does it have any effect on the Insured Person's right to any other benefit under the Group Policy. The Company offers the Voluntary Appeal Review process in an effort that the claim may be resolved in good faith without legal intervention. At any time during the Voluntary Appeal Review process, the Insured Person may request an external review.

Expedited Appeal Review

An Expedited Appeal Review will be made available in a situation where the timeframe of the First-Level Appeal Review would seriously jeopardize the life or health of the Insured Person, or the ability to regain maximum function.

The Insured Person or a designated patient representative acting on behalf of the Insured Person may initiate an Expedited Appeal Review, either orally or in Writing. In an Expedited Appeal Review, all necessary information, including the Company's decision, will be transmitted between the Company and the Insured Person or the provider acting on behalf of the Insured Person by telephone, facsimile or other available similarly expeditious method.

The Company will make a decision and notify the Insured Person as expeditiously as the Insured Person's medical condition requires, but in no event more than 72 hours after receipt of the request for the Expedited Appeal Review.

If the expedited appeal remains unresolved for more than 3 calendar days, the Insured Person has the right to file an external appeal.

The Company will not discriminate against providers based on their actions taken on behalf of the Insured Person in making an appeal.

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

INDEPENDENT MEDICAL REVIEW

Right to Request an Independent Medical Review of Adverse Benefit Determinations

An Independent Medical Review refers to the review by the California Department of Insurance Independent Medical Review System

An Insured Person has the right to request an independent medical review in cases where the Insured Person believes that health care services have been improperly denied, modified, or delayed by the Company, or by one of its contracting providers.

The notice of a final internal Adverse Benefit Determination will include detailed information about an Insured Person's right to request an independent medical review. The notice will also include the process for making such request.

Preliminary Review

Within 5 business days of receipt of the request for an independent medical review (or immediately in the case of a request for an expedited independent medical review); the Company will determine whether:

- The Insured Person had coverage at the time the service was provided or requested;
- The independent medical review is available based on the reason for the Adverse Benefit Determination;
- The Insured Person exhausted the standard appeals process, if required; and
- The Insured Person provided all information needed to process the independent medical review.

Within 1 business day of the preliminary review determination (or immediately in the case of a request for an expedited independent medical review), the Company will send written notice to the Insured Person, attending Physician, or other Ordering Provider as to whether the request has been accepted. If the Insured Person is not eligible for independent medical review, the written notice will explain the reason for the ineligibility.

Request for an Independent Medical Review

All insured grievances involving a Disputed Health Care Service are eligible for review under the Independent Medical Review System if the requirements of this section are met. If the California Department of Insurance (department) finds that an insured grievance involving a Disputed Health Care Service does not meet the requirements of this section for review under the Independent Medical Review System, the insured request for review will be treated as a request for the department to review the grievance. All other insured grievances, including grievances involving Coverage Decisions, remain eligible for review by the department.

The department will be the final arbiter when there is a question as to whether an insured grievance is a Disputed Health Care Service or a Coverage Decision.

The Insured Person may apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the Disputed Health Care Services are not medically necessary or are experimental or investigational, within six months of any of the qualifying periods or events listed below. The commissioner of the department may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

With respect to a request regarding medical necessity, an Insured Person may apply to the department for an independent medical review when all of the following conditions are met:

- The Insured Person's provider has recommended a health care service as medically necessary, or
- The Insured Person has received urgent care or emergency services that a provider determined was medically necessary, or
- The Insured Person, in the absence of a provider recommendation under the first bulleted item above or the receipt of urgent care or emergency services by a provider under the second bulleted item above, has been seen by a contracting provider for the diagnosis or treatment of the medical condition for which the Insured Person seeks independent review. The Company will expedite access to a contracting provider upon request of an Insured Person. The contracting provider need not recommend the Disputed Health Care Service as a condition for the Insured Person to be eligible for an independent review.
- The Disputed Health Care Service has been denied, modified, or delayed by the Company, based in whole or in part on a decision that the health care service is not medically necessary.
- The Insured Person has filed a grievance with the Company, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The Insured Person will not be required to participate in the Company's grievance process for more than 30 days.

With respect to a request regarding decisions for Treatment or Services that are considered Experimental or Investigational, an Insured Person may apply to the department for an independent medical review when all of the following conditions are met:

- The Insured Person has a Life-threatening or Seriously Debilitating condition.
- The Insured Person's Physician certifies that the Insured Person has a Life-threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving the condition of the Insured Person, for which standard therapies would not be medically appropriate for the Insured Person, or for which there is no more beneficial standard therapy covered by the Company than the therapy proposed in the following bulleted item.
- Either (A) the Insured Person's Physician has recommended a drug, device, procedure, or other therapy that the Physician certifies in writing is likely to be more beneficial to the Insured Person than any available standard therapies, or (B) the Insured Person, or the Insured Person's Physician has requested a therapy that is likely to be more beneficial for the Insured Person than any available standard therapy.
- The Insured Person has been denied coverage by the Company for a drug, device, procedure, or other therapy recommended or requested in the prior bulleted item, unless coverage for the specific therapy has been excluded by the Insured Person's contract.
- The specific drug, device, procedure, or other therapy recommended in the above bulleted item would be a covered service except for the Company's determination that the therapy is Experimental or Investigational.

The independent review organization will complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation.

Upon receipt of a notice to reverse the adverse or final determination, the Company will immediately approve the coverage that was the subject of the independent medical review, consistent with the independent review organization's determination. The independent review organization's decision is binding on the Insured Person and the Company; except to the extent that other remedies may be available under State or Federal law.

Expedited Independent Medical Review

The Insured Person may request an expedited independent medical review. This may be done at any time following receipt of an Adverse Benefit Determination (even if the person has not exhausted the internal appeal process), if the Insured Person has a medical condition where the time-frame for completion of a standard independent medical review would seriously jeopardize the Insured Person's life or health or ability to regain maximum function. All necessary information and documents will be delivered to an independent medical review organization within 24 hours of approval of the request for review. An expedited review will be completed by the independent review organization and the Company will notify the Insured Person or authorized representative of the independent review organization's decision within 72 hours after the date of receipt of the request.

An expedited independent medical review does not apply to Retrospective Reviews.

Definitions Applicable to This Section

Coverage Decision means the approval or denial of health care services by the Company, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the policy. A Coverage Decision does not include a decision by the Company regarding a Disputed Health Care Service.

Disputed Health Care Service means any health care service eligible for coverage and payment under the policy that has been denied, modified, or delayed by a decision of the Company, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a Coverage Decision.

Life-threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

DESCRIPTION OF BENEFITS

PRESCRIPTION DRUGS EXPENSE INSURANCE

Payment Conditions

Subject to the terms and limitations of the Group Policy summarized in this booklet, if drugs and medicines are prescribed to treat an Insured Person, the Company will pay 100% of the charges in excess of the Copay amount as described in the Summary of Benefits section.

Benefit payment will be limited to:

- Covered Charges as described in this section; and
- for certain qualified Maintenance Drugs and Medicines, a 90-day supply for each prescription and each refill provided that an amount equal to three-times a 30-day supply Copay amount will apply; and
- for all other drugs and medicines, not more than a 30-day supply for each prescription and each refill; and
- prescriptions filled by a Member Pharmacy.

If the Insured Person uses a Nonmember Pharmacy, Prescription Drugs Covered Charges less the Copay may only be reimbursed up to the amount determined by the Payment Schedule established by the Company for each prescription or refill.

Prescription Drugs Utilization Review Program

For Maintenance Drugs and Medicines

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same Insured Person) and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

For all other Drugs and Medicines

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription or refill (for the same Insured Person) and the previously dispensed quantity of the drug or medicine was for:

- less than a 15-day supply and the dispensing date for the current prescription is more than four days before a previously dispensed supply would be exhausted; or
- more than a 14-day supply and the dispensing date for the current prescription is more than ten days before the previously dispensed supply would be exhausted; or

- more than a 14-day supply and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

Exhaustion of the previously dispensed supply is determined based on when the last dose of the medicine or drug would have been consumed if the previously dispensed supply was consumed by the prescription date. Prescriptions may be refilled prior to exhaustion of a previously dispensed quantity for the same prescription or refill for up to a 30 day quantity once per Calendar Year.

For certain drugs or classes of drugs designated by the Company, the Company reserves the right to:

- require preauthorization for dispensing; and
- limit the quantity of drugs for which benefits will be paid; and
- require the dispensing of certain drugs before paying benefits for another drug within a given class, as established by the Company; and
- require the dispensing of a single daily dose of certain drugs.

For drugs requiring preauthorization, the Pharmacy Benefit Manager must notify the prescribing provider within 72 hours of receipt of a non-urgent request or 24 hours if exigent circumstances exist, whether the request is approved or disapproved. If the Pharmacy Benefit Manager fails to respond within the respective timeframes, the request is deemed approved for the duration of the prescription, including refills. If the request for preauthorization is incomplete or clinically relevant material information necessary to make a coverage determination is not included, the Pharmacy Benefit Manager must notify the prescribing provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or clinically relevant material information is needed to approve or deny the preauthorization or to appeal the denial thereof. Once the requested information is received, the applicable time period to approve or deny a preauthorization or to appeal, will begin to elapse. If a coverage determination or request for additional or clinically relevant material information by the Pharmacy Benefit Manager is not received by the prescribing provider within the time allotted, the preauthorization or appeal of a denial thereof, shall be deemed approved for the duration of the prescription, including refills. In the event of a denial, the Pharmacy Benefit Manager must inform the prescribing provider and insured of the external appeal process below.

Formulary Exception Process. If a Prescription Drug is not on the Formulary, the Insured Person, a designated patient representative, or the prescribing provider may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically.

Standard Review of a Formulary Exception. The Company will make a decision and notify the Insured Person or designated patient representative and the prescribing provider no later than 72 hours after receipt of the request. If the request is approved, the Company will cover the non-Formulary Prescription Drug for the duration of the prescription, including any refills.

Expedited Review of a Formulary Exception. If an Insured Person is suffering from a health condition that may seriously jeopardize his or her health, life or ability to regain maximum function or is undergoing a current course of treatment using a non-Formulary Prescription Drug, the Insured Person, a designated patient representative, or the prescribing provider may request an expedited review of a Formulary exception. The Company will make a decision and notify the Insured Person or designated patient representative and the prescribing provider no later than 24 hours after receipt of the request. If the request is approved, the Company will cover the non-formulary Prescription Drug while the Insured Person suffers from the health condition that may seriously jeopardize his or her health, life or ability to regain maximum function for the duration of the exigency.

Right to Appeal a Denial of a Drug Preauthorization Request or Formulary Exception Denial.

If the Company has denied the Insured Person's request for a drug preauthorization request or for coverage of a non-Formulary Prescription Drug through the Formulary exception process, the Insured Person, a designated patient representative, or the prescribing provider may request a review by an independent review organization.

If the Insured Person's internal drug preauthorization request or Formulary exception request received a standard review through the Formulary exception process, the independent review organization must make a decision on the external appeal and notify the Insured Person or designated patient representative and the prescribing provider of their coverage determination or request for additional or clinically relevant material information necessary to make a coverage determination within 72 hours of receipt of the completed application. If the independent review organization overturns the Company's denial, the Company will cover the non-Formulary Prescription Drug for the duration of the prescription, including any refills.

If the Insured Person's internal drug preauthorization request or Formulary exception request received an expedited review through the Formulary exception process, the independent review organization must make a decision on the external appeal and notify the Insured Person or designated patient representative and the prescribing provider of their coverage determination or request for additional or clinically relevant material information necessary to make a coverage determination within 24 hours of receipt of the completed application. If the independent review organization overturns the Company's denial, the Company will cover the non-formulary Prescription Drug while the Insured Person suffers from the health condition that may seriously jeopardize his or her health, life or ability to regain maximum function for the duration of the exigency.

Prescription Drugs Covered Charges

Prescription Drugs Covered Charges will be the actual cost charged to the Insured Person but only to the extent that the actual cost charged does not exceed the maximum amount allowed under the Payment Schedule as established by the Company.

Prescription Drugs Covered Charges will include charges for:

- the following diabetic supplies:
    - insulin and other antihyperglycemic medications used for the treatment of diabetes; and
    - disposable insulin needles/syringes; and
    - disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, and Clinitest tablets; and
    - lancets; and
    - glucometers (limited to no more than one each Calendar Year); and
    - alcohol swabs; and
    - glucagon (if determined to be medically necessary).
- compounded medications (except for compound medications that use an injectable drug) in which at least one ingredient is a Prescription Legend Drug. Reimbursement for compounded medications will be up to 135% of Average Wholesale Price of the most expensive active ingredient; and
- injectable medications; and
- all FDA-approved contraceptive drugs, devices, or products, including those available over the counter, as prescribed by the Insured Person's Physician; and
- progesterone, all dosage forms when prescribed by a Physician in the course of prenatal treatment; and
- growth hormones; and
- any other drug or medicine that can be legally dispensed only upon the Written prescription of a Physician.

In no event will the maximum amount allowed under the Payment Schedule for each prescription or refill exceed the Average Wholesale Price less 14%.

Definitions

Brand Name Prescription Drug/Brand Name Drug means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

Formulary means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers. The Formulary will be maintained in compliance with state and federal law.

Generic Prescription Drugs/Generic Drugs mean pharmaceutical products manufactured and sold under their chemical, common, or official name or a drug that the Company identifies as a Generic Drug. Classification of a Prescription Drug as a Generic is determined by the Company and not by the manufacturer or pharmacy. The Company classifies a Prescription Drug as a Generic based on available data resources or for cost reduction purposes, therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified as a Generic by the Company.

Mail Services Pharmacy means a pharmacy designated by the Company to administer its Mail Services Prescription Drugs Program where prescription drugs are legally dispensed by mail via the United States Postal Service (USPS) or other private package delivery companies or couriers.

Maintenance Drugs and Medicines mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions to include: coronary artery disease (angina); diabetes (including, diabetic supplies, e.g., insulin and other antihyperglycemic medications used for the treatment of diabetes), disposable insulin needles/syringes; lancets; disposable blood/urine glucose/acetone testing agents, e.g., Chemstrips, Acetest tablets, and Clinitest tablets); hypertension; glaucoma; thyroid disease; seizure disorders; hyperlipidemia; congestive heart failure; clotting disorders; chronic obstructive pulmonary disease; and hormonal deficiencies (hormone replacement)~~;~~. Maintenance Drugs and Medicines will also include legend oral contraceptives.

Member Pharmacy means any pharmacy which has contracted with the Pharmacy Benefit Manager to provide prescription drugs for which benefits are provided under the Group Policy.

Nonmember Pharmacy means any pharmacy which has not contracted with the designated prescription drugs claims administrator to become a Member Pharmacy.

Payment Schedule means the maximum reimbursement amount allowed under the program as established by the Company.

Pharmacy Benefit Manager means CVS Caremark.

Preferred Brand Name Prescription Drugs mean a list of drugs established by the Company that are considered to be clinically appropriate and cost effective. The Preferred Brand Name drugs list is a subset (i.e., a shorter list) of the Formulary list.

Prescription Drug Copay means a specified dollar amount that must be paid by an Insured Person for each prescription and each refill. The Prescription Drug Copay amount will be applied to the Comprehensive Medical Out-of-Pocket Expense Limits.

Prescription Legend Drugs mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

Tier 1 Generic Prescription Drugs (including selected Preferred Brand Name Prescription Drugs) means a list of prescription drugs established by the Company.

Tier 2 Preferred Brand Name Prescription Drugs (including selected Generic Prescription Drugs) means a list of prescription drugs established by the Company.

Tier 3 Non-Preferred Prescription Drugs means a list of prescription drugs established by the Company.

Limitations

Prescription Drugs Covered Charges will not include and no benefits will be payable under the Prescription Drugs Expense Insurance portion of the Group Policy for the following items. However, the first seven items listed below may be eligible for benefits under the Comprehensive Medical Expense portion of the Group Policy as described under the Description of Benefits for Medical Expense Insurance in this booklet-certificate:

- drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which the Insured Person is confined; or
- drugs or medicines delivered or administered by the prescriber; or
- therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except as specifically provided above under Prescription Drug Covered Charges; or
- immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use; or
- administration of any drug or medicine; or
- drugs or medicines that are not Covered Charges; or
- drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for Experimental or Investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or
- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription. This does not apply to over the counter contraceptives for women when prescribed by a Physician; or
- drugs or medicines prescribed or dispensed by any person who is in an Insured Person's Immediate Family; or
- vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or
- dietary supplements; or

- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or
- drugs or medicines for which the Insured Person has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or
- drugs or medicines provided as the result of a sickness or injury that is due to participation in criminal activities; or
- cosmetic, and health and beauty aids; or
- dermatologicals used as hair growth stimulants; or
- drugs labeled "Caution-limited by Federal law to investigational use," or experimental, even though a charge is made to the individual; or
- topical dental fluorides; or
- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- drugs or medicines that are lost, stolen or spilled; or
- anorectics (any drug used for the purpose of weight control); or
- minerals. Exception: Potassium supplements are covered; or
- hematinics; or
- drugs or medicines that are paid for by a Medicare Supplement Insurance Plan; or
- any other drugs or medicines used for cosmetic purposes; or
- herbal supplements, except as provided under Traditional East Asian Medicine.

Payment, Denial and Review

Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on the Insured Person's identification card or contact the Company. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or the Company within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or the Company receives proof of loss. Proof of loss includes the patient's name, the Member's name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. The Pharmacy Benefit Manager or the Company may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the Company's request or the request of Pharmacy Benefit Manager could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager or the Company will send a Written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manager or the Company will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Group Policy may be payable sooner, provided the Pharmacy Benefit Manager or the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager or the Company will submit a detailed explanation of the basis for its denial. See page NBM 5407 GP for the Complaint and Grievance Procedures.

For purposes of this section, “claimant” means the Insured Person.

DESCRIPTION OF BENEFITS

MAIL SERVICE PRESCRIPTION DRUGS EXPENSE INSURANCE

Payment Conditions

Subject to the terms and limitations of the Group Policy summarized in this booklet-certificate, if Mail Service Prescription Drugs are prescribed to treat an Insured Person, the Company will pay 100% of charges in excess of the Copay amount as described in the Summary of Benefits section.

Benefit payment will be limited to:

- prescribed maintenance medications which are necessary to treat a chronic or long-term sickness or injury and that can be legally dispensed only upon the Written prescription of a Physician; and
- a 90-day supply for each prescription and each refill provided that an amount equal to three-times a 30-day supply Copay amount will apply; and
- prescriptions which are filled through the pharmacy designated by the Company to administer the mail order prescription drugs program.

If an Insured Person uses a Nonmember Pharmacy, Prescription Drugs Covered Charges less the Copay may only be reimbursed up to the amount determined by the Payment Schedule established by the Company for each prescription or refill.

Prescription Drugs Utilization Review Program

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same Insured Person) and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

For certain drugs or classes of drugs designated by the Company, the Company reserves the right to:

- require preauthorization for dispensing; and
- limit the quantity of drugs for which benefits will be paid; and
- require the dispensing of certain drugs before paying benefits for another drug within a given class, as established by the Company; and
- require the dispensing of a single daily dose of certain drugs.

For drugs requiring preauthorization, the Pharmacy Benefit Manager must notify the prescribing provider within 72 hours of receipt of a non-urgent request or 24 hours if exigent circumstances exist, whether the request is approved or disapproved. If the Pharmacy Benefit Manager fails to respond within the respective timeframes, the request is deemed approved for the duration of the prescription, including refills. If the request for preauthorization is incomplete or clinically relevant material information necessary to make a coverage determination is not included, the Pharmacy Benefit Manager must notify the prescribing provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or clinically relevant material information is needed to approve or deny the preauthorization or to appeal the denial thereof. Once the requested information is received, the applicable time period to approve or deny a preauthorization or to appeal, will begin to elapse. If a coverage determination or request for additional or clinically relevant material information by the Pharmacy Benefit Manager is not received by the prescribing provider within the time allotted, the preauthorization or appeal of a denial thereof, shall be deemed approved for the duration of the prescription, including refills. In the event of a denial, the Pharmacy Benefit Manager must inform the prescribing provider and insured of the external appeal process described on page NBM 5424 (NGF) – Prescription Drugs Expense Insurance.

Definitions

Brand Name Prescription Drug/Brand Name Drug means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

Formulary means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers. The Formulary will be maintained in compliance with state and federal law.

Generic Prescription Drugs/Generic Drugs mean pharmaceutical products manufactured and sold under their chemical, common, or official name or a drug that the Company identifies as a Generic Drug. Classification of a Prescription Drug as a Generic is determined by the Company and not by the manufacturer or pharmacy. The Company classifies a Prescription Drug as a Generic based on available data resources or for cost reduction purposes, therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified as a Generic by the Company.

Mail Services Pharmacy means a pharmacy designated by the Company to administer its Mail Services Prescription Drugs Program where prescription drugs are legally dispensed by mail via the United States Postal Service (USPS) or other private package delivery companies or couriers.

Maintenance Drugs and Medicines mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions to include: coronary artery disease (angina); diabetes (including, diabetic supplies, e.g., insulin and other antihyperglycemic medications used for the treatment of diabetes, disposable insulin needles/syringes; lancets; disposable blood/urine glucose/acetone testing agents, e.g., Chemstrips, Acetest tablets, and Clinitest tablets); hypertension; glaucoma; thyroid disease; seizure disorders; hyperlipidemia; congestive heart failure; clotting disorders; chronic obstructive pulmonary disease; and hormonal deficiencies (hormone replacement). Maintenance Drugs and Medicines will also include legend oral contraceptives.

Member Pharmacy means any pharmacy which has contracted with Pharmacy Benefit Manager to provide prescription drugs for which benefits are provided under the Group Policy.

Nonmember Pharmacy means any pharmacy which has not contracted with the designated prescription drugs claims administrator to become a Member Pharmacy.

Payment Schedule means the maximum reimbursement amount allowed under the program as established by the Company.

Pharmacy Benefit Manager means CVS Caremark.

Preferred Brand Name Prescription Drugs mean a list of drugs established by the Company that are considered to be clinically appropriate and cost effective. The Preferred Brand Name drugs list is a subset (i.e., a shorter list) of the Formulary list.

Prescription Drug Copay means a specified dollar amount that must be paid by an Insured Person for each prescription and each refill. The Prescription Drug Copay amount will be applied to the Comprehensive Medical Out-of-Pocket Expense Limits.

Prescription Legend Drugs mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

Tier 1 Generic Prescription Drugs (including selected Preferred Brand Name Prescription Drugs) means a list of prescription drugs established by the Company.

Tier 2 Preferred Brand Name Prescription Drugs (including selected Generic Prescription Drugs) means a list of prescription drugs established by the Company.

Tier 3 Non-Preferred Prescription Drugs means a list of prescription drugs established by the Company.

90-Day Supplies

Typically, prescriptions submitted to the Pharmacy will be filled in 90-day supplies. The Insured Person should have his or her Physician contact the Pharmacy at the toll-free number shown on the order form if there are any questions.

How to Order From the Pharmacy

The Insured Person's initial order consists of three parts: the Written prescription from his or her Physician; a Patient/Profile Order form with preaddressed envelope; and a Copay. These are described below. Allow 14 days for the order to be completed and shipped to the Insured Person. All orders are mailed either by Federal Express or First Class U.S. Mail. If the Insured Person wishes to have his or her order shipped Federal Express, the Insured Person will need to pay the cost.

The Written Prescription

When obtaining a prescription, be sure to ask the Physician to specify the following information:

- patient name;
- prescription for a 90-day supply of medication (the Physician should indicate the total number of pills required for that period of time. For example, 270 tablets would be needed for medication that must be taken three times a day.);
- refills (many maintenance drugs can be prescribed for up to one year; therefore, a prescription for a 90-day supply may specify up to three refills.);
- Physician's signature.

Also, it is very important to include the Insured Person's name, address, and member number on the prescription form, so that eligibility for the program can be verified when the Pharmacy receives the order.

Patient Profile/Order Form

Included in the installation package the Insured Person receives, as well as with each order shipped, is the Patient Profile/Order Form. This form is to be completed and sent in the preaddressed envelope with each order. The Patient Profile/Order Form provides information concerning eligibility in addition to health and allergy conditions pertaining to each Insured Person.

Copay

A check or money order for the correct Copay must accompany each order. The Copay amount is described in the Summary of Benefits section. The Insured Person may also be able to charge the Copay to a credit card as explained on the Patient Profile/Order Form. Please do not send cash.

Refills or Follow-up Orders

Each filled order the Insured Person receives includes Refill Ordering Instructions, a Patient/Profile Order Form, and a preaddressed envelope. Orders for refills should be placed approximately 30 days before the current supply of medication is expected to run out.

Special Situations

If a maintenance medication is prescribed for immediate use, the Insured Person should obtain two prescriptions--one for a 14-day supply to be filled immediately at a local Member Pharmacy, and a second for an extended 90-day supply with refills, to be filled by the mail service pharmacy.

Questions

Please call the pharmacy's customer service number with any questions concerning medication or a particular order. The toll-free number is shown on the Insured Person's order form.

Also included with each order filled is a Patient Counseling information sheet which has specific information about the medication included with the order.

Limitations

Prescription Drugs Covered Charges will not include and no benefits will be payable under the Prescription Drugs Expense Insurance portion of the Group Policy for the following items. However, the first seven items listed below may be eligible for benefits under the Comprehensive Medical Expense portion of the Group Policy as described under the Description of Benefits for Medical Expense Insurance in this booklet-certificate:

- drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which the Insured Person is confined; or
- drugs or medicines delivered or administered by the prescriber; or
- therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except as specifically provided above under Prescription Drug Covered Charges; or
- immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use; or
- administration of any drug or medicine; or
- drugs or medicines that are not Covered Charges; or
- drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for Experimental or Investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or
- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription. This does not apply to over the counter contraceptives for women when prescribed by a Physician; or

- drugs or medicines prescribed or dispensed by any person who is in an Insured Person's Immediate Family; or
- vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or
- dietary supplements; or
- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or
- drugs or medicines for which the Insured Person has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or
- drugs or medicines provided as the result of a sickness or injury that is due to participation in criminal activities; or
- cosmetic, and health and beauty aids; or
- dermatologicals used as hair growth stimulants; or
- drugs labeled "Caution-limited by Federal law to investigational use," or experimental, even though a charge is made to the individual; or
- topical dental fluorides; or
- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- drugs or medicines that are lost, stolen or spilled; or
- anorectics (any drug used for the purpose of weight control); or
- minerals. Exception: Potassium supplements are covered; or
- hematinics; or
- drugs or medicines that are paid for by a Medicare Supplement Insurance Plan; or
- any other drugs or medicines used for cosmetic purposes; or
- herbal supplements, except as provided under Traditional East Asian Medicine.

Payment, Denial and Review

Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on the Insured Person's identification card or contact the Company. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or the Company within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or the Company receives proof of loss. Proof of loss includes the patient's name, the Member's name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. The Pharmacy Benefit Manager or the Company may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the Company's request or the request of Pharmacy Benefit Manager could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager or the Company will send a Written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manager or the Company will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Group Policy may be payable sooner, provided the Pharmacy Benefit Manager or the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager or the Company will submit a detailed explanation of the basis for its denial. See page NBM 5407 GP for the Complaint and Grievance Procedures.

For purposes of this section, "claimant" means the Insured Person.

EXTENDED BENEFITS
(after termination of insurance)

Extended benefits are payable if insurance ceases due to termination of the Group Policy. Extended benefits will be payable for up to 12 months, provided:

- the Insured Person has been Totally Disabled from the date insurance ceased until the date of Treatment or Service: and
- the Insured Person would have qualified for benefit payment under this section if insurance had remained in force; and
- the sickness or injury for which the Insured Person receives Treatment or Service is the disabling condition and was diagnosed by a Physician before the date insurance terminated.

These extended benefits are payable whether or not the Group Policy is replaced. However, if the Group Policy is replaced within 60 days, the extended benefits will cease on the earlier of:

- the date 12 months after the date insurance terminates; or
- the date the succeeding carrier provides replacement coverage to the Insured Person without limitation as to the disabling condition.

The extended benefits will not apply to insurance which terminates because the Insured Person transfers to an HMO.

COORDINATION WITH OTHER BENEFITS

Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan (except benefits in Prescription Drugs and Mail Service Prescription Drugs when an Insured Person has health care insurance under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

- will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- may be reduced when, under the order of benefit determination rules, another plan determines its benefits first.

Benefits paid under all other Plans plus the sum of benefits paid under the Group Policy will not exceed the lesser of the financial liability of the Insured Person or the Prevailing Charge for a Treatment or Service.

Definitions

"Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

* - group, blanket or franchise insurance coverage,
* - service plan contracts, group practice, individual practice and other prepayment coverage,
* - any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and
** - any coverage under governmental programs, and any coverage required or provided by any statute.

"Plan" will also mean any coverage under a Worker's Compensation Act or other similar law.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

* In the event a husband and wife or a Member and his or her Domestic Partner are both employed by the Policyholder, each Plan will be considered a separate Plan with respect to these coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for Treatment or Service.

** Not applicable to persons subject to the INTEGRATION WITH MEDICARE provisions as described in page NBM 5157.

The term Plan will not include benefits provided under:

- a student accident policy; or
- a state medical assistance program where eligibility is based on financial need; or
- individual or family policies; or
- individual or family subscriber contracts; or
- entitlements to Medi-Cal benefits; or
- benefits provided under the California Children Services program; or
- the medical payment benefits customarily included in the traditional automobile contracts; or
- any other coverage provided for or required by law when its benefits are excess to any private insurance or other non-governmental program.

"This Plan" is the medical expense benefits described in this booklet-certificate.

Primary Plan/Secondary Plan: The order of benefit determination rules determine whether This Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person.

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

Allowable Expense: A health care service or expense that is covered at least in part by any of the Plans covering the person for whom benefits are claimed. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following is an example of expenses or services that are not allowable expenses:

- The amount a benefit is reduced by the Primary Plan because an Insured Person does not comply with the Plan provisions. Examples of these provisions are Precertification of admissions and preferred provider arrangements.

Claim Determination Period means Calendar Year.

Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. Any such reduced amount will be charged against any applicable benefit limit of this Plan.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;

** - for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B and C whether or not the person is covered under that Part B and C.

** Not applicable to persons subject to the INTEGRATION WITH MEDICARE provisions as described in page NBM 5157.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- **Non-Dependent/Dependent.** The plan which covers the person as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - Secondary to the Plan covering the person as a Dependent and
  - Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee).

Then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent. This provision is not applicable to persons subject to the INTEGRATION WITH MEDICARE provisions as described in page NBM 5157.

- **Dependent Child--Parents Not Separated or Divorced.** If a child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the Calendar Year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

  However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- **Dependent Child--Separated or Divorced Parents.** If a child of legally separated or divorced parents is covered under two or more Plans, benefits for the child are determined in this order:

  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse or Domestic Partner of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.

- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Continuation of Coverage**. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

  - first, the benefits of a Plan covering the person as a Member or subscriber (or as that person's Dependent);
  - second, the benefits under the continuation coverage.

  If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the Plan which covered the Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy. Federal law will usually apply in such instances if:

- the benefits are applicable to an active Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

For persons subject to the INTEGRATION WITH MEDICARE provision, the benefits payable under the Group Policy will be directly reduced by Medicare benefits, as described in this booklet-certificate.

Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for health care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider medical enrollment options carefully.

Payment of Funds

Payment of funds may be made directly between insurers and other provider of benefits.

How COB Works

Example 1: The natural father is insured as a Member under This Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the child and the divorce decree does not establish financial responsibility for medical, dental, or other health care expenses.

The following order of benefits would apply to the child:

1. Company A would be Primary (mother's carrier).
2. Company B would be Secondary (stepfather's carrier).
3. The Company would then determine the benefits payable, if any, under This Plan.

Example 2A: Mrs. Smith has filed a claim for $2,400 with both Company A and Company B. Company A insures Mrs. Smith as an employee and Company B insures her as a dependent spouse under a plan. Both plans provide 80% of Covered Charges after a $200 deductible.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

Company A

Billed Charges	$ 2,400.00
Not Covered By Primary Carrier	$ 200.00 (Personal Items)
Total Covered Charges	$ 2,200.00
Company A's Deductible	$ 200.00
Benefits Payable ($2,000 X 80% = $1,600)	$ 1,600.00

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$ 2,200.00
Less Company A Benefits	$ 1,600.00
Benefits Payable	$ 600.00

The patient is responsible for $200 which is not considered a covered expense under either policy.

Example 2B: The same rules apply in this example as they did in Example 2A. Mrs. Smith has filed an additional claim for $5,000 with both Company A and Company B. Company A insures Mrs. Smith as an employee and Company B insures her as a dependent spouse under a plan. Both plans provide 80% of Covered Charges after a $200 deductible.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits according to their plans Covered Charges as though duplicate coverage did not exist.

Company A

Billed Charges	$ 5,000.00
Not Covered By Primary Carrier	$ 500.00 (Private Room)
Total Covered Charges	$ 4,500.00
Company A's Deductible	$ 200.00
Benefits Payable ($4,300 X 80% = $3,440)	$ 3,440.00

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

Allowable Expenses	$ 4,500.00
Less Company A Benefits	$ 3,440.00
Benefits Payable By Company B	$ 1,060.00

The patient is responsible for $500 which is not considered a covered expense under either policy.

MEDICAL EXPENSE COVERAGE

INTEGRATION WITH MEDICARE

This section will apply to Insured Persons, where permitted by Federal law:

- on the date the Insured Person becomes enrolled in Medicare; and
- who are covered by Medicare Parts A, B and C;

Comprehensive Medical benefits payable under the Group Policy for Treatment or Service received will be reduced by the benefits payable for such Treatment or Service by Medicare Parts A, B and C.

MEDICAL EXPENSE COVERAGE

SUBROGATION AND REIMBURSEMENT

Applicability

Subject to applicable law, this section will apply to Insured Persons who:

- receive benefit payment under the Group Policy as a result of a sickness or injury; and
- have a lawful claim against another party, parties, or insurer (including uninsured, underinsured, and no-fault automobile insurers) for compensation, damages, or other payment because of that same sickness or injury.

Reimbursement

(a) The Company has the right to assert a lien for the recovery of money paid or payable to or on behalf of an Insured Person for Treatment or Service provided under this Group Policy.

The amount of the lien may not exceed the sum of the reasonable costs actually paid by the Company to perfect the lien and one of the following:

- For health care services not provided on a capitated basis, the amount actually paid by the Company pursuant to this Group Policy to any treating medical provider.

- For health care services provided on a capitated basis, the amount equal to 80 percent of the usual and customary charge for the same services by medical providers that provide health care services on a noncapitated basis in the geographic region in which the services were rendered.

(b) If an Insured Person received health care services on a capitated basis and on a noncapitated basis, and the insurer, medical group, or independent practice association that provided the health care services on the capitated basis paid for the health care services the Insured Person received on the noncapitated basis, then a lien that is subject to paragraph (a) above may not exceed the sum of the reasonable costs actually paid to perfect the lien, and the amounts determined pursuant to both bulleted items of paragraph (a) above.

(c) If the Insured Person engaged an attorney, then the lien subject to paragraph (a) above may not exceed the lesser of:

- The maximum amount determined pursuant to paragraph (a) or (b) above, whichever is applicable; or
- One-third of the moneys due to the Insured Person under any final judgment, compromise, or settlement agreement.

(d) If the Insured Person did not engage an attorney, then the lien subject to paragraph (a) above may not exceed the lesser of:

- The maximum amount determined pursuant to paragraphs (a) or (b) above, whichever is applicable; or
- One-half of the moneys due to the Insured Person under any final judgment, compromise, or settlement agreement.

(e) Where a final judgment includes a special finding by a judge, jury, or arbitrator that the Insured Person was partially at fault, the lien subject to subdivision (a) or (b) will be reduced by the same comparative fault percentage by which the Insured Person's recovery was reduced.

CONTINUATION OF COVERAGE – STATE REQUIRED - CALIFORNIA

State Required Continuation: Member

State Required Notice:

Please examine all options carefully before declining this coverage. Be aware that companies selling individual health insurance typically require a review of medical history that could result in a higher premium or denial of coverage entirely.

Member Who has Completed COBRA Continuation (Applicable only if the employer is subject to COBRA requirements)

- **Definitions**

  Qualified Person means a Member or any covered Dependent who, on the day before a Qualifying Event described below, is covered under the Group Policy by means of electing COBRA continuation due to termination of employment or reduction in work hours for reasons other than gross misconduct. Qualified Person will also include any child born to or placed for adoption with the Member who is on continuation.

  Qualifying Event means, except for the election to continue coverage, insurance would otherwise cease due to the Member's completion of the COBRA maximum continuation period of 18 months (or 29 months if determined disabled under COBRA provisions).

- **Qualification for Continuation**

  Qualified Persons who would lose insurance under the Group Policy because of a Qualifying Event may elect to continue insurance on the date insurance would otherwise cease if:

  - the Group Policy is in force; and
  - the Qualified Person timely elects to continue insurance and agrees to pay the required premium; and
  - the Qualified Person is not entitled to Medicare; and
  - the Qualified Person is not covered or eligible for COBRA continuation as a dependent.

- **Period of Continuation**

Insurance for the Qualified Person may be continued until the earliest of:

- the date the Group Policy is terminated; or
- the date insurance would otherwise cease as provided in the Group Policy; or
- the end of the period for which premium is paid, if payment of the required premium is not made within the Grace Period; or
- the date the Qualified Person becomes entitled to Medicare; or
- the date the Qualified Person becomes covered or eligible for COBRA continuation as a dependent; or
- the date insurance has been continued for seven months if the maximum COBRA continuation period was 29 months; or
- the date insurance has been continued for 18 months if the maximum COBRA continuation period was 18 months.

For a Member's child who is born to or placed for adoption with the Member while on continuation, the maximum continuation period for that child will be the Member's maximum continuation period.

- **Notice, Election, and Premium Requirements**

The Company will notify a Qualified Person of the availability to continue insurance prior to the date COBRA continuation will terminate. The notification will include premium information and an election form and will be mailed to the Qualified Person's last known address.

Qualified Persons must notify the Company within 30 days of the date a child is born to or placed for adoption with the Member.

If the Group Policy terminates, Qualified Persons may elect to complete the remaining continuation period under the employer's replacing plan, if any. Qualified Persons must elect continuation and pay the required payment within 30 days after receiving the replacing carrier's notice.

Premium charged for the continuation will be 110% of the applicable group rate.

The first premium payment must be delivered to the Company by first class or certified mail (or other reliable means) within 45 days after the date of election. The first premium payment must be sufficient to pay all required payments. Failure to make the first payment as required will disqualify the Qualified Person from continuation. All subsequent payments are due monthly on or before the due date. Failure to make the required premium payment with the Grace Period will disqualify the Qualified Person from continuation.

- **During a Labor Dispute**. Arrangements may be made to continue the Member's coverage if the Member's active employment ceases because of a labor dispute. The Member may continue coverage up to six months, but only if certain conditions of the Group Policy are met (including payment of the required contribution by at least 75% of the eligible Members). See the employer to make arrangements for continuing coverage. The Member's coverage will be terminated unless arrangements are made within 31 days after active employment ceases because of the labor dispute.

CONTINUATION OF COVERAGE

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that group health insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of the insurance.

NOTE: COBRA Continuation is not available to a Domestic Partner or to a Domestic Partner's Dependent Child.

A. Qualified Persons/Qualifying Events

Continuation of group health coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following qualifying events:

(1) A Member, spouse or Dependent Child following the Member's:

(a) termination of employment for a reason other than gross misconduct; or
(b) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, absence due to sickness or injury, or, when applicable, retirement.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member has a qualifying event when the Member does not return to work after the end of FMLA leave); and

(2) a Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and
(3) a Member's surviving spouse (and any Dependent Children) following the Member's death; and
(4) a Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and

(5) a Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare; and
(6) a Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and
(7) if the Group Policy covers retired Members, a retired Member and his/her spouse or Dependent Child (or surviving spouse or Dependent Child) when retiree health benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and spouse or Dependent Child) following a termination of employment or reduction in work hours is 18 months from the date of the qualifying event. The maximum continuation period for a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the spouse or Dependent Child will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or
(2) 18 months from the date of the qualifying event (termination of employment, or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A (2) through A (5) is 36 months from the date of the qualifying event.

If the Group Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

(1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.
(2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A(2) through A(5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A(2) through A(5), absent the first qualifying event, results in a loss of coverage for the spouse or Dependent Child under the Group Policy. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or spouse or Dependent Child) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end on the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends on the earliest of the following:

(1) The date the maximum continuation period ends; or
(2) The date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in A(7); or
(3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or
(4) The date the Group Policy is terminated (and not replaced by another group health plan); or

(5) The date the qualified person becomes covered by another group health plan; however, this does not apply to a person who is already covered by the other group health plan on the date he or she elects COBRA.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group health plan are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their spouse or Dependent Child (or surviving spouse or Dependent Child) due to qualifying event A (7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent (spouse or Dependent Child) has a qualifying event due to the Member's termination of employment or reduction in work hours, the death of the Member, the Member's entitlement to Medicare, or if the Group Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator within 30 days of the date of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirements

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent Child under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a Written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in Writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make Written election within 60 days after the later of: (a) the date group health coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. **Grace Period** means the first 31-day period following a premium due date. Except for the first payment (see Section F), a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Newly Acquired Spouse or Dependent Child

A qualified person may elect coverage for a spouse or Dependent Child acquired during COBRA continuation. All enrollment and notification requirements that apply to the spouse or Dependent Child of active Members apply to the spouse or Dependent Child acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired spouse or Dependent Child will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired spouse or Dependent Child, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for health care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider medical enrollment options carefully.

M. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

Group Health Plan: California Evolution w. Buy-Up John Doe Health Plan
Contact Name/Area: California Evolution w. Buy-Up John Doe Benefits Department
Address: 900 Anywhere Street
Bonaparts, USA 52620
Phone Number: (319) 592-3166

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

FMLA and Other Continuation Provisions

If the Policyholder is an Eligible Employer and if the continuation portion of the FMLA applies to the Eligible Employee's coverage, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If coverage under the Group Policy is subject to FMLA or a state continuation law, this continuation period will run concurrent with the FMLA or state continuation period.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year.

Eligible Employee (definition for use in this section of the booklet-certificate only)

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
- because of a "qualifying exigency" arising out of a spouse, son, daughter or parent on active duty or having been notified of a call to active duty, as applicable to retired regular armed forces members, reserve members, National Guard members, and members in contingency operations, as defined under federal law.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to Eligible Employees to care for a "covered service member" with a "serious injury or illness".

Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

Contact the Policyholder for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if insurance would otherwise end because the Member enters into active military duty or inactive military duty for training, he or she may elect to continue insurance (including Dependents insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If active employment ends because the Member enters active military duty, insurance may be continued until the earliest of:

- for the Member and Dependents:
  - the date the Group Policy is terminated; or
  - the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
  - the date 24 months after the date the Member enters active military duty; or
  - the date after the day in which the Member fails to return to active employment or apply for reemployment with the Policyholder.
- for the Member's Dependents:
  - the date Dependent Medical Expense Insurance would otherwise cease as provided on page NBM 5125- How To Be Insured – Dependents; or
  - the end of any Insurance Month desired, if requested by the Member before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any. If the Insured Person qualifies for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

For Medical Expense Insurance, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to the Company within 20 calendar days after the occurrence or commencement of any loss covered by the Group Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at its said office, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Forms

Except in the case of medical care received from Preferred Providers, the Company, upon receipt of a notice of claim, will furnish to the Insured Person such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the Insured Person shall be deemed to have complied with the requirements of the Group Policy as to proof of loss upon submitting, within the time fixed in the Group Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which the policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Company receives proof of loss. Proof of loss includes the patient's name, the Insured Person's name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. The Company may request additional information to substantiate the Insured Person's loss or require a Signed unaltered authorization to obtain that information from the provider. The Insured Person's failure to comply with such request could result in declination of the claim.

Time of Payment of Claim

Indemnities payable under the Group Policy for any loss other than loss for which the Group Policy provides any periodic payment will be paid (to the insured employee) as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the Group Policy provides periodic payment will be paid (to the insured employee) and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Subject to any written direction of the Insured in an application or otherwise all or a portion of any indemnities provided by the policy on account of hospital, nursing, medical or surgical service may, at the Company's option, and unless the Insured requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Payment, Denial, and Review

The Employment Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. The Company will reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the Company unless the claim or portion thereof is contested by the Company, in which case the Insured Person will be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the Company. The notice that a claim is being contested or denied will identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the Company for contesting or denying the claim. The Company will provide a copy of the notice to each Insured Person who received services pursuant to the claim that was contested or denied and to the Insured Person's health care provider that provided the services at issue. The notice will advise the provider who submitted the claim and the Insured Person that either may seek review by the department of a claim that the Company contested or denied, and the notice will include the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. If the Company does not deny the claim and requests additional information to complete the review, the Company must pay the claim within 30 working days of receipt of that information.

In actual practice, benefits will be payable sooner, provided, the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Company will submit a detailed explanation of the basis for the denial. See page NBM 5407 GP for the Complaint and Grievance Procedures.

Medical Examinations

The Company may have the person whose loss is the basis for claim examined by a Physician. The Company will pay for these examinations and will choose the Physician to perform them.

Legal Action

No action at law or in equity shall be brought to recover on the Group Policy prior to the expiration of 60 calendar days after written proof of loss has been furnished in accordance with the requirements of the Group Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Time Limits

All time limits listed in this section will be adjusted as required by law.

Recoding of Procedures

When a claim contains one or more procedure codes with the same date of service, the Company may review the claim to determine whether it contains, among other things, coding irregularities (including duplicative or combined codes), coding conflicts or coding errors. The Company will base such review on generally recognized and authoritative coding resources, including but not limited to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding Systems (HCPCS).

If the Company determines, at its discretion, that the claim may be more appropriately coded using the same or different codes, the claim will be recoded and processed accordingly to determine the allowable amount and extent of benefits.

Offsetting of Overpayments

If the Company pays benefits under the Group Policy for expenses incurred by an Insured Person which are later determined to have been paid to the Insured Person or a provider in error--for whatever reason, the Company will be entitled to offset the amount of the overpayment from any benefits under the Group Policy which may later become due the Insured Person or the same provider in connection with treatment or services rendered to the Insured Person, in order to recoup the Company's overpayment. The Company reserves the right to collect overpayments by other means available.

For Medical Insurance

Preferred Providers

When a person becomes insured, he or she will be issued an identification card. This card should be presented to each Preferred Provider at the time an Insured Person receives needed medical care. The Company will assist the Insured Person with the Precertification.

Benefit Advice

Benefit Advice is the Company's toll-free service that can answer questions about an Insured Person's benefit program or specific coverages. The staff provides information on topics such as outpatient surgery, generic drugs, health care alternatives, health care providers and treatment costs in the Insured Person's area.

The staff does not prescribe medical treatment. That is up to the Insured Person's Physician. But they can help the Insured Person understand his or her benefits and how to use them in the most cost-effective manner.

Call the toll-free Health Info Line number (see the ID card or Policyholder for the Health Info Line number) to discuss medical benefits with the Company's Benefit Advice staff. The number is also listed on page NBM 5100 A in this booklet-certificate.

Precertification - Applies to Medical Care received from PPO Providers or Non-PPO Providers

If a Hospital Inpatient Confinement or confinement in an inpatient confinement facility is necessary, the Insured Person will need to follow the procedures below in order to qualify for payment of Hospital Inpatient Confinement Charges and charges for services provided in an inpatient confinement facility at the standard rate for his or her Group Policy. The procedures differ depending on the type of Hospital Inpatient Confinement or confinement in an inpatient confinement facility:

- **For Other than Emergency Services**

  An Insured Person or a designated patient representative must call the Company at the toll-free number shown on the identification card as soon as a Hospital Inpatient Confinement or confinement in an inpatient confinement facility is scheduled, but no later than the day of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

- **For Emergency Services**

  An Insured Person or a designated patient representative must call the Company at the toll-free number shown on the identification card within two business days of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

- **For a Continued Stay Review**

  If the Hospital Inpatient Confinement or confinement in an inpatient confinement facility will exceed the approved number of days, the Company will initiate a Continued Stay Review.

- **For Childbirth**

  A Precertification is not required for the first 48 hours of Hospital Inpatient Confinement following a vaginal delivery or for the first 96 hours of Hospital Inpatient Confinement following a cesarean section, for mother and baby.

  An Insured Person or a designated patient representative must call the Company at the toll-free number shown on the identification card to request a review of the need for continued Hospital Inpatient Confinement for mother or baby before the end of the automatically approved time period if the mother or baby will remain Hospital Inpatient Confined beyond that time period.

  Notification of the number of approval days will be sent to the Insured Person, his or her Physician, and the Hospital.

Facility of Payment For Medical Insurance

The Company will normally pay all benefits to the Member. However, if the claimed benefits result from a Dependent's sickness or injury, the Company may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Company to the full extent of those payments.

- If payment amounts remain due upon the Insured Person’s death, those amounts may, at the Company’s option, be paid to the Insured Person’s estate, spouse, Domestic Partner, child, Domestic Partner’s child, parent, or provider of medical services.
- If the Company believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Company may pay whoever has assumed the care and support of the person.
- Reimbursement for covered medical transportation shall be made directly to the provider of such service.
- Reimbursement for perinatal services shall be made directly to certified nurse midwives or nurse practitioners when providing such service.

- Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of the Insured Person.
- Benefits payable to QuestSelect™, a service of Quest Diagnostics will be paid directly to the laboratory.
- Benefits payable to Transplant Network Providers will be paid directly to the Transplant Network Provider.

Binding Arbitration

Any controversy or claim arising out of or relating to this agreement, or the breach thereof, will be determined by final and binding arbitration administered by the American Arbitration Association ("AAA") under its Commercial Arbitration Rules and Mediation Procedures ("Commercial Rules"). Binding arbitration will be used to settle all disputes, including claims of medical malpractice.

- **Judgement and Jurisdiction**

  The award rendered by the arbitrator(s) will be final and binding on the parties and may be entered and enforced in any court having jurisdiction, and any court where a party or its assets is located.

- **Selection of Arbitrators**

  For those cases or disputes for which the total amount of damages claimed is greater than fifty thousand dollars, there will be three arbitrators. The parties agree that one arbitrator will be appointed by each party within twenty (20) days of receipt by respondent(s) of the request for arbitration or in default thereof appointed by the AAA in accordance with its Commercial Rules, and the third presiding arbitrator will be appointed by agreement of the two party-appointed arbitrators within fourteen (14) days of the appointment of the second arbitrator or, in default of such agreement, by the AAA.

  For those cases or disputes for which the total amount of damages claimed is fifty thousand dollars or less, a single neutral arbitrator will be selected by the parties with no jurisdiction or authority to award more than fifty thousand dollars. If the parties are unable to agree on the selection of a single neutral arbitrator, the arbitrator will be selected in accordance with the method provided in California Code of Civil Procedure § 1281.6.

- **Consolidation, Joinder**

If more than one arbitration is commenced under this Agreement and any party contends that two or more arbitrations are substantially related and that the issues should be heard in one proceeding, the arbitrators selected in the first filed proceeding will determine whether, in the interests of justice and efficiency, the proceedings should be consolidated before those arbitrators. The Parties to this agreement are bound to each other by this arbitration clause, provided that they have signed this agreement. Each related party may be joined as an additional party to an arbitration involving other parties under this agreement.

- **Seat of Arbitration, Languages**

The seat or place of arbitration will be San Diego, California. The arbitration will be conducted and the award will be rendered in the English language.

- **Confidentiality**

Except as may be required by law, neither a party nor the arbitrators may disclose the existence, content or results of any arbitration without the prior Written consent of both parties, unless to protect or pursue a legal right.

- **Remedies**

The arbitrators will have no authority to award punitive damages, consequential damages, or liquidated damages.

- **Interim Relief**

The parties also agree that the AAA Optional Rules for Emergency Measures of Protection will apply to the proceedings.

STATEMENT OF RIGHTS

Federal law requires that this section be included in the booklet-certificate:

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About the Plan and Benefits

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

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the Member, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. The Member and his or her Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce the Member's Rights

If the Member's claim for a welfare benefit is denied or ignored, in whole or in part, the Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps the Member can take to enforce the above rights. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, he or she may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to $110 a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the Member has a claim for benefits which is denied or ignored, in whole or in part, the Member may file suit in a state or Federal court. In addition, if the Member disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Member may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his or her rights, the Member may seek assistance from the U.S. Department of Labor, or the Member may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees, for example, if it finds the Member's claim is frivolous.

Assistance with Member Questions

If the Member has any questions about his or her plan, the Member should contact the plan administrator. If the Member has any questions about this statement or about his or her rights under ERISA, or if the Member needs assistance in obtaining documents from the plan administrator, the Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Member may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SUPPLEMENT
TO THE MEMBER'S BOOKLET-CERTIFICATE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**

   EIN: 99-9999999
   PN: 501

2. **Type of Administration:**

   Medical Expense Coverage: Insurance Contract.

3. **Plan Administrator:**

   Riverside Plastics Incorporated
   900 Washington St
   Bonapart USA 52620

   See the employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**

   Riverside Plastics Incorporated
   900 Washington St
   Bonapart USA 52620

   A complete list of the employers and/or employee organizations sponsoring the plan may be obtained upon written request to the plan administrator and is also available for examination at the business office of the plan administrator.

   Upon Written request, participants may receive from the ERISA Plan Administrator, information as to whether a particular employer or employee organization is a sponsor of the ERISA Plan and, if the employer or employee organization is a plan sponsor, their address.

5. **Agent for Service of Legal Process:**

Riverside Plastics Incorporated
900 Washington St
Bonapart USA 52620
Telephone: (319)592-3166

Legal process may also be served upon the plan administrator.

6. **Type of Participants Covered Under the Plan:**

All active Full-Time Employees of Riverside Plastics Incorporated, and provided that, for each employee, he or she also meets the definition of a Member as defined in the DEFINITIONS section of this booklet (page NBM 5136).

7. **Sources and Methods of Contributions to the Plan:**

Employee pays part of Employee's contribution. Employee pays part of Dependent's contribution (if Employee elects to enroll Dependents in plan).

8. **Ending Date of Plan's Fiscal Year:**

December 31

DEFINITIONS

When used in the Group Policy, the terms listed below will mean:

Adverse Benefit Determination means any of the following:

a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Insured Person's eligibility under the Group Policy, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an Experimental or Investigational Measure or not medically necessary or appropriate, or due to rescission of coverage.

Ambulatory Surgery Center means a facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility; and
- does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

Average Wholesale Price (AWP) means the published cost of a drug product to the wholesaler.

Birthing Center means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care; and
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a Written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with Written procedures for such transfer being displayed and staff members being aware of such procedures.

Calendar Year means January 1 through December 31 of each year.

Community Mental Health Center means a community or county mental health facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient Mental Health and Substance Use Disorders treatment.

Company means Nippon Life Insurance Company of America.

Copayment; Copay means a specified dollar amount that must be paid by an Insured Person each time certain or specified services are rendered. In no event will the Copay amount exceed:

- for services provided by PPO Providers, the negotiated fee; and
- for services provided by Non-PPO Providers, the actual cost charged to the Insured Person.

Cosmetic Treatment or Service means Treatment or Service intended to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such Treatment or Service:

- is performed primarily to improve appearance; or
- is not needed to correct or improve a Functional Impairment of an organ or other body part.

Functional Impairment is a direct and measurable reduction of physical performance of an organ or body part.

Cosmetic Treatment or Service includes, but is not limited to, surgery and pharmacological regimens and all their related charges.

Covered Charges means a Treatment or Service that is:

- prescribed by a Physician and required for the screening, diagnosis or treatment of a medical condition;
- consistent with the diagnosis or symptoms;
- not excessive in scope, duration, intensity or quantity;
- the most appropriate level of services or supplies that can safely be provided; and
- determined by the Company to be Generally Accepted.

Custodial Care means assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), chiropractor, physical therapist, occupational therapist, speech therapist, or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination and taking medications.

Date of Issue means the date the Group Policy is placed in force: January 1, 2023.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges that must be incurred by the Insured Person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the Calendar Year.

Dental Services means any Treatment or Service provided to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); or
- malocclusion (abnormal positioning or relationship of the teeth); or
- ailments or defects of the teeth and supporting tissue and bone (excluding impacted teeth and appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance).

Dependent means:

- The Member's spouse of the same or opposite sex, if that spouse:
  - Resides in the United States; and
  - is not in the armed forces of any country; and
  - is legally wed to the Member; and
- The Member's Domestic Partner as defined below; and
- The Member's Dependent Child (or Children) as defined below; and
- The Domestic Partner's Dependent Child (or Children) who qualifies as defined below.

Dependent Child; Dependent Children means:

- A Member's natural, stepchild or legally adopted child, if that child is less than 26 years of age, regardless of financial dependency (upon the Member or any other person), residency with the Member or with any other person, student status, employment, or any combination of those factors.

  Note: See section NBM 5125 –Termination, for information on when coverage ends.

  A newly adopted child will be considered a Dependent Child from the date of Placement with the Member for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- A Member's foster child, provided:

  - the child meets the requirements above; and
  - the child has been placed with the Member or spouse insured under the Group Policy by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; and
  - the required documentation has been provided and the child is approved in Writing by the Company as a Dependent Child.

- A Domestic Partner's child who otherwise qualifies under this definition.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the Group Policy's definition of a Dependent Child.

Developmental Disability means a Dependent Child's substantial handicap which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

Domestic Partner (Registered in CA) means a Member's opposite sex or same sex partner, provided:

- the Member and partner have filed a Declaration of Domestic Partnership with the CA Secretary of State; and
- the partner Resides in the United States; and
- the partner and the Member are 18 years of age or older or meet the requirements for persons less than 18 years of age as provided below; and
- the partner and the Member are both capable of consenting to the partnership; and
- neither the partner nor the Member is married to other persons; and
- neither the partner nor the Member has a Domestic Partnership with another person that has not been terminated, dissolved or adjudged a nullity; and
- the partner is not a blood relative of the Member.

A person or persons less than 18 years of age who otherwise meets the requirements for a domestic partnership other than the requirement of being at least 18 years of age, must obtain a court order and written consent from a parent or guardian or from the court if there is no parent or guardian, or if such parent or guardian is incapable of consenting, granting permission to the underage person or persons to establish a domestic partnership.

Domestic Partner (Other Than Registered in CA) means a Member's opposite sex or same sex life partner, provided:

- the Member and partner have filed a Declaration of Domestic Partnership with the Company; and
- the partner Resides in the United States; and
- the partner is not in the armed forces of any country; and
- the partner is not covered under the Group Policy as a Member; and
- the partner is at least 18 years of age; and
- neither the partner nor the Member is married to other persons; and
- the partner is not the Member's blood relative.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, a serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services means with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required to Stabilize the patient.

Essential Health Benefits means those services and devices defined by the Federal government as "essential health benefits" as follows: (a) ambulatory patient services, (b) emergency services, (c) hospitalization, (d) maternity and newborn care, (e) mental health and substance use disorder services, including behavioral health treatment, (f) prescription drugs, (g) rehabilitative and habilitative services and devices, (h) laboratory services, (i) preventive and wellness services and chronic disease management, (j) pediatric services, including oral and vision care.

Experimental or Investigational Measures means any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

Full-Time Employee means a person who is regularly scheduled to work for the Policyholder for at least 30 hours a week. The employee must be compensated by the Policyholder and either the employee or employer must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

Full-Time Student means the Member's Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as his or her main focus; and
- carries a minimum load of 12 credit hours; and
- receives more than one-half of his or her financial support from the Member.

Generally Accepted means Treatment or Service for the particular sickness or injury which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the relevant medical community; and
- is not under scientific testing or research.

Group Health Plan means an employee welfare benefit plan, as defined in ERISA, to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Group Policy means the policy and booklet-certificate of group insurance issued to the Policyholder by the Company which describes benefits and provisions for the Policyholder and Insured Persons.

Health Care Extender means a health care provider who assists in the delivery of covered medical services under the direction and supervision of a Physician. Direction and supervision means the Physician co-signs any progress notes Written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

Health Insurance Coverage means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or Health Maintenance Organization (HMO) contract, offered by an insurance company, insurance service, or insurance organization (including an HMO) licensed to engage in the business of insurance and subject to state law which regulates insurance.

Health Maintenance Organization (HMO) means an entity that is:

- a federally qualified Health Maintenance Organization as defined by federal law; or
- an organization recognized under state law as a Health Maintenance Organization; or
- a similar organization regulated under state law for solvency in the same manner and to the same extent as such a Health Maintenance Organization.

Home Health Aide means a person, other than a licensed registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.), who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency means a Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care. In rural areas where there are no licensed home health care agencies or where the supply of home health care agencies does not meet the needs of the community, the services of visiting nurses (if available) may be substituted for the services of a home health care agency.

Home Health Care Plan means a program of home care that:

- is required as the result of a sickness or injury; and
- prevents, delays or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician.

Home Infusion Therapy Services means Treatment or Service required for the administration of intravenous drugs or solutions, which:

- is required as a result of a sickness or injury; and
- prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician.

Hospice means a facility, agency, or service that:

- is licensed by the proper authority of the state in which it is located to establish and manage Hospice Care Programs; and
- arranges, coordinates, and provides Hospice Care Services for dying individuals and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

Hospice Care Program means a program that furnishes palliative or supportive care focused on comfort and not cure and that is:

- managed by a Hospice; and
- established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

Hospice Care Team means a group that provides coordinated Hospice Care Services and normally includes:

- a Physician;
- a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

For the purpose of Mental Health and Substance Use Disorders treatment, the definition of "Hospital" will include each of the following facilities provided it is licensed by the proper authority of the state in which it is located:

- a Psychiatric Hospital; and
- an Inpatient Alcohol or Drug Abuse Treatment Facility; and
- a residential treatment center or facility; and
- any other facility required by state law to be recognized as a treatment facility under the Group Policy.

Hospital Inpatient Confined; Hospital Inpatient Confinement means any period of Treatment or Service in a Hospital in excess of twenty-three consecutive hours for any cause. A Precertification as defined in page NBM 5407 CC is required for Hospital Inpatient Confinements.

Hospital Inpatient Confinement Charges means Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia provided while an Insured Person is Hospital Inpatient Confined.

Hospital Room Maximum means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or
- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Hospitalization Charges means Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia while Hospital Inpatient Confined. Such charges must be incurred while the person is Hospital Inpatient Confined, or for any period of time while undergoing surgery or while receiving emergency treatment as a result of and within 24 hours after an injury

Immediate Family means an Insured Person’s spouse, Domestic Partner, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Inpatient Alcohol or Drug Abuse Treatment Facility means an institution that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services; and

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and
- provides 24-hour a day on-site nursing care by licensed registered nurses (R.N.).

Insurance Month means Calendar month.

Insured/Insured Person means a Member or Dependent who:

- applied for coverage; and
- meets the eligibility rules set forth in the Group Policy; and
- is approved for insurance by the Company; and
- for whom all applicable premiums are paid, and is therefore insured.

When Insured is used alone, it does not include the Dependent.

When Dependent is used alone, it does not include the Member.

Member means any person who Resides in the United States and who is a Full-Time Employee of the Policyholder.

Non-Preferred Provider/Non-PPO Provider means a Hospital, Physician, or other provider not contracted with the preferred provider organization (PPO) network identified by the Company to the Group Policy.

Outpatient Alcohol or Drug Abuse Treatment Facility means a facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient alcohol or drug abuse treatment services.

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Physical Handicap means a Dependent Child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect, or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires to be recognized as a Physician under the Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: audiologist, chiropractor, dentist, genetic counselor, occupational therapist, optometrist, physician's assistant, physical therapist, podiatrist, psychologist, social worker, and speech pathologist.

Physician Visit means a face-to-face meeting or an approved form of on-line consultation between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service except when health care is performed via Telehealth.

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policy Anniversary means January 1, and the same day of each following year.

Policyholder means the business, firm, union, trustee(s), or other entity to whom the Group Policy is issued (see Title Page).

Preferred Provider/PPO Provider means a Hospital, Physician, or other provider contracted with a preferred provider organization (PPO) network identified by the Company to the Group Policy.

The Policyholder's participation in a PPO network does not mean that an insured person's choice of provider will be restricted. The insured person may seek needed medical care from any Hospital, Physician, or other provider of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible.

The Company has the right to terminate the preferred provider organization (PPO) portion of the Group Policy if the Company or the preferred provider organization (PPO) terminates the arrangement.

The Company also has the right to identify different preferred provider organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

Preferred Provider Organization (PPO) Service Area means the geographic area within which Preferred Provider services are available to persons insured under the Group Policy.

Prevailing Charges means: **USE FOR OTHER THAN RBRVS**

- For medical care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.
- For medical care received from Non-Preferred Providers, the amount that is the lesser of:
    - the fee charged under any direct or indirect arrangement the Company has with the provider; or
    - the amount, as determined by the Company, that most health care providers charge within a geographic cost area for a Treatment or Service, except as provided below.

  For the purpose of the second bullet above, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by the Company, 70% or more of all other charges reported to the Company for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

  A Non-Preferred Provider may bill the Insured Person for any part of a charge for Treatment or Service that exceeds Prevailing Charges (balance billing).
- For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.
- For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.

Prevailing Charges means: **USE FOR RBRVS**

- For medical care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.
- For medical care received from Non-Preferred Providers, the following amounts:
    - For non-emergency medical care received from an individual Non-PPO Provider* in a PPO facility, the amount that is the greater of:
        - the average contracted rate; or
        - 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar Treatment or Service in the general geographic region in which the services were rendered.

- For Emergency Services provided by a Non-PPO Provider, the allowable amount must be the greater of:
  - the amount that is the Qualifying Payment Amount as determined under applicable law. The Qualifying Payment Amount has the meaning given the term in 45 CFR § 149.140(a)(16); or
  - the amount billed by the provider or facility.
- For any other Treatment or Service, an amount that is derived by using RBRVS (Resource Based Relative Value Scale).

A Non-Preferred Provider may bill the Insured Person for any part of a charge for Treatment or Service that exceeds Prevailing Charges (balance billing).

- For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.
- For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.

*Excludes medical care received from a dentist.

Preventive Health and Wellness Services means the following services:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; or
- immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the insured persons involved; or
- preventive care and screenings for infants, children, and adolescents, according to guidelines supported by the Health Resources and Services Administration; or
- in addition to the benefits or services listed in the first bullet above, additional preventative care and screening for women according to the guidelines supported by the Health Resources and Services Administration Women's Preventive Services Guidelines; or
- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Additional detailed information is available at the following links:

- https://www.hrsa.gov/womens-guidelines-2016/index.html
- https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
- https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
- https://www.cdc.gov/vaccines/schedules/resource-library/index.html
- https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html
- https://www.healthcare.gov/coverage/preventive-care-benefits/.

Prior Plan means the group medical expense coverage of the Policyholder for which the Group Policy is a replacement.

Psychiatric Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, and is primarily engaged in providing diagnostic and therapeutic Mental Health and Substance Use Disorders treatment.

For the purpose of this definition, a Psychiatric Hospital will also include any inpatient bed in a licensed general Hospital used to provide diagnostic and therapeutic Mental Health and Substance Use Disorders treatment in the absence of a specialized or designated psychiatric or drug treatment unit.

Religious Employer means an entity for which each of the following is true:

- the inculcation of religious values is the purpose of the entity; and
- the entity primarily employs persons who share the religious tenets of the entity; and
- the entity serves primarily persons who share the religious tenets of the entity; and
- the entity is a nonprofit organization pursuant to Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

Reside(s) in the United States means an Insured Person who:

- maintains a home in the United States; and
- lives in that home in the United States; and
- does not leave the United States for more than six consecutive months.

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by the Company.

Skilled Nursing Facility means an institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Skilled Nursing Facility may include Hospitals when the Hospital is providing Nursing Facility level of services. Skilled Nursing Facility does not include rest homes, homes for the aged, nursing homes, or places which furnish Mental Health and Substance Use Disorders treatment.

Social Detoxification means a Treatment or Service designed to achieve detoxification without the use of drugs or other medical interventions.

Stabilize means no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the Insured Person from a facility.

Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of you or your Dependent's health care while you or your Dependent are at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for you or your Dependent and includes synchronous interactions and asynchronous store and forward transfers.

Total Disability; Totally Disabled means:

- For a Member, a Member's inability, as determined by the Company, due to his or her sickness or injury, to work at any job that reasonably fits his or her background or training.
- For a Dependent, a substantial impairment, due to his or her sickness or injury, that prevents the individual from performing the normal function of his or her regular duties or activities.

Transplant Network means any network of providers that the Company determines to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule as provided in page NBM 5402 C.

Treatment or Service, when used in the Group Policy, the term "Treatment or Service" will be considered to mean: "confinement, treatment, service, substance, material, or device".

United States (U.S.) means the contiguous United States consisting of the 48 adjoining U.S. states plus Washington, D.C. (federal district), Alaska, and Hawaii, on the continent of North America.

Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine) means Treatment or Service provided by a Physician conducted via a telephone or internet-based consult by the Company's authorized vendor-supported telemedicine service provider through, Teledoc, that has contracted with the Company to offer these services. Treatment or Service may be provided by two-way audio visual teleconferencing or real time, interactive telephone calls. Treatment or Service given when the Insured Person is not present at the same time as the provider, provided at telemedicine kiosks, and electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke, etc.), as well as dermatology and smoking cessation are not Covered Charges. Common conditions treated via Telemedicine include but are not limited to: sinus problems, urinary tract infection, pink eye, bronchitis, upper respiratory infection, nasal congestion, allergies, flu symptoms, cough, ear infection, behavioral health and other non-emergency illnesses. Telemedicine is for non-emergent medical conditions and should NOT be used if an Insured Person is experiencing an Emergency Medical Condition.

We, Us, and Our mean Nippon Life Insurance Company of America, West Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

BOOKLET-CERTIFICATE NOTICE

California insurance law requires that a Group Policy include the telephone number of the insurance company issuing the Group Policy in order for the persons to present inquiries, to obtain information about coverage, and to provide assistance in resolving complaints.

Consumers who have complaints related to their ability to access needed health care in a timely manner may contact Nippon Life Insurance Company of America or the California Department of Insurance.

Persons may call or write to:

Nippon Life Insurance Company of America
P. O. Box 25951
Shawnee Mission, KS 66225-5951

English and Non-English Toll-Free Telephone Number:
1-800-374-1835 during normal business hours.

Japanese Toll-Free Telephone Number
1-800-971-0638 during normal business hours.

Korean Toll-Free Telephone Number
1-877-827-8713 during normal business hours.

Consumers should contact the Company, their agent or other representative regarding complaints. If the policy or booklet-certificate was issued or delivered by an agent or broker, the Insured Person must contact his or her agent or broker for assistance.

The California Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both have failed to produce a satisfactory resolution to the problem.

Persons may call or write to:

California Insurance Department
Claims Services Bureau
11th Floor
300 South Spring Street
Los Angeles, CA 90013
Phone: 1800-927-HELP (In State)
1-213-897-8921 (Out of State)
1-800-482-4833 (TDD Number)
www.insurance.ca.gov

California law requires Nippon Life Insurance Company of America (Nippon Life Benefits) to provide specific information regarding the use of prescription drug formularies and a telephone number to enable persons to obtain information about their prescription drug coverage.

Prescription drug expense coverage includes a Formulary feature.

For information regarding prescription drug benefits call the telephone number shown on the Member ID card.

This Notice is for the Insured Person's information only and does not become a part or condition of this booklet-certificate.

Confidential Communications Notice

Under California law, an Insured Person who is a Protected Individual has the right to submit a Confidential Communication Request for Medical Information related to Sensitive Services received. The Protected Individual may request that confidential communications be sent in a different format or to a different address when the information is regarding Sensitive Services.

If the Protected Individual has designated an alternative mailing address, Nippon Life Insurance Company of America® (Nippon Life Benefits) will send all communications related to the Protected Individual's receipt of Sensitive Services to the alternative mailing address designated.

If the Protected Individual has not designated an alternative mailing address, Nippon Life Benefits will send all communications related to the Protected Individual's receipt of sensitive services in the name of the Protected Individual at the address on file.

Communications subject to this request will include the following written, verbal, or electronic communications:

- Bills and attempts to collect payment.
- A notice of adverse benefits determinations.
- An explanation of benefits notice.
- A health insurer's request for additional information regarding a claim.
- A notice of a contested claim.
- The name and address of a provider, description of services provided, and other information related to a visit.
- Any written, oral, or electronic communication from a health insurer that contains protected health information.

Confidential Communications Request means a request by an Insured Person covered under a health insurance policy that insurance communications containing Medical Information be communicated to the Insured Person at a specific mail address or specific telephone number, as designated by the Insured Person.

Medical Information means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health insurer, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment.

Protected Individual means any adult Insured Person covered under a health insurance policy or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code.

Sensitive Services means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

A Protected Individual may request a Confidential Communications Request form by mailing or calling Nippon Life Benefits at the contacts listed below.

Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951
Telephone: 1-800-374-1835

Nippon Life Benefits®

Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Notice of Protection Provided by California Life and Health Insurance Guarantee Association - CA

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities, and structured settlements annuities are member of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. The protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, which or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows:

Life Insurance, Annuities and Structured Settlement Annuities:

For life insurance policies, annuities and structured annuities, the Association will provide the following:

Life Insurance

-- 80% of death benefits but not to exceed $300,000

-- 80% of cash surrender or withdrawal values but not to exceed $100,000

Annuities and Structured Settlement Annuities

-- 80% of the present value of annuity benefits, including net case withdrawal and net case surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number if policies or contracts covering the individual.

Health Insurance

The maximum amount of protection by the Association to an individual, as of December 31, 2019, is $602,469. This amount will increase or decrease based upon change in the health care component of the consumer price index from January 1, 1991 to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

Coverage Limitations and Exclusions From Coverage

The Association may not provide coverage for this policy. Coverage by the Association generally required residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage.

-- A policy or contract issued by an insurer that was not authorized to do business when it issued the policy or contract;

-- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual company, an insurance exchange, or a grants and annuities society;

-- If the person is provided coverage by the guaranty association of another state.

-- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guarantee annuity benefits to an individual;

-- Employer and association plans, to the extent they are self-funded or uninsured;

-- A policy or contract providing any health care benefits under Medical Part C or Part D;

-- An annuity issued by an organization that is only licensed to issue charitable gift annuities;

-- A policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract;

-- Any policy of reinsurance unless an assumption certificate was issued;

-- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C).

Notices

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org contract either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hill, CA 90209-3319
Phone: (323) 782-0182

or

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
Phone: (800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Nippon Life Benefits®

Notice of Privacy Practices for Protected Health Information (HIPAA)

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

This Notice describes how your medical information obtained in connection with your health benefit plan administration may be used and disclosed and how you can access the information. The terms of this Notice apply to current and former plan members and dependents for their group medical expense, group dental expense and/or group vision care expense insurance. This Notice was effective April 14, 2003 and has been revised most recently effective November 1, 2013.

We are required by law to maintain the privacy of our current and former members' and dependents' protected health information, to provide notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all protected health information maintained by us. Copies of any revised Notices will be mailed to plan sponsors for distribution to the members then covered by the plan. You have the right to request a paper copy of the Notice although you may have originally requested a copy of the Notice electronically by e-mail.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Authorization

Except as explained below, we will not use or disclose your protected health information for any purpose unless you have signed an authorization form. You have the right to revoke an authorization by written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to revoke an authorization can be obtained from the Privacy Officer and will be honored upon receipt by us.

Disclosures for Treatment

We may disclose your protected health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your protected health information in our possession to assist in your care.

Uses and Disclosures for Payment

We may use and disclose your protected health information as necessary for payment purposes. For instance, we may use it to process or pay claims, to exercise legal subrogation rights, to perform a Precertification, to determine whether services are for medically necessary care, or to perform prospective reviews. We may also forward information to another insurer in order for them to process or pay claims on your behalf.

Uses and Disclosures for Health Care Operations

We may use and disclose your protected health information as necessary for health care operations. For instance, we may use or disclose your protected health information for quality assessment and quality improvement, premium rating (when allowable by law), conducting or arranging for medical review or compliance. We may also disclose your protected health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with your health plan. Your health plan may have its own privacy practices that are not reflected in this Notice. We may disclose your protected health information to your health plan for its health care operations. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures

We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment

We may request and receive from you and your health care providers protected health information prior to your enrollment under the group policy. When allowable by law, we may use this information to determine rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state privacy laws.

Genetic Information

We will not use or disclose any genetic information we obtain about you in any regard, including underwriting purposes.

Business Associate

Certain aspects and components of our insurance services are performed by outside vendors known as 'Business Associates.' Business Associates are under an independent duty to safeguard your privacy. Additionally we require them to sign a Business Associate Agreement, which is a contract to adhere to our privacy practices.

Plan Sponsor

We may disclose your protected health information to the plan sponsor, provided that the plan sponsor certifies that the information will be used and maintained in a compliant confidential manner and will not be utilized or disclosed for employment-related actions or decisions or in connection with any other benefit plan of the plan sponsor.

Family, Friends and Personal Representatives

With your approval, we may disclose to family members, close personal friends, or another person you identify, your protected health information relevant to their involvement with your health care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your protected health information without your approval. We may also disclose your protected health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures

We are permitted or required by law to use or disclose your protected health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Uses and Disclosures Requiring Authorization

We are required by law to obtain your authorization prior to using or disclosing your protected health information in the following circumstances:

- Uses and disclosures of protected health information for marketing purposes.
- Uses and disclosures that constitute the sale of protected health information.
- Most uses and disclosures of psychotherapy notes.
- Other uses and disclosures not described in this notice will be made only with the individual's written authorization. An individual may revoke an authorization, provided that the revocation is in writing and we have not taken action in reliance upon the authorization.

YOUR RIGHTS

Restrictions on Use and Disclosure of Your Protected Health Information

You have the right to request restrictions on how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951.

A form to request a restriction can be obtained from the Privacy Officer. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Protected Health Information

You have the right to request communications regarding your protected health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request a confidential communication can be obtained from the Privacy Officer.

Access to Your Protected Health Information

You have the right to inspect and/or obtain a copy of your protected health information we maintain in your designated record set, with some exceptions. To request access to your information, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request access to your protected health information can be obtained from the Privacy Officer. A fee may be charged for copying and postage.

Amendment of Your Protected Health Information

You have the right to request an amendment to your protected health information to correct inaccuracies. To request an amendment, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an amendment to your protected health information can be obtained from the Privacy Officer. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Protected Health Information

You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, of your protected health information. To request an accounting, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an accounting of your protected health information can be obtained from the Privacy Officer. The first accounting in any 12-month period will be free; however, a fee may be charged for any subsequent request for an accounting during that same time period.

Complaints

If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may call Nippon Life Insurance Company of America at: English and Non-English (800) 374- 1835; Japanese (800) 971-0638; or Korean (877) 827-8713.

Notes

THIS BOOKLET-CERTIFICATE IS ONLY A REPRESENTATIVE SAMPLE, AND DOES NOT CONSTITUTE AN ACTUAL INSURANCE POLICY OR CONTRACT. THIS SAMPLE BOOKLET-CERTIFICATE IS SUBJECT TO CHANGE.

Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, Kansas 66225-5951