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 Eff 6/23/2022 – Compliance Correction)

NJ HDHP LARGE GROUP

EFFECTIVE JANUARY 1, 2022

Group Plan Booklet Certificate

Medical 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.

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

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

CONTROLLING HEALTH CARE COSTS

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

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

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

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

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

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

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

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

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

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

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 NJ) OF THIS BOOKLET-CERTIFICATE FOR MORE DETAILED INFORMATION.

For complaint and grievance procedures, refer to the COMPLAINT AND APPEAL PROCEDURES (NBM 5407 A NJ) and CLAIM PROCEDURES (NBM 5146 NJ) sections of this booklet-certificate or call the Benefit Advice/Health Info Line phone number shown above. The Insured Person may also write to the Company at the Company's claim office (see the address on the claim form).

Complaints and grievances may also be referred to: New Jersey Department of Banking and Insurance, P. O. Box 325, Trenton, NJ 08625-0325, phone number 609-292-5360.

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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 exclusions, 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

NOTE: THE INSURED PERSON'S MEDICAL BENEFITS MAY BE REDUCED IF THE UTILIZATION MANAGEMENT REQUIREMENTS DESCRIBED IN NBM 5407 CC NJ ARE NOT FOLLOWED. IF QUESTIONS, PLEASE CALL THE TOLL-FREE NUMBER SHOWN ON THE ID CARD ON ANY BUSINESS DAY OR SEE THE MEMBER'S POLICYHOLDER FOR THE TOLL-FREE NUMBER.

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 Charges 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. In the event of termination, the level of benefits as described in the Group Policy will not be affected until the earlier of: (1) the next Policy Anniversary following the date of termination; or (2) the date the Policyholder requests a change in benefits.

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 in bold in the table below. **See page NBM 5402 A HDHP NJ 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 – 80% For other than Emergency Services – 60%.
- Deductible	$1,500* per Calendar Year	For Emergency Services – $1,500* per Calendar Year For other than Emergency Services – $3,000 per Calendar Year.
Hospital Services Covered Charges for Birthing Center Services, Ambulatory Surgery Center Services and freestanding dialysis center services will be subject to the applicable Calendar Year Deductible Amount.		
- Outpatient Hospital Services		
- Coinsurance	80%	60%
- Deductible	$1,500* per Calendar Year	$3,000** per Calendar Year

Service	**PPO Providers**	**Non-PPO Providers**
- Emergency Room Visits (including MRIs, CATs, SPECTs, PETs and other similar imaging tests)		
- Coinsurance	80%	For Emergency Services – 80% For other than Emergency Services - 60%.
- Deductible	$1,500* per Calendar Year	For Emergency Services – $1,500* per Calendar Year For other than Emergency Services – $3,000** per Calendar Year
Physician Hospital and Surgery Services		
- Physician Hospital Services (including surgery and surgery performed in an Ambulatory Surgery Center or Physician's office or clinic and Physician Visits on an inpatient or outpatient basis)		
- Coinsurance	80%	60%
- Deductible	$1,500* per Calendar Year	$3,000** per Calendar Year
Physician Office or Clinic Services (For PPO Providers: Preventive Care Services are not subject to plan Deductible)		
- Services at a Physician's office or clinic (other than for Adult Wellness, Well Child Visits and Preventive Health and Wellness Services), including both in-person and Telemedicine/Telehealth visits		
- Coinsurance	80%	60%
- Deductible	$1,500* per Calendar Year	$3,000** per Calendar Year
- Preventive Health and Wellness Services at a Physician's office or clinic		
- Adult Wellness		
- Coinsurance	100%	60%
- Deductible	None	$3,000** per Calendar Year

Service	**PPO Providers**	**Non-PPO Providers**
- Well-Child Visits		
- Coinsurance	100%	60%
- Deductible	None	$3,000** per Calendar Year
- Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine)		
- Coinsurance	80%	No benefits payable
- Deductible	$1,500* per Calendar Year	No benefits payable
All Other Covered Services		
- Ambulance Services		
- Coinsurance	80%	For Emergency Services – 80% For other than Emergency Services – 60%
- Deductible	$1,500* per Calendar Year	For Emergency Services – $1,500* per Calendar Year For other than Emergency Services – $3,000** per Calendar Year
- Other Medical Services (including MRIs, CATs, SPECTs, PETs and other similar imaging tests in any outpatient location)		
- Coinsurance	80%	For Emergency Services – 80% For other than Emergency Services – 60%
- Deductible	$1,500* per Calendar Year	For Emergency Services – $1,500* per Calendar Year For other than Emergency Services – $3,000** per Calendar Year

Service	**PPO Providers**	**Non-PPO Providers**
- Other Preventive Health and Wellness Services		
- Coinsurance	100%	60%
- Deductible	None	$3,000** per Calendar Year
- Contraceptive Methods and Counseling for Women (including FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity).		
- Coinsurance	100%	60%
- Deductible	None	$3,000** per Calendar Year
- Prescription Drugs for generic and single source contraceptives for women		
- Coinsurance	100%	60%
- Deductible	None	$3,000** per Calendar Year
- Other Prescription Drugs		
- Coinsurance	80%	60%
- Deductible	$1,500* per Calendar Year	$3,000** per Calendar Year

If the Insured Person uses a Non-Participating Pharmacy, the Non-Participating Pharmacy should file the claim on the Insured Person's behalf. However, the Insured Person may need to 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 Non-Participating Pharmacy will be subject to the Deductible and coinsurance will be reimbursed up to an amount determined by the Company.

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. If a generic equivalent is available, and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug and the Physician has not indicated "Dispense as Written" on the prescription, the Insured Person will pay the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price. If a generic equivalent is available, and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug and the Physician has not indicated "Dispense as Written" on the prescription, 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.

A non-Preferred Brand Name Prescription Drug will be considered medically necessary if:

- it is approved by the Federal Food, Drug, and Cosmetic Act; or its use is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia-Drug Information; or it is recommended by a clinical study or review article in a major peer-reviewed professional journal; and
- the prescribing Physician states that all Preferred Brand Name Prescription Drugs used to treat the Insured Person's sickness have been ineffective, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the Insured Person.

The Company will respond to the prior approval request by telephone or other telecommunication device within one business day of receiving the necessary information to complete the review. The Company's failure to respond in this time frame will be deemed approval of the request. If the Company approves the non-Preferred Brand Name Prescription Drug, the non-Preferred Brand Name Prescription Drug will be covered. If the Company's determination is not to certify the non-Preferred Brand Name Prescription Drug, an adverse determination letter will be sent to the Insured Person and the prescribing Physician within five business days of receipt of the request. The adverse determination letter will include the clinical reasons for the decision. The Insured Person will have the right to an appeal to the Independent Health Care Appeals Program as described in page NBM 5407 CC NJ.

Services provided by Non-PPO Providers in a PPO Provider Hospital

Services provided by a Non-PPO Provider will be payable at the PPO Provider Deductible and Coinsurance level when such services are provided at a PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed PPO freestanding surgical center.

DEDUCTIBLE AMOUNTS

* **If medical care is received from PPO Providers, for persons enrolled for Member only coverage, his or her Deductible Amount will be** $1,500 each Calendar Year. There is one combined Deductible for medical care and Prescription Drugs.

*- **If medical care is received from PPO Providers, for persons enrolled for Member and Dependent (family) coverage, the Deductible Amount will be** $3,000 each Calendar Year for all members in the same family. There is one combined Deductible for medical care and Prescription Drugs. The family Deductible may be satisfied by any one family member or by two or more family members. No benefits will be payable until the entire family Deductible of $3,000 has been satisfied. No additional Deductible or Out-of-Pocket Expense Limit will be applied to any individual family member in excess of $6,750. After satisfaction of the Deductible, the Company will pay benefits as described in this booklet-certificate.

** **If medical care is received from Non-PPO Providers, for persons enrolled for Member only coverage,** his or her Deductible will be $3,000 each Calendar Year. There is one combined Deductible for medical care and Prescription Drugs.

** **If medical care is received from Non-PPO Providers, for persons enrolled for Member and Dependent (family) coverage,** the Deductible will be $6,000 each Calendar Year. There is one combined Deductible for medical care and Prescription Drugs. The family Deductible may be satisfied by any one family member or by two or more family members. No benefits will be payable until the entire family Deductible of $6,000 has been satisfied. After satisfaction of the Deductible, the Company will pay benefits as described in this booklet-certificate.

Covered Charges used to satisfy the individual and family maximum Calendar Year Deductibles that apply when care is received from PPO Providers will not 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 (applies for Member only coverage)	**$1,500**	**$5,000**
Per Family (applies if the Member is enrolled for family coverage)	**$3,000**	**$10,000**

- Covered Charges used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a PPO Provider 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 applicable Out-of-Pocket Expense Limit shown above, the Company will pay 100% of additional Covered Charges for the remainder of the Calendar Year.
- The per family Out-of-Pocket Expense Limit shown above may be satisfied by any one family member or by two or more family members.

Treatment or Service for which benefits are reduced because a medical necessity review determines that Treatment or Service in whole or in part is not a Covered Charge will not count toward satisfaction of the Out-of-Pocket Expense Limit.

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 count toward satisfaction of the Out-of-Pocket Expense Limit.

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 NJ for a complete description of the Utilization Management Program.**
- For special payment conditions for certain Hospital Inpatient Confinements, see exclusions and limitations in page NBM 5402 Q NJ.
- For Mental Health Condition and Substance Use Disorder Treatment Services, **see page NBM 5402 B NJ for a complete description of the benefits payable for these services.**
- For payment conditions applicable to Transplant Services, see page NBM 5402 C HDHP NJ.

- For payment conditions applicable to Emergency Services, see page NBM 5402 D NJ.
- For payment conditions applicable to Outpatient X-Ray Services and Outpatient Laboratory Services, see page NBM 5402 G HDHP NJ.
- For payment conditions applicable to Emergency Room Services, see page NBM 5402 H HDHP NJ.

If the Insured Person is referred to a Non-PPO 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. If the Insured Person is Hospital Inpatient Confined in a Preferred Provider Hospital, and the admitting Physician is a Non-PPO Provider, the PPO level of benefits will be payable.

SPECIAL PAYMENT CONDITIONS

In-Plan Exception

An Insured Person or the Physician 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 Preferred Providers who are qualified, accessible, and available to perform the medically necessary Treatment or Service.

To request an in-plan exception, the Insured Person or the Physician 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 Deductible level.

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	60 days for all confinements resulting from the same sickness or injury
Temporomandibular Services	$1,500 during an Insured Person's lifetime

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 NJ -- Utilization Management Program or the Insured Person's benefits will be reduced.

See page NBM 5146 NJ for important claim procedures information on filing medical claims and Complaint and Appeal Procedures as described in page NBM 5407 A NJ.

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

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

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, whether provided by a Physician or non-physician practitioner;
- 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 to an available Participating Provider or network facility located within a reasonable travel distance, taking into consideration the individual's medical condition.
  - 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, as determined by the Physician or treating provider, 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 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 NJ) 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. 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 Company may contest a person's insurance at any time if the person is not eligible under the Group Policy or the contest is based on 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 insurance under the Group Policy in Writing and with 31 day notice, if the individual has performed an act that constitutes fraud or made an intentional misrepresentation of a material fact under the terms of the Group Policy.

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".

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 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 60 days after the date of the birth and enrollment is made within 31 days after the later of the date of the marriage, Civil Union Partner relationship, 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, the Member's spouse or Dependent Child if:

(i) the Member is enrolled but failed to enroll the spouse or 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 spouse or 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, the spouse or Dependent Child's insurance will be the first of the Insurance Month coinciding with or next following the date of the enrollment.

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

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

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

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

(i) the Member or Dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage and request for enrollment is made within 60 days after the date coverage is terminated; or
(ii) the Member or Dependent becomes eligible for premium assistance under Medicaid or CHIP to purchase coverage under the Group Policy and request for enrollment is made within 60 days after the date eligibility for premium assistance is determined.

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

Effective Date for Benefit Changes

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

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

Termination

Unless continued as provided below or on page NBM 5117 A NJ, NBM 5117 B NJ, NBM 5117 C, and NBM 5117 D NJ, 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 last contribution is made for the Member's insurance; 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 the Member recovers; or
- the date the Member is re-employed and eligible for other group medical expense coverage; or

- the date insurance would otherwise terminate as described above, but in no event longer than six consecutive months.

In no event will the Member's Medical Expense Insurance terminate solely because the Member is sick or injured.

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

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

The Member's coverage may also be continued, by paying the required contribution, if any, under the continuation provisions described on page NBM 5117 A NJ, NBM 5117 B NJ, NBM 5117 C, and NBM 5117 D NJ.

All continuation options listed above 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.

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. No premium will be charged for the child's coverage during the 60-day period following the date of birth, adoption or Placement for Adoption.

However, if the Member is required to contribute toward the cost of Dependent insurance, the Member must notify the Company within 60 days after the date of birth, adoption or Placement for Adoption, in order to continue the child's insurance beyond the 60-day period. If such notice is not given to the Company within the 60-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 NJ.

If the child's insurance terminates because the Member fails to enroll for insurance (or pay the required contribution) within the 60-day period following the child's date of birth, adoption or Placement for Adoption, benefits will be payable only for Covered Charges incurred by the child during the 60-day period in which insurance was in force. The Extended Benefits (after termination of insurance) will not apply to the child.

Individual Incontestability and Eligibility

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

Termination

Unless continued as provided on page NBM 5117 A NJ, NBM 5117 B NJ, NBM 5117 C and NBM 5117 D NJ:

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

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

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

Continuation

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

See the continuation provisions described on page NBM 5117 A NJ, NBM 5117 B NJ, NBM 5117 C and NBM 5117 D NJ.

Contact the Policyholder with reinstatement questions.

MEDICAL EXPENSE INSURANCE

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 - $1,500 Family - $3,000	Individual - $3,000 Family - 6,000
Out-of-Pocket Expense Limits	Individual - $1,500 Family - $3,000	Individual - $5,000 Family - $10,000

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 Partnership 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 NJ.

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 HDHP NJ, 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 amount; and
- at the Coinsurance payment percentages indicated; and
- to the applicable Maximum Payment Limit;

as described in Summary of Benefits section, page NBM 5102 HDHP NJ.

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 NJ.

Benefits Payable

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

- all listed terms, conditions, additional exclusions and limitations; and
- the terms, conditions and limitations of Utilization Management Program as described in page NBM 5407 CC NJ and Coordination With Other Benefits as described in page NBM 5156 NJ.

Benefits Payable – Required by Federal Law

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

- **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**

  Under Federal law, Group Health Plans and health insurance issuers offering group health coverage 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., the Insured Person's Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

  Also, under Federal law, the plan and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

  In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce the Insured Person's out-of-pocket costs, the Insured Person may be required to obtain precertification. For information on precertification, contact the plan administrator.

  See "Maternity Coverage" under Benefits Payable - State Required - New Jersey below for a 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, the New Jersey Department of Health, 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 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 Breast Surgery" under Benefits Payable – State Required – New Jersey 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/.

Preventive Health and Wellness Services from PPO Providers will be payable at 100% and no Deductible 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 Participating 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 Participating Pharmacy or PPO Provider for generic and single source contraceptive drugs will be payable at 100%. Benefits for Covered Charges from a Participating 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-Participating 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.

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 – New Jersey

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

- **Adolescent Depression Screenings**

  Covered Charges will include charges incurred for screening adolescents between the ages of 12 and 18 for major depressive disorder, so long as screening for major depressive disorder in adolescents continues to receive a rating of "A" or "B" from the United States Preventative Services Task Force. Benefits will not be denied solely on the basis that the screening is provided in conjunction with any other health care evaluation, treatment, or service.

  Benefits will be payable the same as for any other covered Treatment or Service. Benefits will be payable with no cost-sharing, including, but not limited to, deductibles, or coinsurance.

  Benefits will be coordinated with the Preventive Services benefit as described below.

- **Autism and Other Developmental Disabilities**

  Covered Charges will include charges incurred by an Insured Person for screening and diagnosing autism or another developmental disability. Insurance will include medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan.

  Benefits will be payable the same as for any other covered Treatment or Service and will include insurance for expenses incurred by an Insured Person participating in an individualized family service plan through a family cost share.

  For an Insured Person with a primary diagnosis of autism, Covered Charges will include:

  - charges for medically necessary behavioral interventions based on the principles of applied behavioral analysis (ABA) and related structured behavioral programs for treatment of autism.

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

The treatment plan will include, but is not limited to:

- a diagnosis;
- proposed treatment by type, frequency, and duration;
- anticipated outcomes stated as goals;
- frequency by which the treatment plan will be updated; and
- the treating physician's signature.

- **Breastfeeding Support Services and Supplies**

Covered Charges will include charges incurred for comprehensive lactation support, counseling, and consultation, and the costs for renting or purchasing breastfeeding equipment, in conjunction with each birth, for the duration of breastfeeding for Insured Persons.

Coverage of breastfeeding equipment will include:

- Purchase of a single-user breast pump, subject to the following conditions:
  - The purchase of a double electric breast pump. If an Insured Person requests a manual pump in lieu of the double electric breast pump, the Company will cover the purchase of a manual pump.
  - A double electric breast pump of sufficient power and durability to establish and maintain milk supply for the duration of breastfeeding.
  - Documentation of medical necessity, prior authorization, or a prescription for a breast pump provided will not be required.
  - Coverage will be available at any time during pregnancy and the postpartum period, and will continue for the duration of breastfeeding as defined by the Insured Person.
  - Coverage for breast pumps will include repair or replacement if necessary.
- Rental or purchase of a multi-user breast pump, on the recommendation of a licensed Physician, subject to the following conditions:
  - When recommended by a licensed Physician, coverage for a multi-user breast pump.
  - The Company may determine whether a rental or purchase is covered.
  - Coverage for a multi-user breast pump will be covered without regard to coverage or acquisition of a single-user breast pump.
  - The Company may require a letter of medical necessity from a Lactation Consultant or other Physician for coverage of a multi-user pump. The letter will not interfere with the timely acquisition of a multi-user pump.

- Coverage of breastfeeding equipment will include two Breast Pump Kits per birth event, as well as appropriate size breast pump flanges, or other lactation accessories recommended by a Physician.
- Breastfeeding equipment for a single-user breast pump will be furnished: within 48 hours of notification of need, if requested after the birth of the child; or by the later of two weeks before the Insured Person's expected due date or 72 hours after notification, if requested prior to the birth of the child. If the Company cannot ensure an Insured Person receives breastfeeding equipment within 48 hours, an Insured Person may purchase the equipment and the Company will reimburse all out-of-pocket expenses incurred by the Insured Person, including any balance billing amounts.
- Breastfeeding equipment for a multi-user breast pump will be made available within 12 hours of notification of need. If equipment is not available within 12 hours of notification of need, the Company will reimburse all out-of-pocket rental expenses incurred by an Insured Person, including any balance billing amounts, until the Insured Person receives breastfeeding equipment.

Coverage of comprehensive Lactation Counseling and Lactation Consultation will include:

- In-person, one-on-one Lactation Counseling and Lactation Consultation, subject to the following conditions:
  - Coverage will include visits that occur inside and outside a Hospital or office setting. In-person Lactation Counseling and Lactation Consultation will be covered regardless of location and will include home visits.
  - Lactation Counseling and Lactation Consultation will be made available within 24 hours of notification of need.
- Telephonic Lactation Assistance will be covered in addition to, and not as a substitute for, in-person, one-on-one Lactation Counseling or Lactation Consultation, when an Insured Person requests one-on-one, in-person Lactation Counseling or Lactation Consultation. The Telephonic Lactation Assistance will be provided within 12 hours of notification of need.
- Group Lactation Counseling will be covered in addition to, and not as a substitute for, one-on-one, in-person Lactation Counseling or Lactation Consultation, if an Insured Person requests one-on-one, in-person Lactation Counseling or Lactation Consultation. Group counseling will include educational classes and support groups.
- Prior authorization, prescription or referral for any Lactation Counseling or Lactation Consultation will not be required, regardless of provider type or setting.
- The Company will not impose medical management techniques not described in this provision.

"Cost-Sharing" means Deductible, coinsurance or co-payments, or similar charges.

"Breast Pump Kit" means a collection of tubing, valves, flanges, collection bottles, or other parts required to extract human milk using a breast pump.

"Lactation Consultant" means an individual who is an International Board Certified Lactation Consultant.

"Lactation Consultation" means the clinical application by a Lactation Consultant or other licensed health care provider of scientific principles and a multidisciplinary body of evidence for evaluation, problem identification, treatment, education, and consultation to child-bearing families utilizing Lactation Care and Services.

"Lactation Care and Services" will include, but not be limited to:
- lactation assessment through the systematic collection of subjective and objective data;
- analysis of data and creation of a plan of care;
- implementation of a lactation care plan with demonstration and instruction to parents and communication to the primary health care provider;
- evaluation of outcomes;
- provision of lactation education to parents and health care providers; and
- the recommendation and use of assistive devices.

"Lactation Counseling" means breastfeeding education and support services provided by a Lactation Counselor, such as:
- educating women, families, health care professionals, and the community about the impact of breastfeeding and human lactation on health and what to expect in the normal course of breastfeeding;
- acting as an advocate for breastfeeding as the norm for feeding infants and young children;
- providing breastfeeding support, encouragement, and care from preconception to weaning in order to help women and their families meet their breastfeeding goals;
- using principles of adult education when teaching clients, health care providers, and others in the community; and
- identifying and referring high-risk mothers and babies and those requiring clinical treatment appropriately.

"Lactation Counselor" means an individual, other than an International Board Certified Lactation Consultant or a licensed health care provider, who is:

- licensed or certified to practice Lactation Counseling under any law, or who is an accredited member belonging to another profession or occupation, who provides breastfeeding education and support services for which that person is licensed, regulated, accredited, or certified; or
- a community-based lactation supporter who has received at least 40 hours of specialty education in breastfeeding and lactation, and who works within a Lactation Counselor's scope of practice.

"Telephonic Lactation Assistance" means Lactation Counseling or consultation with a Lactation Counselor or Lactation Consultant conducted remotely through live voice communication.

For the purposes of this provision, the term Physician includes a person who is an International Board Certified Lactation Consultant or a Lactation Counselor.

Benefits will be payable with no Cost-Sharing.

Benefits will be coordinated with the Preventive Services benefit as described below.

- **Cancer Treatment**

Covered Charges will include charges incurred by the Insured Person for Treatment or Service for cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants when such treatment is performed by institutions approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Benefits will be payable the same as for any other covered Treatment or Service.

- **Child Immunizations**

Covered Charges will include charges incurred by a Dependent Child for immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health, or such other list of vaccines as mandated by other federal or state laws that are applicable to the Group Policy.

Benefits will be paid at 100% of Prevailing Charges and no Deductible will be applied.

Note: This benefit will be coordinated with the Pediatric Vaccine benefit as described above under Benefits Payable – Required by Federal Law.

- **Colorectal Cancer Screening**

Covered Charges will include charges incurred for colorectal cancer screening.

Benefits will be payable for Insured Persons:

- age 50 and over; and
- any age if the Insured Person is considered high risk for colorectal cancer.

"High risk for Colorectal cancer" means a person has:

- a family history of:
  - familial adenomatous polyposis;
  - hereditary non-polyposis colon cancer;
  - breast, ovarian, endometrial or colon cancer polyps;
- chronic inflammatory bowel disease; or
- a background, ethnicity or lifestyle that the Physician believes puts the person at elevated risk for colorectal cancer.

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

Benefits will be coordinated with the Preventive Services benefit as described below.

- **Congenital Defects and Birth Abnormalities**

Covered Charges will include charges incurred for newly born children for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

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

- **Contraceptive Drugs, Devices and Services**

Covered Charges from a Participating Pharmacy or PPO Provider will include charges for prescription female contraceptives and the following services, drugs, devices, products, and procedures:

- Any contraceptive drug, device or product approved by the United States Food and Drug Administration, subject to all of the following conditions:
  - If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, coverage will be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.
  - Coverage will be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.
  - Coverage will be provided without any infringement upon an Insured Person's choice of contraception and medical necessity will be determined by the Physician for covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.
- Voluntary male and female sterilization.
- Patient education and counseling on contraception.
- Services related to the administration and monitoring of drugs, devices, products and services, including but not limited to:
  - Management of side effects;
  - Counseling for continued adherence to a prescribed regimen;
  - Device insertion and removal;
  - Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the Insured Person's Physician; and
  - Diagnosis and treatment services provided pursuant to, or as a follow-up to, a service covered.

The coverage provided will include prescriptions for dispensing contraceptives for:

- a three-month period for the first dispensing of the contraceptive; and
- a six-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the Group Policy was in effect at the time of the first dispensing, except that the Company will provide coverage for a supply of contraceptives that is for less than a six-month period, if a six-month period would extend beyond the term of the Group Policy.

Benefits from a Participating Pharmacy or PPO Provider will be payable at 100% of Prevailing Charges and no Deductible will apply and will be coordinated with the Contraceptive Methods and Counseling for Women benefit described above. Benefits from a Member Pharmacy or PPO Provider for male sterilization procedures or male contraceptives will be provided at the lowest Deductible and coinsurance permitted for a high deductible health plan under Federal law.

The above services from a Non-Participating Pharmacy or Non-PPO Providers will be subject to Deductible and Coinsurance. Benefits for voluntary sterilization procedures from Non-PPO Providers will not be payable.

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 Hospital Procedures**

Covered Charges will include charges incurred for general anesthesia and hospitalization for dental Treatment or Service. Benefits will be payable for an Insured Person who:

- is age five or under; or
- is severely disabled; and
- has a covered medical condition that requires hospitalization or general anesthesia for dental Treatment or Service rendered by a Dentist regardless of where the dental Treatment or Service is provided.

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

- **Diabetic Supplies and Self-Management Education**

Covered Charges will include charges incurred by the Insured Person for the Treatment or Service of diabetes. Benefits will be payable for:

- blood glucose monitors;
- blood glucose monitors for the legally blind;
- test strips for glucose monitors and visual reading and urine testing strips;
- insulin;
- injection aids;
- cartridges for the legally blind;
- syringes;
- insulin pumps and appurtenances;
- insulin infusion devices; and
- oral agents for controlling blood sugar.

In addition, Covered Charges will include charges incurred for diabetes self-management education, including information on proper diets, when medically necessary and diagnosed by a Physician or nurse practitioner or clinical nurse specialist.

The following licensed health care providers may provide the diabetes self-management education:

- a dietitian registered by a nationally recognized professional association of dietitians;
- a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or
- a registered pharmacist in the state, qualified with regard to management education for diabetes by an institution recognized by the board of pharmacy of the state of New Jersey.

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

NOTE: For the purpose of these state-required benefits, refer to Prescription Drugs 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 this section.

- **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, when:

- the Insured Person is an infant under the age of 6 months; and
- the milk is obtained from a human milk bank that meets quality guidelines established by the Department of Health; and
- a Physician has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; or
- a Physician has issued an order for an infant who meets any of the following conditions:
    - a body weight below healthy levels determined by the Physician;
    - a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis; or

- a congenital or acquired condition that may benefit from the use of donor breast milk as determined by the Department of Health.

This benefit may be subject to utilization review, including periodic review, regarding the medical necessity of pasteurized donated human breast milk.

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 an impairment of fertility caused by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

"May Directly or Indirectly Cause" means a medical treatment with a likely side effect of Iatrogenic Infertility as established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.

"Standard Fertility Preservation Services" means procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health. “Standard Fertility Preservation Services” shall not include the storage of sperm or oocytes.

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

- **FDA Approved Drugs**

Covered Charges will include charges for prescribed drugs approved by the federal Food and Drug Administration (FDA) for any drug prescribed for a condition not specifically noted in the FDA’s approval of the drug, if the drug has been recognized for treatment of that condition by one of the following:

- the American Medical Association Drug Evaluation; or
- the American Hospital Formulary Service Drug Information; or
- the United States Pharmacopeia Drug Information; or
- a clinical study or review article in a major peer-reviewed professional journal.

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

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

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

- **Health Wellness Promotion**

Covered Charges will include charges incurred by an Insured Person for Health Wellness Promotion. Benefits will be payable for:

- annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level; and
- a glaucoma eye test every five years; and
- an annual stool examination for presence of blood; and
- a left-sided colon examination of 35 to 60 centimeters every five years; and
- a pap smear as described below in Pap Smear Screening in this section; and
- a mammogram examination as described below in Mammography Screening in this section; and
- for adults, recommended immunizations; and
- annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

If the Physician or other health care provider recommends that it would be medically appropriate for the Insured Person to receive a different schedule of tests and services than shown above, the Company will provide payment for the tests or services actually provided.

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

Benefits will be coordinated with the Preventive Services benefit as described below.

- **Hearing Aids**

Covered Charges will include expenses incurred in the purchase of a hearing aid for an Insured Person 15 years of age or younger. Insurance includes the purchase of a hearing aid for each ear when medically necessary and as prescribed or recommended by a licensed Physician or audiologist. The benefit is limited to $1,000 per hearing aid for each hearing-impaired ear every 24 months.

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

- **Hearing Loss Screening for Newborns and Infants**

Covered Charges will include charges incurred for Newborn Hearing Loss screening by appropriate Electrophysiologic Screening Measures, and periodic monitoring of Infants for delayed onset Hearing Loss.

"Hearing Loss" means a hearing loss of 30dB or greater in the frequency region important for speech recognition and comprehension in one or both ears, which is approximately 500 through 4000Hz.

"Newborn" means a child up to 28 days old.

"Infant" means a child between the age of 29 days and 36 months.

"Electrophysiologic Screening Measures" means the electrical result of the application of physiologic agents and includes, but is not limited to:

- the procedures currently known as Auditory Brainstem Response testing (ABR); and
- Otoacoustic Emissions testing (OAE), and
- any other procedure adopted by the Commissioner of Health.

Benefits will be payable the same as for any other covered Treatment or Service, except no Deductible will apply.

Benefits will be coordinated with the Preventive Services benefit as described below.

- **Home Treatment of Hemophilia**

Covered Charges will include charges incurred by the Insured Person for treatment of routine bleeding episodes associated with hemophilia. Benefits payable will include the purchase of blood products and Blood Infusion Equipment required for home treatment of routine bleeding infusion episodes associated with hemophilia when the home treatment program is under the supervision of a state approved hemophilia treatment center.

"Blood product" includes, but is not limited to, Factor VIII, Factor IX and cryoprecipitate. "Blood Infusion Equipment" includes, but is not limited to, syringes and needles.

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

- **Initial Prescription for Opioid Drugs**

For an Initial Prescription of an opioid drug prescribed for the treatment of Acute Pain in a quantity or amount that is less than a 30-day supply, the Company will either:

- apply a prorated daily cost-sharing rate for the Initial Prescription and any additional supply of the opioid drug prescribed within the same 30-day period will also be prorated; or
- apply the full 30-day cost-sharing rate for the Initial Prescription and there will be no additional cost-sharing for any additional supply of the opioid drug prescribed within the same 30-day period.

"Acute Pain" means pain, whether resulting from disease, accidental or intentional trauma, or other cause, that the Physician reasonably expects to last only a short period of time. Acute Pain does not include chronic pain, pain being treated as part of cancer care, hospice or other end of life care, or pain being treated as part of palliative care.

"Initial Prescription" means a prescription issued to an Insured Person who:

- has never previously been issued a prescription for the drug or its pharmaceutical equivalent; or
- was previously issued a prescription for the drug or its pharmaceutical equivalent, but the date of the current prescription is more than one year after the date the patient last used or was administered the drug or its equivalent, as determined by the prescribing Physician.

- **Infant Formulas – Specialized Non-Standard**

Covered Charges will include charges incurred for specialized non-standard infant formulas when the:

- Physician has diagnosed the infant as having multiple food protein intolerance, and has determined such formula to be medically necessary; and
- infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

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

- **Infertility Treatment**

  - **Covered Charges**

    Covered Charges will include charges incurred for covered services in the diagnosis and treatment of Infertility including, but not limited to, the following Treatment or Service:

    - artificial insemination with no limit as to the number of cycles;
    - assisted hatching;
    - diagnosis and diagnostic tests;
    - fresh and frozen embryo transfer;
    - while insured under the Group Policy, four (4) completed egg retrievals, including insurance for the donor while under the care of a reproductive endocrinologist;
    - gamete intra fallopian transfer;
    - intracytoplasmic sperm injection;
    - in vitro fertilization;
    - medications;
    - ovulation induction;
    - surgery, including microsurgical sperm aspiration.

    Treatment or Service must be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

    Covered Charges will include charges incurred by an Insured Person for Infertility Treatment or Service as described above. Benefits will be payable the same as for any other covered Treatment or Service.

  - **Charges Not Covered**

    Benefits are not payable for the following:

    - reversal of voluntary sterilization;
    - medical services to a surrogate for the purposes of childbearing not covered by the Group Policy;
    - costs associated with cryopreservation and storage of sperm, eggs and embryos;
    - nonmedical costs of an egg or sperm donor;
    - treatment that is considered an Experimental or Investigational Measure;
    - ovulation kits and sperm testing kits and supplies;

- in vitro fertilization, gamete intra fallopian tube transfer and zygote intra fallopian tube transfer for persons who:

  - have not used all reasonable less expensive and medically appropriate treatment for Infertility;
  - have exceeded the limit of four (4) completed egg retrievals;
  - are 46 years of age or older;

- Infertility medications provided under another group health insurance policy issued to the Policyholder;

- Infertility resulting from voluntary sterilization procedures.

- **Definition**

Infertility" means:

- A disease or condition that results in the abnormal function of the reproductive system as determined pursuant to American Society for Reproductive Medicine practice guidelines by a Physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the Insured Person has met one of the following conditions:

  - a male is unable to impregnate a female;
  - a female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
  - a female with a male partner and 35 years of age and over is unable to conceive after 6 months of unprotected sexual intercourse;
  - a female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
  - a female without a male partner and over 35 years of age who is unable to conceive after 6 failed attempts of intrauterine insemination under medical supervision;
  - partners are unable to conceive as a result of involuntary medical sterility;
  - a female is unable to carry a pregnancy to live birth; or
  - a previous determination of Infertility.

- **Inherited Metabolic Disease**

Covered Charges will include charges incurred by the Insured Person for Medical Foods and Low Protein Modified Food Products prescribed by a Physician for the treatment of Inherited Metabolic Diseases.

"Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry for which testing is required.

"Low Protein Modified Food Product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of this disease, but does not include a natural food that is naturally low in protein.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Physician.

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

- **Lead Poisoning Screening**

Covered Charges will include charges incurred by Dependent Children for screening for lead poisoning, including:

- confirmatory blood lead testing as specified by the New Jersey Department of Health; and
- medical evaluation; and
- any necessary follow-up evaluations and treatment.

Benefits for lead poisoning screening will be payable the same as for any other Treatment or Service except that no Deductible will be applied. Benefits for follow-up evaluations and treatment will be payable the same as any other covered Treatment or Service.

Benefits will be coordinated with the Preventive Services benefit as described below.

- **Mammography Screening**

Covered Charges will include charges incurred for Mammography Screening.

Covered Charges will also include an ultrasound evaluation, a magnetic resonance imaging scan, a three-dimentional mammography, or other additional testing of an entire breast or breasts, if:

- A baseline mammogram examination:
  - demonstrates extremely dense breast tissue;
  - is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
- the patient has additional risk factors for breast cancer including, but not limited to:
  - family history of breast cancer;
  - prior personal history of breast cancer;
  - positive genetic testing;
  - extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
  - other indications as determined by the patient's health care provider.

This benefit may be subject to utilization review, including periodic review, regarding the medical necessity of the additional screening and diagnostic testing.

Benefits for digital tomosynthesis conducted to detect or screen for breast cancer in women 40 years of age and over will be payable at 100% and no Deductible or Copay will apply. Benefits for digital tomosynthesis conducted for diagnostic purposes in women of any age will be payable the same as any other covered Treatment or Service.

If services are provided by a PPO provider, benefits for outpatient, clinic or office-based screening mammograms for women forty (40) 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 Services.

Benefits will be coordinated with the Preventive Services benefit as described below.

- **Mastectomy**

Covered Charges will include charges incurred by the Insured Person for mastectomy for the Treatment or Service of breast cancer. Benefits will be payable for Hospital Inpatient Confinement Charges for a minimum of 72 hours following a modified radical mastectomy and a minimum of 48 hours following a simple mastectomy. Benefits will be payable the same as for any other covered Treatment or Service; however, the 72-hour and 48-hour minimum will not be subject to the Precertification or Covered Charges requirements of the Group Policy. Any benefits in excess of the 72-hour or 48-hour minimum will be subject to all terms and conditions of the Group Policy that apply to any other Treatment or Service.

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

- **Maternity Coverage**

Covered Charges will include Hospital Inpatient Confinement Charges incurred by a mother and newly born child 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 Covered Charges requirements of the Group Policy. Any benefits payable in excess of the 48-hour and 96-hour minimum requirement will be subject to all terms and conditions of the Group Policy that apply to any other condition.

- **Orally Administered Anticancer Medications**

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

The level of benefits provided for orally administered anticancer medications will not be less than the level of benefits provided for intravenously administered or injected anticancer medications, i.e., the insurance cannot be subject to any prior authorization, dollar limit, Copayment, Deductible, or Coinsurance that does not apply to intravenously administered or injected anticancer medications.

- **Orthotic and Prosthetic Appliances**

Covered Charges will include charges incurred for expenses incurred in obtaining an Orthotic Appliance or Prosthetic Appliance as determined medically necessary by the Insured Person's Physician.

Benefits for services provided by a PPO Provider or a Non-PPO Provider will be payable the same as for any other Physician Office or Clinic Service, but benefits for a Non-PPO Provider are subject to the maximum benefit payable under the federal Medicare reimbursement schedule.

"Orthotic Appliance" means a brace or support, but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

"Prosthetic Appliance" means any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage, or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs, or other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

- **Pap Smear Screening**

Covered Charges will include charges incurred by the Insured Person for Pap Smear screening.

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

Benefits will be coordinated with the Preventive Services benefit as described below.

- **Prescription Eye Drop Refills**

Covered Charges will include charges for prescription eye drop refills according to the Guidance for Early Refill Edits of Topical Ophthalmic Products provided by the Centers for Medicare and Medicaid Services, provided that:

- the prescribing Physician indicates on the original prescription that additional quantities of the prescription eye drops are needed; and
- the refill requested by the Insured Person does not exceed the number of additional quantities indicated on the original prescription by the prescribing Physician.

- **Preventive Services**

Covered Charges will include charges for the following preventive 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;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention;
- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, any additional preventive care and screenings not described above as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Benefits will be coordinated with the Preventive Health and Wellness Services benefit as described above under Benefits Payable – Required by Federal Law.

Preventive Services from PPO Providers will be payable at 100% and no Deductible will apply. Preventive 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 Service to the extent such service is not specified in the guidelines or recommendations.

- **Prostate Cancer Screening**

Covered Charges will include charges incurred by the Insured Person for annual screenings for prostate cancer. The screening must consist, at a minimum, of the following tests:

- digital rectal examination; and
- a prostate-specific antigen (PSA) blood test.

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

Benefits will be coordinated with the Preventive Services benefit as described above.

- **Reconstructive Breast Surgery**

Covered Charges will include charges incurred by the Insured Person for Treatment or Service for reconstructive breast surgery performed as a result of a mastectomy on one or both breasts, for surgery to restore and achieve symmetry between the two breasts, for the cost of prostheses and the cost of outpatient chemotherapy following a surgical procedure performed in connection with 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.

- **Sickle Cell Anemia Treatment**

Covered Charges will include charges incurred by the Insured Person for Treatment or Service for sickle cell anemia, including the cost of prescription drugs associated with the Treatment or Service. Benefits will be payable the same as for any other covered Treatment or Service.

- **Speech and Hearing Disorders**

Covered Charges will include charges incurred by the Insured Person for Treatment or Service of speech and hearing disorders. Services must be determined by a Physician to be medically necessary, and performed or rendered by a licensed audiologist or speech-language pathologist within the scope of their practice.

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

- **Synchronized Prescription Fills/Refills**

Covered Charges will include charges incurred for synchronization of prescription drug medications. At least one time per year for each Insured Person, the Company must:

- apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a network pharmacy for less than a 30 days' supply, if the prescriber or pharmacist indicates the fill or refill is:
  - in the best interest of the Insured Person; or
  - is for the purpose of synchronizing the Insured Person's chronic medications;
- provide insurance for a drug prescribed for the treatment of a chronic illness dispensed according to a plan between the Insured Person, the prescriber and the pharmacist to synchronize the refilling of multiple prescriptions for the Insured Person; and
- determine dispensing fees based exclusively on the total number of prescriptions dispensed; and
- dispensing fees must not be prorated or based on the number of the days' supply of medication prescribed or dispensed.

These requirements do not apply to prescriptions for Opioid Analgesics.

"Opioid Analgesic" means a drug in the Opioid Analgesic drug class prescribed to treat moderate to severe pain or other conditions:

- whether in immediate release or extended release form; and
- whether or not combined with other drug substances to form a single drug product or dosage form.

- **Telehealth and Telemedicine Services**

Covered Charges will include charges by a PPO Provider or Non-PPO Provider for medically necessary Treatment or Service delivered through Telehealth or Telemedicine.

"Telehealth" means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services according to the provisions of the telehealth and telemedicine rules.

"Telemedicine" means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider, and according to the provisions of the telehealth and telemedicine rules. "Telemedicine" does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

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

- **Wilm's Tumor**

Covered Charges will include charges incurred by the Insured Person for Treatment or Service of Wilm's tumor, including autologous bone marrow transplants when chemotherapy is unsuccessful, even though such treatment may be experimental or investigational.

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

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, additional exclusions and limitations; and
- all Payment Provisions as described in page NBM 5400 NJ; and
- the terms, conditions and limitations of Utilization Management Program as described in page NBM 5407 CC NJ and Coordination With Other Benefits as described in page NBM 5156 NJ.

COVERED CHARGES

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

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

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

NOTE: If the Company fails to pay for a listed Covered Charge under the Group Policy for any reason, the Insured Person will have no financial liability for payments due to Preferred Providers for any sums, other than any required Copays, Deductibles, and Coinsurance.

- **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 and Surgery 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; and
  - the services of a Physician for surgery received in a Physician's office, clinic or an Ambulatory Surgery Center.

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

  - charges for Treatment or Service furnished at the Physician's office or clinic other than charges for surgery or anesthesia received in a Physician's office, clinic or Ambulatory Surgery 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; and
  - the services of a Health Care Extender; and
  - outpatient physical, occupational, and speech therapy not to exceed 30 visits per Calendar Year for each Insured Person; 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.
  - Telemedicine or Telehealth Treatment or Service; and
  - Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine).

- **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 as described in page NBM 5402 R HDHP NJ; and
  - Contraceptive methods and counseling for women as described in page NBM 5400 NJ; 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 as determined by the Company; and
  - surgical dressings, supplies, covered orthotics, casts, splints, braces, crutches, artificial limbs, artificial eyes, and other prosthetic appliances (including repair, maintenance, and replacements which are functionally necessary; and equipment not considered to be Durable Medical Equipment as described in page NBM 5402 J NJ; and

- Skilled Nursing Facility Care as described in page NBM 5402 M NJ; and
- Hospice Care as described in page NBM 5402 L NJ; and
- Home Health Care as described in page NBM 5402 I NJ; and
- Home Infusion Therapy Services, for other than Home Treatment of Hemophilia, as described in page NBM 5402 I NJ; and
- Durable Medical Equipment as described in page NBM 5402 J NJ; and
- the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), but only when such services are provided as part of Home Health Care, Home Infusion Therapy Services or Hospice Care as required by state law; and
- cornea or skin transplants; and
- anesthesia received in a Physician's office or clinic or an Ambulatory Surgery Center; 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
- Dental Services to repair damages to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within twelve months after the accident. Covered Charges are limited to the least expensive procedure that would provide professionally acceptable results; and
- Temporomandibular Services, limited to a lifetime maximum benefit of $1,500 for each Insured Person. These services will not include services for orthodontic procedures or restoration of the dentition, supporting tissues, and bone; and
- unattended (home) sleep studies.

Drug and Medicine Management

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

- require prior authorization for dispensing; and
- limit the quantity of drugs for which benefits will be paid; and
- require the dispensing of a single daily dose of certain drugs.

For more information about prescription drug insurance, the Insured Person can call the number on the Insured Person's ID card. By accessing the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com, the Insured Person can review the Formulary or prior authorization requirements.

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, except Treatment or Service for Reconstructive Breast Surgery and Congenital Defects and Birth Abnormalities is not subject to the 18 months restriction. 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.

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

MENTAL HEALTH CONDITION AND SUBSTANCE USE DISORDER TREATMENT SERVICES

The following benefits will be payable for Mental Health Condition and Substance Use Disorder 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, as determined by the Company.

- **Inpatient Hospital Services**

  If an Insured Person is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Substance Use Disorder Treatment Facility, or a psychiatric or a Substance Use Disorder 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 under the Same Terms and Conditions. Hospital Inpatient Confinements are subject to the Utilization Management Program, including Precertification requirements, as described on NBM 5407 CC NJ.

- **Outpatient Services**

  If an Insured Person receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Community Mental Health Center, or Outpatient Substance Use Disorder Treatment Facility, benefits will be payable under the Same Terms and Conditions.

  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 Condition and Substance Use Disorder Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined.

  Covered Charges for Outpatient Services include but are not 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 Substance Use Disorder medication management;
- biofeedback;
- behavior modification treatment;
- Substance Use Disorder 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 Condition and Substance Use Disorder 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 Condition and Substance Use Disorder Treatment Services by a Physician or Health Care Extender, benefits will be payable under the Same Terms and Conditions.

- **Benefits Payable**

Benefits for Mental Health Condition and Substance Use Disorder Treatment Services are payable the same as for any other covered Treatment or Service.

- **Substance Use Disorder Treatment or Service from PPO Providers**

Benefits payable will include charges incurred by an Insured Person for Inpatient Services or Outpatient Services for Substance Use Disorder from PPO Providers. Covered Charges incurred for Inpatient Services or Outpatient Services for Substance Use Disorder from PPO Providers are not subject to the Precertification requirements of the Utilization Management Program, as described on NBM 5407 CC NJ for the first 180 days per Calendar Year. However, the Insured Person or his or her designated representative must notify the Company of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility and the initial treatment plan within 48 hours of the admission or initiation of treatment.

Covered Charges incurred for Inpatient Services or Outpatient Services for Substance Use Disorder from PPO Providers after the first 180 days per Calendar Year will be subject to the medical necessity determinations of the Company and the Precertification requirements of the Utilization Management Program, as described on NBM 5407 CC NJ.

Covered Charges for Inpatient Services will be subject to concurrent review beginning on day 29 of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility. A request for approval of Inpatient Services beyond the first 28 days of confinement must be submitted for a concurrent review before the expiration of the initial 28-day period. All subsequent requests for approval of Inpatient Services beyond any period that is approved under concurrent review must be submitted before the expiration of the period that is currently approved.

A concurrent review is a review by the Company of a Physician's report of the need for continued Inpatient Services. The report (verbal or Written) must include the:

- reason(s) for requesting continued Inpatient Services; and
- significant symptoms, physical findings, and treatment plan; and
- Treatment or Services provided or to be provided 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 Inpatient Services that are in excess of those approved by the Company for Hospital Inpatient Confinement or confinement in an inpatient confinement facility will not be considered Covered Charges.

If the Company determines that continued Inpatient Services are not considered a Covered Charge, the Company will provide Written notice to the Insured Person, the Insured Person's Physician, and the Hospital or inpatient confinement facility within 24 hours. The Insured Person has the right to request an expedited internal appeal review of the Adverse Benefit Determination. The Company will review the expedited internal appeal and make a decision within 24 hours of receipt of the expedited internal appeal request. The Company will communicate its decision to the Insured Person and the Insured Person's Physician.

If the Company's decision is to uphold the Adverse Benefit Determination, the Insured Person and the Insured Person's Physician have the right to request an expedited external appeal through the Independent Health Care Appeals Program (IHCAP) to an independent IURO. An independent review organization will make a determination within 24 hours of receipt of the expedited external appeal.

If the IURO upholds the Company's Adverse Benefit Determination, the Company will continue to provide benefits for Covered Charges incurred for Inpatient Services through the day following the date the determination by the IURO is made. The Insured Person will only be responsible for any applicable Deductibles and Coinsurance for the Inpatient Services through that date. The Insured Person will not be discharged or released from the Hospital or inpatient confinement facility until all internal appeals and independent utilization review organization appeals are exhausted. Any charges incurred for Inpatient Services after the day following the date the determination by the IURO is made until the day of discharge, the Insured Person will only be responsible for any applicable cost-sharing, and any additional charges will be paid by the Hospital or inpatient confinement facility or Physician.

Covered Charges for intensive Outpatient Services, Partial Hospitalization or Day Treatment Services will be subject to Post-Service Claim review beginning on day 29 of Treatment or Services in accordance with the Post-Service Claim review requirements of the Utilization Management Program, as described on NBM 5407 CC NJ.

The first 180 days per Calendar Year will be computed based on inpatient days. Benefits may be substituted for other levels of care for inpatient days as follows:

- two outpatient visits for one inpatient day; and
- one day of extended outpatient services such as intensive Outpatient Services, Partial Hospitalization or Day Treatment Services for one inpatient day.

Covered Charges incurred for outpatient Prescription Drugs to treat Substance Use Disorders from PPO Providers are payable the same as for any other covered Treatment or Service.

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

"Inpatient Services" means Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

"Outpatient Services" mean Substance Use Disorder Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined.

For this purpose, "Substance Use Disorder" is as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and any subsequent editions and includes substance use withdrawal.

"Mental Health Condition" means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

"Same Terms and Conditions" means that the Company will not apply more restrictive non-quantitative limitations, such as utilization review and other criteria or more quantitative limitations such as Copayments, Deductibles, aggregate or annual limits or benefit limits to Mental Health Condition and Substance Use Disorder benefits than those applied to substantially all other medical or surgical benefits.

"Substance Use Disorder" means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

Charges Not Covered

The general Comprehensive Medical exclusions and limitations, as described in page NBM 5402 Q NJ, will apply to Mental Health Condition and Substance Use Disorder 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 per lifetime.

      - Acute Lymphoblastic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
      - Acute Myelogenous Leukemia - Autologous bone marrow transplant or peripheral stem cell infusion;
      - Acute Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
      - Chronic Lymphocytic Leukemia – Allogeneic bone marrow transplant or peripheral stem cell infusion;
      - Chronic Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
      - Aplastic Anemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;

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

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

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

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

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

Exception: See page NBM 5400 NJ for a description of benefits payable for Cancer Treatment and Wilm's Tumor.

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%, in excess of the applicable 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.

- **Charges Not Covered: Applicable Within the Transplant Network**

The general Comprehensive Medical exclusions and limitations listed in page NBM 5402 Q NJ will apply to Transplant Services. In addition, exclusions and 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 PPO level of benefits will be paid subject to the applicable Calendar Year Deductible.
- If the Insured Person goes to a PPO or non-PPO Physician's office or clinic and the Physician sends the x-ray(s) to a non-PPO facility, the level of benefits for Non-Preferred Providers will apply.
- If the Insured Person goes to a PPO freestanding x-ray facility, the PPO level of benefits will be paid subject to the applicable Calendar Year Deductible. If the x-ray facility is not a Preferred Provider, the level of benefits for Non-Preferred Providers will apply.

- OUTPATIENT LABORTORY SERVICES

Benefits payable for outpatient laboratory services will be 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 specimen to a PPO facility for processing, the PPO level of benefits will be paid. If the Insured Person is not seen within that facility, the PPO level of benefits will be paid subject to the applicable Calendar Year Deductible.
- If the Insured Person goes to a PPO or non-PPO Physician's office or clinic and the Physician sends the specimen to a non-PPO facility, the level of benefits for Non-Preferred Providers will apply.
- If the Insured Person goes to a PPO freestanding laboratory, the PPO level of benefits will be paid subject to the applicable Calendar Year Deductible. If the laboratory is not a Preferred Provider, the level of benefits for Non-Preferred Providers will apply.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

EMERGENCY ROOM SERVICES

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

- first, the Calendar Year Deductible; and
- then, the applicable Coinsurance percentage will be applied.

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

HOME HEALTH CARE AND HOME INFUSION THERAPY SERVICES

- HOME HEALTH CARE SERVICES

- Covered Charges

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

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

In addition, the attending Physician must certify that Home Health Care Services are necessary to prevent, delay or shorten Hospital Inpatient Confinement 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.) or 24-hour nursing care if needed on a short-term basis and authorized by the attending Physician; and
- part-time or intermittent home care by a Home Health Aide or 24-hour services if needed on a short-term basis and authorized by the attending Physician; and
- the services of a physical therapist, occupational therapist, speech therapist, or respiratory therapist; and
- nutrition services; and
- medical social work; and
- services of a registered dietician or social worker; and
- Home Health Aide services; and
- drugs and medicines which require a Physician's prescription, (unless a Covered Charge under Home Infusion Therapy Services), special meals, as well as other supplies prescribed by the attending Physician; and
- laboratory services (unless a Covered Charge under Home Infusion Therapy Services); and
- diagnostic and therapeutic services, including surgical services, performed in a Hospital outpatient department, a Physician’s office, or any other licensed health care facility if the cost of these services would have been Covered Charges had the Insured Person been Hospital Inpatient Confined.

Covered Charges for Home Health Care will be payable on the same basis as would have been payable had the Insured Person been Hospital Inpatient Confined.

- **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.

- **Charges Not Covered**

The general Comprehensive Medical exclusions and limitations listed in page NBM 5402 Q NJ 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.

- **Charges Not Covered**

The general Comprehensive Medical exclusions and limitations listed in page NBM 5402 Q NJ 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 Company will make a determination as to whether to purchase or rent the equipment based on factors such as length of expected use of equipment, frequency of service, cost of maintenance and repairs. 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.

- **Charges Not Covered**

The general Comprehensive Medical exclusions and limitations listed in page NBM 5402 Q NJ 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

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.

- **Charges Not Covered**

The general Comprehensive Medical exclusions and limitations listed in page NBM 5402 Q NJ 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 a 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 NJ.

- **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 60 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 (D.O.).

- **Charges Not Covered**

The general Comprehensive Medical exclusions and limitations listed in page NBM 5402 Q NJ 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

GENERAL EXCLUSIONS AND 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 NJ. 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, except for Treatment or Service of Wilm's Tumor as described in page NBM 5400 NJ. (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 for under Hearing Aids as described in page NBM 5400 NJ; 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), except for the treatment of Inherited Metabolic Disease as described in page NBM 5400 NJ, or special diets, except for Infant Formulas Specialized Non-Standard as described in page NBM 5400 NJ (whether or not they require a Physician's prescription); or
- wigs or hair prostheses; or
- Cosmetic Treatment or Service which does not qualify for coverage as described in page NBM 5402 A HDHP NJ; 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 as described in the definition of Custodial Care in page NBM 5136 NJ including, but not limited to dressing, bathing, preparation or feeding of meals; or
- "barrier free" home modifications, whether or not recommended by a Physician, including, but not limited to ramps, grab bars, railings or standing frames; or
- non-implantable communication-assist devices, including, but not limited to, communication boards and computers; or
- Treatment or Service for work-hardening programs or vocational rehabilitation services; or

- cryopreservation or storage; or
- Treatment or Service for education or training, except as provided for under Diabetic Supplies and Self-Management Education as described in page NBM 5400 NJ; 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 under Hospice Care as described in page NBM 5402 L NJ), marital counseling or sexual disorder therapy, except for gender identity, gender transformation, or sexual orientation; or
- Treatment or Service for which the Insured Person has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- Treatment or Service for a sickness or injury:
  - as a result of war or an act of war, occurring while the Insured Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and
  - as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, occurring while the Insured Person is serving in such forces and is outside the home area; and
  - as a result of war or an act of war while the Insured Person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and
  - as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, occurring while the Insured Person is serving in such unit and is outside the home area; and
  - as a result of war or an act of war while the Insured Person is not in the military, naval or air forces of any country, combination of countries or international organization, or in any civilian non-combatant unit supporting or accompanying such forces, occurring outside the home area; or
- Treatment or Service that results from the Insured Person's commission of or attempted commission of a felony; or
- Treatment or Service for:
  - human-to-human organ or bone marrow transplants, except as described under Transplant Services or Covered Charges; or
  - animal-to-human organ or tissue transplants; or
  - implantation within the human body of artificial or mechanical devices designed to replace human organs; or
- behavior modification or group therapy, except as provided for under Mental Health Condition and Substance Use Disorder Treatment Services as described in page NBM 5402 B NJ; or
- Treatment or Service for smoking cessation or nicotine addiction except as provided under Substance Use Disorder Treatment or Service as described in page NBM 5402 B NJ, and Preventive Health and Wellness Services as described in page NBM 5400 NJ, gambling addiction, or stress management; or

- Treatment or Service for insertion, removal or revision of breast implants, unless provided post-mastectomy; 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 that results from:
    - an injury arising 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 NJ; or
- Treatment or Service performed for the purpose of voluntary abortion; 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, except as provided under Diabetic Supplies and Self-Management Education as described in page NBM 5400 NJ, unless provided while the Insured Person is Hospital Inpatient Confined, or as provided under Home Health Care as described in NBM 5402 I NJ or Hospice Care as described in NBM 5402 L NJ; 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 as described in NBM 5102 HDHP NJ, 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; or
- Treatment or Service for vision therapy or orthoptic therapy; or
- charges for e-mail communication or e-mail consultation; or
- charges that are billed incorrectly or separately for Treatment or Service that are an integral part of another billed Treatment or Service as determined by the Company; or
- charges for venipuncture when billed with other laboratory services; or
- charges for lab specimen handling fees when billed with other laboratory services; or
- charges for Physician overhead, including but not limited to surgical suites or rooms, or equipment used to perform the particular Treatment or Service (i.e. laser equipment); or
- Treatment for non-synostotic plagiocephaly (positional head deformity) except that this limitation will not apply to cranial helmets for such deformities if more conservative treatment has been tried but has failed; or
- additional charges incurred because care was provided after hours, on a Sunday, holidays or week-end; or
- charges for heating pads, heating and cooling units, ice bags or cold therapy units; or
- Sleep studies using devices that do not provide a measurement of Apnea Hypopnea Index (AHI) and oxygen saturation; or
- charges for DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- charges for devices used specifically as safety items or to affect performance in sports-related activities; or
- Treatment or Service for gynecomastia (abnormal breast enlargement in males); 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 incurred after termination of coverage under this booklet-certificate, except as provided under Extended Benefits as described in NBM 5449 NJ; or
- charges for travel and lodging except as indicated under Transplant Services as described in page NBM 5402 C HDHP NJ; 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 as described in page NBM 5402 A HDHP NJ; or
- Treatment or Service 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, unless the cosmetic surgery is for Reconstructive Breast Surgery or Congenital Defects and Birth Abnormalities as described in page NBM 5400 NJ; or
- recreational therapy, except as provided for under Mental Health Condition and Substance Use Disorder Treatment Services; or
- art therapy, except as provided for under Mental Health Condition and Substance Use Disorder 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.

DESCRIPTION OF BENEFITS

PRESCRIPTION DRUGS

Payment Conditions

Subject to the terms, exclusions 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 for those drugs and medicines under All Other Covered Services, as described in the Summary of Benefits section.

Benefit payment will be limited to:

- Covered Charges as described in this section; and
- prescriptions filled by a Participating Pharmacy; and
- not more than a 90 day supply for each prescription and each refill at a pharmacy designated by the Company to administer its Mail Service Prescription Drugs program.

If the Insured Person uses a Non-Participating Pharmacy, the Insured Person must:

- pay the full cost of the Prescription Drug to the Non-Participating Pharmacy; and
- complete a prescription drug claim form and submit the claim form to the Company, subject to the CLAIM PROCEDURES as described in page NBM 5146 NJ.

If an Insured Person uses a Non-Participating Pharmacy, Prescription Drugs Covered Charges less the Deductible and Coinsurance may only be reimbursed up to the Maximum Amount Allowed for each prescription or refill.

To request benefit payment for a clinically appropriate drug not otherwise covered under the Group Policy, the Insured Person can call the number on the Insured Person's ID card.

Prescription Drugs Program

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

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

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

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

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

- require prior authorization for dispensing; and
- limit the quantity of drugs for which benefits will be paid.

For more information about prescription drug insurance, the Insured Person can call the number on the Insured Person's ID card. By accessing the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com, the Insured Person can review the Formulary or prior authorization requirements.

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 as established by the Company.

Prescription Drugs Covered Charges will include charges for:

- the following diabetic supplies:
  - insulin; 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
- legend oral contraceptives; and
- progesterone, all dosage forms; and
- growth hormones for specific conditions as determined by the Company; and
- FDA Approved Drugs as described in page NBM 5400 NJ; and
- Infant Formulas - Specialized Non-Standard as described in page NBM 5400 NJ; and
- Infertility Treatment as described in page NBM 5400 NJ; and

- any other drug or medicine that can be legally dispensed only upon the Written prescription of a Physician; and
- Prescription Eye Drop Refills as described in page NBM 5400 NJ.

In no event will the Maximum Amount Allowed for each prescription or refill exceed the Average Wholesale Price less 14%.

Definitions

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

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

Generic Prescription Drugs means a therapeutically equivalent prescription drug, as determined by the Food and Drug Administration (FDA), which is identical to the Brand Name Drug in strength or concentration, dosage form and route of administration, which is used unless the practitioner prescribes a Brand Name Drug.

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. Mail Services Pharmacy will include any pharmacy that agrees to the same terms, conditions, price and services applicable to the designated mail order pharmacy designated by the Company.

Maximum Amount Allowed means, except as otherwise required by law, either (a) an amount agreed upon by the Pharmacy Benefit Manager and a Participating Pharmacy as full compensation for Prescription Drugs Covered Charges dispensed to an Insured Person; or (b) with respect to a Non-Participating Pharmacy, an amount determined by the Company.

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

Non-Participating Pharmacy means any pharmacy which has not contracted with the designated prescription drugs claims administrator to become a Participating Pharmacy.

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 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."

Charges Not Covered

Prescription Drugs Covered Charges will not include and no benefits will be paid for the following items:

- 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, except as provided under Infant Formulas – Specialized Non-Standard as described in page NBM 5400 NJ; or
- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or
- drugs or medicines for which the Insured Person has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- drugs or medicines provided as the result of a sickness or injury:
    - as a result of war or an act of war, occurring while the Insured Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and
    - as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, occurring while the Insured Person is serving in such forces and is outside the home area; and
    - as a result of war or an act of war while the Insured Person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and

- as a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, occurring while the Insured Person is serving in such unit and is outside the home area; and
- as a result of war or an act of war while the Insured Person is not in the military, naval or air forces of any country, combination of countries or international organization, or in any civilian non-combatant unit supporting or accompanying such forces, occurring outside the home area; or

- drugs or medicines provided as the result of a sickness or injury that is due to the commission of or attempted commission of a felony; or
- drugs or medicines provided as the result of:
  - an injury arising 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, unless the cosmetic drugs are for Congenital Defects and Birth Abnormalities as described in page NBM 5400 NJ, 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 provided under Substance Use Disorder Treatment or Service as described in page NBM 5402 B NJ, and 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
- any other drugs or medicines used for cosmetic purposes; or
- herbal supplements.

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 Participating Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on the identification card or contact the Company. To file a claim for benefits when utilizing a Non-Participating Pharmacy or when an identification card is not utilized at a Participating 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. Failure to provide notice or proof within the time specified will not invalidate or reduce any claim if it was not reasonably possible to furnish notice or proof within such time if such notice or proof is furnished as soon as reasonably possible.

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 A NJ for the Complaint and Appeal Procedures.

For purposes of this section, "claimant" means the Insured Person.

Review for Prescription Drugs

The Insured Person, or patient representative, Physician or other health care provider of the patient may appeal a utilization management decision for prescription drugs. The appeal process will follow the same procedures as outlined in the NBM 5407 CC NJ form.

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 a confinement in an inpatient confinement facility is scheduled, but no later than the day of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility, for other than Emergency Services; or as soon as reasonably possible. For Inpatient Services or Outpatient Services for Substance Use Disorders from PPO Providers, refer to the Precertification requirements as described in page NBM 5402 B NJ. 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 Condition;
    - Inpatient Substance Use Disorder Treatment Facility or Substance Use Disorder unit of a general Hospital or any other facility required by state law to be recognized as a treatment facility under the Group Policy for Substance Use Disorder 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 or as soon as possible 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. If the Insured Person does not have internet access, the Insured Person can call the number on the Insured Person's ID card. 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 Physician 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 NJ Coordination With Other Benefits.

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

Adverse Benefit Determination

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Insured Person's eligibility under the Group Policy, and including a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because the Company determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, not medically necessary or appropriate or because the Company has rescinded insurance.

Claim

A request by an Insured Person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the Insured Person, for payment relating to health care services or supplies covered under a health benefits plan issued by the Company.

Concurrent Review

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

Continued Stay Review

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

Final Internal Adverse Benefit Determination

An Adverse Benefit Determination that has been upheld by the Company at the completion of the internal appeal process, an Adverse Benefit Determination with respect to which the Company has waived its right to an internal review of the appeal, an Adverse Benefit Determination for which the Company did not comply with the requirements of these regulations and an Adverse Benefit Determination for which the Insured Person or provider has applied for expedited external review at the same time as applying for an expedited internal appeal.

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 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 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.

Post-Service Claim

Any claim for a benefit that is not a Pre-Service Claim.

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.

Pre-Service Claim

Any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Urgent Care

Urgent care review must be completed within 24 hours for a non-life threatening condition.

Urgent Care Claim

Any claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function, or which, 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 the care or treatment that is the subject of the claim.

Utilization Management

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

Utilization Review

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

- **Utilization Review Program**

If an Insured Person or designated patient representative fails to follow the Company's procedures for filing a claim for a Precertification, a Pre-Service Claim, or an Urgent Care review, Concurrent Review, or Post-Service Claim, the Company will notify the Insured Person or designated patient representative of the failure and the proper procedures to be followed.

- **Pre-Service Claim**

For an initial Pre-Service Claim, 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. For Adverse Benefit Determinations, notification will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

- **Urgent Pre-Service Claim**

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 request 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. For Adverse Benefit Determinations, notification 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 24 hours.

- **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.

- **Post-Service Claim**

For a Post-Service Claim, 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. For Adverse Benefit Determinations, notification 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 their 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. For Adverse Benefit Determinations, notification 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
- within one (1) business day for an Expedited Appeal Review; or
- within five (5) business days for a Standard Appeal Review.

The appeal process will resume and be completed within the applicable timeframe described below.

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
- within one (1) business day for an Expedited Appeal Review; or
- within five (5) business days for a Standard Appeal Review.

The appeal process will resume and be completed within the applicable timeframe described below.

- **Expedited 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 Urgent Care. 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 for Urgent Care 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 a second appeal review. The second appeal review may be requested by telephone, fax or in Writing within 180 calendar days of the receipt of the first appeal review of the 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 second appeal review. The Company will make a decision within 72 hours of request for a second appeal review.

Note: The expedited appeal process does not apply to Post-Service Claims.

- **Standard 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 10 calendar days of receiving the request for an appeal for a Pre-Service Claim and a Post-Service Claim.

If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, attending Physician, or other Ordering Provider can request a second appeal review. The second appeal review may be requested by fax or in Writing within 180 calendar days of the receipt of the appeal review of the 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 second appeal review. The Company will make a decision within 15 calendar days of request for a second appeal review for Pre-Service Claims and 20 business days for Post-Service Claims.

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

MEDICAL EXPENSE INSURANCE

COMPLAINT AND APPEAL PROCEDURES

Adverse Benefit Determination

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an Insured Person's eligibility under the Group Policy, and including, a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because the Company determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, not medically necessary or appropriate or because the Company has rescinded the insurance.

Stage 1 Appeal

The Insured Person or a designated patient representative, Physician, or other health care provider acting on behalf of the Insured Person may request an appeal of a claim denial or an Adverse Benefit Determination by Written request to the Company within 180 calendar days of receipt of the notice of denial or 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 Company may require additional information to make the review. For Adverse Benefit Determinations, the Company will notify the Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf in Writing of the appeal decision within 10 calendar days of receiving the appeal request for post-service claims and for pre-service claims.

For a claim denial not relating to medical necessity, the Company will notify the Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf 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.

An Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf may request an appeal of an urgent or emergency care claim (including when the patient is Inpatient confined) orally or in Writing. The Company will notify the Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf in Writing of the appeal decision within 72 hours for urgent or emergency care claims.

In addition, the Insured Person, or a designated patient representative, Physician or other health care provider acting on the Insured Person's behalf will have access to the peer clinical reviewer who rendered the Adverse Benefit Determination, by telephone, if requested. If the original peer clinical reviewer is not available, another peer clinical reviewer or a medical director will be available to discuss the review.

The appeal review for a claim denial not relating to medical necessity must be completed before filing a civil action or pursuing any other legal remedies.

Stage 2 Appeal

If the Adverse Benefit Determination is affirmed on the Stage 1 Appeal Review, the Insured Person or a designated patient representative, Physician, or other health care provider acting on behalf of the Insured Person may request a Stage 2 Appeal Review. The Stage 2 Appeal Review must be requested in Writing within 180 calendar days of receipt of the Stage 1 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 or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf may submit Written comments, documents, records and other information relating to the claim for benefits. The Company will acknowledge receipt, in Writing, of the Stage 2 Appeal request within ten business days of receipt. The Company will notify the Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf in Writing of the appeal decision within 20 business days of request for a Stage 2 Appeal Review for post-service claims and 15 calendar days for pre-service claims.

An Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf may request an appeal of an urgent or emergency care claim (including when the patient is Inpatient confined) orally or in Writing. The Company will notify the Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf in Writing of the appeal decision within 72 hours for urgent or emergency care claims.

A panel of physicians and/or other health care providers who have not been involved in the Adverse Benefit Determination will conduct a review of the documentation provided. At least one of the peer clinical reviewers or other health care professionals participating on the panel will be in the same or similar specialty as the attending physician or other ordering provider.

After exhaustion of the formal appeal process for a claim denial not relating to medical necessity, the Insured Person or a designated patient representative, Physician, or other health care provider 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 appeal decision. 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 or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf may submit written comments, documents, records, and other information relating to the claim for benefits. For a voluntary appeal review not relating to medical necessity, the Company will notify the Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf 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 for a claim denial not relating to medical necessity is voluntary and does not negate the Insured Person's right to bring civil action following the first appeal, 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 for a claim denial not relating to medical necessity in an effort that the claim may be resolved in good faith without legal intervention. At any time during the voluntary appeal review process for a claim denial not relating to medical necessity, the Insured Person may file a civil action or pursue any other legal remedies.

Stage 3 Appeal (External Review)

If the Adverse Benefit Determination is affirmed on the Stage 2 Appeal review, an Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf may appeal a final internal Adverse Benefit Determination through the Independent Health Care Appeals Process (IHCAP) to an independent IURO, except where the final internal Adverse Benefit Determination was based on eligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity.

The Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf must comply with the Company's internal appeal process before an appeal will be considered at the IHCAP, unless the Company either fails to meet the required deadlines for completing a Stage 1 Appeal or Stage 2 Appeal of the Company's internal appeal process described above, or expressly waives its right to perform an internal appeal review, or the Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf applies for an expedited external review at the same time as applying for an appeal of an urgent or emergency care claim.

The Stage 3 Appeal must be requested in Writing to the Department of Banking and Insurance within four months of receipt of the Stage 2 final internal Adverse Benefit Determination for an IURO Stage 3 Appeal. The Written request must be mailed to the following address:

Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P. O. Box 329
Trenton, New Jersey 08625-0329
Telephone: (888) 393-1062

The Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf must complete the provided Application for the Independent Health Care Appeals Program including the applicable authorization for release of information section.

The Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf must pay a $25.00 filing fee for a Stage 3 Appeal, payable by check or money order to the "New Jersey Department of Banking and Insurance." The health care provider acting on the Insured Person's behalf must bear all costs associated with the appeal that are normally paid by the Insured Person. The filing fee will be refunded to the Insured Person or a designated patient representative, Physician, or other health care provider acting on the Insured Person's behalf if the final internal Adverse Benefit Determination is reversed by the IURO. The filing fee will be waived if there is financial hardship evidenced by participation in the Pharmaceutical Assistance to the Aged or Disabled program, Medicaid, NJFamilyCare, General Assistance, SSI or New Jersey Unemployment Assistance. Annual filing fees for any one Insured Person will not exceed $75.00.

The Company will bear the costs of the review by the IURO.

Upon receipt of the Application for the Independent Health Care Appeals Program form, the New Jersey Department of Banking and Insurance will assign the appeal request to an approved IURO. The IURO will complete a preliminary review and notify the Insured Person and/or provider in Writing immediately upon receipt of the request, about the acceptance or rejection of the request for processing. The IURO notification will also include additional information to the Insured Person or his or her provider of the right to submit, in Writing within five (5) business days of receipt of the notice of acceptance of his or her appeal, any additional information to be considered in the IURO's review. The IURO will provide the Company with any such additional information within one (1) business day of receipt of the information.

Upon acceptance of the appeal, the IURO will conduct a full review to determine whether, as a result of the Company's final internal Adverse Benefit Determination, the Insured Person was deprived of medically necessary Covered Charges. The IURO must complete its review and issue its decision, in Writing as soon as possible, but in no event later than 45 business days, from receipt of all documentation necessary to complete the review.

If the appeal involves care for an urgent or emergency case, an admission, availability of care, continued stay, health care services for which the Insured Person received Emergency Services but has not been discharged from a facility or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function, the IURO will complete its review within no more than 48 hours following its receipt of the appeal. If the IURO's determination of the appeal provided within no more than 48 hours was not in Writing, the IURO will provide Written confirmation of its determination within 48 hours of providing the verbal determination.

Upon completion of the review, the IURO will send its decision in Writing to the Insured Person and/or provider and the Company. If the organization determines that the denial of benefits deprived the Insured Person of medically necessary health care services, it will make a recommendation to the Insured Person and/or provider, the Company, and the New Jersey Department of Banking and Insurance regarding the appropriate medically necessary health care services the Insured Person should receive.

The IURO's decision is binding, on the Company and the Insured Person, except to the extent that other remedies are available to either party under state or federal law. The Company will submit a Written report to the Insured Person and his or her provider (if the provider assisted in filing the appeal), the Department of Banking and Insurance and the IURO describing how the Company will implement the IURO's decision within 10 business days of the date that the Company first receives the decision of the IURO.

Review by Ombudsman

Upon the request of an Insured Person, the Ombudsman may conduct a review of any disputed insurance claim settlement where there is reasonable cause to believe that the Company has failed or refused to settle a claim in accordance with the provisions of the Group Policy or has engaged in 90any practice that may constitute a violation of New Jersey law.

Insured Persons seeking review in accordance with the above may file a complaint with the Ombudsman in any form, which indicates that the complainant is seeking review of a disputed claim. All complaints shall be sent to:

The Office of Insurance Claims Ombudsman
20 West State Street
PO Box 472
Trenton, NJ 08625–0472
Telephone: (800) 446–7467
Telefax: (609) 292–2431
E-mail: ombudsman@dobi.state.nj.us

MEDICAL EXPENSE COVERAGE

EXTENDED BENEFITS
(after termination of insurance)

Extended benefits are payable if insurance ceases due to termination of the Group Policy. Extended benefits will be payable for up to 12 months provided:

- the Insured Person has been Totally Disabled from the date insurance ceased until the date of Treatment or Service; and
- the Insured Person would have qualified for benefit payment under this section if insurance had remained in force; and
- the sickness or injury for which the Insured Person receives Treatment or Service is the disabling condition and was diagnosed by a Physician before the date insurance terminated.

These extended benefits are payable whether or not the Group Policy is replaced. However, if the Group Policy is replaced, 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

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

An Insured Person may be covered for health benefits or services by more than one Plan. For instance, he or she may be insured by the Group Policy as a Member and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows the Company to coordinate what the Company pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Insured Person is covered.

DEFINITIONS

The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Insured Person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When the Group Policy is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs, or hearing aids, Allowable Expense is limited to like items of expense.

The Company will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is medically necessary and appropriate.

When the Group Policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, the Company will only consider corresponding services, supplies, or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which an Insured Person is insured by the Group Policy and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

*Plan: Coverage with which coordination of benefits is allowed. Plan includes:

- Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- Group hospital indemnity benefit amounts that exceed $150 per day;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

- Individual or family insurance contracts or subscriber contracts;
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice, and individual practice plans;
- Group or group-type coverage where the cost of coverage is paid solely by the Insured Person except that coverage being continued pursuant to a Federal or State continuation law will be considered a Plan;
- Group hospital indemnity benefit amounts of $150 per day or less;
- School accident –type coverage;
- A State plan under Medicaid.

* In the event a husband and wife 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.

Primary Plan: A Plan whose benefits for an Insured Person's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exist:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the Insured Person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by the Company, based on a standard which is most often charged for a given service by a provider within the same geographic area.

Secondary Plan: A Plan which is not a Primary Plan. If an Insured Person is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision will be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

The Company considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan will not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that Precertification, preapproval, notification or precertification procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Insured Person as a Member, subscriber or retiree will be determined before those of the Plan that covers the Insured Person as a Dependent. The coverage as a Member, subscriber, or retiree is the Primary Plan.

The benefits of the Plan that covers the Insured Person as a Member who is neither laid off nor retired, or as a Dependent of such person, will be determined before those for the Plan that covers the Insured Person as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision will be ignored.

The benefits of the Plan that covers the Insured Person as a Member, subscriber or retiree, or Dependent of such person, will be determined before those of the Plan that covers the Insured Person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision will be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year will be determined before those of the parent whose birthday falls later in the Calendar Year.
- If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time will be determined before those of the plan which covered the other parent for a shorter period of time.
- Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
- If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision will be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the Plan of the parent with custody of the child will be determined first.
- The benefits of the Plan of the spouse of the parent with custody will be determined second.
- The benefits of the Plan of the parent without custody will be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan will be determined first. The benefits of the plan of the other parent will be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision will be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the Member or subscriber for a longer period of time will be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

- the basis on which the Primary Plan and the Secondary Plan pay benefits; and
- whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the Insured Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Insured Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Insured Person uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that the HMO or other plans pay the provider a fixed amount per Insured Person. The Insured Person is liable only for the applicable deductible, coinsurance or copayment. If the Insured Person uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The Secondary Plan will pay the lesser of:

- the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit will be reduced in proportion, and the amount paid will be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense will be the fee schedule of the Primary Plan. The Secondary Plan will pay the lesser of:

- the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary plan, the Secondary plan and the Insured Person will not exceed the fee schedule of the Primary Plan. In no event will the Insured Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan will pay the lesser of:

- the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Insured Person will only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Insured Person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event will the Insured Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan will be the fee schedule of the Primary Plan. The Secondary Plan will pay the lesser of:

- the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured Person receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan will pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Insured Person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan will pay the lesser of:

- the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan**.**

If the Insured Person receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan will be liable to pay the capitation to the provider and will not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Insured Person will not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

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.

MEDICAL EXPENSE INSURANCE

BENEFITS FOR AUTOMOBILE RELATED INJURIES

Purpose

When expenses are incurred as a result of an Automobile Related Injury, and the injured person has coverage under PIP or OSAIC, this section will be used to determine whether the Group Policy provides coverage that is primary to auto coverage or secondary to auto coverage. It will also be used to determine the amount payable if the Group Policy provides primary or secondary coverage.

Definitions

As used in this section, the terms listed below will mean:

Automobile Related Injury means bodily injury sustained by the Insured Person as a result of an accident:

- while occupying, entering, leaving, or using an automobile; or
- as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

Allowable Expense means a medically necessary, reasonable, and customary item of expense covered at least in part as an Eligible Expense by:

- the Group Policy;
- PIP; or
- OSAIC.

Eligible Expense means that portion of expense incurred for treatment of an injury, which is covered under the Group Policy without application of Deductibles or Copays, if any.

Out-of-State Automobile Insurance Coverage or OSAIC means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

PIP means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of Primary or Secondary Coverage

The Group Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Insured Person covered under the Group Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Group Policy may be primary for one covered person, but not for another if the persons have separate automobile policies and have made different selections regarding primacy of health coverage.

The Group Policy is secondary to OSAIC, unless the OSAIC contains provisions, which make it secondary or excess to the Group Policy. In that case, the Group Policy will be primary.

If there is a dispute as to which plan is primary, the Group Policy will pay benefits as if it were primary.

Benefits the Group Policy Will Pay if it is Primary to PIP or OSAIC

If the Group Policy is primary to PIP or OSAIC, it will pay benefits payable for Eligible Expenses in accordance with the terms provided in the Group Policy.

The rules as provided in the Coordination with Other Benefits sections of the Group Policy will apply if:

- the Insured Person is covered under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits the Group Policy Will Pay if it is Secondary to PIP or OSAIC

If the Group Policy is secondary to PIP or OSAIC, the actual benefits payable will be the lesser of:

- the Allowable Expenses left uncovered after PIP or OSAIC has provided coverage after applying Deductibles and Copays; or
- the benefits that would have been paid if the Group Policy had been primary.

Medicare

If the Group Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

CONTINUATION OF INSURANCE – STATE REQUIRED – NEW JERSEY

State Required Continuation – New Jersey

Member Total Disability

- **Qualification for Continuation**

  The Member may elect to continue insurance under the Group Policy if insurance terminates because the Member ceases to be actively employed due to Total Disability. Insurance will also be continued for the Member's then insured Dependents subject to the conditions applicable to the Member. The Member must have been insured by the Group Policy for at least three months immediately prior to the date insurance ceases.

- **Period of Continuation**

  If the Member qualifies as set forth above, insurance may be continued until the earliest of:

  - the date the Group Policy is terminated; or
  - the end of the period for which the last premium is paid for the Member's insurance; or
  - the end of the period in which the Member ceases to be in a class for which Member Medical Expense Insurance is provided; or
  - the date the Member is re-employed and eligible for other group medical expense coverage.

  If insurance under the Group Policy is subject to COBRA, USERRA or a state continuation law, this continuation period will run concurrent with the COBRA, USERRA or state continuation period.

- **Dependents Who Lose Eligibility Due to the Member's Death**

  If the Member should die while insured, the Member's Dependent's Medical Expense Insurance under the Group Policy will be continued, subject to payment of any required contribution, until the earliest of:

  - the date the Dependent's insurance would otherwise cease as provided in the Group Policy; or
  - the date the Group Policy terminates; or
  - the end of the period for which contributions are paid, if the Dependent fails to make timely payment of a required contribution; or
  - the date insurance has been continued for 180 days.

- **Dependent Child - Insurance to Age 31**

  - **Qualification**

    A Dependent Child may elect to continue his or her Medical Expense Insurance under the Group Policy if the Dependent Child attains the limiting age under the Group Policy provided the Dependent Child is the Member's child by blood or by law who:

    - is 30 years of age or younger; and
    - is unmarried or not in a Civil Union Partner relationship or Domestic Partner relationship; and
    - does not have any children; and
    - is a resident of New Jersey or is enrolled as a Full-Time Student in an accredited public or private institution of higher education; and
    - is not covered as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Medicare at the time continuation of Dependent Child insurance under this provision will begin; and there is evidence of prior, creditable coverage or a receipt of benefits under a benefits plan or by law as described in this provision. Such prior insurance must have been in effect on the date the Dependent Child attains the limiting age under the Group Policy, or at any time after such date but prior to making an election for this continuation insurance.

  - **Continuation Period**

    Insurance for a Dependent Child who qualifies above may be continued until the earlier of:

    - the date the Dependent Child no longer qualifies above; or
    - the date the insurance would otherwise cease as provided in the Group Policy; or
    - the date insurance for Dependent Children is removed from the Group Policy; or
    - the date the Member elects to discontinue insurance for all Dependent Children; or
    - the end of the premium period for which premium is paid if the Member or Dependent Child fails to make timely payment of required premium; or
    - the date the Member is no longer insured under the Group Policy; or
    - the date the Group Policy is terminated.

- **Notification, Election, and Premium**

The Company will notify the Dependent Child of:

- his or her right to continue insurance under the Group Policy;
- the monthly premium he or she must pay to continue insurance; and
- the times and manner in which monthly payments must be made.

Dependent Children electing to continue insurance will be required to pay 102% of the cost for the applicable insurance.

The Dependent Child must make Written election to continue insurance as described below and pay the initial premium to the Company within 30 days of the due date:

- within 30 days prior to termination of insurance due to attainment of the limiting age under the Group Policy;
- within 30 days after meeting the requirements to qualify for continuation;
- during an open enrollment period if the Dependent Child meets the requirements to qualify for continuation during the open enrollment period.

- **Group Policy Changes**

Continued insurance will be identical to the insurance provided to that Dependent Child prior to termination of insurance at the specific age specified in the Group Policy. If insurance or premium is modified for similarly situated Dependent Children, the insurance will also be modified for this Dependent Child.

CONTINUATION OF COVERAGE

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding Calendar Year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that group health insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of the insurance.

NOTE: COBRA Continuation is not available to a 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 a newly acquired spouse or Dependent Child, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for health care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider medical enrollment options carefully.

M. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

Group Health Plan: New Jersey John Doe Health Plan
Contact Name/Area: New Jersey 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 NJ; 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, by the health care provider, within 20 calendar days after the date of loss for which claim is made. 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, by the health care provider, in order to obtain payment of benefits. The Policyholder will provide forms to assist the Insured Person in filing claims, if the Insured Person has chosen the option to submit a claim on his or her own behalf. The Member's plan provides that claim forms will be provided within 15 days after the Company receives notice of claim. If the claimant does not receive these claim forms within 15 days after the Company receives notice of claim, he or she will be considered to have complied with the Group Policy requirements of providing 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 for which claim is made.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written notice of claim must be given to the Company, by the health provider or Insured Person if he or she has chosen the option to submit claims on his or her own behalf, 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 health care provider or Insured Person's failure to comply with such request could result in declination of the claim. Failure to provide notice or proof within the time specified will not invalidate or reduce any claim if it was not reasonably possible to furnish notice or proof within such time if such notice or proof is furnished as soon as reasonably possible.

Payment, Denial, and Review

The Employment Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. 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.

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 A NJ for the Complaint and Appeal Procedures.

The Health Care Quality Act requires the Company to inform the Insured Person that a final claim denial or a final denial of benefits may be appealed through the Independent Health Care Appeals Program. The Insured Person will be sent an appeal form. The Insured Person must file the appeal form with the state within 60 business days of receiving the final claim denial or the final denial of benefits. For more information, see Appeal of Adverse Benefit Determinations in page NBM 5407 CC NJ section of this booklet-certificate.

Also, a claim that is denied based on medical necessity is subject to a three stage appeal process. The first two stages are an internal appeal, followed by an external appeal. For more information, please see page NBM 5407 A NJ of this booklet-certificate.

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

Medical Examinations

The Company may have the person whose loss is the basis for claim examined by a Physician as often as reasonably necessary. The Company will pay for these examinations and will choose the Physician to perform them.

Legal Action

Legal action with respect to a claim may not be started earlier than 60 calendar days after proof of loss is filed. 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.

Reimbursement for Overpayment

In seeking overpayments from health care providers, the Company will not attempt to collect:

- overpayments on or before the 45th calendar day following the submission of the reimbursement request to the health care provider;
- overpayments if the health care provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care provider and until the health care Provider's Rights to Appeal set forth below are exhausted;
- a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee.

The Company can collect the funds for the overpayment request by assessing them against payment of any future claims submitted by the health care provider after the 45th calendar day following the submission of the reimbursement request to the health care provider or after the health care provider's right to appeal set forth above has been exhausted. The Company will submit an explanation in Writing to the provider in sufficient detail so that the provider can reconcile each Insured Person's bill.

If the Company determines that the overpayment to the health care provider is a result of fraud committed by the health care provider and the Company has conducted an investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor, as required by law, the Company can collect an overpayment by assessing it against payment of any future claims submitted by the health care provider.

Health care providers cannot seek reimbursement from the Company or an Insured Person for underpayment of a claim submitted pursuant to this section later than 18 months from the date the first payment on the claim was made, except if the claim is the subject of an appeal as discussed above in this section or the claim is subject to continual claims submission. Health care providers cannot seek more than one reimbursement for underpayment of a particular claim.

Provider's Rights to Appeal

The Company has established an internal appeal procedure to resolve disputes raised by health care providers. This internal appeal procedure does not pertain to medical necessity, which is eligible to be submitted to the Independent Health Care Appeals Program. There is no cost to the health care provider to conduct this appeal.

A health care provider may initiate an appeal on or before the 90th calendar day following the health care provider's receipt of the Company's claims determination, which is the basis of the appeal. The appeal will be on a form prescribed by the Commissioner of Banking and Insurance. Such form will describe the type of substantiating documentation that must be submitted with the form. The Company will conduct a review of the appeal and notify the health care provider of the determination on or before the 30th calendar day following the receipt of the appeal form. If the Company does not notify the health care provider within 30 calendar days, the health care provider may refer the dispute to arbitration as discussed below.

If the Company issues a determination in favor of the health care provider, the Company will pay the amount of money in dispute, if applicable, with accrued interest at the rate of 12% per annum, on or before the 30th calendar day following the Company's notification of the determination on the appeal. Interest begins to accrue on the day the appeal was received by the Company.

If the Company issues a determination against the health care provider, the Company will notify the health care provider of the Company's findings on or before the 30th calendar day following the receipt of the appeal form. The Company will include in the notification Written instructions for referring the dispute to arbitration, as provided below.

The Company is required to report annually to the Commissioner of Banking and Insurance the number of appeals received and the resolution of each appeal.

If the Company's determination of the internal appeal conducted is disputed, the dispute may be referred to arbitration. The Commissioner of Banking and Insurance has contracted with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings.

Arbitration may be initiated on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. The payment amount in dispute must be $1,000 or more in order to be accepted for arbitration, except that a health care provider may aggregate his or her own disputed claim amounts for the purposes of meeting the threshold requirements. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program will be subject to arbitration.

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 NJ in this booklet-certificate.

Precertification - Applies to Medical Care received from PPO Providers or Non-PPO Providers

If a Hospital Inpatient Confinement or confinement in an inpatient confinement facility is necessary, the Insured Person will need to follow the procedures below in order to qualify for payment of Hospital Inpatient Confinement Charges and charges for services provided in an inpatient confinement facility at the standard rate for his or her Group Policy. The procedures differ depending on the type of Hospital Inpatient Confinement or confinement in an inpatient confinement facility:

- **For Other than Emergency Services**

  An Insured Person or a designated patient representative must call the Company at the toll-free number shown on the identification card as soon as a Hospital Inpatient Confinement or confinement in an inpatient confinement facility is scheduled, but no later than the day of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

- **For Emergency Services**

  An Insured Person or a designated patient representative must call the Company at the toll-free number shown on the identification card within two business days of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility, or as soon as reasonably possible.

- **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 Transplant Network Providers will be paid directly to the Transplant Network Provider.

STATEMENT OF RIGHTS

Federal law requires that this section be included in the booklet-certificate:

As a participant in this plan the Member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About the Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the Member, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. The Member and his or her Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of Members and other plan participants and beneficiaries. No one, including the employer, union, or any other person, may fire the Member or otherwise discriminate against the Member in any way to prevent him or her from obtaining a welfare benefit or exercising rights under ERISA.

Enforce the Member's Rights

If the Member's claim for a welfare benefit is denied or ignored, in whole or in part, the Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps the Member can take to enforce the above rights. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, the Member may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to $110 a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the Member has a claim for benefits which is denied or ignored, in whole or in part, the Member may file suit in a state or Federal court. In addition, if the Member disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Member may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his or her rights, the Member may seek assistance from the U.S. Department of Labor, or the Member may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees, for example, if it finds the Member's claim is frivolous.

Assistance with Member Questions

If the Member has any questions about his or her plan, the Member should contact the plan administrator. If the Member has any questions about this statement or about his or her rights under ERISA, or if the Member needs assistance in obtaining documents from the plan administrator, the Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Member may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SUPPLEMENT
TO THE MEMBER'S BOOKLET-CERTIFICATE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**

   EIN: 99-9999999
   PN: 501

2. **Type of Administration:**

   Medical Expense Coverage: Insurance Contract

3. **Plan Administrator:**

   Riverside Plastics Incorporated
   900 Washington St
   Bonaparts USA 52620

   See the employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**

   Riverside Plastics Incorporated
   900 Washington St
   Bonaparts 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
Bonaparts USA 52620
Telephone: (319)592-3166

Legal process may also be served upon the plan administrator.

6. **Type of Participants Covered Under the Plan:**

All active Full-Time Employees of Riverside Plastics Incorporated, and provided that, for each employee, he or she also meets the definition of a Member as defined in the DEFINITIONS section of this booklet (page NBM 5136 NJ).

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 denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Insured Person's eligibility under the Group Policy, and including, a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, denial of a request for an in-plan exception, as well as a failure to cover an item or service for which benefits are otherwise provided because the Company determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, not medically necessary or appropriate or because the Company has rescinded 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 means the legally recognized union of two eligible individuals of the same sex established pursuant to New Jersey Law.

Civil Union Partner means for two persons to establish a Civil Union in New Jersey, it is necessary that they satisfy all of the following criteria:

- not be a part to another Civil Union, or marriage in New Jersey;
- be of the same sex and therefore be excluded from the marriage laws of New Jersey or any other state;
- be at least 18 years of age, except as provided in New Jersey law.

A Civil Union will also include two individuals in a same-sex relationship who are eligible for a legally recognized union, established in other jurisdictions, that most closely provides substantially all of the rights and benefits of marriage provided under New Jersey law and as determined by the Company.

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.

Coinsurance means the Company's share of the costs of a Covered Charge, calculated as a percentage of the Prevailing Charge amount for the Treatment or Service.

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 Condition and Substance Use Disorder Treatment Services.

Company means Nippon Life Insurance Company of America.

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
- determined by the Company to be Generally Accepted.

Custodial Care means assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), chiropractor, physical therapist, occupational therapist, speech therapist or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination and taking medications.

Date of Issue means the date the Group Policy is placed in force: January 1, 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).

Dentist means:

- a person licensed to practice dentistry; and
- a licensed Physician who provides dental Treatment or Service.

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.

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

- The Member's Dependent Child (or Dependent Children) as defined below.

- The Member's Civil Union Partner's Dependent Child (or Dependent 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 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.

- A Civil Union Partner's child who otherwise qualifies above, or if the Member or Civil Union Partner has been appointed the child's guardian under a valid 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 handicap which:

- results from intellectual 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) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, a serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services means with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required to Stabilize the patient.

Essential Health Benefits means those services and devices defined by the Federal government as "essential health benefits" as follows: (a) ambulatory patient services, (b) emergency services, (c) hospitalization, (d) maternity and newborn care, (e) mental health and substance use disorder services, including behavioral health treatment, (f) prescription drugs, (g) rehabilitative and habilitative services and devices, (h) laboratory services, (i) preventive and wellness services and chronic disease management, (j) pediatric services, including oral and vision care.

Experimental or Investigational Measures means any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

Full-Time Employee means a person who is regularly scheduled to work for the Policyholder for at least 30 hours a week. The employee must be compensated by the Policyholder and either the employee or employer must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

Full-Time Student means the Member's Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as his or her main focus; and
- carries a minimum load of 12 credit hours; and
- receives more than one-half of his or her financial support from the Member.

Generally Accepted means accepted standards of medical practice, for Treatment or Service for the particular sickness or injury which is the subject of the claim, that are based on:

- credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and
- Physician and health care provider specialty society recommendations; and
- the views of Physicians and health care providers practicing in relevant clinical areas; and
- any other relevant factor as determined by the commissioner by regulation.

Group Health Plan means an employee welfare benefit plan, as defined in ERISA, to the extent that the plan provides medical care and including items and services paid for as 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 provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as 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 as a home health care agency by Medicare; or
- licensed by the New Jersey Commissioner of Health as a home health care agency.

Home Health Care Plan means a program of home care that is:

- required as the result of a sickness or injury; and
- established in Writing by the attending Physician within 14 days after Home Health Care begins; and
- certified by the attending Physician as a replacement for Hospital Inpatient Confinement or Skilled Nursing Facility confinement that would otherwise be necessary; and
- reviewed and re-certified by the attending Physician every 30 days.

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 Condition and Substance Use Disorder 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
- a state-licensed detoxification facility and an Inpatient Substance Use Disorder Treatment Facility; and
- a state-approved 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 NJ 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 Substance Use Disorder 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 Substance Use Disorder 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 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 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 Condition means a condition defined to be consistent with generally recognized independent standards of current medical practice referenced in the current version of the Diagnostic and Statistical Manual of Mental Disorders.

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 Substance Use Disorder 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 Substance Use Disorder treatment services.

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Physical Handicap means a Dependent Child's substantial physical or intellectual 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, a Board Certified Behavior Analyst – Doctoral (BCBA-D) or a Board Certified Behavior Analyst (BCBA), including persons under the direct supervision of such BCBA-D or BCBA, 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. In the event of termination, the level of benefits as described in the Group Policy will not be affected until the earlier of: (1) the next Policy Anniversary following the date of termination; or (2) the date the Policyholder requests a change in benefits.

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 Treatment or Service received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.

- For Treatment or Service received from Non-Preferred Providers, the amount that is the lesser of:

  - the fee charged under any direct or indirect arrangement the Company has with the provider; or
  - the amount, as determined by the Company, that most health care providers charge within a geographic cost area for a Treatment or Service.

  For the purpose of the second bullet above, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by the Company, 70% or more of all other charges reported to the Company for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

  A Non-Preferred Provider may bill the Insured Person for any part of a charge for Treatment or Service that exceeds Prevailing Charges (balance billing).

- For Home Infusion Therapy Services, the amount will be established by the Company, not to exceed the Average Wholesale Price.
- For Treatment or Service 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.
- 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 Care means services or supplies that are not provided in connection with the Treatment or Service of injury or illness. Preventive care includes, but is not limited to: routine physical examinations including related laboratory tests and x-rays, immunizations and vaccines, screening tests, well baby care, well child care and well adult care.

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 United States Public Health Service 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 Condition and Substance Use Disorder 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 Condition and Substance Use Disorder 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 Condition and Substance Use Disorder 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.

Substance Use Disorder is as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and any subsequent editions and includes substance use withdrawal.

Temporomandibular Services means any Treatment or Service to diagnose, prevent, or correct malfunction, degeneration, disease, injury, and all other ailments or defects (congenital or hereditary) related to the joints, muscles, and tissues that connect the jaw to the skull.

Total Disability; Totally Disabled means:

- For a Member, a Member's inability, as determined by the Company, due to his or her sickness or injury, to work at any job that reasonably fits his or her background or training.
- For a Dependent a substantial impairment, due to his or her sickness or injury, that prevents the individual from performing the normal function of his or her regular duties or activities.

Transplant Network means any network of providers that the Company determines to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule as provided in page NBM 5402 C PPO NJ.

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. 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.

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.

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.

Disclosures to Insured Persons Regarding Out-of-Network Treatment

THIS SUMMARY ONLY PROVIDES AN OVERVIEW OF HOW AN INSURED PERSON'S HEALTH BENEFITS PLAN COVERS OUT-OF-NETWORK TREATMENT. IT IS ONLY GUIDANCE TO HELP AN INSURED PERSON UNDERSTAND THEIR OUT-OF-NETWORK BENEFITS. THIS SUMMARY DOES NOT ALTER YOUR COVERAGE IN ANY WAY.

THE INSURED PERSON SHOULD REFER TO THEIR BOOKLET-CERTIFICATE OR SUMMARY OF BENEFITS AND COVERAGES FOR MORE INFORMATION ABOUT YOUR OUT-OF-NETWORK BENEFITS AND ABOUT COVERAGES AND COSTS FOR IN-NETWORK TREATMENT.

FOR ADDITIONAL INFORMATION – INCLUDING WHETHER A HEALTH CARE PROFESSIONAL OR FACILITY IS IN-NETWORK OR OUT-OF-NETWORK, EXAMPLES OF OUT-OF-NETWORK COSTS AND ESTIMATES FOR SPECIFIC SERVICES - PLEASE CONTACT US AT: 1-866-702-6961 OR VISIT OUR WEBSITE AT: https://www.nipponlifebenefits.com/member-service/nj-state-specific-requirements/

Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Medically Necessary Treatment on an Emergency or Urgent Basis by Out-Of-Network Health Care Professionals/Facilities	Emergency - You are covered for out-of-network treatment for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain; psychiatric disturbances and/or symptoms of Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual or unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman or unborn child. Urgent – You are covered for out-of-network treatment of a non-life-threatening condition that requires care by a health care professional within 24 hours.	Except as discussed below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost- sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: www.state.nj.us/dobi/consumer.htm. Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the emergent/urgent medical services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of- pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled. If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the medical services.

		The amount awarded by the arbitrator may exceed what the carrier has already paid to the out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).
Your Policy Covers:	**What this Means:**	**How Am I Protected by NJ law?**
Inadvertent out-of-network services	You are covered for treatment by an out-of- network health care professional for covered services when you use an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in-network health care services are unavailable or provided by an out-of-network health care professional in that in-network facility. This includes laboratory testing ordered by an in-network health care professional and performed by an out-of-network bio-analytical laboratory (e.g., imaging, x-rays, blood tests, and anesthesia).	Except as provided below, you should not be billed by an out-of-network health care professional or facility, for any amount in excess of any deductible, copayment, or coinsurance amounts (also known as "cost-sharing") applicable to the same services when received in-network. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: https://www.state.nj.us/dobi/consumer.htm Your carrier and the out-of-network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent out-of-network services. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled. If an agreement cannot be reached, your carrier or the out-of-network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the inadvertent out-of-network services. The amount awarded by the arbitrator may exceed what the carrier has already paid to an out-of-network health care professional/facility; however, any additional amount paid by the carrier pursuant to the arbitration award will not increase your cost-sharing

		liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total allowed charge/amount for the service(s).
Your Policy Covers:	**What this Means:**	**How Am I Protected by NJ law?**
Treatment from out-of-network health care professionals/ facilities if in-network health care professionals/facilities are unavailable.	Plans are required to have adequate networks to provide you with access to professionals/facilities within certain time/distance requirements so you can obtain medically necessary treatment of all illnesses or injuries covered by your plan.	You can request treatment from an out-of-network health care professional/facility when an in-network health care professional/facility is unavailable through an appeal, often called a request for an "in-plan exception." Please see the Department of Banking and Insurance's guide at: https://nj.gov/dobi/appeal/.
Your Policy Covers:	**What this Means:**	**How Am I Protected by NJ law?**
Voluntary out-of-network services	You are covered for treatment by an out-of- network health care professional/facility when you knowingly, voluntarily and specifically select an out-of-network health care professional/facility, even if you have the opportunity to be serviced by an in-network health care professional/facility. <u>We will cover voluntary out-of-network services as follows</u>: All out-of-network policy provisions will apply including deductible, coinsurance and any amounts in excess of the out-of-network allowed amount.	Carriers must provide ready access to information about how to determine when a health care professional/facility is in- network. Please contact us if you have any questions about the status of a particular professional/facility. Additionally, health care professionals/facilities must disclose to you, in writing or on a website, the plans in which they participate as in-network providers. Note, indications that a professional/facility "accepts" a certain health plan does not necessarily indicate in- network status. So, when seeking treatment, you can check with both us and your prospective health care professional/facility.

	Please be advised that the ALLOWED CHARGE/AMOUNT (discussed above) is not the same as the amount billed by your Out-of-Network Health Care Professional/Facility, and is usually less. WE CALCULATE THE ALLOWED CHARGE/AMOUNT AS FOLLOWS: Allowed amounts are subject to plan provisions by using either a usual and customary amount or a Resource-Based relative value scale (RBRVS). Usual and Customary amounts are based on Fair Health data and RBRVS is a Medicare reimbursement based on the resource costs needed to provide the service.	Carriers must provide a method to enable you to be able to calculate an estimate of out-of-network costs when voluntarily seeking to use an out-of-network health care professional/facility. YOU CAN CONTACT US VIA THE METHODS ABOVE TO OBTAIN MORE INFORMATION REGARDING THE ALLOWED CHARGE/AMOUNTS FOR SPECIFIC SERVICES IF YOU CAN PROVIDE A CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE. If you do not have a CPT code, you can estimate your costs by: Contacting your provider for the amount that he/she will charge, or by visiting www.fairhealthconsumer.org/ to determine the estimated cost for these services in your geographic area or zip code or you may contact us at 866-702-6961 to request an estimated allowed amount for a specific service under your plan.
	You will be RESPONSIBLE FOR PAYMENT OF: a) Your cost-sharing portion of the allowed charge/amount as disclosed above; PLUS, b) the difference between our allowed charge/amount and the amount the out-of-network health care professional/facility bills for the services (commonly referred to as the "balance bill").	You can also visit our website above for examples of the average costs (allowed charge/amount, billed amount, consumer responsibility without cost-sharing under plan) for ten more frequently billed out-of-network services.

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

General Information Regarding The Life and Health Insurance Guaranty Association Act - NJ

TO: All Group Life and Health Policyholders in New Jersey
RE: New Jersey Life and Health Insurance Guaranty Association
State Required Disclosure Statement

Residents of New Jersey who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.
Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.
Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy. Policyholders with additional questions may contact:

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center
Newark, NJ 07102
State of New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

Coverage

The following is a brief summary of the law's coverages, exclusions, and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health, or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage

However, persons holding such policies are **not** protected by this Association if:

-- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
-- the insurer was not authorized to do business in that state;
-- their policy was issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does **not** provide coverage for:

-- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
-- any policy of reinsurance (unless an assumption certificate was issued);
-- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
-- dividends;
-- credits given in connection with the administration of a policy by a group contract holder;
-- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

Limits on Amount of Coverage

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net case surrender and net cash withdrawals values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in case surrender values for annuity benefits, $500,000 in life insurance death benefits, or $500,000 in present value of annuities – again, no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are no limits on the benefits the Associates will pay with respect to any one group, blanket, or individual accident and health insurance policy.

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.

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.

Please attach the Member's copy of the enrollment card to this page. The effective date of the Member's coverage is as shown on the card.

Any Change of Beneficiary or Change of Name forms should also be attached to this page after having been properly recorded and returned to the Member.

The Member should also attach any riders to this page.

Notes

THIS BOOKLET-CERTIFICATE IS ONLY A REPRESENTATIVE SAMPLE, AND DOES NOT CONSTITUTE AN ACTUAL INSURANCE POLICY OR CONTRACT. THIS SAMPLE BOOKLET-CERTIFICATE IS SUBJECT TO CHANGE.

Nippon Life Benefits®

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