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

(Revised Effective 6/17/22 – State Approved)

IL EVOLUTION LARGE GROUP WITH BUY-UP

EFFECTIVE JANUARY 1, 2022

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.

_____

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.

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.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. The Insured Person should be aware that when he or she elects to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of the Insured Person's benefit payment will be determined according to the Group Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Group Policy. THE INSURED PERSON CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE GROUP POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and Deductible Amounts. The Insured Person may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on his or her identification card.

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

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 receive bills 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.

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.

BOOKLET-CERTIFICATE TABLE OF CONTENTS

BOOKLET-CERTIFICATE TABLE OF CONTENTS (Continued)

SUMMARY OF BENEFITS
(Effective January 1, 2022)

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 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		
- 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	$100 per admission (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)	For Emergency Services – Same as PPO Providers. For other than Emergency Services – $100 per admission (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)
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		
- Coinsurance	80%	60%
- Deductible	$1,000* per Calendar Year	$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		
- 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
- Copay	None	None

Service	PPO Providers	Non-PPO Providers
Physician Office or Clinic Services (Including Urgent Care Center Services)		
- 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, Behavioral, Alcohol or Drug Abuse Treatment Services, 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
- Preventive Health and Wellness Services at a Primary Care Physician's office or clinic		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	None	None
- Services at a Specialty Provider's office or clinic (other than Urgent Care Center services, Preventive and Wellness Health 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%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	None	None

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)

Service	**PPO Providers**	**Non-PPO Providers**
- 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
- 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%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	None	None

Services provided by a Non-PPO anesthesiologist, radiologist, pathologist, neonatologist, and emergency room Physician

For services provided by a Non-PPO anesthesiologist, radiologist, pathologist, neonatologist, and emergency room Physician, benefits will be payable at the PPO coinsurance level when such services are provided at a PPO Hospital (inpatient, outpatient, and emergency room) or a licensed PPO freestanding surgical center.

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, the Copay provision does not 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 maximum 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	$3,000	$4,500
Per Family	$6,000	$9,000

- 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 $8,700.

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 Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, **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 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.

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.

SPECIAL PAYMENT CONDITIONS

In-Plan Exception

An Insured Person may request an in-plan exception to obtain medically necessary Treatment or Service from a Non-Preferred Provider if the designated service area does not have the appropriate Preferred Providers due to insufficient number, type, or unreasonable travel distance or delay. The Insured Person must make a good faith effort, as evidenced by accessing the provider directory, calling the network plan, and calling the provider, to utilize Preferred Providers for medically necessary Covered Charges.

To request an in-plan exception, the Insured Person may submit an exception request, in Writing.

Nippon Life Insurance Company of America
P. O. Box 25951
Shawnee Mission, KS 66225-5951
Phone: 1-800-374-1835

If the Company approves the in-plan exception, the Treatment or Service provided by the Non-Preferred Provider will be payable at the Preferred Provider copayment, Deductible and coinsurance level.

This provision does not apply if the Insured Person willfully chooses to access a Non-Preferred Provider for Treatment or Service available through the panel of Preferred Providers.

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 for important claim procedures information on filing medical claims.

Prior approval is also required for certain other services, including, but not limited to Skilled Nursing Facility Care.

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

PRESCRIPTION DRUGS

Benefits Payable

For each prescription and each refill:

- For generic and single source contraceptives for women..... 100% of Covered Charges.
- 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. If a generic equivalent is available, the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price will apply toward satisfaction of the Deductible. 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. In no event will the cost difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price, in addition to any applicable cost-sharing exceed the actual cost of the Prescription Drug.

The Member and the Policyholder can locate the most current Drug Formularies (Preferred Drug List) at the following web address: www.NipponLifeBenefits.com. Generally, the drug cost is significantly lower when a Preferred Brand Name Prescription Drug is used by an Insured Person.

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 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. If a generic equivalent is available, the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price will apply toward satisfaction of the Deductible. 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. In no event will the cost difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price, in addition to any applicable cost-sharing exceed the actual cost of the Prescription Drug.

The Member and the Policyholder can locate the most current Drug Formularies (Preferred Drug List) at the following web address: www.NipponLifeBenefits.com. Generally, the drug cost is significantly lower when a Preferred Brand Name Prescription Drug is used by an Insured Person.

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.
- 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 amount is based on one of the following:
- an applicable Specified State Law,
- an All Payer Model Agreement if adopted, or
- in a state that does not have in effect an applicable Specified State Law, 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.

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. Continuity of Care

The Act provides that if an Insured Person is currently receiving Treatment or Service for Covered Charges from a provider whose network status changes from in-network to out-of-network during such Treatment or Service due to Termination (non-renewal or expiration) of the provider's contract, the Insured Person may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to Termination of the provider's contract for specified conditions and timeframes.

For the purposes of this “Continuity of Care” provision the following definitions apply:

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.

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.

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:

- notify each Insured Person, on a timely basis, who is enrolled under the Group Policy who is a Continuing Care Patient with respect to a provider or facility at the time of such Termination and the Insured Person's right to elect continued transition care from the provider or facility;
- provide the Insured Person with an opportunity to notify the Company of the Insured Person's need for transitional care; and
- 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 date the Insured Person is no longer a Continuing Care Patient.

IV. 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) who Resides in the United States.

If the person is a Member on January 1, 2022, 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
- 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 a 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 a 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 a 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 solely due to the other coverage; and

(ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, termination of a Civil Union 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, Civil Union Partner relationship, birth, adoption or Placement for Adoption; and
(iii) enrollment is made within 31 days after the later of the date of the marriage, Civil Union 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 Civil Union Partner relationship, the date of marriage; 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 and the Member's Dependent Child if:

(i) the Member is enrolled but failed to enroll the Dependent Child during a previous enrollment period; and
(ii) the Member is required by a court or administrative order to provide health insurance for the Dependent Child; and
(iii) enrollment is made within 31 days after the issue date of the court or administrative order.

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.

(5) 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, NBM 5117 B, NBM 5117 C, and NBM 5117 D, 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, 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 for one of the following reasons:

- travel, provided the travel is for a reason other than securing health care diagnosis or treatment; or
- a business assignment; or
- Full-Time Student status, provided the Insured Person is either:
  - enrolled and attending an accredited school in a foreign country; or
  - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U. S. grants academic credit.

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 pages NBM 5117 A, NBM 5117 B, NBM 5117 C, and NBM 5117 D.

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.

HOW TO BE INSURED - DEPENDENTS

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. A child residing with the Member pursuant to an interim court order of adoption is considered an adopted 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.

If the child's insurance terminates because the Member fails to request 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 Individual Purchase Rights and 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, NBM 5117 B, NBM 5117 C, and NBM 5117 D:

- 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 desired, if requested by the Member before that date.

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 or other care providers for primary support. The Member must apply for this continuation within 31 days after the child reaches the maximum age.

Termination of Insurance While Outside of the United States

A Member's Dependents will be subject to the Termination of Insurance While Outside of the United States provisions as described on page NBM 5115 O 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 pages NBM 5117 A, NBM 5117 B, NBM 5117 C, and NBM 5117 D.

Contact the Policyholder with reinstatement questions.

MEMBER BENEFIT OPTIONS

- **Benefit Option Election**

There are two medical benefit options available to choose from. The Member may elect any one of these benefit options by filing a Written request on the enrollment form provided by the Policyholder. If the Member elects to insure his or her Dependents, they will be enrolled in the same benefit option elected by the Member.

The two benefit options available are:

Option I:

	PPO Providers	**Non-PPO Providers**
Coinsurance	80%	60%
Deductible	Individual – $1,000 Family – $2,000	Individual – $1,000 Family – $2,000
Out-of-Pocket Expense Limits	Individual – $2,000 Family – $4,000	Individual – $4,000 Family – $8,000

Option II:

	PPO Providers	**Non-PPO Providers**
Coinsurance	90%	70%
Deductible	Individual – $1,000 Family – $2,000	Individual – $2,000 Family – $4,000
Out-of-Pocket Expense Limits	Individual – $2,000 Family – $4,000	Individual – $4,000 Family – $8,000

- **Benefit Option Transfer**

The benefit option elected initially will remain in effect until the Member elects to change benefit options. The Member may transfer to another benefit option during the annual open enrollment period designated by the Policyholder for such transfers. The Member's new benefit option will become effective on the day after the annual open enrollment period ends.

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 Member may transfer to another benefit option if one of the following events occur to change his or her family status, provided the Member completes the appropriate enrollment form within 31 days after the date the event occurred. See the Policyholder for details. The family status changes are as follows:

- marriage or divorce;
- establishment or termination of a Civil Union Partner relationship;
- death of a spouse or child;
- birth or adoption of a child;
- termination of employment by the Member's spouse or a change in the spouse's employment that causes loss of group coverage;
- the Member's spouse becomes employed;
- the Member's employment or his or her spouse's employment changes from part-time to full-time or from full-time to part-time;
- the Member or his or her spouse take an unpaid leave of absence; or
- a significant change is made in the Member's or his or her spouse's group health coverage.

A benefit option transfer may also be made on any premium due date, if the Member's request is due to a special enrollment period and the Member completes the appropriate enrollment form within the time specified for a special enrollment period described on page NBM 5115 O.

If the Member elects not to enroll for Medical Expense Insurance under the Group Policy, the Member will be eligible to apply for coverage under one of the benefit options at the next annual open enrollment period. In no event will Dependent Medical Expense Insurance be in force for the Member's Dependents if the Member is not insured for Member Medical Expense Insurance.

Any benefit option transfer will be subject to the following provisions:

- Charges for Treatment or Service received by an Insured Person while insured under any benefit option may be applied toward satisfaction of the Calendar Year Deductible under the benefit option the Member transfers to for the Calendar Year in which the transfer occurs, provided the charges are limited to those that:
  - would have been Covered Charges under the Group Policy; and
  - were not paid under the other benefit option; and
  - would have counted toward satisfaction of the Deductible under the other benefit option.

- Charges for Treatment or Service received by an Insured Person while insured under any benefit option may be counted to determine the payment percentage under the benefit option the Member transfers to for the Calendar Year in which the transfer occurs, provided the charges are limited to those that:
  - would be Covered Charges under the Group Policy; and
  - were for Treatment or Service received during the Calendar Year in which the transfer occurred.

- Benefits will be payable under each benefit option only for Covered Charges incurred while insured under that particular benefit option.

PPO Network Options

The Policyholder has selected two PPO networks for the Member to choose from. The Member may elect any one of these PPO networks by filing a Written request on the enrollment form provided by the Policyholder. If the Member elects to insure his or her Dependents, they will be enrolled in the same PPO network elected by the Member.

Persons electing coverage under either PPO network will have free choice of providers. However, benefits will be reduced as described on page NBM 5102 PPO, if medical care is not received from a Preferred Provider.

The PPO network the Member elects initially will remain in effect until the Member elects to change PPO networks. The Member may transfer to another PPO network during the annual open enrollment period designated by the Policyholder for such transfers. The Member's new PPO network will become effective on the day after the annual open enrollment period ends.

The annual open enrollment period is the one-month period immediately prior to the Policy Anniversary date. The Policy Anniversary date is January 1.

Any PPO network transfer will be subject to the following provisions:

- Charges for Treatment or Service received by Insured Persons while insured under one PPO network may be applied toward satisfaction of the Calendar Year Deductible under the PPO network the Member transfers to for the Calendar Year in which the transfer occurs, provided the charges are limited to those that:

  - would have been Covered Charges under the Group Policy; and
  - were not paid under the other PPO network; and
  - would have counted toward satisfaction of the Deductible under the other PPO network.

- Charges for Treatment or Service received by Insured Persons while insured under one PPO network may be counted to determine the payment percentage under the PPO network the Member transfers to for the Calendar Year in which the transfer occurs, provided the charges are limited to those that:

  - would be Covered Charges under the Group Policy; and
  - were for Treatment or Service received during the Calendar Year in which the transfer occurred.

- Benefits will be payable under each PPO network only for Covered Charges incurred while insured under that particular PPO network.

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.

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 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 - Illinois 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.

- **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.

See "Reconstructive Surgery After Mastectomy" under Benefits Payable – State Required - Illinois below.

- **Preventive Health and Wellness 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; 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/. The Preventive Health and Wellness Services list is subject to change as the federal guidelines are updated.

- Services with an A or B rating in the current recommendations of the U.S. Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- Preventive care for infants, children and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Preventive care for women provided in the comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF.

Covered Preventive Services for Adults:

Benefits under this section include the following when required by Federal law.

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Behavioral counseling for adults with cardiovascular disease risk factors
- Blood pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults ages 45 to 75 years
- Depression screening for adults

- Diabetes (Type 2) screening for adults ages 35 to 70 years who are overweight or obese
- Diet and physical activity counseling for adults at higher risk for chronic disease
- Drug Use assessments for adults age 18 and older
- 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 Preexposure Prophylaxis (PrEP)
- HIV screening for all adults at higher risk
- Hypertension screening for adults aged 18 years or older without known hypertension
- Immunization vaccines for adults - doses, recommended ages, and recommended populations vary:
    - Haemophilus influenza type b;
    - Hepatitis A;
    - Hepatitis B;
    - Herpes Zoster (shingles);
    - 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
- 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 use to prevent cardiovascular disease for men and women ages 40-75 with certain risk factors
- 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

Benefits under this section include the following when required by Federal law.

- 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 for pregnant persons
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screening every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast cancer preventive medication
- 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 at 24 weeks of gestation or after
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Hepatitis C screening for adolescents
- 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
- Osteoporosis screening for women over age 60 depending on risk factors
- Osteoporosis screening with bone measurement testing to prevent osteoporotic fractures in women 65 years and older and postmenopausal women younger than 65 who are at increased risk of osteoporosis
- Perinatal Depression Counseling Interventions
- Preeclampsia screening with blood pressure measurements for pregnant women throughout pregnancy
- 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:

Benefits under this section include the following when required by Federal law.

- 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
- Gonococcal 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
- Hepatitis C screening for adolescents
- HIV Preexposure Prophylaxis (PrEP)
- 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.

- 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 6 months-24 years
- Tobacco Use Interventions, including education or grief 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
- Future Benefit.

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 will be subject to Deductible and coinsurance.

The Company may use reasonable medical management techniques to determine appropriate frequency, method or setting for a Preventive Health and Wellness Service to the extent such service is not specified in the guidelines or recommendations.

- **Contraceptive Methods and Counseling for Women**

Covered Charges from a Member Pharmacy or PPO Provider will include charges incurred by a woman covered under the Group Policy for all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

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. 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**

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 and will be coordinated with the Qualified Clinical Cancer Trials benefit described below under Benefits Payable – State Required – Illinois.

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 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

- whose referring health care professional participates in the trial and has concluded that the Insured Person's participation in such trial would be appropriate based on Generally Accepted and established standards of care to treat the Insured Person's cancer or other Life-Threatening Condition; or
- the Insured Person provides medical and scientific information establishing that the Insured Person's participation in such trial would be appropriate based on Generally Accepted and established standards of care to treat the Insured Person's cancer or other Life-Threatening Condition.

Benefits Payable - State Required – Illinois

Subject to the benefits payable provisions described above, including any required under Federal law, benefits will be payable for:

- **A1C Testing**

  Covered Charges will include charges for A1C Testing recommended by a Physician for prediabetes, type 1 diabetes, and type 2 diabetes in accordance with prediabetes and diabetes risk factors identified by the United States Centers for Disease Control and Prevention.

  - Risk factors for prediabetes may include, but are not limited to, being overweight or obese, being aged 35 or older, having an immediate family member with type 2 diabetes, previous diagnosis of gestational diabetes and being African American, Hispanic or Latino American, American Indian, or Alaska Native.

  - Risk factors for type 1 diabetes may include, but are not limited to, family history of diabetes.

  - Risk factors for type 2 diabetes may include, but are not limited to, having prediabetes, being overweight or obese, being aged 35 or older, having an immediate family member with type 1 or type 2 diabetes, previous diagnosis of gestational diabetes and being African American, Hispanic or Latino American, American Indian, or Alaska Native.

  "A1C Testing" means blood sugar level testing used to diagnose prediabetes, type 1 diabetes, and type 2 diabetes and to monitor management of blood sugar levels.

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

- **Abortion Coverage**

  Covered Charges will include charges for abortion. Benefits will be payable the same as any other covered pregnancy-related benefit.

  "Abortion" means the use of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of an individual known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

- **Amino Acid-based Elemental Formula**

  Covered Charges will include charges incurred for amino acid-based elemental formulas, regardless of the method of delivery, for the diagnosis and treatment of eosinophilic disorders and short-bowel syndrome if the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is considered medically necessary.

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

- **Autism Spectrum Disorder**

  Covered Charges will include charges incurred by the Member's Dependent Child who is under 21 years of age for the Medically Necessary Diagnoses of and Treatment for Autism Spectrum Disorder. Benefits will be payable the same as for any other covered Treatment or Service. Each Calendar Year, the first $38,527 in Covered Charges for Treatment or Service for Autism Spectrum Disorder are not subject to any dollar, day or visit limits for such Dependent Child. There are no dollar limits on any benefits defined as "essential" by PPACA. This annual amount may be adjusted according to the consumer price index (CPI). The Treatment for Autism Spectrum Disorder must be identified in a treatment plan.

  Benefits for covered Treatment or Services provided through Illinois's Early Intervention Program must be provided by a "Certified Early Intervention Specialist" as defined by Illinois law.

  "Autism Spectrum Disorder" means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, including autism, Asperger's disorder, and pervasive development disorder not otherwise specified.

  "Diagnoses of Autism Spectrum Disorder" means one or more tests, evaluations or assessments to diagnose whether an individual has an Autism Spectrum Disorder that is prescribed by a licensed Physician or licensed clinical psychologist with expertise in diagnosing autism spectrum disorder.

"Medically Necessary" for purposes of Autism Spectrum Disorders means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following:

- prevent the onset of an illness, condition, injury, disease or disability;
- reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, disease or disability; or
- assist to achieve or maintain maximum functional occupation in performing daily activities.

"Treatment for Autism Spectrum Disorder**"** means care that is prescribed, ordered, or provided by a licensed Physician, or a certified, registered ,or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder when the care is determined to be Medically Necessary for your Dependent Child diagnosed with Autism Spectrum Disorder.

Treatment includes but is not limited to psychiatric care, psychological care, habilitative or rehabilitative care (meaning professional counseling, and guidance, services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.) Treatment also includes therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment for self care and feeding, pragmatic, receptive, and expressive language, cognitive functioning, applied behavioral analysis, intervention, and modification, motor planning and sensory processing. Treatment for Autism Spectrum Disorder will not be limited because of the location wherein the clinically appropriate services are provided.

- **Biomarker Testing**

Covered Charges will include charges for Biomarker Testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an Insured Person's disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

- labeled indications for an FDA-approved test or indicated tests for an FDA-approved drug;
- federal Centers for Medicare and Medicaid Services National Coverage Determinations;
- nationally recognized clinical practice guidelines;
- consensus statements;
- professional society recommendations;
- peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database of Health Services Technology Assessment Research; and

- peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. "Biomarker" includes, but is not limited to, gene mutations or protein expression.

"Biomarker Testing" means the analysis of a patient's tissue, blood, or fluid biospecimen for the presence of a Biomarker. "Biomarker Testing" includes, but is not limited to, single-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

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

- **Breast Cancer Pain Medication and Therapy**

Covered Charges will include charges for all medically necessary pain medication and pain therapy related to the treatment of breast cancer. Benefits will be payable the same as for any other covered Treatment or Service.

"Pain therapy" means pain therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain with periodic evaluations of the efficacy of the pain therapy against these goals.

- **Breast Implant Removal**

Covered Charges will include charges incurred for breast implant removal when the removal of the implant is a Covered Charge for treatment of a sickness or injury. Covered Charges do not include charges incurred for removal of breast implants when implanted solely for cosmetic reasons. Cosmetic reasons do not include Cosmetic Surgery performed as reconstruction resulting from a sickness or injury.

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

- **Cancer Drug Parity**

  Covered Charges for the treatment of cancer will include prescribed orally administered cancer medication.

  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.

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

- **Cardiopulmonary Monitors**

  Covered Charges will include cardiopulmonary monitors determined to be medically necessary for an Insured Person who is 18 years of age or younger who has had a cardiopulmonary event.

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

- **Cervical or Pap Smear Screening**

  Covered Charges will include charges incurred for an annual cervical or pap smear test for female insureds.

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

- **Clinical Breast Examinations**

  Covered Charges will include charges incurred for a complete and thorough clinical breast examination as indicated by guidelines of practice to check for lumps and other changes for the purpose of early detection and prevention of breast cancer. Coverage is provided for:

  - at a minimum every three years for women over 20 years of age but less than 40; and,
  - annually for women 40 years of age and older.

  The breast examination must be performed by:

  - a Physician licensed to practice medicine in all its branches;
  - a licensed advance practice registered nurse; or
  - a licensed physician assistant.

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

- **Colorectal Cancer Screening and Laboratory Tests**

  Covered Charges will include charges incurred for colorectal cancer examinations and laboratory tests as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention and the American College of Gastroenterology.

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

- **Colonoscopy Coverage**

  Covered Charges will include charges for a colonoscopy that is a follow-up exam based on an initial screen where the colonoscopy was determined to be medically necessary by a Physician licensed to practice medicine in all its branches, an advanced practice registered nurse, or a physician assistant.

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

- **Comprehensive Cancer Testing**

  Covered Charges will include charges for medically necessary Comprehensive Cancer Testing and Testing of Blood or Constitutional Tissue for Cancer Predisposition Testing as determined by a Physician licensed to practice medicine in all of its branches.

  "Comprehensive Cancer Testing" includes, but is not limited to, the following forms of testing:
  - Targeted cancer gene panels.
  - Whole-exome genome testing.
  - Whole-genome sequencing.
  - RNA sequencing.
  - Tumor mutation burden.

  "Testing of Blood or Constitutional Tissue for Cancer Predisposition Testing" includes, but is not limited to, the following forms of testing:
  - Targeted cancer gene panels.
  - Whole-exome genome testing.
  - Whole-genome sequencing.

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

- **Contraceptive Drugs, Devices and Services**

Covered Charges from a Member Pharmacy or PPO Provider will include charges for Contraceptive Services and all contraceptive prescription drugs or devices that are approved by the federal Food and Drug Administration (FDA). This includes all over-the-counter contraceptive drugs, devices, and products approved by the federal Food and Drug Administration (FDA), excluding male condoms.

The following will apply:

- If the FDA has approved one or more Therapeutic Equivalent Versions of a contraceptive drug, device, or product, at least one Therapeutic Equivalent Version will be covered.
- If an Insured Person's Physician recommends a particular service or item approved by the FDA based on a determination of Medical Necessity that service or item will be covered.
- Coverage will provide for the dispensing of 12 months' worth of contraception at one time.

Covered Charges will include follow-up services related to the drugs, devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal. Covered Charges will also include voluntary sterilization procedures.

"Contraceptive Services" means consultations, examinations, procedures, and medical services related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

"Medical necessity" includes, but is not limited to, considerations such as severity of side effects, differences in permanence and reversibility of contraceptive, and ability to adhere to the appropriate use of the item or service, as determined by the Physician.

"Therapeutic Equivalent Version" means drugs, devices, or products that can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling and satisfy the following general criteria:

- they are approved as safe and effective;
- they are pharmaceutical equivalents in that they contain identical amounts of the same active drug ingredient in the same dosage form and route of administration and meet compendial or other applicable standards of strength, quality, purity, and identity;
- they are bioequivalent in that they do not present a known or potential bioequivalence problem and they meet an acceptable in vitro standard or if they do present such a known or potential problem, they are shown to meet an appropriate bioequivalence standard;
- they are adequately labeled; and
- they are manufactured in compliance with Current Good Manufacturing Practice regulations.

Except as otherwise provided above, benefits from a Member Pharmacy or PPO Provider will be payable at 100% and will be coordinated with the Contraceptive Methods and Counseling for Women benefit described above.

Some or all of the above services, contraceptive prescription drugs or devices may not be payable when received from a Non-Member Pharmacy or Non-PPO Providers. The above services from a Non-Member Pharmacy or Non-PPO Providers will be subject to Deductible and coinsurance. Benefits for voluntary sterilization procedures from Non-PPO Providers will be payable the same as for any other covered Treatment or Service.

NOTE: For the purpose of these state-required benefits, legend oral contraceptive drugs will be payable under Prescription Drug Expense Covered Charges or Mail Service Prescription Drug Expense Covered Charges.

- **Dental Anesthesia and Hospital Charges**

Covered Charges will include charges incurred and anesthetics provided for dental procedures performed in a Hospital or Ambulatory Surgery Center.

Benefits are payable when incurred by:

- a Dependent Child who is age six or under; or
- an Insured Person who has a Disability; or
- an Insured Person who has a medical condition that requires hospitalization or general anesthesia for dental care.

Covered Charges will also include charges incurred and anesthetics provided by a licensed dentist in conjunction with dental care that is provided to an Insured Person in a dental office, oral surgeon's office, Hospital, or Ambulatory Surgery Center if the Insured Person is under age 26 and has been diagnosed with an Autism Spectrum Disorder or a Developmental Disability. The Insured Person will be required to make two visits to the dental care provider prior to accessing coverage under this provision. Covered Charges will not include and no benefits will be payable for dental services.

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

“Autism Spectrum Disorder” means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, including autism, Asperger’s disorder, and pervasive development disorder not otherwise specified.

"Developmental Disability" means a Disability that is attributable to an intellectual Disability or a related condition, if the related condition meets all of the following conditions:

- it is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
- it is manifested before the Insured Person reaches age 22;
- it is likely to continue indefinitely; and

- it results in substantial functional limitations in three or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and capacity for independent living.

"Disability" means a chronic disability if the chronic disability meets all of the following conditions:

- It is attributable to a mental or physical impairment or combination of mental and physical impairments.
- It is likely to continue.
- It results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, capacity for independent living, or economic self-sufficiency.

- **Diabetes Treatment**

Covered Charges will include the following equipment, supplies, outpatient self-management training, and related services for the treatment of Type I diabetes, Type II diabetes and gestational diabetes mellitus, when medically necessary and prescribed by a Physician. The benefits will be payable on the same basis as for any other covered Treatment or Service. A 30-day supply of a covered Prescription Insulin Drug, regardless of quantity or type, will not exceed $100 when obtained from a Member Pharmacy.

- **Equipment and Supplies**

Covered Charges will include: blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, lancets and lancing devices, insulin, syringes and needles, test strips for glucose monitors, FDA approved oral agents used to control blood sugar and glucagon emergency kits.

- **Outpatient Self-Management Training**

Covered Charges will include Diabetes Self-Management Training. **Diabetes Self-Management Training** means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Training includes the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy, habilitative services and education programs that allow the patient to maintain an A1c level within the range identified in nationally recognized standards of care. Training may be provided as part of an office visit, group setting, or home visit.

Coverage for Diabetes Self-Management Training is limited to the Covered Charge requirements for visits to a Physician or certified, registered or licensed health care professional with expertise in diabetes management upon (i) the diagnosis of diabetes; and (ii) the occurrence of significant change in the patient's symptoms or medical condition.

- **Related Services**

Covered Charges will include regular foot care examinations by a Physician.

"Prescription Insulin Drug" means a Prescription Drug that contains insulin and is used to control blood glucose levels to treat diabetes but does not include an insulin drug that is administered to a patient intravenously.

NOTE: For the purpose of these state-required benefits, refer to Prescription Drugs Expense Insurance Covered Charges or Mail Service Prescription Drugs Expense Insurance Covered Charges for diabetic supplies payable under that section.

All other diabetic supplies will be payable the same as any other covered Treatment or Service under Benefits Payable – State Required – Illinois.

- **Digital Rectal Examination and Prostate Specific Antigen Testing**

Covered Charges will include charges incurred for an annual digital rectal examination and a prostate-specific antigen test for the detection of prostate cancer in men.

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

Benefits will be payable upon the recommendation of a Physician for:

- asymptomatic men age 50 and over; and
- African-American men age 40 and over; and
- men age 40 and over with a family history of prostate cancer.

- **Donated Human Breast Milk**

Covered Charges will include charges for expenses incurred in the provision of pasteurized donated human breast milk, including human milk fortifiers if indicated by the prescribing Physician, if the Insured Person is an infant under the age of 6 months, the Physician prescribes the milk for the Insured Person, and all of the following conditions are met:

- the milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health; and
- the infants mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated; and
- the milk has been determined to be medically necessary for the infant; and
- one or more of the following applies:
  - the infant's birth weight is below 1,500 grams;
  - the infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis;
  - the infant has infant hypoglycemia;
  - the infant has congenital heart disease;
  - the infant has had or will have an organ transplant;
  - the infant has sepsis; or
  - the infant has any other serious congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the infant.

Covered Charges will include charges for expenses incurred in the provision of pasteurized donated human breast milk, including human milk fortifiers if indicated by the prescribing Physician, if the Insured Person is a child 6 months through 12 months of age, the Physician prescribes the milk for the Insured Person, and all of the following conditions are met:

- the milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health; and
- the infants mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated; and
- the milk has been determined to be medically necessary for the infant; and

- one or more of the following applies:
  - the child has spinal muscular atrophy;
  - the child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity;
  - the child has had or will have an organ transplant; or
  - the child has a congenital or acquired condition for which the use of donated human breast milk is medically necessary and supports the treatment and recovery of the child.

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

- **Epinephrine Injectors**

Covered Charges will include medically necessary Epinephrine Injectors for Insured Persons 18 years of age or under.

"Epinephrine Injector" includes an auto-injector approved by the United States Food and Drug Administration for the administration of epinephrine and a pre-filled syringe approved by the United States Food and Drug Administration and used for the administration of epinephrine that contains a pre-measured dose of epinephrine that is equivalent to the dosages used in an auto-injector.

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

- **Fertility Preservation Services**

Covered Charges will include charges incurred for medically necessary expenses for Standard Fertility Preservation Services when a necessary medical treatment May Directly or Indirectly Cause Iatrogenic Infertility to an Insured Person.

"Iatrogenic Infertility" means in impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

"May Directly or Indirectly Cause" means the likely possibility that treatment will cause a side effect of infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

"Standard Fertility Preservation Services" means procedures based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

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

- **Fibrocystic Breast Condition**

Coverage for fibrocystic breast condition will not be excluded or denied in the absence of a breast biopsy demonstrating an increased disposition to the development of breast cancer unless the Insured Person's medical history is able to confirm a chronic, relapsing, symptomatic breast condition.

- **FDA Approved Drugs**

Covered Charges will include charges incurred by an Insured Person for any drug prescribed for the treatment of cancer, regardless of the type of cancer for which the drug is approved, provided:

- the drug is approved by the United States Food and Drug Administration; and
- the drug has been prescribed by one of the following:
    - the American Hospital Formulary Service Drug Information; or
    - National Comprehensive Cancer Network's Drug & Biologics Compendium; or
    - Thomson Micromedex's Drug Des; or
    - Elsevier Gold Standard's Clinical Pharmacology; or
    - other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services; or
    - if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.
- the drug is recognized for the treatment of cancer in standard reference compendia or a substantially accepted peer-reviewed medical literature.

Coverage for prescribed drugs for certain types of cancer will not be excluded on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration if proper documentation, as outlined, is provided.

Benefits payable will not include charges for any experimental or investigational cancer drug or any cancer drug, which the FDA has determined to be contraindicated for the specific treatment for which it was prescribed.

Coverage will include all medically necessary services associated with the administration of the drug.

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

- **Habilitative Services for Children**

Covered Charges will include charges incurred by a Dependent Child who is under 19 years of age for occupational therapy, physical therapy, speech therapy and other services prescribed by the child's Physician pursuant to a treatment plan to enhance the ability of a child to function if the child has a congenital, genetic or early acquired disorder. Congenital, genetic and early acquired disorders may include, but are not limited to autism spectrum disorder, cerebral palsy and other disorders from early childhood illness, trauma or injury.

Benefits will be payable the same as any other covered Treatment or Service, subject to the visit limitation for physical, occupational and speech therapy described in page NBM 5402 A PPO.

- **Hearing Aids**

Covered Charges will include charges incurred by the Member's Dependent Child who is under 18 years of age for medically necessary Hearing Instruments and related services when a Hearing Care Professional prescribes a Hearing Instrument to augment communication.

Coverage is provided for:

- one Hearing Instrument will be covered for each ear every 36 months;
- related services, such as audiological exams and selection, fitting, and adjustment of ear molds to maintain optimal fit will be covered when deemed medically necessary by a Hearing Care Professional; and
- Hearing Instrument repairs may be covered when deemed medically necessary.

"Hearing Care Professional" means a person who is a licensed hearing instrument dispenser, licensed audiologist, or licensed Physician.

"Hearing Instrument" or "Hearing Aid" means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold but excluding batteries and cords.

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

- **Human Papillomavirus Vaccine**

Covered Charges will include charges for a human papillomavirus vaccine approved for marketing by the federal Food and Drug Administration.

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

- **Immune Gamma Globulin Therapy**

Covered Charges will include charges incurred for Immune Gamma Globulin Therapy for an Insured Person who is diagnosed with a primary immunodeficiency when prescribed as medically necessary by a Physician and if provided as a covered Treatment or Service.

Upon diagnosis of primary immunodeficiency by the prescribing Physician, determination of an initial authorization for Immune Gamma Globulin Therapy will be no less than 3 months. Reauthorization for Immune Gamma Globulin Therapy for an Insured Person with a primary immunodeficiency diagnosis may occur every six months thereafter. For an Insured Person with a diagnosis of primary immunodeficiency who has been receiving Immune Gamma Globulin Therapy for at least two years with sustained beneficial response based on the treatment notes or clinical narrative detailing progress to date, reauthorization shall be no less than 12 months unless a more frequent duration has been indicated by the prescribing Physician.

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

- **Infertility Treatment**

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

- **Definitions**

"Infertility" means a disease, condition, or status characterized by:

- a failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility;
- a person's inability to reproduce either as a single individual or with a partner without medical intervention; or
- a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

- **Rate of Payment**

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

- **Covered Services**

Coverage for procedures for in-vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer will be provided if:

- the Insured Person has been unable to attain a viable pregnancy, maintain a viable pregnancy, 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 during the Calendar Year, except that if a live birth follows a completed oocyte retrieval during the then two more completed oocyte retrievals will be covered, provided that benefits for such treatment will only be payable if the Insured Person has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments. This requirement will be waived in the event the Insured Person or partner has a medical condition that renders such treatment useless. Following the final oocyte retrieval, coverage for one subsequent procedure used to transfer the oocytes or sperm to the covered recipient must be provided; and
- the procedures are performed at medical facilities that conform to the American Society for Reproductive Medicine (ASRM) guidelines for in-vitro fertilization clinics or the ASRM minimal standards for programs of in-vitro fertilization.

Benefits will be payable for medical expenses incurred by an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and for any subsequent procedure used to transfer the oocytes or sperm to the insured recipient. Associated donor medical expenses, including but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs.

Covered Charges will include charges incurred by an Insured Person for prescription drug therapies for infertility.

- **Covered Services Limitations**

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

- reversal of voluntary sterilization, however, in the event a voluntary sterilization is successfully reversed, infertility benefits must be available if the Insured Person's diagnosis meets the definition of infertility above; or
- payment for services rendered to a surrogate for purposes of childbirth (however, costs for procedures to obtain eggs, sperm or embryos from an Insured Person must be covered if the Insured Person chooses to use a surrogate and if the individual has not exhausted benefits for completed oocytes retrievals); 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
- 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.

- **Long-term Antibiotic Therapy for Tick-Borne Diseases**

Covered Charges will include charges incurred for Long-Term Antibiotic Therapy, including necessary office visits and ongoing testing, for an Insured Person with a Tick-Borne Disease when determined to be medically necessary and ordered by a Physician licensed to practice medicine in all its branches after making a thorough evaluation of the Insured Person's symptoms, diagnostic test results, or response to treatment.

An experimental drug will be covered as a Long-Term Antibiotic Therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a Tick-Borne Disease if the drug has been approved by the United States Food and Drug Administration.

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

"Long-Term Antibiotic Therapy" means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of 4 weeks.

"Tick-Borne Disease" means a disease caused when an infected tick bites a person and the tick's saliva transmits an infectious agent (bacteria, viruses, or parasites) that can cause illness, including, but not limited to, the following:

- a severe infection with borrelia burgdorferi;
- a late stage, persistent, or chronic infection or complications related to such an infection;

- an infection with other strains of borrelia or a Tick-Borne Disease that is recognized by the United States Centers for Disease Control and Prevention; and
- the presence of signs or symptoms compatible with acute infection of borrelia or other Tick-Borne Diseases.

- **Mammography Services**

Covered Charges will include screening by low-dose mammography for all women age 35 and older according to the following schedule:

- Women age 35 to 39 – one baseline mammogram; and
- Women age 40 or older – one mammogram annually.

"Low-Dose Mammography" means an x-ray or digital examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of the average size breast. The term also includes Digital Mammography and includes Breast Tomosynthesis.

"Breast Tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

"Diagnostic Mammogram" means a mammogram obtained using Diagnostic Mammography.

"Diagnostic Mammography" means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

For women under age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors, coverage will include a mammogram at the age and intervals considered medically necessary by the woman's health care provider.

If a routine mammogram reveals heterogeneous or dense breast tissue, coverage will include a comprehensive ultrasound screening and MRI of an entire breast or breasts or when determined to be medically necessary by a Physician licensed to practice medicine in all of its branches.

Covered Charges will include a screening MRI when determined to be medically necessary by a Physician.

Covered Charges will include a Diagnostic Mammogram when medically necessary, as determined by a Physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

If services are provided by a PPO provider, benefits for outpatient, clinic or office-based screening mammograms for women thirty five (35) years of age and over will be payable at 100% and no Deductible or Copay will apply. All other mammograms will be payable the same as any other Physician Office or Clinic Service.

- **Mastectomy**

Covered Charges will include Hospital Inpatient Confinement charges incurred for a mastectomy. The length of inpatient care will be determined by the attending physician based upon:

- Covered Charge requirements;
- protocols and guidelines based on scientific evidence; and
- evaluation of the patient.

Covered Charges will also include charges incurred for a post-discharge physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

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

- **Maternity Coverage**

Covered Charges will include Hospital Inpatient Confinement charges incurred by a mother and newborn Dependent Child. Benefits 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 Charge 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. The above listed benefits will also apply to a Dependent Child.

- **Medication Synchronization**

Covered Charges will include charges incurred for synchronization of prescription drug medications if all of the following conditions are met:

- the Insured Person meets all utilization management criteria specific to the prescription drugs at the time of Medication Synchronization;
- the prescription drugs to be included in the Medication Synchronization meet all of the following requirements:
  - be covered by the Group Policy or have been approved by a formulary exception process;
  - be maintenance medications and have available refill quantities at the time of Medication Synchronization;
  - not have special handling or sourcing needs, as determined by the Group Policy, that require a single, designated pharmacy to fill or refill the prescription;
  - be formulated so that the quantity or amount dispensed can be safely split into short-fill periods in order to achieve synchronization;
  - not be Schedule II, III, or IV controlled substances.

The Company will apply a prorated daily cost-sharing rate for a supply of a prescription drug subject to Medication Synchronization that is dispensed at a network pharmacy. Dispensing fees will not be prorated and all dispensing fees will be based on the number of prescriptions filled or refilled.

"Medication Synchronization" means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

- **Multiple Sclerosis Preventative Physical Therapy**

Covered Charges will include charges incurred for medically necessary preventative physical therapy.

Preventative physical therapy means physical therapy that is prescribed by a Physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

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

- **Opioid Antagonists**

Covered Charges will include at least one Opioid Antagonist including the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the Opioid Antagonist.

"Opioid Antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

Coverage will include refills for expired or utilized Opioid Antagonists.

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

- **Osteoporosis**

Covered Charges will include coverage for medically necessary bone mass measurement and for the diagnosis and treatment of osteoporosis.

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

- **Ovarian Cancer Screening**

Covered Charges will include surveillance tests for women at risk for ovarian cancer.

Surveillance test for ovarian cancer means annual screening using:

- CA-125 serum tumor marker testing; or
- Transvaginal ultrasound; or
- Pelvic examinations.

"At risk for ovarian cancer" means:

- having a family history with:
    - one or more first degree relatives with ovarian cancer;
    - clusters of women relatives with breast cancer;
    - nonpolyposis colorectal cancer; or

- testing positive for BRCA1 or BRCA2 mutations.

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

- **Pancreatic Cancer Screening**

  Covered Charges will include charges for medically necessary pancreatic cancer screening.

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

- **Port-Wine Stain Treatment**

  Covered Charges will include charges for treatment to eliminate or provide maximum feasible treatment of nevus flammeus, also known as port-wine stains, including, but not limited to, port-wine stains caused by Sturge-Weber syndrome. Treatment or maximum feasible treatment shall include early intervention treatment, including topical, intralesional, or systemic medical therapy and surgery, and laser treatments approved by the U.S. Food and Drug Administration in Dependent Children aged 18 years and younger that are intended to prevent functional impairment related to vision function, oral function, inflammation, bleeding, infection, and other medical complications associated with port-wine stains.

  Covered Charges will not include treatment solely for cosmetic purposes.

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

- **Pediatric Disorders**

  Covered Charges will include charges incurred for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy.

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

- **Prenatal HIV Testing**

  Covered Charges will include charges incurred for prenatal HIV testing.

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

- **Prescription Topical Eye Medication**

Covered Charges will include charges for a refill of prescription topical eye medication if the following conditions have been met:

- the medication is to treat a chronic condition of the eye; and
- the refill is requested by the Insured Person prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use; and
- the prescribing Physician licensed to practice medicine in all its branches or optometrist indicates on the original prescription that refills are permitted and that the early refills requested by the Insured Person do not exceed the total number of refills prescribed.

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

- **Prosthetics and Customized Orthotic Devices**

Covered Charges will include charges for a Prosthetic Device or Customized Orthotic Device obtained from an Illinois Licensed Provider. Repairs and replacements of prosthetic and orthotic devices will be covered unless necessitated by misuse or loss.

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

"Customized Orthotic Device" means a supportive device for the body or a part of the body, the head, neck, or extremities, and includes the replacement or repair of the device based on the patient's physical condition as medically necessary, excluding foot orthotics defined as an in-shoe device designed to support the structural components of the foot during weight-bearing activities.

"Licensed Provider" means a prosthetist, orthotist, or pedorthist licensed to practice in the state of Illinois.

"Prosthetic Device" means an artificial device to replace an arm or leg and includes accessories essential to the effective use of the device and the replacement or repair of the device based on the patient's physical condition as medically necessary

- **Psychiatric Collaborative Care Model**

Covered Charges will include reimbursement for medically necessary benefits that are delivered through the Psychiatric Collaborative Care Model. The following American Medical Association 2018 current procedural terminology codes and Healthcare Common Procedure Coding System code shall be used to bill for benefits delivered through the psychiatric Collaborative Care Model:

- 99492;
- 99493;
- 99494; and
- G0512.

"Psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes, but is not limited to, the following elements:

- care directed by the primary care team;
- structured care management;
- regular assessments of clinical status using validated tools; and
- modification of treatment as appropriate.

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

- **Qualified Clinical Cancer Trials**

Covered Charges will include Routine Patient Care administered to an Insured Person who is a qualified individual participating in a qualified clinical cancer trial, if the same Routine Patient Care is a Covered Charge for an Insured Person not enrolled in a qualified clinical cancer trial.

Coverage is provided only for qualified clinical cancer trials that meet each of the following criteria:

- the effectiveness of the treatment has not been determined relative to established therapies;
- the trial is under clinical investigation as part of an approved cancer research trial in Phase II, Phase III, or Phase IV of investigation; and

- the trial is:
  - approved by the Food and Drug Administration; or
  - approved and funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the United States Department of Defense, the United States Department of Veterans Affairs, or the United States Department of Energy in the form of an investigational new drug application, or a cooperative group or center of any such entity; and
- the Insured Person's primary care Physician, if any, is involved in the coordination of care.

"Routine Patient Care" means all Covered Charges provided in the qualified clinical cancer trial if those items or services would have been considered as Covered Charges had they not been provided in connection with a qualified clinical cancer trial consistent with the standard of care for the treatment of cancer, including the type and frequency of any diagnostic modality, that a provider typically provides to a cancer patient who is not enrolled in a qualified clinical cancer trial.

"Routine Patient Care" does not include coverage for:

- a health care service, item, or drug that is the subject of the qualified clinical cancer trial; or
- a health care service, item, or drug provided solely to satisfy data collection and analysis needs for the qualified clinical cancer trial that is not used in the direct clinical management of the Insured Person; or
- an investigational drug or device that has not been approved for market by the United States Food and Drug Administration; or
- transportation, lodging, food, or other expenses for the Insured Person or a family member or companion of the Insured Person that are associated with the travel to or from a facility providing the qualified clinical cancer trial; or
- a health care service, item, or drug customarily provided by the qualified clinical cancer trial sponsors free of charge for the Insured Person; or
- a health care service or item, which except for the fact that it is being provided in a qualified clinical cancer trial, is otherwise specifically excluded from coverage under the Group Policy, including costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for the fact that the Insured Person is participating in the qualified clinical cancer trial; and costs of nonhealth care services that the Insured Person is required to receive as a result of participation in the approved qualified clinical cancer trial; or

- costs for services, items, or drugs that are eligible for reimbursement from a source other than the Group Policy providing for third-party payment or prepayment of health or medical expenses, including the sponsor of the approved qualified clinical cancer trial; or
- costs associated with approved qualified clinical cancer trials designed exclusively to test toxicity or disease pathophysiology; or
- a health care service or item that is eligible for reimbursement by a source other than the Group Policy, including the sponsor of the qualified clinical cancer trial.

Benefits will be payable the same as for any other covered Treatment or Service and will be coordinated with the Clinical Trials benefit described above under Benefits Payable – Required by Federal Law.

- **Reconstructive Surgery After Mastectomy**

Covered Charges will include charges incurred for prosthetic devices or reconstructive surgery performed as a result of a mastectomy. Benefits will be payable the same as for any other covered Treatment or Service.

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

- **Shingles Vaccine**

Covered Charges will include charges incurred for vaccine for shingles that is approved by the federal Food and Drug Administration if the vaccine is ordered by a physician licensed to practice medicine and the Insured Person is 60 years of age or older.

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

- **Telehealth and Telemedicine Services**

Covered Charges from a PPO Provider will include charges by a Physician for clinically appropriate and medically necessary Telehealth Services. Licensed dietitian nutritionists and certified diabetes educators who counsel senior diabetes patients in the senior diabetes patients' homes will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license.

"Asynchronous Store and Forward System" means the transmission of a patient's medical information through an electronic communications system at an Originating Site to a health care professional or facility at a Distant Site that does not require real-time or synchronous interaction between the health care professional and the patient.

"Distant Site" means the location at which the health care professional rendering the Telehealth Service is located.

"Established Patient" means a patient with a relationship with a health care professional in which there has been an exchange of an individual's protected health information for the purpose of providing patient care, treatment, or services.

"E-Visits" means a patient-initiated non-face-to-face communication through an online patient portal between an Established Patient and a health care professional.

"Interactive Telecommunications System" means an audio and video system, an audio-only telephone system (landline or cellular), or any other telecommunications system permitting 2-way, synchronous interactive communication between a patient at an Originating Site and a health care professional or facility at a Distant Site. "Interactive Telecommunications System" does not include a facsimile machine, electronic mail messaging, or text messaging. "Interactive Telecommunications System" does not include Virtual Check-Ins.

"Originating Site" means the location at which the patient is located at the time Telehealth Services are provided to the patient via telehealth.

"Remote Patient Monitoring" means the use of connected digital technologies or mobile medical devices to collect medical and other health data from a patient at one location and electronically transmit that data to a health care professional or facility at a different location for collection and interpretation.

"Telehealth Services" means the evaluation, diagnosis, or interpretation of electronically transmitted patient-specific data between a remote location and a licensed health care professional that generates interaction or treatment recommendations. "Telehealth Services" includes telemedicine and the delivery of health care services, including mental health treatment and substance use disorder treatment and services to a patient, regardless of patient location, provided by way of an Interactive Telecommunications System, Asynchronous Store and Forward System, Remote Patient Monitoring technologies, E-Visits, or Virtual Check-Ins.

"Virtual Check-In" means a brief patient-initiated communication using a technology-based service, excluding facsimile, between an Established Patient and a health care professional. "Virtual Check-In" does not include communications from a related office visit provided within the previous 7 days, nor communications that lead to an office visit or procedure within the next 24 hours or soonest available appointment.

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

- **Temporomandibular Joint Disorder and Craniomandibular Disorder**

Covered Charges will include charges incurred for medically necessary treatment of temporomandibular joint disorder and craniomandibular disorder. Benefits will be payable the same as for any other covered Treatment or Service up to a lifetime maximum benefit of $2,500 for each Insured Person.

- **Treatment Models for Early Treatment of Serious Mental Illnesses**

Covered Charges will include the following bundled, evidence-based treatment for an Insured Person under age 26:

- Coordinated specialty care for first episode psychosis treatment, covering the elements of the treatment model included in the most recent national research trials conducted by the National Institute of Mental Health in the Recovery After an Initial Schizophrenia Episode (RAISE) trials for psychosis resulting from a serious mental illness, but excluding the components of the treatment model related to education and employment support.
- Assertive community treatment (ACT) and community support team (CST) treatment. The elements of ACT and CST to be covered shall include those covered under Article V of the Illinois Public Aid Code.

For purposes of ensuring adherence to the coordinated specialty care for first episode psychosis treatment model, only providers contracted with the Department of Human Services' Division of Mental Health to be FIRST.IL providers to deliver coordinated specialty care for first episode psychosis treatment will be permitted to provide such treatment and such providers must adhere to the fidelity of the treatment model. For purposes of ensuring fidelity to ACT and CST, only providers certified to provide ACT and CST by the Department of Human Services' Division of Mental Health and approved to provide ACT and CST by the Department of Healthcare and Family Services, or its designee, will be permitted to provide such services and such providers shall be required to adhere to the fidelity of the models.

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

- **Vitamin D Testing**

Covered Charges will include charges for vitamin D testing recommended by a Physician in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention. Risk factors for vitamin D deficiency include, but are not limited to:

- having osteoporosis or other bone-health problems;
- having conditions that affect fat absorption, including celiac disease or weight loss surgery;
- routinely taking medications that interfere with vitamin D activity, including anticonvulsants and glucocorticoids;
- Insured Persons aged 55 and older;
- having a darker skin color;
- inadequate sunlight exposure;
- being obese;
- previous diagnosis of diabetes or kidney disease; and
- exhibiting poor muscle strength or constant tiredness.

Vitamin D Testing" means vitamin D blood testing that measures the level of vitamin D in an individual's blood.

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

- **Whole Body Skin Examination**

Covered Charges will include one annual office visit, using appropriate routine evaluation and management Current Procedural Terminology codes or any successor codes, for a whole body skin examination for lesions suspicious for skin cancer. The whole body skin examination will be indicated using an appropriate International Statistical Classification of Diseases and Related Health Problems code or any successor codes.

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

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 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 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
  - 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, less any therapy visits payable for the Calendar Year under Physician's Office or Clinic Services.

- **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
  - the services of a Health Care Extender; and
  - outpatient physical, occupational or speech therapy not to exceed 30 visits per Calendar Year for each Insured Person; and
  - Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine); and
  - dressings, supplies, equipment not considered to be Durable Medical Equipment as described in page NBM 5402 J, anesthesia; and
  - Dental Services to repair damage to the jaw and sound natural teeth, if damage is the direct result of an accident 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 Physician or licensed acupuncturist for acupuncture treatment, up to a maximum benefit of $500 each Calendar Year for each Insured Person.

- **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 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 services (including air ambulances) provided by a Hospital or a licensed service 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. Not provided for long distance trips because it is more convenient than other transportation; and
- covered orthotics, casts, splints, braces and crutches; and
- Skilled Nursing Facility Care as described in page NBM 5402 M; and
- Hospice Care as described in page NBM 5402 L; 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 and 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 may:

- require prior authorization 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.

Cosmetic Treatment or Service

Covered Charges will include Cosmetic Treatment or Service resulting from a sickness or an accidental injury, 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.

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. Covered Charges for a non-Doctor of Medicine, non-Doctor of Osteopathy or a non-Doctor of Podiatry registered surgical assistant will be paid up to 15% of the Prevailing Charge.

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.

Continuity of Care

When an Insured Person's Physician or Hospital provider ceases to participate in the Preferred Provider network (for reasons other than misconduct, breach of contract, loss of license or other similar reason), the Insured Person may continue an Ongoing Course of Treatment with that Physician during a transitional period of up to 90 days. If the Insured Person has entered the third trimester of pregnancy, the transitional period includes post-partum care directly related to the delivery.

The Physician must agree to all of the following during the transitional period:

- continue to accept reimbursement at the rates and terms and conditions applicable prior to the start of the transitional period as payment in full;
- adhere to the Preferred Provider network's quality assurance requirements, including provision of necessary medical information related to such care; and
- otherwise adhere to the Company's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining Precertification for Treatment or Service.

This provision does not apply if the Insured Person has successfully transitioned to another Physician participating in the Preferred Provider network, if the Insured Person has already met or exceeded the benefit limitations, or if the Treatment or Service is not medically necessary.

"Ongoing Course of Treatment" means treatment for a life-threatening condition, which is a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the Insured Person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; a course of treatment for a health condition that a treating Physician or Hospital provider attests that discontinuing care by that Physician or Hospital provider would worsen the condition or interfere with anticipated outcomes; or the third trimester of pregnancy through the post-partum period.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

MENTAL HEALTH, BEHAVIORAL, ALCOHOL OR DRUG ABUSE TREATMENT SERVICES

The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In the event the Insured Person receives Treatment or Services for more than one condition during the same period of time, benefits will be paid based on the primary focus of the Treatment or Service.

- **Inpatient Hospital Services**

  If an Insured Person is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, or a psychiatric or an alcohol/drug unit of a general Hospital, 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 will be 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 Services**

  If an Insured Person receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Community Mental Health Center, or Outpatient Alcohol or Drug 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.

  "Outpatient Services" mean Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined.

  Covered Charges for Outpatient Services are limited to 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;
- alcohol or drug 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.

"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, Behavioral, Alcohol or Drug Abuse Treatment Services 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.

- **Physician Visits**

If an Insured Person receives any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable the same as for any other Physician Visit.

- **Benefits Payable**

Benefits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services are payable the same as for any other covered Treatment or Service.

Limitations

The general Comprehensive Medical limitations, as described in page NBM 5402 Q, will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

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 within a 12-month period.
    - 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 an 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 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

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 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. Lab Card, 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 Lab Card program is chosen. If the Lab Card 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, benefits will be more favorable if the Lab Card program is chosen.

The Insured Person must show Lab Card identification at the Physician's office or clinic and request that the laboratory work be sent through the Lab Card program to a participating Quest Diagnostics laboratory for processing. The Physician's office or clinic must call the Lab Card program to have specimens picked up by courier. The paperwork accompanying the specimens must indicate the Insured Person participates in the Lab Card 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 Lab Card 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 an approved Lab Card collection site with a Physician's directive and presents his or her medical or Lab Card identification card and verbally requests that the Lab Card program be used, the Company will pay 100% of Covered Charges for the Laboratory Services. If the collection site is not an approved Lab Card 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 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.

Coverage is included for any Emergency Services or other medical, hospital or surgical expenses incurred as a result of and related to an injury sustained while an Insured Person is either intoxicated or under the influence of a narcotic, regardless of the condition under which the substance is administered.

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 or 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.); 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 subject to a maximum of 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 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. Benefits payable will be based on the Company's allowable charge. The maximum allowable charge for drugs and medicines for Home Infusion Therapy Services will be established by the Company and will not exceed the Average Wholesale Price.

- **Limitations**

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

- are in excess of the limits described in this section; or
- 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.

- **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 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

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. 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
- 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, except as provided under Hearing Aids as described in page NBM 5400; 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; or
- vitamins, minerals (except prescription potassium supplements) and herbal supplements 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
- drugs that are not included in the formulary; or
- wigs or hair prostheses; or
- Cosmetic Treatment or Service which does not qualify for coverage as described in page NBM 5402 A PPO, 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, except as provided under Fertility Preservation Services as described in page NBM 5400; or

- Treatment or Service for education or training; or
- Treatment or Service for learning disorders; or
- Treatment or Service for developmental delay (except for outpatient occupation, speech and physical therapy services); or
- social counseling, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services (and except as provided under Hospice Care), marital counseling, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, or sexual disorder therapy, except that benefits will be payable for gender identity disorder and gender dysphoria; 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) unless charges are imposed against the Insured Person for such Treatment or Service; or
- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from the commission of or attempt to commit a felony or to which a contributing cause is being engaged in an illegal occupation; 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 any Experimental or Investigational Measures for artificial or mechanical devices designed to replace human organs; or
- behavior modification or group therapy, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; or
- Treatment or Service for smoking cessation or nicotine addiction except as provided under Preventive Health and Wellness Services, gambling addiction, or stress management; or
- Treatment or Service for insertion or revision of breast implants, unless provided post-mastectomy; or
- Treatment or Service for the removal of breast implants unless:
  - the implants were implanted for reconstruction due to sickness or injury; and
  - removal of the implants is medically necessary for a sickness or injury; 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
- 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
- Treatment or Service covered by medical expense insurance issued under the Individual Purchase Rights described in this booklet-certificate; or

- Treatment or Service that results from:
  - an injury sustained out of or in the course of any employment for wage or profit if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
  - a sickness covered by a Workers' Compensation Act or other similar law; 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; except as provided under Infertility Treatment as described in page NBM 5400; 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 provided outside the United States, unless the Insured Person is temporarily outside the United States for a period of six months or less for one of the following reasons:
  - travel, provided the travel is for a reason other than securing health care diagnosis or treatment; or
  - a business assignment; or
  - Full-Time Student status, provided the Insured Person is either
    - enrolled and attending an accredited school in a foreign country; or
    - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
- Treatment or Service provided for weight loss or reduction of obesity, except as covered under Preventive Health and Wellness Services, even if the Insured Person has other health conditions which might be helped by weight loss or reduction of obesity; 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, except as provided under Multiple Sclerosis Preventative Therapy as described in page NBM 5400; 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; 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 or Services 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); or
- charges for physicals, health examinations, immunizations or screening procedures which are performed solely for school, sports, employment, insurance, licensing or travel; 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
- public health surveillance testing for COVID-19 including surveillance tests conducted for the purpose of employment, education, travel, or entertainment; 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; 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 with growth hormones for adult growth hormone deficiency and for idiopathic short stature; or
- Treatment or Service for reduction mammoplasty (except when following a mastectomy); 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 or injury; 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 or as soon as reasonably possible, 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;
    - Psychiatric Hospital or psychiatric unit of a general hospital for Mental Health or Behavioral Treatment Services;
    - 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 Alcohol or Drug Abuse Treatment Services;
    - 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 a guarantee that benefits will be payable.

Outpatient services requiring Precertification generally include, but are not limited to the following:

- Complex imaging, including but not limited to MRI, MRA, CT-PET SCANS, and IMRT;
- Certain cosmetic and reconstructive surgery, including but not limited to breast related procedures, varicose vein procedures, septoplasty, blepharoplasty, and abdominoplasty;
- Back surgery, including but not limited to artificial discs, laminectomy, lumbar fusion, facet joint injection; and
- Certain selective surgery, including but not limited to hysterectomy, bariatric surgery, and sterotactic radiosurgery.

The above list of outpatient services are representative of common procedures requiring Precertification, however they are subject to change. For a current list of outpatient services requiring Precertification, please see the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com. 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 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 in a facility, the office of a Health Professional, or other inpatient or outpatient health care setting.

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 Covered 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 the provision of a health care service 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 that is a request for a benefit that is not a Concurrent Review or Prospective Review. Retrospective Review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

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 medical necessity, appropriateness, efficacy of the use of health care services, procedures and 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 15 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 issue an Adverse Benefit Determination or send an explanation of the information needed to complete the review prior to expiration of the 15 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.

- **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 within 60 calendar days of the receipt of the appeal review Adverse Benefit Determination. 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 72 hours of request for a voluntary appeal review.

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 decision 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 for post-service claims and 15 calendar days for pre-service claims.

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 fax or in Writing within 60 calendar days of the receipt of the appeal review Adverse Benefit Determination. 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 for post-service claims and 15 calendar days for pre-service claims.

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.

- **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.

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

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).

Nippon Life Benefits Appeal Review
P. O. Box 25951
Shawnee Mission, KS 66225-5951

Toll-Free Telephone Number: 1-800-374-1835 (English/Spanish line), 1-800-971-0638 (Japanese line), 1-877-827-8713 (Korean line)

The Company will make a full and fair review of the claim. The Company may require additional information to make the review. The Company will notify the Insured Person or a designated patient representative acting on behalf of the Insured Person, within three business days, of all information required to evaluate the appeal. The Company will notify the Insured Person in Writing of the appeal decision within 15 business days of receiving the appeal request. Notification will be made orally followed up by Written notice of the appeal decision.

Voluntary Appeal Review

If the Adverse Benefit Determination is affirmed on the First-Level Appeal Review resulting in a final internal Adverse Benefit Determination, the Insured Person or a designated patient representative acting on behalf of the Insured Person may request a Voluntary Appeal Review. The Voluntary Appeal Review must be requested in Writing within 60 calendar days of receipt of the final internal 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 Company will make a full and fair review of the claim. The Insured Person may submit Written comments, documents, records and other information relating to the claim for benefits. The Company will notify the Insured Person in Writing of the appeal decision within 30 calendar days of receiving the appeal request for post-service claims and 15 calendar days for pre-service claims.

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 and Voluntary 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 notify the Insured Person or a designated patient representative acting on behalf of the Insured Person, as soon as possible, but in no event more than 24 hours after receipt of the request for the Expedited Appeal Review, of all information required to evaluate the appeal.

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 24 hours after receipt of the request for the Expedited Appeal Review. Notification will be made orally followed up by Written notice of the decision.

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

EXTERNAL REVIEW

Right to Request an External Review of an Adverse Benefit Determination or Final Adverse Determination

An external review is available when an Adverse Benefit Determination or Final Adverse Determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness.

If the Insured Person has a medical condition where the timeframe for completion of (A) an expedited internal review of an appeal involving an Adverse Benefit Determination, or (B) a Final Adverse Determination, or (C) a standard external review, would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function, then the Insured Person or a designated representative may file a request for an expedited external review.

The Insured Person must exhaust the Complaint and Grievance Procedures as described on page NBM 5407 GP or the appeal procedures for Adverse Benefit Determinations under the Utilization Management Program as described in page NBM 5407 CC before requesting an external review or expedited external review. An Insured Person will be considered to have exhausted the Company's internal grievance appeals procedures if:

- the Insured Person or a designated representative acting on behalf of the Insured Person has filed an appeal under the Company's internal appeals process and has not received a Written decision on the appeal within thirty (30) business days following the date the Insured Person or a designated representative acting on behalf of the Insured Person files an appeal of an Adverse Benefit Determination that involves a Concurrent Review or a Prospective Review request or sixty (60) business days following the date the Insured Person or a designated representative acting on behalf of the Insured Person files an appeal of an Adverse Benefit Determination that involves a Retrospective Review request, except to the extent the Insured Person or a designated representative acting on behalf of the Insured Person requested or agreed to a delay;

- the Insured Person or a designated representative acting on behalf of the Insured Person filed a request for an expedited internal review of an Adverse Benefit Determination and has not received a decision on such request from the Company within 48 hours, except to the extent the Insured Person or a designated representative acting on behalf of the Insured Person requested or agreed to a delay;

- the Company agrees to waive the exhaustion requirement;

- the Insured Person has a medical condition in which the timeframe for completion of an expedited internal review of an appeal involving an Adverse Benefit Determination, a Final Adverse Determination, or a standard external review would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function;

- an Adverse Benefit Determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's health care provider certifies in Writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated; in such cases, the Insured Person or a designated representative acting on behalf of the Insured Person files a request for an expedited external review at the same time the Insured Person or a designated representative acting on behalf of the Insured Person files a request for an expedited internal appeal involving an Adverse Benefit Determination; the independent review organization assigned to conduct the expedited external review will determine whether the Insured Person is required to complete the expedited review of the appeal prior to conducting the expedited external review; or

- the Company has failed to comply with applicable State and federal law governing internal claims and appeals procedures.

An Insured Person or a designated representative acting on behalf of the Insured Person may not file a subsequent request for external review involving the same Adverse Benefit Determination or Final Adverse Determination that has already received an external review decision.

Standard External Review

The Insured Person or a designated representative acting on behalf of the Insured Person has the right to file a request for an external review with the Illinois Department of Insurance within four months of receiving notice of an Adverse Benefit Determination or Final Adverse Determination if the Insured Person has exhausted the Complaint and Grievance Procedures as described in page NBM 5407 GP or the appeal procedures for Adverse Benefit Determinations under the Utilization Management Program as described in page NBM 5407 CC.

Within five (5) business days of the receipt of the external review request, the Company will complete a preliminary review of the external review request to determine whether:

- the individual is or was an Insured Person at the time the health care service was recommended or requested or, in the case of a retrospective review, at the time the health care service was provided;

- the recommended or requested health care service or treatment that is the subject of the Adverse Benefit Determination or Final Adverse Determination is a Covered Charge but the Company has determined that the health care service is not covered or the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit;

- in the case of the Company's determination that the health care service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit;

- the Insured Person's health care provider has certified that one of the following situations is applicable:
  - standard health care services or treatments have not been effective in improving the condition of the Insured Person;
  - standard health care services or treatments are not medically appropriate for the Insured Person; or
  - there is no available standard health care service or treatment that is a Covered Charge that is more beneficial than the recommended or requested health care service or treatment;
- the Insured Person's health care provider:
  - has recommended a health care service or treatment that the Physician certifies, in Writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
  - who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in Writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the Insured Person that is the subject of the Adverse Benefit Determination or Final Adverse Determination is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;

- the Insured Person has exhausted the Complaint and Grievance Procedures as described in page NBM 5407 GP or the appeal procedures for Adverse Benefit Determinations under the Utilization Management Program as described in page NBM 5407 CC;
- the Insured Person has provided all the information and forms required to process an external review.

Within one (1) business day after completion of a preliminary review of the request, the Company will notify the Illinois Department of Insurance and the Insured Person or designated representative in Writing whether the request is complete and eligible for external review. If the request:

- is not complete, the Company will inform the Illinois Department of Insurance and the Insured Person or designated representative in Writing and include in the notice what information or materials are required to make the request complete; or
- is not eligible for external review, the Company will inform the Illinois Department of Insurance and the Insured Person or designated representative in Writing and include in the notice the reasons for ineligibility.

If the Insured Person or designated representative's request is eligible for external review, the Illinois Department of Insurance will notify the Company and the Insured Person or designated representative in Writing within one (1) business day of the name of the independent review organization. Within five (5) business days after the date of receipt of the name of the assigned independent review organization, the Company will provide to the assigned independent review organization the documents and any information considered in making the Adverse Benefit Determination or Final Adverse Determination.

Within five (5) business days of the receipt of this notice, the Insured Person or designated representative may submit in Writing additional information to the assigned independent review organization. The independent review organization is not required to accept and consider additional information submitted after five (5) business days.

Upon receipt of a notice of a decision reversing the Adverse Benefit Determination or Final Adverse Determination, the Company immediately will approve the health care service that was the subject of the Adverse Benefit Determination or Final Adverse Determination.

Expedited External Review

An Insured Person or a designated representative acting on behalf of the Insured Person may request an expedited external review if the Insured Person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or if a Final Adverse Determination concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility; or if a Final Adverse Determination concerns a denial of coverage based on the determination that the recommended or requested health care service or treatment is experimental or investigational, and the Insured Person's health care provider certifies in Writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

A request for an expedited external review may be submitted with the Illinois Department of Insurance orally or in Writing immediately after the date of receipt of a notice of an Adverse Benefit Determination; Final Adverse Determination; or if the Company does not complete the expedited internal appeal within 48 hours. An expedited external review will not be provided for a Retrospective Review of an Adverse Benefit Determination or Final Adverse Determination, or in a case in which the Company has denied or reduced payment for a treatment after the treatment has already been provided.

Immediately upon receipt of the request for an expedited external review, the Company will notify the Illinois Department of Insurance and the Insured Person or designated representative in Writing whether the request is complete and eligible for external review.

If the Insured Person or designated representative's request is eligible for external review, the Illinois Department of Insurance will immediately notify the Company and the Insured Person or designated representative of the name of the independent review organization. Immediately upon receipt of the name of the assigned independent review organization, but in no case more than 24 hours after receiving such notice, the Company will provide or transmit to the assigned independent review organization all necessary documents and information considered in making the Adverse Benefit Determination or Final Adverse Determination electronically or by telephone or facsimile or any other available expeditious method.

Upon receipt of a notice of a decision reversing the Adverse Benefit Determination or Final Adverse Determination, the Company immediately will approve the health care service that was the subject of the Adverse Benefit Determination or Final Adverse Determination.

If the Insured Person or designated representative has any questions regarding the external review, the Insured Person may contact the Illinois Department of Insurance at the following addresses for assistance:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington Street
Springfield, IL 62767
Toll-free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

The Company's initial determination that the external review request is ineligible for review may be appealed to the Illinois Department of Insurance.

To appeal an initial determination of ineligibility for standard external review, the Insured Person should contact:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street
Springfield, IL 62767
Toll-free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

To appeal an initial determination of ineligibility for an expedited external review, the Insured Person should contact:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 West Washington Street
Springfield, IL 62767
Toll-free Telephone: (877) 850-4740
Fax: (217) 557-8495
Email: doi.externalreview@illinois.gov
Website: https://mc.insurance.illinois.gov/messagecenter.nsf

The Insured Person may also contact the Illinois Department of Insurance at:
Illinois Department of Insurance
122 S. Michigan Avenue, 19th floor
Chicago, IL 60603
Toll Free Telephone: (312)-814-2420

Payment for External Review

The Company will pay for the costs of the external review.

External Independent Review Decisions

If an external independent review decision upholds a determination adverse to the Insured Person, the Insured Person has the right to appeal the final decision with the Illinois Department of Insurance. The Illinois Department of Insurance may overturn the external independent review decision and require the Company to pay for the health care service or treatment. If an external independent review decision is overturned by the Illinois Department of Insurance and the Company requests, the Illinois Department of Insurance will assign a new independent review organization to reconsider the overturned decision.

DESCRIPTION OF BENEFITS

PRESCRIPTION DRUGS EXPENSE INSURANCE

Payment Conditions

Subject to the terms and limitations of the Group Policy summarized in this booklet-certificate, 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 may:

- require prior authorization 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.

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
- compounded medications in which at least one ingredient is a Prescription Legend Drug; and
- injectable medications; and
- legend oral contraceptives; and
- progesterone, all dosage forms; and
- growth hormones for specific conditions as determined by the Company; 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. If a drug is not included in the Formulary, no benefits will be paid. 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.

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
- infertility drugs, immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use; or
- administration of any drug or medicine; or
- Levonorgestrel (Norplant); 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; 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) unless charges are imposed against the Insured Person for such Treatment or Service; 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 the commission of or attempt to commit a felony or to which a contributing cause is being engaged in an illegal occupation; or
- drugs or medicines covered by medical expense insurance issued under the Individual Purchase Rights described in page NBM 5452 of this booklet-certificate; or
- drugs or medicines provided as the result of:
  - an injury sustained out of or in the course of any employment for wage or profit, if the Insured Person is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
  - a sickness covered by a Workers' Compensation Act or similar law; 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
- smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms except as covered under Preventive Health and Wellness Services; or
- anorectics (any drug used for the purpose of weight control); or
- minerals. Exception: Potassium supplements are covered; or
- drugs or medicines prescribed or dispensed outside the United States unless the Insured Person is temporarily outside the United States for a period of six months or less for one of the following reasons:

  - travel, provided the travel is for a reason other than securing health care diagnosis or treatment; or
  - a business assignment; or
  - Full-Time Student status, provided the Insured Person is either:
    - enrolled and attending an accredited school in a foreign country; or
    - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; 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; or
- drugs that are not included in the Formulary.

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 may:

- require prior authorization 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.

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. If a drug is not included in the Formulary, no benefits will be paid. 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.

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, UPS 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
- infertility drugs, immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use; or
- administration of any drug or medicine; or
- Levonorgestrel (Norplant); 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; 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) unless charges are imposed against the Insured Person for such Treatment or Service; 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 the commission of or attempt to commit a felony or to which a contributing cause is being engaged in an illegal occupation; or
- drugs or medicines covered by medical expense insurance issued under the Individual Purchase Rights described in page NBM 5452 of this booklet-certificate; or

- drugs or medicines provided as the result of:
    - an injury sustained out of or in the course of any employment for wage or profit, if the Insured Person is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
    - a sickness covered by a Workers' Compensation Act or other similar law; 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
- smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms except as covered under Preventive Health and Wellness Services; or
- anorectics (any drug used for the purpose of weight control; or
- minerals. Exception: Potassium supplements are covered; or
- drugs or medicines prescribed or dispensed outside the United States unless the Insured Person is temporarily outside the United States for a period of six months or less for one of the following reasons:
    - travel, provided the travel is for a reason other than securing health care diagnosis or treatment; or
    - a business assignment; or
    - Full-Time Student status, provided the Insured Person is either:
        - enrolled and attending an accredited school in a foreign country; or
        - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; 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; or
- drugs that are not included in the Formulary.

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.

MEDICAL EXPENSE COVERAGE

EXTENDED BENEFITS
(after termination of insurance)

If Medical Expense Insurance under the Group Policy ceases and if the Insured Person qualifies, the Company will pay Comprehensive Medical benefits for Treatment or Service received after termination of insurance to the extent that these benefits would have been paid had insurance remained in force.

An Insured Person will qualify if Hospital Inpatient Confined from the date insurance ceases to the date of Treatment or Service.

However, extended benefits will be payable only for Treatment or Service received for the condition which caused the Hospital Inpatient Confinement and which was diagnosed by a Physician before the date insurance terminated.

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, 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.

MEDICAL EXPENSE INSURANCE

INDIVIDUAL PURCHASE RIGHTS

If a Member's Medical Expense Insurance terminates and the Member has been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaces) for at least the three-month period immediately prior to the date insurance terminates, the Member may buy other medical expense insurance from the Company. Except that, the Member may not buy other medical expense insurance if his or her Medical Expense Insurance terminates because:

- the Member failed to pay any required contribution; or
- the Group Policy terminates and continuous coverage is provided under a replacement group medical expense coverage; or
- the Member's continuation of insurance ends as provided in the Group Policy, and such continuation ends because the Member:
  - fails to pay any required premium; or
  - becomes covered under other group medical expense coverage.

A statement of health will not be required. The other coverage will be on one of the forms the Company then issues to persons who apply for individual purchase.

NOTE: The benefits provided under the conversion policy are not the same as the benefits provided under the Group Policy. Specific details regarding the terms of the conversion policy may be obtained from the Company or from the Policyholder.

The persons to be covered under the other medical expense insurance will be Insured Persons who are covered under the Group Policy on the date insurance ceases, except that any Developmentally Disabled or Physically Disabled child beyond the maximum age for Dependent Children will be covered as provided in the last paragraph.

The Company will not issue other medical expense insurance if the Member is or could be covered by Medicare or if the Member is covered by similar coverage which, together with this coverage, may result in overinsurance based on the Company standards for overinsurance.

Notice of the individual purchase right must be given to the Member by the Policyholder before insurance under the Group Policy terminates. The Member must apply for individual purchase and pay the first premium to the Company not later than the later of:

- 31 days after the date insurance terminates under the Group Policy; or
- 15 days after the Member has been given notice of the individual right;

but in no event later than 60 days after such termination. The premium the Member pays will be at the Company's normal rate for the Member's age and for the risk class to which the Member belongs. Contact the Policyholder for the proper forms. The other medical expense insurance will then be in force on the day after that termination date.

The Member's spouse may buy other medical expense insurance in the same manner as described above for the Member, if insurance under the Group Policy ceases for the Member's spouse because:

- of the Member's death; or
- of divorce or legal separation from the Member or termination of a Civil Union Partner relationship with the Member; or
- continuation ends as provided in the Group Policy for a Member's spouse unless continuation ends because the spouse:
  - fails to pay any required premium; or
  - becomes covered under other group medical expense coverage.

A Dependent Child may also buy other medical expense insurance in the same manner as described above for the Member, if insurance under the Group Policy ceases for the Dependent Child because:

- the child is no longer eligible as a Dependent; or
- of the Member's death; or
- continuation ends as provided in the Group Policy unless continuation ends because the Dependent Child:
  - fails to pay any required premium; or
  - becomes covered under other group medical expense coverage.

A Dependent Child beyond the maximum age for Dependent Children, who is incapable of self-support because of a Developmental Disability or Physical Disability may also buy other medical expense insurance in the same manner as described above for the Member, if the Dependent Child's insurance under the Group Policy ceases because the Member's insurance terminates as described above.

NOTE: Individual Purchase is also available at the end of any continuation period, provided the person is not then covered for similar coverage which, together with this coverage, may result in overinsurance based on Company standards for overinsurance.

If the Policyholder offers coverage under an HMO as an alternative to this coverage, these Individual Purchase Rights will not apply to any person who is covered by an HMO on the date insurance terminates or to any person who becomes covered by an HMO within 31 days after this insurance terminates.

MEDICAL EXPENSE INSURANCE

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" is any of these which provides benefits or services for, or because of, medical care or treatment:

* - individual and group insurance and group subscriber contracts; and

- uninsured arrangements of individual, group or group-type coverage; and
- individual and group or group-type coverage through a Health Maintenance Organization or other prepayment, group practice and individual practice plans; and
- group-type contracts; and
- the amount by which individual, group or group-type hospital indemnity benefits exceed $100 per day; and
- the medical benefits coverage in individual or group automobile contracts, in group or individual automobile “no-fault” contacts, and in traditional automobile “fault” type contracts, to the extent those contracts are primary plans; and
- Medicare or other government benefits, except as provided below.

* In the event a Member, spouse or state-sanctioned 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.

The term Plan will not include benefits provided under:

- hospital indemnity coverage benefits or other fixed indemnity coverage that exceeds $100 per day; or
- accident only coverage; or
- specified disease or specified accident coverage; or
- limited benefit health coverage; or
- school accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; or
- benefits provided in long term care insurance policies for non-medical services or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; or
- Medicare supplement policies; or
- a state plan under Medicaid; or
- a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or
- disability income protection coverage.

"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, including Deductibles, coinsurance, and Copayments, if any, 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 are examples of expenses or services that are not allowable expenses:

- If an Insured Person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the Insured Person's stay in a private Hospital room is medically necessary in terms of Generally Accepted medical practice, or one of the Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
- 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 the part of a Calendar Year during which an Insured Person would receive benefit payments under This Plan if this section were not in force.

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.

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.

- **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 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.

- **Young Adult/Dependent.** If a Dependent Child is covered under either or both parents' Plans and also covered as a dependent under a spouse's Plan, the Plans covering the Dependent Child shall follow the order of benefit determination rules for longer/shorter length of coverage. However, if the Dependent Child's coverage under the spouse's Plan began on the same date as the Dependent Child's coverage under either or both parents' Plans, the Plans covering the Dependent Child shall follow the order of benefit determination birthday 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.

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.

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 Plan's 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 INSURANCE

SUBROGATION AND REIMBURSEMENT

Subrogation

If an Insured Person receives a benefit payment under the Group Policy as a result of a sickness or injury that occurred due to the negligence of a third party:

> The Company is assigned the right to recover from the negligent third party, or the Insured Person's insurer, to the extent of the benefits the Company paid for that sickness or injury. The Insured Person is required to furnish any information or assistance, or provide any documents that the Company may reasonably require in order to exercise the Company's rights under this provision. This provision applies whether or not the third party admits liability.

The Insured Person will not take any action that prejudices the Company's rights. If the Insured Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Insured Person must not prejudice, in any way, the Company's subrogation rights under this section.

The cost of legal representation retained by the Company in matters related to subrogation will be borne solely by the Company. The cost of legal representation retained by the Insured Person will be borne solely by the Insured Person.

Reimbursement

If the Insured Person recovers benefits for sickness or injury that occurred due to the negligence of a third party, the Company has the right to first reimbursement for all benefits the Company paid from any and all damages collected from the negligent third party for those same benefits whether by action at law, settlement, or compromise, by the Insured Person, or his or her legal representative as a result of that sickness or injury. The Insured Person is required to furnish any or assistance, or provide any documents that the Company may reasonably require in order to exercise the Company's rights under this provision. This provision applies whether or not the third party admits liability.

CONTINUATION OF COVERAGE – STATE REQUIRED - ILLINOIS

State Required Continuation – Illinois

- **Definitions**

Qualified Person means an individual who, on the day before a Qualifying Event, is insured under the Group Policy by virtue of being the Member or the Dependent spouse or Dependent Child of the Member.

NOTE: The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75, allows both same sex and different sex couples to enter into a Civil Union with all the obligations, protections and legal rights that Illinois provides to heterosexual couples.

Qualifying Event means any of the following events which, except for the election to continue insurance, would result in a loss of coverage to a Qualified Person:

- the Member's termination of employment or reduction in work hours below the minimum required by the Group Policy (unless termination of employment was due to the Member's commission of a felony or theft in connection with his or her work, the employer was in no way responsible, and the Member either admitted committing the act or such act resulted in a conviction or order of supervision by a court of competent jurisdiction). In this instance, covered Dependents are eligible for continuation of coverage only if the Member has elected to continue coverage under these provisions; or
- the Member's death; or
- the Member's dissolution of marriage (divorce) or termination of a Civil Union Partner relationship; or
- the Member's retirement; or
- the Member’s Dependent Child attains the limiting age under the Group Policy.

- **Qualification for Continuation**

A Qualified Person who would lose insurance under the Group Policy because of a Qualifying Event may elect to continue the insurance, if, on the date insurance would otherwise cease:

- the Qualified Person is not eligible under Medicare; and
- the Group Policy is in force.

In addition, the following Qualification provisions apply:

- if the Qualifying Event is the Member's termination of employment or reduction in work hours below the minimum required by the Group Policy, the Member must have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least the three-month period immediately preceding the termination of employment; and
- if the Qualifying Event is the Member's Dependent Child attaining the limiting age under the Group Policy, the child is not covered by any other insured or self-insured plan; and
- if the Qualifying Event is the Member's retirement and the Group Policy covers retired Members, the Member's spouse must be at least 55 years of age on the date of the Member's retirement.

- **Period of Continuation**

Persons who qualify for continuation as described above may continue insurance until:

- If the Qualifying Event is the Member's termination of employment or reduction in work hours below the minimum required by the Group Policy, the earliest of:
  - the date insurance would otherwise cease as provided in the Group Policy; or
  - the date the Member first becomes covered (after electing continuation) under another group medical expense plan; or
  - the date insurance has been continued for twelve months.

- If the Qualifying Event is the Member's death, dissolution of marriage, termination of a Civil Union Partner relationship or retirement, the earliest of:
  - the date insurance would otherwise cease as provided in the Group Policy. Exception: During the first 120 days after the Qualifying Event, insurance may be terminated only if such termination is due to termination of the Group Policy; or
  - the date the spouse first becomes (after electing continuation) a covered employee under any other group medical expense plan; or
  - the date the Member's former (surviving or divorced) spouse remarries or for a former Civil Union Partner, the Civil Union Partner establishes a new Civil Union Partner relationship; or
  - if the spouse is under age 55 when continuation begins, the date insurance has been continued for two years; or
  - if the spouse is age 55 or older when continuation begins, the date the spouse becomes eligible for Medicare.

- If the Qualifying Event is the Member's Dependent Child attaining the limiting age under the Group Policy, the earliest of:

  - the date the Dependent Child becomes covered by Medicare; or
  - the date the insurance would otherwise cease as provided in the Group Policy; or
  - the date the Dependent Child first becomes (after electing continuation) a covered employee under any other group medical expense plan; or
  - the date insurance has been continued for two years.

- For all Qualifying Events, the earliest of:

  - the applicable date specified above; or
  - the end of the premium period for which premium is paid, if the Qualified Person fails to make timely payment of a required premium within the Grace Period; or
  - the date the Group Policy is terminated. (The continuation period may be completed under the Policyholder's replacement coverage if the Member is, or would have been, covered under the replacement policy.)

- **Notice, Election, and Premium Requirements**

- If the Qualifying Event is the Member's termination of employment or reduction in work hours below the minimum required by the Group Policy, the employer must give the Member Written notice of the continuation right within 10 days after the termination of employment or reduction in work hours below the minimum required by the Group Policy. The Member must request continuation in Writing, and pay the initial premium within 30 days after the later of: (i) the date insurance would otherwise terminate or (ii) the date the Member is given Written notice of the continuation right. In no event, however, may the Member elect continuation more than 60 days after the date insurance would otherwise end.

- If the Qualifying Event is the Member's death, dissolution of marriage, termination of a Civil Union Partner relationship, or retirement or the Member's Dependent Child attaining the limiting age under the Group Policy, the Qualified Person must give the Member's employer or the Company Written notice of the Qualifying Event within 30 days after it occurs. Within 15 days after receipt of that notice, the employer must: (i) send notice of the Qualifying Event to the Company and (ii) send a copy of the notice sent to the Company to the Qualified Person. Within 30 days after receipt of the employer's or Qualified Person's notice, the Company must send the Qualified Person information concerning continuation, including an election form. The Qualified Person must return the completed election form to the employer and pay the initial premium, within 30 days after receipt of the continuation information.

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 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 Civil Union Partner or a Civil Union 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. Individual Purchase Rights

When a qualified person is no longer eligible for continued coverage, he/she may apply for Individual Purchase. Persons who are eligible for similar benefits which would result in over-insurance may not purchase conversion coverage. An application for Individual Purchase will be provided 180 days prior to the end of the maximum continuation period. Application for Individual Purchase, and payment of the required premium, must be made within 31 days after the continued coverage ends. Dental, Vision Care, and Prescription Drug coverages are not included with the Individual Purchase Option (however, benefits for prescription drugs are included in the Individual Purchase coverage).

M. 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.

N. 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: Illinois John Doe Health Plan
Contact Name/Area: Illinois 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).

NOTE: USERRA Continuation is not available to a Civil Union Partner or a Civil Union Partner's Dependent Child.

Continuation

If active employment ends because the Member enters active military duty or inactive military duty for training, 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; 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 date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Except in the case of medical care received from Preferred Providers, claim forms and other information needed to prove loss, must be filed with the Company in order to obtain payment of benefits. The Policyholder will provide forms to assist the Insured Person in filing claims. If the forms are not provided within 15 calendar days after the Company receives such notice of claim, the Insured Person will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to the Company within 12 months after the date of loss. 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 Claims

The Employment Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. Claims must be paid within 30 days following receipt of Written due proof of loss. If a claim cannot be processed due to incomplete information, the Company will either deny the claim or send a Written explanation requesting information prior to the expiration of the 30 calendar days. If the Company does not deny the claim and requests additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. 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. The Company will pay interest at the rate of 9% per annum from the 30th calendar day after receipt of sufficient information for claim, to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

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.

For purpose of this section, "claimant" means Member or Dependent.

Physical 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 Actions

Legal action with respect to a claim may not be started earlier than 90 calendar days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

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 overpayments, the Company must provide a remittance advice, which must include an explanation of a recoupment or offset taken by the Company.

The Written notice must include the name of the patient; the date of service; the service code or if no service code is available a service description; the recoupment amount; and the reason for the recoupment or offset. The Company will provide with the remittance advice, or with any demand for recoupment or offset, a telephone number or mailing address to initiate an appeal of the recoupment or offset together with the deadline for initiating an appeal. The Company must also provide a telephone number or mailing address to initiate an appeal of the recoupment or offset together with the deadline for initiating an appeal with the remittance advice, or with any demand for recoupment or offset. Any appeal of a recoupment or offset by a provider must be made within sixty (60) days after receipt of the remittance advice.

No recoupment or offset may be requested or withheld from future payments eighteen (18) months or more after the original payment is made, except in cases in which:

- a court, government administrative agency, other tribunal, or independent third-party arbitrator makes or has made a formal finding of fraud or material misrepresentation;
- an insurer is acting as a plan administrator for the Comprehensive Health Insurance Plan under the Comprehensive Health Insurance Plan Act; or
- the provider has already been paid in full by any other payer, third party, or workers' compensation insurer.

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 or as soon as reasonably possible.

- **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 mother and baby for 48 hours following a vaginal delivery or 96 hours following a cesarean section.

  An Insured Person or a designated patient representative must call the Company at the toll-free number shown on the identification card 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, 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.
- Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of the Insured Person.
- Benefits payable to Lab Card, 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").

a. 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.

b. Selection of Arbitrators

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.

c. 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.

d. Seat of Arbitration, Languages.

The seat or place of arbitration will be Illinois. The arbitration will be conducted and the award will be rendered in the English language.

e. 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.

f. Remedies

The arbitrators will have no authority to award punitive damages, consequential damages, or liquidated damages.

g. 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, 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 does 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, 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: 99-99999999
   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-certificate (page NBM 5136).

7. **Sources and Methods of Contributions to the Plan:**

Employee pays none 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:

- a determination by the Company or designated Utilization Management organization that, based upon the information provided, a request for a benefit under the Company's benefit plan upon application of any utilization review technique does not meet the Company's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational, and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made for the benefit; or
- the denial, reduction, or termination of or failure to provide or make payment for a benefit that is based on a determination of an Insured Person's eligibility under the Group Policy; or
- a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost 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.

Civil Union

The legal relationship between two persons either of the same or opposite sex.

Civil Union Partner

For two persons to establish a Civil Union, it will be necessary that they satisfy all of the following criteria:

a. not be a party to another Civil Union, marriage, or substantially similar legal relationship;

b. be at least 18 years of age;

c. not be an ancestor and a descendent or be siblings whether the relationship is by the half or the whole blood or by adoption;

d. not be an aunt or uncle and a niece or nephew, whether the relationship is by the half or the whole blood or by adoption;

e. not be first cousins.

A Civil Union will also include marriage between two persons of the same-sex, a Civil Union, or a substantially similar legal relationship other than common law marriage, legally entered into in another jurisdiction.

NOTE: For the purposes of the Group Policy, the term “spouse” will include a Civil Union Partner, except as otherwise provided in the Group Policy.

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, Behavioral, Alcohol or Drug Abuse Treatment Services.

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 prevent or relieve social, emotional or psychological distress; 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
- 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, 2022.

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, if that spouse:
  - Resides in the United States; and
  - is not in the armed forces of any country; and
  - is not insured under the Group Policy as a Member; and
  - is legally wed to the Member.

  A Member's spouse will also include a Civil Union Partner.

- The Member's Dependent Child (or Children) as defined below; and
- The Member's Civil Union 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.

  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 child residing with the Member pursuant to an interim court order of adoption is considered an adopted child.

- A Member's foster child, provided:

  - the child meets the requirements above; and
  - the child has been placed with the Member or the Member's spouse insured under this booklet-certificate 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.

- The Member's unmarried child 26 years of age until his or her 30th birthday who otherwise qualifies, if that child:

  - is an Illinois resident; and
  - served as an active or reserve member of any branch of the Armed Forces of the United States, including the National Guard; and
  - has received a release or discharge other than a dishonorable discharge; and
  - receives principal support from the Member.

- A Civil Union Partner's child who otherwise qualifies above or if the Member or Civil Union Partner is the child's guardian by court order.

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 disability which:

- results from mental disability, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), regardless of the final diagnosis given, 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; or inadequate controlled pain; or with respect to a pregnant woman who is having contractions; inadequate time to complete a safe transfer to another Hospital before delivery or a transfer to another Hospital may pose a threat to the health and safety of the woman or unborn child.

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.

Final Adverse Determination means an Adverse Determination involving a covered benefit that has been upheld by the Company, or its designated Utilization Management organization, at the completion of the Company's internal grievance appeals procedures.

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.), 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.

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, Behavioral, Alcohol or Drug Abuse Treatment Services, 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.

Immediate Family means an Insured Person’s spouse, 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.

Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services means Treatment or Service provided to alter a person's behavior, regardless of the cause of that behavior, including but not limited to: individual, family or group psychotherapy; psychological testing; electroconvulsive therapy; psychiatric diagnostic interviews or examinations; behavior modification; psychiatric, alcohol or drug abuse medication management; alcohol or drug abuse rehabilitation or counseling services; hypnotherapy; narcosynthesis; biofeedback, milieu or other therapies (physical, occupational or speech therapy) used to diagnose or treat mental health, behavioral, alcohol or drug abuse problems. Treatment or Service includes any mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

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 Disability 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 between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service.

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:

- 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 arrangement the Company has with the provider; or
  - the amount that most health care providers charge within a geographic cost area for a Treatment or Service.

  For the purpose of the second bullet above, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if 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).

  Exception: For medical care received in a PPO Hospital from a Non-PPO anesthesiologist, radiologist, pathologist, neonatologist or emergency room Physician, the percentage above will instead be 80%.

- For Home Infusion Therapy Services, the amount will be established by the Company, not to exceed the Average Wholesale Price. To request the Average Wholesale Price used as a maximum allowable charge, the Insured Person can call the number on the Insured Person's ID card.
- 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. To request the Average Wholesale Price used as a maximum allowable charge, the Insured Person can call the number on the Insured Person's ID card.
- For purposes of Treatment or Service for Emergency Services provided outside the United States, the Prevailing Charge will be calculated based on the Policyholder's United States address.

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.

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, Behavioral, Alcohol or Drug Abuse Treatment Services.

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, Behavioral, Alcohol or Drug Abuse Treatment Services in the absence of a specialized or designated psychiatric or drug treatment unit.

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, Behavioral, Alcohol or Drug Abuse Treatment Services.

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.

Total Disability; Totally Disabled means:

- For a Member, a Member's inability 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 is 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 PPO.

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, Teladoc, that has contracted with the Company to offer these services. Licensed dietitian nutritionists and certified diabetes educators who counsel senior diabetes patients in the senior diabetes patients' homes will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license. 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. NOTE: Vendor-Supported Telemedicine Services may have different cost-sharing than state mandated Telehealth/Telemedicine benefits payable. See the schedule of benefits for more information.

Waiting Period means with respect to a Group Health Plan and an individual who is a potential enrollee in the plan, the period of time that must pass before coverage for an individual who is otherwise eligible to enroll for benefits under the terms of the plan can become effective.

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.

ILLINOIS NOTICE

If an Insured Person has any complaints about this insurance, please contact:

Nippon Life Insurance Company of America
P. O. Box 25951
Shawnee Mission, KS 66225-5951
Telephone: 1-800-374-1835

or

Illinois Department of Insurance
Consumer Division or
Public Services Section
320 West Washington Street
Springfield, Illinois 62767
Telephone: 1-217-782-4515
Toll Free: 1- (866) 445-5364

or

Illinois Department of Insurance
122 S. Michigan Avenue, 19th floor
Chicago, IL 60603
Phone Number: 312-814-2420
Toll Free: 877 527-9431

Please identify all correspondence with the group account number and the Insured Person's full name and address. Please be as specific as possible about the nature of the complaint. Include all relevant information so that prompt action can be taken to resolve the complaint satisfactorily.

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

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCAE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per Insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in case surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and case values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to hospital, medical and surgical insurance benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health
Insurance Guaranty Association
1520 Kensington Road, Suite 112
Oak Brook, Illinois 60523-2140
(773) 714-8050

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767
(217) 782-4515

Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to 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 Illinois law, then Illinois 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.

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