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

TEXAS SINGLE EMPLOYER EVOLUTION WITH BUY UP

EFFECTIVE JANUARY 1, 2024

Group Plan Booklet Certificate

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

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

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

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.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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.

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

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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Nippon Life Insurance Company of America
To get information or file a complaint with your insurance company or HMO:
Call: Nippon Life Insurance Company of America at 1-800-374-1835
Toll-free: 1-800-374-1835
Email: RPerrin@hlthben.com
Mail: P.O. Box 25951, Shawnee Mission, KS 66225-5951

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Nippon Life Insurance Company of America
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Nippon Life Insurance Company of America al 1-800-374-1835
Teléfono gratuito: 1-800-374-1835
Correo electrónico: RPerrin@hlthben.com
Dirección postal: P.O. Box 25951, Shawnee Mission, KS 66225-5951

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

GROUP MEDICAL EXPENSE COVERAGE
BOOKLET-CERTIFICATE RIDER

TEXAS DEPARTMENT OF INSURANCE NOTICE

You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

You have the right, in most cases, to obtain estimates in advance:

- from out-of-network providers of what they will charge for their services; and

- from your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.nipponlifebenefits.com or by calling 1-800-374-1835 during normal business hours for assistance in finding available preferred providers.

If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon, including the amount unpaid by the administrator or insurer, is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network facility, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

NIPPON LIFE INSURANCE COMPANY OF AMERICA (Nippon Life Benefits)
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) OF THIS BOOKLET-CERTIFICATE FOR MORE DETAILED INFORMATION.

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SUMMARY OF BENEFITS
(Effective January 1, 2024)

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

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

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

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

PREFERRED PROVIDER ORGANIZATION (PPO)

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

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

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

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

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

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

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

MEDICAL CARE COVERED CHARGES

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

BENEFITS PAYABLE

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

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

Service	**PPO Providers**	**Non-PPO Providers**
- Emergency Room Visits (including MRIs, CATs, SPECTs, PETs and other similar imaging tests)		
- Coinsurance	100%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%.
- Deductible	None	For Emergency Services – Same as PPO Providers. For other than Emergency Services – $1,000* per Calendar Year
- Copay	$150 per-visit (Waived if admitted.)	For Emergency Services – Same as PPO Providers. For other than Emergency Services – None
Physician Hospital Services		
- Physician Hospital Services (including surgery and Physician Visits on an inpatient or outpatient basis)		
- Coinsurance	80%	60%
- Deductible	$1,000* per Calendar Year	$1,000* per Calendar Year
Physician Office or Clinic Services		
- Services at a Primary Care Physician's office or clinic (other than Urgent Care Center services, Preventive Health and Wellness Services and MRIs, CATs, SPECTs, PETs and other similar imaging tests), including both in-person and Telemedicine/Telehealth visits		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	$25 per visit	None
- Preventive Health and Wellness Services at a Primary Care Physician's office or clinic		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	None	None

Service	**PPO Providers**	**Non-PPO Providers**
- Services at a Specialty Provider's office or clinic (other than Urgent Care Center services, Preventive Health and Wellness Services and MRIs, CATs, SPECTs, PETs and other similar imaging tests), including both in-person and Telemedicine/Telehealth visits		
"Specialty Provider" means any Physician other than a Primary Care Physician who is classified as a specialist by the American Boards of Medical Specialties; or who is designated by the Group Policy as a Specialty Provider.		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	$25 per visit	None
- Preventive Health and Wellness Services at a Specialty Provider's office or clinic		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	None	None
Service	**PPO Providers**	**Non-PPO Providers**
- Services at an Urgent Care Center (other than MRIs, CATs, SPECTs, PETs and other similar imaging tests)		
"Urgent Care Center" means a facility that provides Treatment or Services for a sickness or injury that develops suddenly or unexpectedly outside of a Physician's normal business hours that requires immediate treatment, but is not of sufficient severity to be considered emergency treatment.		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	$25 per visit	None
- Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine)		
- Coinsurance	100%	No benefits payable
- Deductible	None	No benefits payable
- Copay	None	No benefits payable

All Other Covered Services		
- Ambulance Services		
- Coinsurance	80% (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%. (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)
- Deductible	$1,000* per Calendar Year (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)	For Emergency Services - Same as PPO Providers. For other than Emergency Services - $1,000* per Calendar Year (Waived for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services)
- Copay	None	None
- Other Medical Services (including MRIs, CATs, SPECTs, PETs and other similar imaging tests in any outpatient location)		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services - 60%
- Deductible	$1,000* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services – $1,000* per Calendar Year
- Copay	None	None
- Other Preventive Health and Wellness Services		
- Coinsurance	100%	60%
- Deductible	None	$1,000* per Calendar Year
- Copay	None	None

For a covered medical care or health care service performed for or a covered supply related to that service provided at an in-network facility by a Non-PPO Provider who is a Facility-Based Provider, benefits will be payable at the usual and customary rate or at an agreed rate. Facility-Based Provider means a Physician or health care provider who provides covered medical care or health care services to patients of a health care facility.

For diagnostic imaging or laboratory services provided by a Non-PPO Provider performed in connection with an in-network service, benefits will be payable at the usual and customary rate or at an agreed rate if the Non-PPO Provider performed the service in connection with a covered medical care or health care service performed by a Preferred Provider.

There are certain out-of-network services (Emergency Services, services provided in an in-network facility, and diagnostic imaging or laboratory services performed in connection with an in-network service), where balance billing by the Non-Preferred Provider is prohibited. In these situations, the Insured Person's financial responsibility is limited to the applicable Copay, coinsurance, and Deductible based on Prevailing Charges

COPAY AMOUNTS

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

In addition, the Copay provision does not apply to charges incurred for MRIs, CATs, SPECTs, PETs and other similar imaging tests. These charges are subject to the Calendar Year Deductible.

DEDUCTIBLE AMOUNTS

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

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

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

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

- Covered Charges used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a PPO Provider or Member Pharmacy will not be used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a Non-PPO Provider and vice versa.
- If the amount the Insured Person pays for Covered Charges in any one Calendar Year reaches the Out-of-Pocket Expense Limit shown above, the Company will pay 100% of additional Covered Charges.
- The Out-of-Pocket Expense Limit for PPO Providers applied to any individual Insured Person under family coverage will not exceed $9,450.

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

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

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

- For medical care received from PPO Providers and Non-PPO Providers: Hospital Inpatient Confinement Charges and charges for services provided in an inpatient confinement facility or selected outpatient procedures, are subject to Utilization Management Requirements. **See page NBM 5407 CC for a complete description of the Utilization Management Program.**
- For Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, **see page NBM 5402 B for a complete description of the benefits payable for these services.**
- For payment conditions applicable to Transplant Services, see page NBM 5402 C PPO.
- For payment conditions applicable to Emergency Services, see page NBM 5402 D.

- For payment conditions applicable to Gene-Based, Cellular And Other Innovative Therapies (GCIT), see page NBM 5402 F.
- For payment conditions applicable to Outpatient X-Ray Services and Outpatient Laboratory Services, see page NBM 5402 G PPO.
- For payment conditions applicable to Emergency Room Services, see page NBM 5402 H PPO.
- For payment conditions applicable to Traditional East Asian Medicine, see page NBM 5402 N.
- For payment conditions applicable to Treatment or Service not available from a PPO Provider, see Special Payment Conditions described below.

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

SPECIAL PAYMENT CONDITIONS

Treatment or Service Not Available from a Preferred Provider

When no Preferred Provider is reasonably available within the designated service area and the Insured Person receives such Treatment or Service for a listed Covered Charge from a Non-Preferred Provider, the Company will pay benefits as follows:

- The Non-Preferred Provider will be reimbursed at the same coinsurance rate as the Preferred Provider would have been reimbursed had the Insured Person been treated by a Preferred Provider.
- The Non-Preferred Provider will be reimbursed at the usual and customary charge for the service, less any applicable coinsurance, copayment, or deductible.
- Any out-of-pocket amounts paid by the Insured Person when care is received from a Non-Preferred Provider will count toward satisfaction of the Out-of-Pocket Expense Limits and the Calendar Year Deductible that applies when care is received from a Preferred Provider.

If a Dependent Child receives Treatment or Service from Other Than a Preferred Provider and is covered subject to a court or administrative order and resides outside the PPO service area, benefits will be paid as if Treatment or Service had been provided by a Preferred Provider.

BENEFIT MAXIMUMS

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

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

The Insured Person's Responsibilities

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

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

PRESCRIPTION DRUGS

Benefits Payable

For each prescription and each refill:

- For generic and single source contraceptives for women..... 100% of Covered Charges.
- For all others ..... 100% of Covered Charges in excess of the Copay amount.

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

Copay Amount

For each prescription and each refill:

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

For all others:

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

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

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

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

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

MAIL SERVICE PRESCRIPTION DRUGS

Benefits Payable

For each prescription and each refill:

- For generic and single source contraceptives for women ..... 100% of Covered Charges.
- For all others ..... 100% of Covered Charges in excess of the Copay amount.

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

Copay Amount

For each prescription and each refill:

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

For all others:

- For Tier 1 Generic Prescription Drugs (including selected Preferred Brand Name Prescription Drugs).....	$45
- For Tier 2 Preferred Brand Name Prescription Drugs.....	$90
- For Tier 3 Non-Preferred Prescription Drugs	$150

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

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

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

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

BOOKLET-CERTIFICATE RIDER

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

Consolidated Appropriations Act
Nippon Life Insurance Company of America

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

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

I. No Surprises Act

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

Definitions Applicable to the No Surprises Act

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

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

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

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

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

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

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

- The patient is in such a condition to receive information as stated the preceding bullet above and to provide informed consent in accordance with applicable law.

Health Care Facility in the context of non-emergency services means:
- a Hospital as defined in section 1861(e) of the Social Security Act;
- a Hospital outpatient department;
- a critical access Hospital as defined in section 1861 of the Social Security Act; and
- an Ambulatory Surgery Center described in section 1833(i)(1)A of the Social Security Act.

Independent Freestanding Emergency Department means a Health Care Facility that:
- is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- provides Emergency Health Care Services.

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

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

Out-of-Network Rate means, with respect to Surprise Medical Bills for Emergency Services, Surprise Medical Bills for Non-Emergency Services and Surprise Medical Bills for Air Ambulance Services, as defined herein, the total payment for Covered Charges furnished by a Nonparticipating Provider, Nonparticipating Emergency Facility, or Nonparticipating Provider of Air Ambulance Services. If a "Specified State Law" applies, the Out-of-Network Rate will be determined in accordance with such law. If no "Specified State Law" applies, the Out-of-Network Rate will be equal to:
- With respect to Surprise Medical Bills for Emergency Services and Surprise Medical Bills for Non-Emergency Services: the lesser of the billed amount or Qualifying Payment Amount reduced by the Insured Person's Cost-Sharing amount. The Insured Person's Cost-Sharing amount for this purpose is based on the Recognized Amount, as defined herein.
- With respect to Surprise Medical Bills for Air Ambulance Services: the lesser of the billed amount or Qualifying Payment Amount reduced by the Insured Person's Cost-Sharing amount. The Insured Person's Cost-Sharing amount, for this purpose, is as specified herein under the section captioned "Surprise Medical Bills for Air Ambulance Services".

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

services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

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

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

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

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

- Out-of-network Emergency Health Care Services.
- Non-emergency health care services received at certain network facilities by out-of-network Physicians, when such services are either Ancillary Services, or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain network facilities" are limited to a Hospital (as defined in 1861(e) of the Social Security Act), a Hospital outpatient department, a critical access Hospital (as defined in 1861(mm)(1) of the Social Security Act), an Ambulatory Surgery Center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following:
- an applicable Specified State Law,
- an All Payer Model Agreement if adopted, or
- in a state that does not have in effect an applicable Specified State Law, the lesser of:
  - the amount that is the Qualifying Payment Amount as determined under applicable law. The Qualifying Payment Amount has the meaning given the term in 45 CFR § 149.140(a)(16); or
  - the amount billed by the provider or facility.

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

Surprise Medical Bills for Emergency Services

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

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

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

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

Surprise Medical Bills for Non-Emergency Services

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

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

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

Surprise Medical Bills for Air Ambulance Services

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

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

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

II. Dispute Resolution

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

III. Continuity of Care

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

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

Continuing Care Patient means an individual who is:

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

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

If a contractual relationship between a health care provider or facility and the network is Terminated or the benefits being provided to an Insured Person under the Group Policy is Terminated because of either a change of terms in the participation of such a provider or a loss of benefits being provided under the Group Policy; the Company will:

- notify each Insured Person, on a timely basis, who is enrolled under the Group Policy who is a Continuing Care Patient with respect to a provider or facility at the time of such Termination and the Insured Person's right to elect continued transition care from the provider or facility;
- provide the Insured Person with an opportunity to notify the Company of the Insured Person's need for transitional care; and
- permit the Insured Person to elect to continue to have benefits provided under the Group Policy, with the same terms and conditions, as would have applied and with respect to such Treatment or Service as would have been covered had such Termination not occurred, with respect to the course of treatment furnished by the provider or facility as related to the Insured Person's status as a Continuing Care Patient until the date the Insured Person is no longer a Continuing Care Patient.

IV. Provider Directories

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

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

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

NIPPON LIFE INSURANCE COMPANY OF AMERICA

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HOW TO BE INSURED – MEMBERS

MEDICAL EXPENSE INSURANCE

Eligibility

Persons enrolling for insurance must be a Member (as defined in page NBM 5136).

If the person is a Member on January 1, 2024, the person will be eligible on that date.

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

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

Individual Incontestability and Eligibility

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

- the insurance has been in force for less than two years during the Insured Person's lifetime; and
- the statement is in Written form Signed by the Insured Person; and
- a copy of the form which contains the statement is given to the Insured Person or the Insured Person's beneficiary at the time insurance is contested.

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

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

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

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

Effective Date for Non-Contributory Insurance

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

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

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

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

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

Effective Date for Contributory Insurance

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

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

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

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

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

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

Statement of Health Requirements

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

Late Enrollment Provisions

- **Definition**

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

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

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

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

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

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

- **Effective Date for Late Enrollees**

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

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

- **Annual Open Enrollment Period**

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

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

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

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

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

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

- **Special Enrollment Periods**

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

The Special Enrollment Periods are:

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

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

(ii) the other coverage terminated due to loss of eligibility (including loss due to divorce, 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, birth, adoption, Placement for Adoption or if the Member becomes a party in a suit for adoption; and
(iii) enrollment is made within 31 days after the later of the date of the marriage, birth, adoption, Placement for Adoption or if the Member becomes a party in a suit 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, 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, Placement for Adoption or the date the Member becomes a party in a suit for adoption, whichever is earlier.

(3) Court-Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) or the Texas Child Support Order. 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 or is eligible to be enrolled but failed to enroll during a previous enrollment period; and
(ii) the Member failed to enroll his or her spouse or Dependent Child during a previous enrollment period; and
(iii) the Member is required by a court or administrative order to provide health insurance for the spouse or Dependent Child; and
(iv) request for enrollment for the spouse is made within 31 days after the issue date of the court or administrative order. A request for enrollment for the Member or the Member's Dependent Child may be made at any time after the issue date of the court or administrative order.

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

(5) Loss of Medicaid or Texas CHIP Coverage for a Dependent Child. A special enrollment will apply to a Member's Dependent Child if:

- the Member is enrolled but failed to enroll his or her Dependent Child during a previous enrollment period; and
- the Member's Dependent Child lost coverage under:
  - Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits for substance abuse under Section 1928 of the Social Security Act; or
  - the Texas Child Health Plan for Certain Low-Income Children (CHIP) under Chapter 62 of the Health and Safety Code; and
- request for enrollment is made within 60 days after the date the other coverage terminates.

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

- Eligibility for Medicaid or Texas CHIP Coverage for the Member or the Member's Dependent. A Special Enrollment Period will apply to the Member or the Member's Dependent if:

  - the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
  - the Member has failed to enroll his or her Dependent during a previous enrollment period; and
  - the Texas Department of Health or a designee of the Texas Department of Health provides written Notice that the Member or the Member's Dependent is eligible for medical assistance under the state Medicaid program or the Member's Dependent Child is enrolled in the Texas Child Health Plan for Certain Low-Income Children (CHIP) under Chapter 62 of the Health and Safety Code and is participating in the state health insurance premium payment reimbursement program for medical assistance recipients under the Texas Human Resources Code.

  The request for enrollment

  - may be made at any time after the issue date of the Notice; and
  - will apply only to the Member or the Member's Dependent listed in the Notice.

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

(6) Loss of Eligibility for Medical Assistance Under the State Medicaid Program (or the Texas Child Health Plan for Certain Low-Income Children (CHIP). A Special Enrollment Period will apply to the Member or the Member's Dependent if:

- the Member is enrolled (or is eligible to be enrolled but has failed to enroll during a previous enrollment period); and
- the Member has failed to enroll his or her Dependent during a previous enrollment period; and
- the Member or the Member's Dependent has lost eligibility for medical assistance under the state Medicaid program or CHIP; and
- the Member requests enrollment within 31 days after the date eligibility for medical assistance terminates.

The request for enrollment will apply only to the Member or the Member's Dependent if medical assistance under the state Medicaid program or CHIP has been discontinued.

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

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

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

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

Effective Date for Benefit Changes

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

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

Termination

Unless continued as provided below or on page NBM 5117 A, NBM 5117 B, NBM 5117 C, and NBM 5117 D, a Member's insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the end of the Insurance Month in which the last premium payment is made for the Member's insurance; or
- for contributory insurance, the end of the Insurance Month, if requested by the Member before that date; or
- the end of the Insurance Month in which the Member ceases to belong to a class for which insurance is provided; or
- the end of the Insurance Month in which the Member ceases to be a Member; or
- the end of the Insurance Month in which the Member ceases to be actively employed; or
- the date the Member transfers to an HMO offered by the Policyholder as an alternative to coverage under the Group Policy.

With respect to termination due to ceasing to belong to a class for which insurance is provided, to be a Member or to be actively employed, the Member's insurance under the Group Policy will terminate at the end of the Insurance Month following the date the Company receives notice from the Policyholder that the Member is no longer eligible under the Group Policy, during which time, the Policyholder remains liable for the Member's premium. The Member's insurance remains in effect through the end of the Insurance Month for which the Policyholder has paid premium.

Continuation

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

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

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

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

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 will be eligible for Dependent insurance on the latest of:

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

Effective Date

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

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

Insurance for a Newborn or Newly Adopted Child

A newborn child will be insured for medical benefits from the moment of birth provided the child meets the Group Policy's definition of a Dependent Child. A newly adopted child will be covered for medical benefits, at the Member's option, not later than the 31st day following the date the Member becomes a party to a suit in which the Member seeks to adopt the child, the date of adoption or Placement for Adoption (whichever is earlier), provided the child meets the Group Policy's definition of a Dependent Child. Any applicable prior application or first of the Insurance Month provisions will be waived with respect to such child.

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

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

Individual Incontestability and Eligibility

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

Termination

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

- Insurance for all of the Member's Dependents will terminate on the earliest of:
    - the end of the Insurance Month in which the Member ceases to belong to a class for which Dependent insurance is provided; or
    - the date Dependent coverage is removed from the Group Policy; or
    - the date the Member's insurance ceases; or
    - the end of the Insurance Month in which the last premium is paid for the Member's Dependent Medical Expense Insurance.
- Insurance for any one Dependent will terminate on the earliest 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.

With respect to termination when the Member's spouse or Dependent Child ceases to be his or her Dependent, or ceases to belong to a class for which insurance is provided, insurance for that Dependent will terminate at the end of the Insurance Month following the date the Company receives notice from the Policyholder that the Dependent is no longer eligible under the Group Policy, during which time, the Policyholder remains liable for the Member's premium.

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. Further proof that the child remains incapable of self-support must be provided when the Company requests, but not more frequently than annually after the two-year period following the date the child reaches the maximum age.

Continuation

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

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

Contact the Policyholder with reinstatement questions.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

GENERAL PROVISIONS

Payment Conditions

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

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

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

Benefit Qualification

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

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

Benefits Payable

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

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

Benefits Payable – Required by Federal Law

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

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

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

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

- **Pediatric Vaccines**

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

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

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

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

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

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

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

Also see "Reconstructive Surgery After Mastectomy" under Benefits Payable – State Required – Texas 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 or Copay will apply. Preventive Health and Wellness Services from Non-PPO Providers will be subject to Deductible and coinsurance.

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

- **Contraceptive Methods and Counseling for Women**

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

Benefits for Covered Charges from a Member Pharmacy or PPO Provider for generic and single source contraceptive drugs will be payable at 100%. Benefits for Covered Charges from a Member Pharmacy or PPO Provider for brand name contraceptive drugs will be payable the same as any other covered Treatment or Service and will be subject to cost-sharing. Benefits for Covered Charges from a Member Pharmacy or PPO Provider for brand name contraceptive drugs will be payable at 100% if there is no generic equivalent available or if there is a generic equivalent available but the Physician has specified that the medication prescribed must be a brand name contraceptive drug and has indicated "Dispense as Written" on the prescription.

The above services from Non-PPO Providers will be subject to Deductible and coinsurance.

- **Clinical Trials**

Covered Charges will include charges incurred for routine patient care costs in connection with an Approved Clinical Trial. Benefits will be payable the same as any other covered Treatment or Service and will be coordinated with the Clinical Trials benefit described below under Benefits Payable - State Required – Texas.

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 –Texas

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

- **Acquired Brain Injury**

  - **Coverage for Services**

    Covered Charges will include charges for:

    - cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury; and
    - post-acute transition services, community reintegration services, including Outpatient Day Treatment Services or other Post-Acute Care Treatment Services necessary as a result of and related to an acquired brain injury.

    Covered Charges will include charges for reasonable expenses, as determined by the Company, related to periodic reevaluation of the care of the individual insured under the Group Policy who:

    - has incurred an Acquired Brain Injury;
    - has been unresponsive to treatment; and
    - becomes responsive to treatment at a later date.

    Benefits payable in a post-acute rehabilitative hospital or assisted living facility will be provided.

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

  - **Definitions**

    "Acquired Brain Injury" means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

    "Cognitive Communication Therapy" means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

"Cognitive Rehabilitation Therapy" means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

"Community Reintegration Services" means services that facilitate the continuum of care as an affected individual transitions into the community.

"Neurobehavioral Testing" means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

"Neurobehavioral Treatment" means interventions that focus on behavior and the variables that control behavior.

"Neurocognitive Rehabilitation" means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

"Neurocognitive Therapy" means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

"Neurofeedback Therapy" means services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

"Neurophysiological Testing" means an evaluation of the functions of the nervous system.

"Neurophysiological Treatment" means interventions that focus on the functions of the nervous system.

"Neuropsychological Testing" means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

"Neuropsychological Treatment" means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

"Outpatient Day Treatment Services" means structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

"Post-Acute Care Treatment Services" means services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

"Post-Acute Transition Services" means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

"Psychophysiological Testing" means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

"Psychophysiological Treatment" means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

"Remediation" means the process(es) of restoring or improving a specific function.

- **Amino Acid-Based Elemental Formulas**

Covered Charges will include coverage for amino acid-based elemental formulas, regardless of the formula delivery method, that are prescribed by a Physician and that are used for the diagnosis and treatment of:

- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; or
- severe food protein-induced enterolocolitis syndrome; or
- eosinophilic disorders, as evidenced by the results of a biopsy; or
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

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

- **Autism Spectrum Disorder**

  Covered Charges will include charges incurred by the Member's Dependent Child for screening for Autism Spectrum Disorder at the ages of 18 months and 24 months and for an Insured Person who is diagnosed with Autism Spectrum Disorder from the date of diagnosis, only if the diagnosis was in place prior to the Insured Person's 10th (tenth birthday). Benefits will be payable the same as for any other covered Treatment or Service.

  Covered Charges will include charges for Generally Recognized Services prescribed for the Autism Spectrum Disorder by the Insured Person's Primary Care Physician in the treatment plan recommended by that Physician.

  Generally Recognized Services includes, but is not limited to, the following services, when the services are prescribed in accordance with the required coverage:

  - evaluation and assessment services;
  - applied behavior analysis;
  - behavior training and behavior management;
  - speech therapy;
  - occupational therapy;
  - physical therapy; and
  - medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

  Covered Charges will include charges for behavior analysis provided by a Health Care Practitioner not licensed by an agency of the state of Texas as long as the Health Care Practitioner otherwise meets one of the requirements of a Health Care Practitioner.

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

  "Applied behavior analysis" means the design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. Applied behavior analysis includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

"Autism Spectrum Disorder" means a Neurobiological Disorder that includes Autism, Asperger's syndrome, or Pervasive Developmental Disorder – Not Otherwise Specified.

"Health Care Practitioner" means a Physician, advance practice nurse, physician assistant, or other individual appropriately licensed, registered, or certified, or whose professional credential is recognized and accepted as described by the required coverage for certain children.

Under this autism spectrum disorder benefit, "Primary Care Physician" means a Physician selected or otherwise designated as the Primary Care Physician following the provisions of the Group Policy or, if the Group Policy does not contain provisions concerning selection or designation of a Primary Care Physician, a Physician selected or otherwise designated by an Insured Person or a Dependent Child's parent or guardian to develop a treatment plan for the purpose of treating autism spectrum disorder.

"Neurobiological Disorder" means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

- **Biomarker Testing**

Covered Charges will include charges for Biomarker Testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an Insured Person's disease or condition to guide treatment when the test is supported by the following kinds of medical and scientific evidence:

- a labeled indication for a test approved or cleared by the United States Food and Drug Administration;
- an indicated test for a drug approved by the United States Food and Drug Administration;
- a national coverage determination made by the Centers for Medicare and Medicaid Services or a local coverage determination made by a Medicare administrative contractor;
- Nationally Recognized Clinical Practice Guidelines; or
- Consensus Statements.

Coverage will be provided only when use of Biomarker Testing provides clinical utility because use of the test for the condition:

- is evidence-based;
- is scientifically valid based on the medical and scientific evidence;
- informs a patient's outcome and a provider's clinical decision; and
- predominately addresses the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. The term includes gene mutations and protein expression.

"Biomarker Testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a Biomarker. The term includes single-analyte tests; multiplex panel tests; and whole genome sequencing.

"Consensus Statements" means statements that:

- address specific clinical circumstances based on the best available evidence for the purpose of optimizing clinical care outcomes; and
- are developed by an independent, multidisciplinary panel of experts that uses a transparent methodology and reporting structure and is subject to a conflict of interest policy.

"Nationally Recognized Clinical Practice Guidelines" means evidence-based clinical practice guidelines that:

- establish a standard of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options;
- include recommendations intended to optimize patient care; and
- are developed by an independent organization or medical professional society that uses a transparent methodology and reporting structure and is subject to a conflict of interest policy.

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

- **Bone-Mass Measurement**

Covered Charges will include charges for medically accepted bone-mass measurement for the detection of low bone mass and to determine the individual's risk of osteoporosis. Benefits will be payable the same as for any other covered Treatment or Service.

- **Cancer Screening Colorectal**

Covered Charges will include, for an Insured Person who is 45 years of age or older and at normal risk for developing colon cancer, charges for medically recognized screening examinations for the detection of colorectal cancer including, but not limited to, screenings with:

- all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and

- an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Benefits from a PPO Provider will be payable at 100% of Prevailing Charges and no Deductible or Copay will apply. The above services from Non-PPO Providers will be payable the same as for any other covered Treatment or Service.

All other flexible sigmoidoscopies or colonoscopies will be payable the same as any other covered Treatment or Service.

- **Cervical Cancer Screening**

Covered Charges will include, for females age 18 and over, a CA 125 blood test, an annual Pap smear screening or a screening using a liquid-based cytology method, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus, and any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer. If services are provided by a PPO Provider, benefits for the annual screening will be payable the same as the Preventive Health and Wellness Services benefit as described in NBM 5102 PPO. All other screenings will be payable the same as any other covered Treatment or Service.

- **Child Immunizations**

Covered Charges will include charges incurred for immunizations administered to a Dependent Child from birth to six years of age. The term immunizations will include vaccines for Diphtheria, Haemophilus Influenza type B, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella, and any other immunization that is required by law. Benefits for immunizations will be paid at 100% of Prevailing Charges and no Deductible or Copay will be applied.

NOTE: This benefit will be coordinated with the Pediatric Vaccines benefit described above under Benefit Payable – Required by Federal law.

- **Clinical Trials**

  Covered Charges will include charges incurred for Routine Patient Care Costs incurred in connection with a Clinical Trial. Benefits will be payable the same as for any other covered Treatment or Service and will be coordinated with the Clinical Trials benefit described above under Benefits Payable – Required by Federal Law.

  "Clinical Trial" means a Phase I, Phase II, Phase III or Phase IV clinical trial conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

  - the Centers for Disease Control and Prevention of the United States Department of Health and Human Services; or
  - the National Institute of Health; or
  - the United States Food and Drug Administration; or
  - the United States Department of Defense; or
  - the United States Department of Veterans Affairs; or
  - an institutional review board of an institution in Texas that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

  "Routine Patient Care Costs" means costs of any medically necessary health care for which benefits are provided under the Group Policy, without regard to whether the person is participating in a clinical trial. Routine patient care costs do not include:

  - the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial; or
  - the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial; or
  - the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
  - a cost associated with managing a clinical trial; or
  - the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

- **Contraceptive Drugs, Devices, and Services**

  Covered Charges will include charges incurred for prescription contraceptive drugs or devices that are approved by the United States Food and Drug Administration.

Covered Charges will also include charges for outpatient contraceptive services including consultations, examinations, procedures, and medical services provided on an outpatient basis and that are related to the use of a drug or device intended to prevent pregnancy.

The Insured Person may obtain up to a three-month supply of a covered prescription contraceptive drug at one time the first time the Insured Person obtains the prescription contraceptive drug and a 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the Insured Person obtains the same prescription contraceptive drug.

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

- **Craniofacial Abnormalities**

Covered Charges include Treatment or Service for Reconstructive Surgery for Craniofacial abnormalities.

"Reconstructive Surgery for Craniofacial Abnormalities" means surgery to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.

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

- **Dental Services**

Covered Charges will include charges incurred by an Insured Person who is unable to undergo dental treatment in an office setting or under local anesthesia due to documented physical, mental, or medical reason as determined by the Physician or dentist providing the dental care. Benefits will be payable the same as for any other covered Treatment or Service.

- **Diabetes Treatment**

Covered Charges will include charges incurred by an Insured Person for the following equipment, supplies, and related services for the treatment of diabetes when medically necessary and with a Written order from a Physician or licensed health care provider. Benefits will be payable the same as for any other covered Treatment or Service.

Covered Charges will include medications, supplies, and equipment with a Written order from a Physician or licensed health care provider unless the Physician or licensed health care provider approves a substitution.

- **Equipment and Supplies**

  Covered Charges will include blood glucose monitors, including noninvasive glucose monitors and monitors designed to be used by blind individuals; insulin pumps and associated appurtenances including insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies; podiatric appliances for the prevention of complications associated with diabetes, including up to two pairs of therapeutic foot wear per year; test strips for blood glucose monitors; visual reading and urine test strips and tables which test for glucose, ketones, and proteins; lancet and lancet devices; insulin and insulin analogs; injection aids, including devices used to assist with insulin injection and needleless systems; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; glucagon emergency kits; biohazard disposable containers; and repairs and necessary maintenance on pumps not provided under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repairs.

  Covered Charges will include new or improved diabetes treatment and monitoring equipment or supplies, including other prescription drugs, if:

  - approved by the United States Food and Drug Administration; and
  - determined by the Physician or licensed health care provider to be medically necessary and appropriate.

- **Related Services**

  Covered Charges will also include diabetes self-management training for an Insured Person or Caretaker. Self-management training is provided upon the following occurrences:

  - the initial diagnosis of diabetes;
  - a Physician's or other health care provider's diagnosis of a significant change in the patient's symptoms or condition requiring changes in the management regime; or
  - a Physician or other health care provider prescribes periodic or episodic education warranted by the development of new techniques and treatment for diabetes.

"Caretaker" means a family member or significant other responsible for ensuring that a patient who is not able to manage his or her illness (due to age or infirmity) is properly managed, including overseeing diet, administration of medications, and use of equipment and supplies.

- **Accessibility of Diabetes Self-Management Training**

Diabetes self-management training must be provided by a:

- licensed health care professional, including a Physician, a physician assistant, a registered nurse, a licensed or registered dietician, or a pharmacist; who has been determined by their licensing board to have recent didactic and experiential preparation in diabetes clinical and educational issues;
- a diabetes self-management training program recognized by the American Diabetes Association;
- a multidisciplinary team coordinated by a Certified Diabetes Educator which consists of at least a dietitian and a nurse educator; or
- a Certified Diabetes Educator.

- **Emergency Refill of Insulin or Insulin-Related Equipment or Supplies**

Covered Charges will also include an emergency refill of Insulin or Insulin-Related Equipment or Supplies. The quantity of an emergency refill of Insulin will not exceed a 30-day supply. The quantity of an emergency refill of Insulin-Related Equipment or Supplies will not exceed the lesser of a 30-day supply or the smallest available package.

"Insulin" includes an Insulin analog and an insulin-like medication, regardless of the activation period or whether the solution is mixed before the prescription is dispensed.

"Insulin-Related Equipment or Supplies" includes needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and test strips, but excludes insulin pumps.

- **Benefits Payable for Equipment and Supplies**

  For the purpose of these state-required benefits, the following diabetic supplies will be payable under Prescription Drugs Expense Insurance Covered Charges or Mail Service Prescription Drugs Expense Insurance Covered Charges: insulin; disposable insulin needles/syringes; disposable blood/urine glucose acetone testing agents (e.g., Chemstrips, Acetest tablets, and Clinitest tablets) and lancets.

  Covered Charges will also include an emergency refill of Insulin or Insulin-Related Equipment or Supplies. The quantity of an emergency refill of Insulin will not exceed a 30-day supply. The quantity of an emergency refill of Insulin-Related Equipment or Supplies will not exceed the lesser of a 30-day supply or the smallest available package.

  "Insulin" includes an Insulin analog and an insulin-like medication, regardless of the activation period or whether the solution is mixed before the prescription is dispensed.

  "Insulin-Related Equipment or Supplies" includes needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and test strips, but excludes insulin pumps.

  Only one copayment will be charged for a 30-day supply of any item of diabetes supplies. The amount of supplies that constitutes a 30-day supply for an Insured Person is the Written order amount, a 30-day supply, by the Physician or practitioner of the Insured Person.

  A 30-day supply of a covered Prescription Insulin Drug, regardless of quantity or type, will not exceed $25 per prescription. "Insulin" means a Prescription Drug that contains insulin and is used to treat diabetes. The term does not include an insulin drug that is administered to a patient intravenously.

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

- **Fertility Preservation Services**

  Covered Charges will include charges incurred for Fertility Preservation Services for an Insured Person who will receive medically necessary treatment for cancer, including surgery, chemotherapy, or radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility. Fertility Preservation Services must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

  "Fertility Preservation Services" means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue; and does not include the storage of such unfertilized genetic materials.

  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 chronic, disabling, or life-threatening illness or 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:

  - a prescription drug reference compendium approved by the commissioner for the purposes of this requirement; or
  - substantially accepted peer-reviewed medical literature.

  Benefits payable will not include charges for any Experimental or Investigational drug not otherwise approved for a condition by the FDA, any disease or condition that may be excluded from coverage under this Group Policy, or any drug which the FDA has determined to be contraindicated for the specific treatment for which it was prescribed.

  Any prescription drug coverage 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.

- **Hearing Aids and Cochlear Implants**

  Covered Charges will include medically necessary hearing aids or cochlear implants and related services and supplies.

  Covered Charges will also include charges for fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids; any Treatment or Service related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for education gain; and for a cochlear implant, an external speech processor and controller with necessary components replacement every three years.

  Covered Charges are limited to one hearing aid in each ear every three years and one cochlear implant in each ear with internal replacement as medically or audiologically necessary.

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

- **Hearing Tests for Newborns**

  Covered Charges will include charges incurred for each insured Dependent Child for a screening test for hearing loss from birth through the date the child is 30 days old. Covered Charges will also include charges for any necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

  Benefits will be payable the same as for any other covered Treatment or Service, except that no Deductible will be applied. Diagnostic follow-ups related to the screening will be payable the same as for any other covered Treatment or Service.

- **Mammography Services and other Breast Imaging**

  Covered Charges will include charges for low-dose mammography services for all women age 35 and over.

  A low-dose mammography means an x-ray or digital examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression devise, and screens, with an average radiation exposure delivery of less than 1 rad mid-breast and with two views for each breast. The term also includes Digital Mammography and includes Breast Tomosynthesis. "Breast Tomosynthesis" means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast. "Diagnostic Imaging" means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate a subjective or objective abnormality detected by a Physician or patient in a breast; an abnormality seen by a Physician on a screening mammogram; an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or an individual with a personal history of breast cancer or dense breast tissue.

  Diagnostic Imaging will be payable the same as screening mammograms without any age restrictions.

  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 Service.

- **Mastectomy**

  Covered Charges will include Hospital Inpatient Confinement charges incurred by an Insured Person for a mastectomy and lymph node dissection for the treatment of breast cancer. Benefits will be payable for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection. Benefits will be payable the same as for any other covered Treatment or Service; however, the 48-hour and 24-hour minimum will not be subject to the Preauthorization or Covered Charges requirements of the Group Policy. Any benefits payable in excess of the 48-hour or 24-hour minimum will be subject to all terms and conditions of the Group Policy that apply to any other covered Treatment or Service.

- **Maternity Coverage**

  Covered Charges will include Hospital Inpatient Confinement charges incurred by a mother and newborn Dependent Child.

- **Hospital Inpatient Confinement**

  Benefits will be payable for a minimum of 48 hours following an uncomplicated vaginal delivery, excluding the day of delivery, and a minimum of 96 hours following an uncomplicated cesarean section, excluding the day of delivery. 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 Preauthorization or Covered Charges requirements of the Group Policy. Any benefits payable in excess of the 48-hour or 96-hour minimum will be subject to all terms and conditions of the Group Policy that apply to any other covered Treatment or Service.

- **Post-Delivery Care**

  Covered Charges will also include charges for timely Post-delivery care if the decision is made by the Physician, in consultation with the mother, to discharge the mother and newborn child before the expiration of the time periods stated above. The Post-delivery care must be provided by a Physician, registered nurse or other appropriate licensed health care provider. The Post-delivery care must be provided in the mother's home, a provider's office, or other health care facility.

  "Post-delivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care will be determined in accordance with recognized medical standards for that care.

- **Medication Synchronization**

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

- the Insured Person elects to participate in medication synchronization;
- the Insured Person, the prescriber, and a pharmacist agree that Medication Synchronization is in the best interest of the Insured Person;
- the prescription drug to be included in the Medication Synchronization meets all of the following requirements:
  - be covered by the Group Policy;
  - be prescribed for the treatment and management of a Chronic Illness and be subject to refills;
  - satisfy all relevant prior authorization criteria;
  - not have quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized;
  - not have special handling or sourcing needs, as determined by the Group Policy, that require a single, designated pharmacy to fill or refill the prescription;
  - be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization;
  - not be a schedule II controlled substance or a schedule III controlled substance containing hydrocodone.

Medication Synchronization will be provided when the prescription drug is dispensed in a quantity or amount that is less than a thirty-day supply and only once for each prescription drug subject to Medication Synchronization for the same Insured Person, except when either of the following occurs:

- the prescriber changes the dosage or frequency of administration of the prescription drug subject to medication synchronization.
- the prescriber prescribes a different drug.

The Company will permit and apply a prorated daily cost-sharing rate for a supply of a prescription drug subject to Medication Synchronization. Dispensing fees will not be prorated.

"Chronic Illness" means an illness or physical condition that may be reasonably expected to continue for an uninterrupted period of at least three months and controlled but not cured by medical treatment.

“Medication Synchronization” means a plan established for the purpose of synchronizing the filling or refilling of multiple prescriptions.

- **Newborn Screening Tests**

  For a newborn Dependent Child, Covered Charges will include charges for the administration of a newborn screening test as required by the Health and Safety Code, including the cost of the newborn screening test kit in the amount provided by the Department of State Health Services.

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

- **Orally Administered Anti-Cancer Medication**

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

  The level of benefits provided for orally administered anti-cancer drugs will not be less than the level of benefits provided for intravenously administered or injected anti-cancer medication.

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

- **Ovarian Cancer Screening**

  Covered Charges will include charges incurred for an annual CA 125 blood test.

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

- **Phenylketonuria (PKU) Treatment or Other Heritable Disease**

  Covered Charges will include formulas and other special dietary items prescribed by a Physician or ordered by a Physician for Treatment or Service of Phenylketonuria (PKU) or other Heritable Disease. Benefits will be payable the same as for any other covered Treatment or Service.

  “Phenylketonuria” means an inherited condition that may cause a severe intellectual disability if not treated. “Heritable Disease” means an inherited disease that may result in a physical intellectual disability or death.

- **Prescription Eye Drops**

  Covered Charges for a refill of prescription eye drops to treat a chronic eye disease or condition will allow the refill of prescription eye drops if the Insured Person timely pays at the point of sale and:

  - the original prescription states that additional quantities of the eye drops are needed;
  - the refill does not exceed the total quantity of dosage units authorized by the prescribing Physician on the original prescription, including refills; and
  - the refill is dispensed on or before the last day of the prescribed dosage period and:
    - not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
    - not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
    - not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

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

- **Prostate Cancer Screening**

  Covered Charges will include charges incurred for an annual digital rectal examination and a prostate specific antigen test.

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

- **Prosthetic Devices, Orthotic Devices, and Related Services**

  Covered Charges will include prosthetic or orthotic devices, and professional services related to the fitting of these devices.

  Covered Charges will include repair or replacement of a prosthetic or orthotic device except when necessitated by an Insured Person’s misuse or loss.

  Benefits will be payable the same as for any other covered Treatment or Service. Benefits payable to Non-PPO Providers are subject to the maximum benefit payable under the federal Medicare reimbursement schedule.

  “Orthotic device” means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

"Prosthetic device" means an artificial device designed to replace, wholly or partly, an arm or leg.

See page NBM 5402 K for additional coverage for Prosthetics.

- **Reconstructive Surgery After Mastectomy**

Covered Charges will include charges incurred for reconstructive surgery performed as a result of a partial or total mastectomy and for reconstructive surgery on a nondiseased breast to establish symmetry with a diseased breast. Covered Charges will include prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Benefits will be payable the same as for any other covered Treatment or Service.

NOTE: This benefit will be coordinated with the Breast Reconstructive Surgery Following Mastectomy benefit described above under Benefits Payable – Required by Federal law.

- **Speech or Hearing Impairment**

Covered Charges will include charges for medically necessary Treatment or Service of loss or impairment of speech or hearing. Benefits will be payable the same as for any other covered Treatment or Service

- **Telemedicine Medical Service and Telehealth Service**

Covered Charges will include charges by a Physician when health care is performed via Telemedicine Medical Service or Telehealth Service. Covered Charges will not include Telemedicine Medical Services or Telehealth Services provided by only synchronous or asynchronous audio interaction, including an audio-only telephone consultation, a text-only e-mail message, or a facsimile transmission.

"Telemedicine Medical Service" means a health care service delivered by a Physician or by a health care professional acting under the delegation and supervision of a Physician using telecommunications or information technology.

"Telehealth Service" means a health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification using telecommunications or information technology.

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

- **Temporomandibular Joint Disorders (TMJ)**

  Covered Charges will include charges incurred for medically necessary surgical and nonsurgical treatment of temporomandibular (jaw or craniomandibular) joint disorders (TMJ). Coverage must include treatment for diagnosis or surgery resulting from an accident, trauma, a congenital defect, a developmental defect or pathology. However, Covered Charges will not include any charges for appliances, orthodontic services, or treatment for replacement or restoration of the dentition, supporting tissues, and bone.

  Benefits will be payable the same as for treatment to any other joint in the body.

- **Tests for Early Detection of Heart Disease**

  Covered Charges will include a noninvasive screening test for atherosclerosis and abnormal artery structure and function. The noninvasive screening may be either a:

  - Computed tomography (CT) scan that measures coronary artery calcification; or
  - Ultrasonography that measures carotid intima-media thickness and plaque.

  The screening must be performed by a laboratory that is certified by a national organization recognized by the commissioner.

  To be eligible, the Insured Person must be a diabetic or have a risk of developing coronary heart disease based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher, and meet the following age requirements:

  - males who are older than 45 years of age and younger than 76 years of age; or
  - females who are older than 55 years of age and younger than 76 years of age.

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

COVERED CHARGES

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

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

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

- **Hospital Services** include:

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

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

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

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

  - charges for Treatment or Service furnished at the Physician's office or clinic or an Urgent Care Center. Such services include charges for a Physician Visit, injections, take-home drugs, blood, blood plasma, x-ray and laboratory examinations, x-ray, radium, and radioactive isotope therapy, removal of impacted teeth. EXCEPTION: Benefits will be payable for Bone Mass Measurement, Cancer Screening Colorectal, Cervical Cancer Screening, Child Immunizations, Hearing Tests for Newborns, Mammography Services, Prostate Cancer Screening and Tests for Early Detection of Heart Disease as described in page NBM 5400; and
  - the services of a Health Care Extender; and
  - speech therapy; and
  - outpatient physical and occupational therapy not to exceed 30 visits per Calendar Year for each Insured Person, except that outpatient physical, occupational, and speech therapy will not be subject to any visit limits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; and
  - Traditional East Asian Medicine as described in page NBM 5402 N; and
  - Telemedicine or Telehealth Treatment or Service; and
  - Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine); and
  - Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described in page NBM 5402 F; and
  - dressings, supplies, equipment not considered to be Durable Medical Equipment as described in page NBM 5402 J, anesthesia; 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 Dental Services are completed within twelve months after the accident or completed within twelve months after the insurance under the Group Policy is effective for the Insured Person. Covered Charges are limited to the least expensive procedure that would provide professionally acceptable results; and
  - the services of a licensed marriage and family therapist (except charges for marital counseling will not be a Covered Charge).

- **All Other Covered Services** include:

  - drugs and medicines: (i) requiring a Physician's prescription; and (ii) approved by the Food and Drug Administration for general marketing; and (iii) which are not otherwise considered Covered Charges under the Comprehensive Medical Expense portion of the Group Policy; and (iv) so long as said drugs or medicines are not subject to the limitations as described in page NBM 5402 Q and excluding those charges paid under Prescription Drugs Expense Insurance as described in page NBM 5424 and Mail Service Prescription Drugs Expense Insurance as described in page NBM 5425; and
  - charges for ambulance services (including air ambulances) provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) or to and from a Hospital when needed to transition to a more cost effective level of care as determined by the Company; and
  - covered orthotics, casts, splints, braces, crutches; and
  - Skilled Nursing Facility Care as described in page NBM 5402 M; and
  - Hospice Care as described in page NBM 5402 L; and
  - Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described in page NBM 5402 F; and
  - Home Health Care as described in page NBM 5402 I; and
  - Home Infusion Therapy Services as described in page NBM 5402 I; and
  - Durable Medical Equipment as described in page NBM 5402 J; and
  - Prosthetics as described in page NBM 5402 K; and
  - the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.), but only when such services are provided as part of Home Health Care, Home Infusion Therapy Services or Hospice Care as required by state law; and
  - cornea or skin transplants; and
  - oxygen (including rental of equipment for its administration) and nebulizers and related charges; and
  - formulas and other special dietary items prescribed by a Physician or ordered by a Physician for the treatment of Phenylketonuria (PKU) or Other Heritable Disease as described in page NBM 5400; and
  - the following services performed while the Insured Person is not Hospital Inpatient Confined, or is not in a Hospital emergency room: magnetic resonance imaging (MRIs), computerized axial tomography (CATs) positron emission tomography (PETs), and single photon emission computerized tomography (SPECTs), or other similar imaging tests and all related services (other than evaluation and management services) including but not limited to drugs and supplies; and
  - unattended (home) sleep studies.

Drug and Medicine Management

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

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

Cosmetic Treatment or Service

Covered Charges will include Cosmetic Treatment or Service resulting from a sickness or an accidental injury, and rendered within 18 months after the date the sickness or accidental injury was first diagnosed or rendered within 18 months after the insurance under the Group Policy is effective for the Insured Person. 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.

Covered Charges Carried Forward

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

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

whichever would result in the greater benefit payment.

Continuity of Care

If an Insured Person is receiving medical care from a Preferred Provider, and the Preferred Provider ceases to participate in the Preferred Provider network, except for reason of medical competence or professional behavior, the Insured Person may continue to receive medical care from such provider with benefits payable at the PPO coinsurance level if:

- Special Circumstances exist in accordance with the dictates of medical prudence; and
- the Special Circumstance is identified by the treating Physician who may request, with the approval of the Insured Person, that the person who is receiving medical care be permitted to continue treatment under the Physician's care.

"Life Threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Special Circumstances" mean a condition regarding which the treating Physician or Health Care Extender reasonably believes that discontinuing care by the treating Physician or Health Care Extender could cause harm to the Insured Person. Examples of an Insured Person who has a Special Circumstance include an Insured Person with a disability, acute condition, or Life-Threatening illness or an Insured Person who is past the 24th week of pregnancy.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

MENTAL HEALTH, BEHAVIORAL, ALCOHOL OR DRUG ABUSE TREATMENT SERVICES

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

- **Inpatient Hospital Services**

  If an Insured Person is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, a Chemical Dependency Treatment Center, or a psychiatric or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. Benefits will be payable the same as for any other Hospital Inpatient Confinement.

  Benefits for confinement in a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents are also payable under these Inpatient Hospital benefits, provided:

  - the Insured Person would otherwise require hospitalization if medically necessary care was not available through a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents; and
  - services are based on an individualized treatment plan.

  Hospital Inpatient Confinements are subject to the Utilization Management Program, including Preauthorization requirements, as described on NBM 5407 CC.

- **Outpatient Services**

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

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

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

Covered Charges for Outpatient Services are limited to the following services:

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

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

“Partial Hospitalization or Day Treatment Services” mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

- **Physician Visits**

If an Insured Person receives any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable the same as for any other Physician Visit, except that outpatient physical, occupational, and speech therapy will not be subject to any visit limits.

- **Benefits Payable**

  Benefits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services are payable the same as for any other covered Treatment or Service. There will be no imposition of any quantitative or non-quantitative Treatment or Service limits that are more restrictive than those imposed on Treatment or Service for medical or surgical expenses.

Limitations

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

- TRANSPLANT SERVICES

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

- Covered Transplants

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

- Heart;
- Heart/lung (simultaneous);
- Lung;
- Liver;
- Kidney;
- Kidney-Pancreas;
- Pancreas;
- Small Bowel;
- Bone marrow transplant or peripheral stem cell infusion for the following conditions when a positive response to standard medical treatment or chemotherapy has been documented. Unless otherwise indicated, coverage is for one transplant or infusion only per lifetime.

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

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

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

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

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

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

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

- **Covered Charges**

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

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

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

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

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

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

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

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

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

  For Transplant Services provided by other than a Transplant Network provider, benefits will be payable the same as any other covered Treatment or Service.

  No benefits will be payable for travel and lodging expenses if services are provided outside the Transplant Network.

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

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

  For each transplant episode Covered Charges will include:

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

  Covered Charges will not include, and no benefits will be paid for a human organ transplant or post-transplant care if:

  - the transplant operation is performed in a country known to have participated in forced organ harvesting, as designated by the commissioner of state health services; or
  - the human organ to be transplanted was procured by a sale or donation originating in a country known to have participated in forced organ harvesting, as designated by the commissioner of state health services.

  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.

When an Insured Person cannot reasonably reach a Preferred Provider, the following Emergency Services, by a Non-Preferred Provider, will be reimbursed at the usual and customary rate or at an agreed rate and at the Preferred Provider level of benefits until the Insured Person can reasonably be expected to transfer to a Preferred Provider:

- a medical screening exam or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital that is necessary to determine whether a medical emergency condition exists;
- necessary Emergency Services, including the treatment and stabilization of an Emergency Medical Condition;
- services originating in a Hospital emergency facility or freestanding emergency medical care facility following treatment and stabilization of an Emergency Medical Condition; and
- supplies related to the Emergency Services.

There are certain out-of-network services (Emergency Services), where balance billing by the Non-Preferred Provider is prohibited. In these situations, the Insured Person’s financial responsibility is limited to the applicable Copay, coinsurance, and Deductible based on Prevailing Charges.

Treatment or Service from a Non-PPO Provider for conditions that are not Emergency Services will be paid at the Non-PPO level.

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

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

- **Covered Charges**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Limitations**

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

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

OUTPATIENT X-RAY SERVICES AND OUTPATIENT LABORATORY SERVICES

- OUTPATIENT X-RAY SERVICES

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

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

- OUTPATIENT LABORATORY SERVICES

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

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

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

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

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

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

EMERGENCY ROOM SERVICES

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

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

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

The emergency room Copay amount, if any:

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

HOME HEALTH CARE AND HOME INFUSION THERAPY SERVICES

- HOME HEALTH CARE SERVICES

- Covered Charges

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

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

In addition, the attending Physician must certify that Home Health Care Services are necessary to prevent, delay or shorten Hospital Inpatient Confinement 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 a licensed vocational nurse (L.V.N.) under the supervision of at least one licensed registered nurse (R.N.) and at least one physician; and
- part-time or intermittent home care by a Home Health Aide; and
- the services of a physical therapist, occupational therapist, speech therapist or respiratory therapist; and
- intermittent services of a registered dietician or social worker; and
- drugs and medicines which require a Physician's prescription, (unless a Covered Charge under Home Infusion Therapy Services), as well as other supplies prescribed by the attending Physician; and
- laboratory services (unless a Covered Charge under Home Infusion Therapy Services).

- **Benefits Payable**

  Benefits will be payable the same as for any other covered Treatment or Service, subject to a maximum of 100 Home Health Care visits per Calendar Year for each Insured Person. Each visit by a representative of a Home Health Care Agency will be considered one visit; four hours of Home Health Aide service will be considered one visit. If service of a Home Health Aide extends beyond four hours, each four-hours, or portion of that period, will be counted as one visit. Covered providers include a: Home Health Aide, licensed registered nurse (R.N.), licensed vocational nurse (L.V.N.), licensed practical nurse (L.P.N.), registered dietician, social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, or any other member of the Home Health Care team.

- **Limitations**

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

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

- **HOME INFUSION THERAPY SERVICES**

  - **Covered Charges**

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

    - intravenous chemotherapy;
    - intravenous antibiotic therapy;
    - intravenous steroidal therapy;
    - intravenous pain management;
    - intravenous hydration therapy;
    - intravenous antiretroviral and antifungal therapy;
    - intravenous inotropic therapy;

- total parenteral nutrition;
- intravenous gamma globulin;
- intrathecal and epidural;
- blood and blood products;
- injectable antiemetics;
- injectable diuretics; and
- injectable anticoagulants.

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

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

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

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

- **Benefits Payable**

Benefits will be payable the same as for any other covered Treatment or Service. Benefits payable will be based on the Company's allowable charge. The maximum allowable charge for drugs and medicines for Home Infusion Therapy Services will be established by the Company and will not exceed the Average Wholesale Price.

- **Limitations**

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

DURABLE MEDICAL EQUIPMENT

- **Covered Charges**

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

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

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

- **Benefits Payable**

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

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

- **Limitations**

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

PROSTHETICS

- **Covered Charges**

  Covered Charges will include charges for prosthetic devices, except as provided in page NBM 5400, (including external electronic voice boxes and similar hand held communication devices after laryngectomy) and supplies which replace all or part of:

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

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

- **Benefits Payable**

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

- **Limitations**

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

HOSPICE CARE

- **Covered Charges**

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

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

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

Hospice Care Services consist of:

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

- **Benefits Payable**

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

- **Limitations**

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

SKILLED NURSING FACILITY CARE

- **Covered Charges**

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

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

  either

  - the Skilled Nursing Facility confinement 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.

- **Benefits Payable**

  Benefits will be payable the same as for any other covered Treatment or Service, except that Covered Charges for each day will not be more than 50% of:

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

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

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

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

- **Limitations**

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

- TRADITIONAL EAST ASIAN MEDICINE

- Covered Charges

Covered Charges will include charges for:

- acupuncture;
- acupressure.

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

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

- Definitions

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

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

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

- **Benefits Payable**

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

- **Limitations**

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

LIMITATIONS

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

- Treatment or Service that is not a Covered Charge; or
- Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure prescribed in the notice of that claim decision); or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is in an Insured Person's Immediate Family, except for Dental Services; or
- Dental Services or materials, including dental implants, except as described under Covered Charges; or
- eye examinations for the correction of vision or the fitting of glasses, eye refractions; vision materials including but not limited to frames or lenses; or
- hearing aids, except as provided under Hearing Aids and Cochlear Implants as described in page NBM 5400; or
- acupressure treatment; acupuncture treatment, except as described under Traditional East Asian Medicine; or
- drugs or medicines that do not require a Physician's prescription or have not been approved by the Food and Drug Administration for general marketing; or
- vitamins, minerals (except prescription potassium supplements) and herbal supplements, except as provided under Traditional East Asian Medicine whether or not they require a Physician's prescription; or
- nutritional supplements (even if the only source of nutrition), or special diets (whether or not they require a Physician's prescription except as specifically provided under (i) Phenylketonuria (PKU) Treatment or Other Heritable Disease or (ii) Amino Acid-Based Elemental Formulas as described in page NBM 5400; or
- drugs that are not included in the formulary; or
- wigs or hair prostheses; or
- Cosmetic Treatment or Service which does not qualify for coverage as described in page NBM 5402 A PPO, and any complications arising therefrom, unless the Treatment or Service results from a congenital disease or anomaly of a newborn Dependent Child which has resulted in a defect; or

- personal hygiene, comfort or convenience items, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, hoyer lift, gait belts, bedpans, physical fitness equipment, stair glides, elevators or lift, adaptive equipment for the purpose of aiding in the performance of Activities of Daily Living including, but not limited to dressing, bathing, preparation or feeding of meals; or
- "barrier free" home modifications, whether or not recommended by a Physician, including, but not limited to ramps, grab bars, railings or standing frames; or
- non-implantable communication-assist devices, including, but not limited to, communication boards and computers; or
- Treatment or Service for work-hardening programs or vocational rehabilitation services; or
- Treatment or Service leading to, in connection with, or resulting from sexual transformation or intersex surgery; or
- cryopreservation or storage; or
- Treatment or Service for education or training; or
- Treatment or Service for learning disorders; or
- Treatment or Service for developmental delay (except for outpatient occupation, speech and physical therapy services); or
- social counseling (except as provided under Hospice Care), marital counseling or sexual disorder therapy; 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 (not applicable to tax-supported institutions of the State of Texas); 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 other medical assistance plans for the needy or indigent or as required under Federal law); or
- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from participation in criminal activities; or
- Treatment or Service for and complications related to:
  - human-to-human organ or bone marrow transplants, except as described under Transplant Services or Covered Charges; or
  - animal-to-human organ or tissue transplants; or
  - implantation within the human body of artificial or mechanical devices designed to replace human organs; or
- behavior modification or group therapy, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; or
- Treatment or Service for smoking cessation or nicotine addiction, except as provided under Preventive Health and Wellness Services, gambling addiction, or stress management; or
- Treatment or Service for insertion, 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; or
- Treatment or Service performed for the purpose of abortion, except when the Treatment or Service rendered is permitted by state law in the applicable jurisdiction where the Treatment or Service is rendered; or
- Treatment or Service performed for the purpose of reversal of voluntary sterilization; or
- Treatment or Service for routine foot care including the removal of corns and calluses or trimming of toenails, flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary; or
- dietetic counseling, unless provided while the Insured Person is Hospital Inpatient Confined, except as covered under Preventive Health and Wellness Services, or as provided under Home Health Care or Hospice Care; or
- Treatment or Service by any type of health care practitioner not otherwise provided for in this booklet-certificate, unless recognition is state mandated; or
- Treatment or Service provided for weight loss or reduction of obesity, except as covered under Preventive Health and Wellness Services, even if the Insured Person has other health conditions which might be helped by weight loss or reduction of obesity; or
- Treatment or Service for Custodial Care; or
- Treatment or Service for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained; 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 or Services for non-synostotic plagiocephaly (positional head deformity) except that this limitation will not apply to cranial helmets for such deformities if more conservative treatment has been tried but has failed; or
- additional charges incurred because care was provided after hours, on a Sunday, holidays or week-end; or
- charges for heating pads, heating and cooling units, ice bags or cold therapy units; or
- Sleep studies using devices that do not provide a measurement of Apnea Hypopnea Index (AHI) and oxygen saturation; or
- charges for DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- charges for devices used specifically as safety items or to affect performance in sports-related activities; or
- Treatment or Service for gynecomastia (abnormal breast enlargement in males); or
- charges for physicals, health examinations, immunizations or screening procedures which are performed solely for school, sports, employment, insurance, licensing or travel; or
- Treatment or Service for complications of a non-covered Treatment or Service; or
- Treatment or Service incurred after termination of coverage under this booklet-certificate, except as provided under Extended Benefits; or
- charges for travel and lodging except as indicated under Transplant Services and Gene-Based, Cellular And Other Innovative Therapies (GCIT); 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, except as covered under Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described on page NBM 5402 F; or
- charges for transportation services except as described for ambulance services under All Other Covered Services; or
- Treatment or 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; or
- drugs or medicines which are eligible for coverage under the Prescription Drugs Expense Insurance section of this booklet-certificate, including those for which benefits are not payable under that section of this booklet-certificate, for whatever reason; or
- recreational therapy, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; or
- art therapy, except as provided for under Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services and unless provided while the Insured Person is Hospital Inpatient Confined; or
- relaxation techniques; or
- massage; or
- spiritual healing; or
- imagery; or
- energy healing; or
- homeopathy.

MEDICAL EXPENSE INSURANCE

UTILIZATION MANAGEMENT PROGRAM

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

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

  - For Hospital Inpatient Confinement Charges and charges for services provided in an inpatient confinement facility, a Preauthorization is requested from the Company by the Insured Person or a designated patient representative as soon as a Hospital Inpatient Confinement or confinement in an inpatient confinement facility is scheduled, but no later than the day of a Hospital Inpatient Confinement or confinement in an inpatient confinement facility, for other than Emergency Services. Preauthorization is not a guarantee that benefits will be payable. The Company will not deny or reduce payment to the Physician or health care provider for those services based on medical necessity or appropriateness of care unless the Physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services.

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

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

    An inpatient confinement facility includes:

    - Hospital;
    - Skilled Nursing Facility;
    - Rehabilitation hospital;
    - Hospice;
    - Long term acute care facility;
    - Gene-Based, Cellular And Other Innovative Therapies (GCIT) facility/provider;
    - Psychiatric Hospital or psychiatric unit of a general Hospital for Mental Health and Behavioral Treatment Services;

- Inpatient Alcohol or Drug Abuse Treatment Facility or drug or alcohol unit of a general Hospital or any other facility required by state law to be recognized as a treatment facility under the Group Policy for Alcohol and Drug Abuse Treatment Services;
- Residential treatment center or facility.

Certain exceptions apply to Hospital Inpatient Confinement for childbirth and breast cancer treatment as described below.

- For Emergency Services admissions, the Insured Person or a designated patient representative must contact the Company within two business days, if possible, of a Hospital Inpatient Confinement or of a confinement in an inpatient confinement facility. Preauthorization 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. Preauthorization is not a guarantee that benefits will be payable. The Company will not deny or reduce payment to the Physician or health care provider for those services based on medical necessity or appropriateness of care unless the Physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services.

  Outpatient services requiring Preauthorization 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;
  - Certain selective surgery, including but not limited to hysterectomy, bariatric surgery, and sterotactic radiosurgery; and
  - Gene-Based, Cellular And Other Innovative Therapies (GCIT) facility/provider.

  The above list of outpatient services are representative of common procedures requiring Preauthorization, however they are subject to change. For a current list of outpatient services requiring Preauthorization, please see the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com. Please be aware that some outpatient services while not requiring Preauthorization may nevertheless be subject to medical necessity reviews to determine whether it is a Covered Charge.

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

A Preauthorization by the Company is required for all Hospital Inpatient Confinements or inpatient facility confinements and selected outpatient procedures. Preauthorization is not a guarantee that benefits will be payable.

Preauthorization 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 authorized Hospital Inpatient Confinement for childbirth or breast cancer treatment).

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 authorized 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 authorized 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 Preauthorization is not required for mother and baby, for:

- A 48-hour Hospital Inpatient Confinement following an uncomplicated vaginal delivery, not counting the day of delivery; or
- A 96-hour Hospital Inpatient Confinement following an uncomplicated cesarean section, not counting the day of delivery.

For breast cancer treatment, Covered Charges requirements are waived and a Preauthorization is not required for:

- a 48-hour Hospital Inpatient Confinement following mastectomy; or
- a 24-hour Hospital Inpatient Confinement following a lymph node dissection.

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

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

If Preauthorization 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 Preauthorization requirements do not apply when the Company will pay as a secondary plan as described in page NBM 5156 Coordination With Other Benefits.

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

Concurrent Review

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

Continued Stay Review

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

Health Professional

An individual who:

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

Initial Clinical Review(er)

Clinical review conducted by appropriate licensed or certified Health Professionals. Initial Clinical Review staff may authorize 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 authorization or Adverse Benefit Determination.

Notification of Utilization Review Services

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

Ordering Provider

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

Peer Clinical Review(er)

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

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

Preauthorization

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 authorized Hospital Inpatient Confinement for childbirth or breast cancer treatment) or selected outpatient procedures to determine whether the services being recommended are considered Covered Charges. Preauthorization is not a guarantee that benefits will be payable.

Prospective Review

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

Retrospective Review

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

Urgent Review

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

Utilization Management

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

Utilization Review

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

- **Utilization Review Program**

  - **Prospective Review and Urgent Prospective Review**

    For an initial Prospective Review or an Urgent Review of a Prospective Review, a decision and notification of the decision will be made within three (3) 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 issue an Adverse Benefit Determination. For authorizations, 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 authorization. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person within three (3) calendar days.

  - **Concurrent Review**

    For a Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously authorized by the Company will be decided within 24 hours of receipt of the Notification of Utilization Review Services. Written notification of Adverse Benefit Determinations will be sent within three (3) working days to the attending Physician or other Ordering Provider, the facility rendering service, and the Insured Person. Adverse Benefit Determinations for prescription drugs and intravenous infusions will be made not later than 30 days before the date on which the prescription drugs or intravenous infusions will be discontinued.

  - **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 authorized 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 authorized period or number of treatments. If a request is made less than 24 hours prior to the expiration of the previously authorized period or number of treatments, a decision and notification of the decision will be made within 24 hours of receipt of the Notification of Utilization Review Services.

- **Retrospective Review**

  For a Retrospective Review, a decision and notification of the decision will be made within 30 calendar days after the Company receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Company will either issue an Adverse Benefit Determination or send an explanation of the information needed to complete the review prior to the expiration of the 30 calendar days. If the Company does not issue an Adverse Benefit Determination and requests additional information to complete the review, the Insured Person, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Company will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For authorizations, 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 authorization. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person, within three (3) business days (but not later than 30 calendar days from receipt of Notification of Utilization Review Services).

- **Request for Reconsideration**

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

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

- **Request for Renewal**

A renewal of an existing Preauthorization issued by the Company can be requested by a Physician or other health care provider up to 60 days before the expiration of the existing Preauthorization. If the Company receives a Preauthorization renewal request before the existing Preauthorization expires, the Company will, if practicable, review the request and issue a determination indicating whether the medical or health care service is preauthorized before the existing Preauthorization expires.

- **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 telephone, fax, or in Writing. The Company will make a full and fair review of the Adverse Benefit Determination.

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

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

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

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

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

- **Expedited Appeal Review**

An expedited appeal review is a request, usually by telephone but can be verbal or Written, for a review of a decision not to certify an Urgent Review or a denial of a continued stay for a hospitalized Insured Person, denial of prescription drugs or intravenous infusions. An expedited appeal review must be requested within 180 calendar days or as soon thereafter as reasonably possible of the receipt of an Adverse Benefit Determination.

For Adverse Benefit Determinations of prescription drugs or intravenous infusions, the Insured Person is entitled to an immediate appeal to an Independent Review Organization, and is not required to comply with the requirements for internal review.

A decision and notification of the decision on the expedited appeal of an Urgent Review decision will be made within 72 hours from request of an expedited appeal review (but not later than one (1) business day from the date the Company receives all the necessary information needed to complete the review. The decision timeframe will be the earlier of one (1) business day from the date all information necessary to complete the appeal is received or 72 hours after the Company receives the request for an expedited appeal review. A letter will also be sent within 3 working days following the initial telephone call or electronic transmission, also confirming this determination). Written or electronic notification of the appeal review outcome will be made to the attending Physician or other Ordering Provider and the Insured Person.

A decision and notification of the decision on the expedited appeal of a denial of a continued stay for a hospitalized Insured Person will be made within one (1) business day from the date the Company receives all the necessary information needed to complete the review. The decision timeframe will be the earlier of one (1) business day from the date all information necessary to complete the appeal is received or 72 hours after the Company receives the request for 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.

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

- **Standard Appeal Review**

  A standard appeal may be requested either in Writing or verbally. It must be requested within 180 calendar days or as soon thereafter as reasonably possible of the receipt of an Adverse Benefit Determination. If the request is made verbally, a one-page appeal form will be sent to the person who made the request. If the request is Written, a letter acknowledging the date of receipt of the appeal and a list of documents needed to be submitted will be sent to the person who made the request within five (5) working days from receipt of the appeal. A final decision will be made in Writing to the Insured Person, the attending Physician or other Ordering Provider within 30 calendar days of receiving the request for an appeal for post-service claims and 15 calendar days for pre-service claims.

  For retrospective appeals, an extension of up to 15 calendar days may be applied if necessary due to matters beyond the control of the reviewer and if the provider and patient are notified before the end of the initial 30 day period. The notice will include the date by which the reviewer expects to make a determination. If extension is needed because the provider or patient has not provided information needed to complete the appeal, the notice must specifically describe the information needed and allow at least 45 calendar days for the information to be provided. In the latter case, the time period for making the determination begins on the date the notification of the extension is sent until the earliest of:

  - the date on which the provider or patient responds to the request; or
  - the date by which the information was to have been submitted.

  If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, attending Physician, or other Ordering Provider can request an External Review as shown in Page NBM 5407 ER.

- **Determination of Medical Necessity – Acquired Brain Injury**

  The Company must respond to the Insured Person, the patient, attending Physician, or other Ordering Provider requesting Utilization Review or appealing for an extension of coverage based on an allegation of medical necessity for Acquired Brain Injury not later than three business days after the date on which the person makes the request or submits the appeal. The Insured Person, patient, attending Physician, or other Ordering Provider must make the request or submit the appeal in the manner prescribed above. The Company must respond through a direct telephone contact.

Preauthorization Procedures (Applicable to medical care received from a Preferred Provider)

- **For medical care or services that do not involve concurrent hospitalization care, post-stabilization treatment or a life-threatening condition**

  Upon receipt of a request for Preauthorization, if the Company preauthorizes the proposed medical care or health care services, a decision will be made and communicated no later than three (3) calendar days after the date the request is received. If the request is received outside the time period appropriate personnel are available, as described below, the decision will be made and communicated within three (3) calendar days from the beginning of the next time period requiring such personnel.

- **For concurrent hospitalization care**

  Upon receipt of a request for Preauthorization, if the Company preauthorizes the proposed medical care or health care services, a decision will be made and communicated within 24 hours after the request is received. If the request is received outside the time period appropriate personnel are available, as described below, the decision will be made and communicated within 24 hours from the beginning of the next time period requiring such personnel.

- **For medical care or services that involve post-stabilization treatment or a life-threatening condition**

  Upon receipt of a request for Preauthorization, if the Company preauthorizes the proposed medical care or health care services, a decision will be made and communicated within the time period appropriate to the circumstance relating to the delivery of services and the condition of the Insured Person, but in no case to exceed one (1) hour from receipt of the request. If the request is received outside the time period appropriate personnel are available, as described below, the decision will be made and communicated within one (1) hour from the beginning of the next time period requiring such personnel. In such circumstances, the decision will be provided to the treating Physician or other Ordering Provider.

  For Adverse Benefit Determinations of prescription drugs or intravenous infusions referred to an Independent Review Organization for an immediate appeal, the Independent Review Organization must make a determination not later than the third day after the organization receives the information necessary to make the determination.

- **Availability of Appropriate Personnel**

  Appropriate personnel will be reasonably available to provide Preauthorization decisions between 6:00 a.m. and 6:00 p.m. (central standard time) Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon (central standard time) on Saturday, Sunday and legal holidays. A telephone system capable of accepting or recording incoming inquires will be available after 6:00 p.m. (central standard time) Monday through Friday and after noon (central standard time) on Saturday, Sunday and legal holidays, and the Company will acknowledge any such call no later than 24 hours after the call is received. Written notification will be provided to the treating Physician or other Ordering Provider within three (3) calendar days of receipt of a request.

- **Notice of Utilization Review**

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

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

Note: For a request for Utilization Review or an appeal for an extension of coverage based on an allegation of medical necessity for an Acquired Brain Injury, refer to Determination of Medical Necessity – Acquired Brain Injury above.

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

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

COMPLAINT AND GRIEVANCE PROCEDURES

First-Level Appeal Review

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

The Company will make a full and fair review of the claim. The Company may require additional information to make the review. The Company will notify the Insured Person in Writing of the appeal decision within 30 calendar days of receiving the appeal request for post-service claims and pre-service claims. For Adverse Benefit Determinations of prescription drugs and intravenous infusions, the Company will make a full and fair review of the claim within 30 calendar days before the date on which the prescription drugs or intravenous infusions will be discontinued.

Specialty Provider Review

If the Insured Person disagrees with an Adverse Benefit Determination, and the person's medical provider can show good cause for a specialty provider to review the case, the medical provider may submit a Written request to the Company within 10 working days of the Adverse Benefit Determination. The Adverse Benefit Determination will be reviewed by a Physician in the same or similar specialty who would typically manage the medical or dental condition, procedure, or treatment under consideration. The specialty review must be completed within 15 working days of receipt of the request.

Expedited Appeal Review

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

For Adverse Benefit Determinations of emergency care, continued hospitalization, prescription drugs or intravenous infusions, and for a step therapy exception request, the Insured Person is entitled to an Expedited Appeal Review.

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

The Company will make a decision and notify the Insured Person as expeditiously as the Insured Person's medical condition requires, but in no event more than 72 hours after receipt of the request for the Expedited Appeal Review (but not later than one (1) business day from the date the Company receives all the necessary information needed to complete the review. The decision timeframe will be the earlier of one (1) business day from the date all information necessary to complete the appeal is received or 72 hours after the Company receives the request for the Expedited Appeal Review. A letter will also be sent within 3 working days following the initial telephone call or electronic transmission, also confirming this determination).

For Adverse Benefit Determinations of prescription drugs or intravenous infusions, the Insured Person is entitled to an immediate appeal to an Independent Review Organization, and is not required to comply with the requirements for internal review.

The Company will not discriminate against providers based on their actions taken on behalf of the Insured Person in making an appeal. The Company also will not discriminate against the Insured Person or a person acting on the Insured Person's behalf for actions taken in making an appeal.

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

EXTERNAL REVIEW

Right to Request an External Review of Adverse Benefit Determinations

The notice of a final internal Adverse Benefit Determination will include detailed information about an Insured Person's right to request an external review. The notice will also include the process for making such request. With respect to the external review process, an Adverse Benefit Determination shall only include those determinations that involve medical judgment, including, but not limited to: medical necessity; appropriateness; experimental/investigational; health care setting; level of care, or effectiveness of a covered benefit; and rescissions of coverage.

The Insured Person will have 4 months after the date of the final internal Adverse Benefit Determination to request an external review.

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

Expedited External Review

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

An expedited external review does not apply to Retrospective Reviews.

Preliminary Review

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

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

Within 1 business day of the preliminary review determination (or immediately in the case of a request for an expedited external review), the Company will send written notice to the Insured Person, attending Physician, or other Ordering Provider as to whether the request has been accepted. If the Insured Person is not eligible for external review, the written notice will explain the reason for the ineligibility and provide contact information for the Employee Benefits Security Administration. If the request for external review is not complete, the written notice will describe the information or materials needed and will give the Insured Person until the end of the 4 month period or 48 hours, whichever is later, to provide such information or materials.

DESCRIPTION OF BENEFITS

PRESCRIPTION DRUGS EXPENSE INSURANCE

Payment Conditions

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

Benefit payment will be limited to:

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

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

The Company will apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of an Insured Person for Prescription Drugs toward the Insured Person’s deductible, copay, cost-sharing responsibility, or Out-of-Pocket Expense Limits.

Prescription Drugs Utilization Review Program

For Maintenance Drugs and Medicines

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same Insured Person) and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician, except as provided under Prescription Eye Drops as described in page NBM 5400.

For all other Drugs and Medicines

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

- less than a 15-day supply and the dispensing date for the current prescription is more than four days before a previously dispensed supply would be exhausted; or
- more than a 14-day supply and the dispensing date for the current prescription is more than ten days before the previously dispensed supply would be exhausted; or
- more than a 14-day supply and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician, except as provided under Prescription Eye Drops as described in page NBM 5400.

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

Prescription Drugs Covered Charges

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

Covered Charges will include charges incurred for synchronization of prescription drug medications under Medication Synchronization as described in page NBM 5400.

The Company will not require the Insured Person to make a payment for Prescription Drugs in an amount greater than the lesser of:

- the applicable copayment;
- the allowable claim amount for the Prescription Drug; or
- the amount the individual would pay for the Prescription Drug if purchased without health benefits or any other source of drug benefits or discounts.

Prescription Drugs Covered Charges will include charges for:

- the following diabetic supplies:
  - insulin and other antihyperglycemic medications used for the treatment of diabetes; and
  - disposable insulin needles/syringes; and
  - disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, and Clinitest tablets); and
  - lancets; and
- compounded medications in which at least one ingredient is a Prescription Legend Drug; and
- injectable medications; and
- legend oral contraceptives or devices; and
- formulas and other special dietary items prescribed by a Physician or ordered by a Physician for treatment of Phenylketonuria (PKU) Treatment or Other Heritable Disease as described in page NBM 5400; and
- Orally Administered Anti-Cancer Medications, as described in page NBM 5400; and
- prescribed drugs approved by the federal Food and Drug Administration (FDA) for any 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:
  - a prescription drug reference compendium approved by the commissioner for the purposes of this requirement; or
  - substantially accepted peer-reviewed medical literature;
- any prescription drug coverage required above must also include medically necessary services associated with the administration of the drug; and
- progesterone, all dosage forms; and
- growth hormones for specific conditions as determined by the Company; and
- any other drug or medicine that can be legally dispensed only upon the Written prescription of a Physician.

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

Definitions

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

Formulary means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers. If a drug is not included in the Formulary, no benefits will be paid. The Formulary will be maintained in compliance with state and federal law.

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

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

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

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

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

Pharmacy Benefit Manager means CVS Caremark.

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

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

Prescription Legend Drugs mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

Tier 1 Generic Prescription Drugs (including selected Preferred Brand Name Prescription Drugs) means a list of prescription drugs established by the Company.

Tier 2 Preferred Brand Name Prescription Drugs (including selected Generic Prescription Drugs) means a list of prescription drugs established by the Company.

Tier 3 Non-Preferred Prescription Drugs means a list of prescription drugs established by the Company.

Limitations

Prescription Drugs Covered Charges will not include and no benefits will be payable under the Prescription Drugs Expense Insurance portion of the Group Policy for the following items. However, the first seven items listed below may be eligible for benefits under the Comprehensive Medical Expense portion of the Group Policy as described under the Description of Benefits for Medical Expense Insurance in this booklet-certificate:

- drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which the Insured Person is confined; or
- drugs or medicines delivered or administered by the prescriber; or
- therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except as specifically provided above under Prescription Drugs Covered Charges; or
- infertility drugs, immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use; or
- administration of any drug or medicine; or
- Levonorgestrel (Norplant); or
- drugs or medicines that are not Covered Charges; or
- drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for Experimental or Investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or

- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or
- drugs or medicines prescribed or dispensed by any person who is in an Insured Person's Immediate Family, except for Dental Services; or
- vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or
- dietary supplements, except as specifically provided for formulas and other special dietary items prescribed by a Physician or ordered by a Physician for Phenylketonuria (PKU) Treatment or Other Heritable Disease as described in page NBM 5400; 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 (not applicable to tax supported institutions of the State of Texas); or
- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or
- drugs or medicines provided as the result of a sickness or injury that is due to participation in criminal activities; or
- 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, and health and beauty aids; or
- dermatologicals used as hair growth stimulants; or
- drugs labeled "Caution-limited by Federal law to investigational use," or experimental, even though a charge is made to the individual; or
- topical dental fluorides; or
- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- drugs or medicines that are lost, stolen or spilled; or
- smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms except as covered under Preventive Health and Wellness Services; or
- anorectics (any drug used for the purpose of weight control); or
- minerals. Exception: Potassium supplements are covered; or

- hematinics; or
- drugs or medicines prescribed for treatment leading to, in connection with or resulting from sexual transformation or intersex surgery; or
- any other drugs or medicines used for cosmetic purposes; or
- herbal supplements, except as provided under Traditional East Asian Medicine; or
- drugs that are not included in the Formulary. Drugs removed from the Formulary will continue to be covered until the Group Policy's next Policy Anniversary.

Pament, Denial and Review

Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on the Insured Person's identification card or contact the Company. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or the Company within 90 calendar days after the date of loss or the 90th day after the beginning of the period for which the Company is liable. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or the Company receives proof of loss. Proof of loss includes the patient's name, the Member's name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. The Pharmacy Benefit Manager or the Company may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the Company's request or the request of Pharmacy Benefit Manager could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. However, state law requires that 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 18 calendar days for electronic claims and 21 calendar days for nonelectronic claims. 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.

State law requires that all benefits payable under the Group Policy must be payable not more than 60 days after receipt of proof of loss. In actual practice, benefits under the Group Policy may be payable sooner, provided the Pharmacy Benefit Manager or the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Pharmacy Benefit Manager or the Company will submit a detailed explanation of the basis for its denial. See page NBM 5407 GP for the Complaint and Grievance Procedures.

For prescription drug claims submitted electronically through a Preferred Provider plan, the total amount of the claim must be paid through electronic funds transfer no later than the eighteenth day after the date on which the claim was affirmatively adjudicated. For prescription drug claims submitted non-electronically through a Preferred Provider plan, the total amount of the claim must be paid no later than the twenty-first day after the date on which the claim was affirmatively adjudicated.

If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, or attending Physician, can request an External Review as described in page NBM 5407 ER.

Texas Notice

Texas requires the Company to provide specific information regarding the use of prescription drug Formularies.

Prescription Drug Expense Coverage under the Group Policy uses one or more drug Formularies.

The Formulary is reviewed by CVS/Caremark's Pharmacy & Therapeutics (P&T) Committee on a quarterly basis. This committee is responsible for making decisions regarding tier changes and removal of drugs from the Formulary. Negative changes are typically made at the beginning of each Calendar Year.

There is also a Formulary Review Committee. The P&T Committee is charged with reviewing all drugs, including generics, that are represented on the CVS/Caremark approved drug lists. The committee establishes that the selections made are nonbiased, quality driven and evidence-based. The Formulary Review Committee (FRC) is an internal CVS/Caremark committee that evaluates additional factors which may affect the formulary. For example, when two or more drugs produce similar clinical results, the FRC may evaluate several factors. The FRC may make business recommendations based on such factors to the P&T Committee. It is important to note that any drug product must first be deemed safe and effective by the P&T Committee before it is considered eligible for inclusion on CVS/Caremark Formularies, and that any recommendations made by the FRC must be approved by the P&T Committee before implementation.

P&T Committee decisions are based on, among other criteria, scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines and other appropriate information such as pharmacoeconomic studies.

A Formulary is not a complete list of drugs. Any drug that is not listed on or that has been removed from the drug Formulary is reviewed and if approved is paid through the Member's Prescription Drug benefit. Modifications to the drug Formulary list will apply on the Group Policy's first renewal date following the modification and will be applied uniformly among all identical or substantially identical group health benefit plans. Notice of such modification will be provided 60 days prior to each Group Policyholder's renewal date. Any drug removed from the drug formulary list, will continue to be covered until the Group Policy's first renewal date following the drug's removal from the Formulary list.

A response will be provided within three (3) business days when an Insured Person inquires regarding whether or not a specific drug is included in a particular drug Formulary. Inclusion of a particular drug in the drug Formulary does not guarantee that the Physician or Health Care Extender will prescribe that drug for a particular medical condition or mental illness.

For information on the Formulary call CVS/Caremark at 1-866-644-7527 or contact them at www.caremark.com.

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

DESCRIPTION OF BENEFITS

MAIL SERVICE PRESCRIPTION DRUGS EXPENSE INSURANCE

Payment Conditions

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

Benefit payment will be limited to:

- prescribed maintenance medications which are necessary to treat a chronic or long-term sickness or injury and that can be legally dispensed only upon the Written prescription of a Physician; and
- a 90-day supply for each prescription and each refill provided that an amount equal to three-times a 30-day supply Copay amount will apply; and
- prescriptions which are filled through the pharmacy designated by the Company to administer the mail order prescription drugs program.

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

The Company will apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of an Insured Person for Prescription Drugs toward the Insured Person’s deductible, copay, cost-sharing responsibility, or Out-of-Pocket Expense Limits.

Covered Charges will include charges incurred for synchronization of prescription drug medications under Medication Synchronization as described in page NBM 5400.

Prescription Drugs Utilization Review Program

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same Insured Person) and the dispensing date for the current prescription is earlier than the date on which approximately 66.6% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician, except as provided under Prescription Eye Drops as described in page NBM 5400.

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

Definitions

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

Formulary means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers. If a drug is not included in the Formulary, no benefits will be paid. The Formulary will be maintained in compliance with state and federal law.

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

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

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

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

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

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

Pharmacy Benefit Manager means CVS Caremark.

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

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

Prescription Legend Drugs mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

Tier 1 Generic Prescription Drugs (including selected Preferred Brand Name Prescription Drugs) means a list of prescription drugs established by the Company.

Tier 2 Preferred Brand Name Prescription Drugs (including selected Generic Prescription Drugs) means a list of prescription drugs established by the Company.

Tier 3 Non-Preferred Prescription Drugs means a list of prescription drugs established by the Company.

90-Day Supplies

Typically, prescriptions submitted to the Pharmacy will be filled in 90-day supplies. The Insured Person should have his or her Physician contact the Pharmacy at the toll-free number shown on the order form if there are any questions.

How to Order From the Pharmacy

The Insured Person's initial order consists of three parts: the Written prescription from his or her Physician; a Patient/Profile Order form with preaddressed envelope; and a Copay. These are described below. Allow 14 days for the order to be completed and shipped to the Insured Person. All orders are mailed either by Federal Express, UPS or First Class U.S. Mail. If the Insured Person wishes to have his or her order shipped Federal Express, the Insured Person will need to pay the cost.

The Written Prescription

When obtaining a prescription, be sure to ask the Physician to specify the following information:

- patient name;
- prescription for a 90-day supply of medication (the Physician should indicate the total number of pills required for that period of time. For example, 270 tablets would be needed for medication that must be taken three times a day.);
- refills (many maintenance drugs can be prescribed for up to one year; therefore, a prescription for a 90-day supply may specify up to three refills.);
- Physician's signature.

Also, it is very important to include the Insured Person's name, address, and member number on the prescription form, so that eligibility for the program can be verified when the pharmacy receives the order.

Patient Profile/Order Form

Included in the installation package the Insured Person receives, as well as with each order shipped, is the Patient Profile/Order Form. This form is to be completed and sent in the preaddressed envelope with each order. The Patient Profile/Order Form provides information concerning eligibility in addition to health and allergy conditions pertaining to each Insured Person.

Copay

A check or money order for the correct Copay must accompany each order. The Copay amount is described in the Summary of Benefits section. The Insured Person may also be able to charge the Copay to a credit card as explained on the Patient Profile/Order Form. Please do not send cash.

Refills or Follow-up Orders

Each filled order the Insured Person receives includes Refill Ordering Instructions, a Patient/Profile Order Form, and a preaddressed envelope. Orders for refills should be placed approximately 30 days before the current supply of medication is expected to run out.

Special Situations

If a maintenance medication is prescribed for immediate use, the Insured Person should obtain two prescriptions--one for a 14-day supply to be filled immediately at a local Member Pharmacy, and a second for an extended 90-day supply with refills, to be filled by the mail service pharmacy.

Questions

Please call the pharmacy's customer service number with any questions concerning medication or a particular order. The toll-free number is shown on the Insured Person's order form.

Also included with each order filled is a Patient Counseling information sheet which has specific information about the medication included with the order.

Limitations

Prescription Drugs Covered Charges will not include and no benefits will be payable under the Prescription Drugs Expense Insurance portion of the Group Policy for the following items. However, the first seven items listed below may be eligible for benefits under the Comprehensive Medical Expense portion of the Group Policy as described under the Description of Benefits for Medical Expense Insurance in this booklet-certificate:

- drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which the Insured Person is confined; or
- drugs or medicines delivered or administered by the prescriber; or
- therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except as specifically provided above under Prescription Drugs Covered Charges; or
- infertility drugs, immunization agents, biological sera, blood, blood plasma, or any prescription directing parenteral administration or use; or

- administration of any drug or medicine; or
- Levonorgestrel (Norplant); or
- drugs or medicines that are not Covered Charges; or
- drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for Experimental or Investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or
- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or
- drugs or medicines prescribed or dispensed by any person who is in an Insured Person's Immediate Family, except for Dental Services; or
- vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or
- dietary supplements, except as specifically provided for formulas and other special dietary items prescribed by a Physician or ordered by a Physician for Phenylketonuria (PKU) Treatment or Other Heritable Disease as described in page NBM 5400; 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 (not applicable to tax supported institutions of the State of Texas); or
- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or
- drugs or medicines provided as the result of a sickness or injury that is due to participation in criminal activities; or

- 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, and health and beauty aids; or
- dermatologicals used as hair growth stimulants; or

- drugs labeled "Caution-limited by Federal law to investigational use," or experimental, even though a charge is made to the individual; or
- topical dental fluorides; or
- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- drugs or medicines that are lost, stolen or spilled; or
- smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms except as covered under Preventive Health and Wellness Services; or
- anorectics (any drug used for the purpose of weight control); or
- minerals. Exception: Potassium supplements are covered; or
- hematinics; or
- drugs or medicines prescribed for treatment leading to, in connection with or resulting from sexual transformation or intersex surgery; or
- any other drugs or medicines used for cosmetic purposes; or
- herbal supplements, except as provided under Traditional East Asian Medicine; or
- drugs that are not included in the Formulary. Drugs removed from the Formulary will continue to be covered until the Group Policy's next Policy Anniversary.

Payment, Denial and Review

Any transaction at a pharmacy for prescription drug benefits is not a claim for benefits under the Employee Retirement Income Security Act (ERISA). To file a claim for benefits when utilizing a Member Pharmacy, contact the Pharmacy Benefit Manager at the telephone number listed on the Insured Person's identification card or contact the Company. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or the Company within 90 calendar days after the date of loss or the 90th day after the beginning of the period for which the Company is liable. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or the Company receives proof of loss. Proof of loss includes the patient's name, the Member's name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. The Pharmacy Benefit Manager or the Company may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the Company's request or the request of Pharmacy Benefit Manager could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. However, state law requires that 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 18 calendar days for electronic claims and 21 calendar days for nonelectronic claims. 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.

State law requires that all benefits payable under the Group Policy must be payable not more than 60 days after receipt of proof of loss. 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 NBM 5407 GP for the Complaint and Grievance Procedures.

For prescription drug claims submitted electronically through a Preferred Provider plan, the total amount of the claim must be paid through electronic funds transfer no later than the eighteenth day after the date on which the claim was affirmatively adjudicated. For prescription drug claims submitted non-electronically through a Preferred Provider plan, the total amount of the claim must be paid no later than the twenty-first day after the date on which the claim was affirmatively adjudicated.

If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, or attending Physician, can request an External Review as described in page NBM 5407 ER.

Texas Notice

Texas requires the Company to provide specific information regarding the use of prescription drug Formularies.

Prescription Drug Expense Coverage under the Group Policy uses one or more drug Formularies.

The Formulary is reviewed by CVS/Caremark's Pharmacy & Therapeutics (P&T) Committee on a quarterly basis. This committee is responsible for making decisions regarding tier changes and removal of drugs from the Formulary. Negative changes are typically made at the beginning of each Calendar Year.

There is also a Formulary Review Committee. The P&T Committee is charged with reviewing all drugs, including generics, that are represented on the CVS/Caremark approved drug lists. The committee establishes that the selections made are nonbiased, quality driven and evidence-based. The Formulary Review Committee (FRC) is an internal CVS/Caremark committee that evaluates additional factors which may affect the formulary. For example, when two or more drugs produce similar clinical results, the FRC may evaluate several factors. The FRC may make business recommendations based on such factors to the P&T Committee. It is important to note that any drug product must first be deemed safe and effective by the P&T Committee before it is considered eligible for inclusion on CVS/Caremark Formularies, and that any recommendations made by the FRC must be approved by the P&T Committee before implementation.

P&T Committee decisions are based on, among other criteria, scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines and other appropriate information such as pharmacoeconomic studies.

A Formulary is not a complete list of drugs. Any drug that is not listed on or that has been removed from the drug Formulary is reviewed and if approved is paid through the Member's Prescription Drug benefit. Modifications to the drug Formulary list will apply on the Group Policy's first renewal date following the modification and will be applied uniformly among all identical or substantially identical group health benefit plans. Notice of such modification will be provided 60 days prior to each Group Policyholder's renewal date. Any drug removed from the drug formulary list, will continue to be covered until the Group Policy's first renewal date following the drug's removal from the Formulary list.

A response will be provided within three (3) business days when an Insured Person inquires regarding whether or not a specific drug is included in a particular drug Formulary. Inclusion of a particular drug in the drug Formulary does not guarantee that the Physician or Health Care Extender will prescribe that drug for a particular medical condition or mental illness.

For information on the Formulary call CVS Caremark at 1-866-644-7527 or contact them at www.caremark.com.

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

MEDICAL EXPENSE INSURANCE

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 90 days, 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 90 days after the date insurance terminates; or
- the date the succeeding carrier provides replacement coverage to the Insured Person, with substantially equivalent or greater benefits, 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 WITH OTHER BENEFITS

Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan (except benefits in Prescription Drugs and Mail Service Prescription Drugs when an Insured Person has health care insurance under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
- may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

Benefits paid under all other Plans plus the sum of benefits paid under the Group Policy will not exceed the lesser of the financial liability of the Insured Person or the Prevailing Charge for a Treatment or Service.

Definitions

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

- any program required or established by state or Federal law (including Medicare Parts A and B and C); and
- group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; and
- individual and group coverage through a Health Maintenance Organization; and
- individual accident and health insurance policies; and
- individual and group preferred provider benefit plans and exclusive provider benefit plans; and
- group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care; and
- medical care components of individual and group long-term care contracts; and
- limited benefit coverage that is not issued to supplement individual or group in-force policies; and
- uninsured arrangements of group or group-type coverage; and
- the medical benefits coverage in automobile insurance contracts.

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.

The term Plan will not include benefits provided under:

- disability income protection coverage; or
- the Texas Health Insurance Pool; or
- workers' compensation insurance coverage; or
- hospital confinement indemnity coverage or other fixed indemnity coverage; or
- specified disease coverage; or
- supplemental benefit coverage; or
- accident-only coverage; or
- specified accident coverage; or
- school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "twenty-four hour basis" or on a "to and from school" basis; or
- benefits provided in long-term care insurance contracts for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; or
- Medicare supplement policies; or
- a state plan under Medicaid; or
- a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or
- an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

"This Plan" is the medical expense benefits described in this booklet-certificate.

Primary Plan/Secondary Plan: The order of benefit determination rules determine whether This Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person.

When This Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

Allowable Expense: Except as provided below, or where a statute requires a different definition, any health care expense, including coinsurance or Copayments and without reduction for any applicable Deductible, that is covered in full or in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses or services that are not Allowable Expenses:

- If an Insured Person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the Insured Person's stay in a private Hospital room is medically necessary in terms of Generally Accepted medical practice, or one of the Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
- The amount a benefit is reduced by the Primary Plan because an Insured Person does not comply with the Plan provisions. Examples of these provisions are preauthorization of admissions and preferred provider arrangements.

Effect on Benefits

When This Plan is the Secondary Plan, benefits payable under This Plan will be reduced by the sum of benefits payable for the same Treatment or Services under all other Plans, and will not exceed more than the total Allowable Expense.

Claims Procedure for Secondary Plan

In determining the amount to be paid by the Secondary Plan on a claim, should the Plan wish to coordinate benefits:

- The Secondary Plan must:
- Calculate the benefits it would have paid on the claim in the absence of other health care coverage;
- Apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan; and
- Credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
- The Secondary Plan may reduce its payment by the amount that results in the total benefits paid or provided by all Plans for the claim equaling 100 percent of the total Allowable Expense for that claim, when combined with the amount paid by the Primary Plan.

Benefits otherwise payable under This Plan for Allowable Expenses may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately. Any such reduced amount will be charged against any applicable benefit limit of This Plan.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;
- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B and C whether or not the person is covered under that Part B and C.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- **Non-Dependent/Dependent.** The Plan which covers the person as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

  - Secondary to the Plan covering the person as a Dependent; and
  - Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee).

  Then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

- **Dependent Child--Parents Married or Living Together (Whether or not they have been married).** If a child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the Calendar Year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

- **Dependent Child— Divorced Parents, or Parents not Living Together (Whether or not they have been married).** If a child of divorced parents or parents not living together is covered under two or more Plans, benefits for the child are determined in this order:

    - if a court order states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Dependent Child – Parents Married or Living Together (Whether or not they have been married) above will determine the order of benefits; and
    - if there is no court order allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Dependent Child are as follows:
        - first, the plan covering the custodial parent;
        - then, the plan covering the spouse of the custodial parent;
        - then, the plan covering the noncustodial parent; then
        - finally, the plan covering the spouse of the noncustodial parent.

    However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent Children of parents who are not divorced.

- **Dependent Child – Individuals not Parents of the Child**

  For a Dependent Child covered under more than one plan of individuals who are not the parents of the child:
  - The order of benefits must be determined as outlined above as if the individuals were parents of the child.

- **Dependent Child – Coverage under either or both parents' plans and his/her own coverage as a dependent under a spouse's plan**

  In the event the Dependent Child's coverage under the spouse's plan began on the same date as the Dependent Child's coverage under either or both parents' plans:
  - The order of benefits must be determined by applying the birthday rule to the Dependent Child's parent(s) and the dependent's spouse.

  See also **Longer/Shorter Length of Coverage** below.

- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Continuation of Coverage**. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

  - first, the benefits of a Plan covering the person as a Member or subscriber (or as that person's Dependent);
  - second, the benefits under the continuation coverage.

  If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Longer/Shorter Length of Coverage (including a Dependent Child who has coverage under either or both parents' Plan and his or her own coverage as a Dependent under a spouse's Plan).** If none of the above rules determine the order of benefits, the benefits of the Plan which covered the Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

- **Sharing equally between the plans:**

  If the above rules for "**COB and Order of Benefits**" do not determine the order of benefits:
  - The Allowable Expenses must be shared equally between the plans.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy. Federal law will usually apply in such instances if:

- the benefits are applicable to an active Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

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

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

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

How COB Works

Example 1: The natural father is insured as a Member under This Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the child and the divorce decree does not establish financial responsibility for medical, dental, or other health care expenses.

The following order of benefits would apply to the child:

1. Company A would be Primary (mother's carrier).
2. Company B would be Secondary (stepfather's carrier).
3. The Company would then determine the benefits payable, if any, under This Plan.

Example 2A: Mrs. Smith has filed a claim for $2,400 with both Company A and Company B. Company A insures Mrs. Smith as an employee and Company B insures her as a dependent spouse under a Plan. Both Plans provide 80% of Covered Charges after a $200 deductible.

Both Plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

Company A

Billed Charges	$ 2,400.00
Not Covered By Primary Carrier	$ 200.00 (Personal Items)
Total Covered Charges	$ 2,200.00
Company A's Deductible	$ 200.00
Benefits Payable ($2,000 X 80% = $1,600)	$ 1,600.00

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A Plan.

Company B

Allowable Expenses	$ 2,200.00
Less Company A Benefits	$ 1,600.00
Benefits Payable	$ 600.00

The patient is responsible for $200 which is not considered a covered expense under either policy.

Example 2B: The same rules apply in this example as they did in Example 2A. Mrs. Smith has filed an additional claim for $5,000 with both Company A and Company B. Company A insures Mrs. Smith as an employee and Company B insures her as a dependent spouse under a Plan. Both Plans provide 80% of Covered Charges after a $200 deductible.

Both Plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits according to their plans Covered Charges as though duplicate coverage did not exist.

Company A

Billed Charges	$ 5,000.00
Not Covered By Primary Carrier	$ 500.00(Private Room)
Total Covered Charges	$ 4,500.00
Company A's Deductible	$ 200.00
Benefits Payable ($4,300 X 80% = $3,440)	$ 3,440.00

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A Plan.

Company B

Allowable Expenses	$ 4,500.00
Less Company A Benefits	$ 3,440.00
Benefits Payable By Company B	$ 1,060.00

The patient is responsible for $500 which is not considered a covered expense under either policy.

MEDICAL EXPENSE INSURANCE

SUBROGATION AND REIMBURSEMENT

Applicability

Subject to applicable law, this section will apply to Insured Persons who:

- receive benefit payment under the Group Policy as a result of a sickness or injury; and
- have a lawful claim against another party, parties, or insurer (including uninsured, underinsured, and no-fault automobile insurers) for compensation, damages, or other payment because of that same sickness or injury.

The Company will have the right of first reimbursement from any recovery an Insured Person receives even if the Insured Person has not been made whole. The Company will have the right of first reimbursement only if the Insured Person or his or her Immediate Family did not pay the premiums for uninsured/underinsured motorist coverage or medical payments coverage.

Transfer of Rights

In those instances where this section applies, the rights of the Insured Person to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to the Company.

If the Insured Person is not represented by an attorney in recovering damages, the Company is entitled to the lesser of:

- one-half of the Insured Person’s gross recovery; or
- the extent of benefit payments made under the Group Policy.

If the Insured Person is represented by an attorney in recovering damages, the Company is entitled to the lesser of:

- one half of the Insured Person’s gross recovery minus attorney’s fees and procurement costs; or
- the extent of benefit payments made under the Group Policy minus attorney’s fees and procurement costs.

Insured Person Obligations

To secure the Company's rights under this section, an Insured Person may be required to:

- Complete any applications or other instruments and provide any documents the Company might reasonably require.

- If payment from the other party or parties has been received, reimburse the Company for benefit payment made under the Group Policy (but not more than the amount paid by the other party or parties.)
- The Insured Person will not take any action that prejudices the Company's rights. If the Insured Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Insured Person must not prejudice, in any way, the Company's subrogation rights under this section.

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

CONTINUATION OF COVERAGE – STATE REQUIRED - TEXAS

State Required Continuation - Texas

Member - Continuation

- **Continuation**

  The Member may continue insurance as described below.

- **Qualification for Continuation**

  The Member will qualify for continuation if:

  - insurance under the Group Policy terminates for any reason other than involuntary termination for cause; and
  - the Member has been continuously insured under the Group Policy (or similar benefits under any group policy which it replaces) for at least the three month period immediately prior to the date insurance terminates.

- **Period of Continuation**

  If the Member qualifies for continuation as described above and also qualifies for COBRA or USERRA continuation, the Member may elect to begin this period of continuation upon completion of the COBRA or USERRA continuation.

  This period of continuation will begin on the date insurance would otherwise terminate under the Group Policy, or on the date of completion of the COBRA or USERRA continuation period (whichever is applicable), and will be continued until the earliest of:

  - the date the Group Policy is terminated (the continuation period may be completed under the Policyholder's replacement insurance; if any); or
  - the end of the period for which premium is paid, if the Member fails to make timely payment of a required premium; or
  - the date the Member becomes eligible or covered for similar benefits under another group medical expense plan or Medicare; or
  - the date on which similar benefits are provided or are available to the Member under state or federal law; or
  - the date insurance would otherwise cease as provided in the Group Policy; or
  - the date insurance has been continued for six months if the Member elects to begin continuation upon the completion of COBRA continuation; or
  - the date insurance has been continued for nine months for all others.

- **Notice, Election and Premium Requirements**

  The Member must notify the Policyholder in Writing within 60 days after the date insurance would otherwise end under the Group Policy, or within 31 days after the completion of the COBRA or USERRA continuation period (whichever is applicable).

  If the Member is not currently insured on COBRA Continuation, the Member's first premium payment is due 45 days after the date of election. If the Member is currently insured on COBRA Continuation, the Member's first premium payment is due within 31 days after the date COBRA Continuation ends.

Member Continuation: Labor Dispute

- **Qualification for Continuation**

  If the Member ceases to be actively employed because of a labor dispute, the Member's insurance may be continued during the dispute, if:

  - the Group Policy is in force; and
  - the Member elects to continue insurance and agree to pay the required contribution; and
  - at least 75% of the eligible Members elect to continue insurance; and
  - We receive the information needed to administer the plan as outlined in the Group Policy.

- **Period of Continuation**

  If the Member qualifies as described above, the Member's insurance, and the Member's insured Dependents' insurance, may be continued until the earliest of:

  - the date the Member becomes insured by similar group medical expense insurance; or
  - the date insurance would otherwise cease as provided in the Group Policy; or
  - the end of the period for which premium is paid, if the Member fails to make timely payment of a required premium; or
  - the date participation under this continuation provision drops below 75%; or
  - the date insurance has been continued for six months.

Dependent Continuation: Nine-Month Continuation Period

The Member's insured Dependents may continue insurance for up to nine months if the Dependent's insurance would terminate for any reason other than involuntary termination for cause or the Member's failure to pay any required premium. The terms and conditions of such continuation are as described for the Member above.

Dependent Continuation: Three-Year Continuation Period

- **Qualification for Continuation**

  A Dependent will qualify for continuation if:

  - insurance would otherwise end because of the Member's death, severance of the family relationship (dissolution of marriage) or the Member's retirement; and
  - the Dependent has been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaces) for at least the 12-month period immediately prior to the date insurance terminates, or if an infant less than 12 months of age; and
  - the Dependent is not eligible for substantially similar insurance under any other plan or program (including Medicare).

- **Period of Continuation**

  Insurance for a Dependent who qualifies as described above may be continued until the earliest of:

  - the date the Group Policy is terminated (the continuation period may be completed under the Policyholder's replacement insurance; if any); or
  - the end of the premium period for which premium is paid, if the Dependent fails to make timely payment of a required premium; or
  - the date the Dependent becomes eligible for substantially similar insurance under any other plan or program (including Medicare); or
  - the date insurance would otherwise cease as provided in the Group Policy; or
  - the date insurance has been continued for three years.

- **Notice, Election and Premium Requirements**

  The Member or the Member's Dependent must give the Policyholder Written notice of severance of the family relationship within 15 days after it occurs. Upon receipt of such notice, or upon receiving notice of the Member's death or retirement, the Policyholder must give the Dependent Written notice of the right to continue insurance. The Dependent must request continuation and pay the first premium within 60 days after the date insurance would otherwise terminate.

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.

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: Texas Single Employer Evolution w. Buy-Up John Doe Health Plan
Contact Name/Area: Texas Single Employer John Doe Benefits Department
Address: 900 Anywhere Street
Bonaparts, USA 52620
Phone Number: (319) 592-3166

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

FMLA and Other Continuation Provisions

If the Policyholder is an Eligible Employer and if the continuation portion of the FMLA applies to the Eligible Employee's coverage, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

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

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year.

Eligible Employee (definition for use in this section of the booklet-certificate only)

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
- because of a “qualifying exigency” arising out of a spouse, son, daughter or parent on active duty or having been notified of a call to active duty, as applicable to retired regular armed forces members, reserve members, National Guard members, and members in contingency operations, as defined under Federal law.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to Eligible Employees to care for a “covered service member” with a “serious injury or illness”.

Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

Contact the Policyholder for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if insurance would otherwise end because the Member enters into active military duty or inactive military duty for training, he or she may elect to continue insurance (including Dependents insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If active employment ends because the Member enters active military duty or inactive military duty for training, insurance may be continued until the earliest of:

- for the Member and Dependents:
    - the date the Group Policy is terminated; or
    - the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
    - the date 24 months after the date the Member enters active military duty; or
    - the date after the day in which the Member fails to return to active employment or apply for reemployment with the Policyholder.
- for the Member's Dependents:
    - the date Dependent Medical Expense Insurance would otherwise cease as provided on page NBM 5125; or
    - the end of any Insurance Month desired, if requested by the Member before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any. If the Insured Person qualifies for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

For Medical Expense Insurance, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to the Company within 20 calendar days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

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

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Failure to provide Written proof of loss within the time specified does not invalidate or reduce a claim if (1) it was not reasonably possible to provide Written proof of the loss within that time; (2) Written proof of the loss is provided as soon as reasonably possible; and (3) unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date the proof of loss is otherwise required. Written proof of loss should be sent to the Company within 12 months after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Company receives proof of loss. Proof of loss includes the patient's name, the Insured Person's name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. The Company may request additional information to substantiate the Insured Person's loss or require a Signed unaltered authorization to obtain that information from the provider. The Insured Person's failure to comply with such request could result in declination of the claim.

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 for electronic claims and 45 calendar days for nonelectronic claims. 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.

State law requires that all benefits payable under the Group Policy must be payable not more than 60 days after receipt of proof of loss. In actual practice, benefits will be payable sooner, provided the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Company will submit a detailed explanation of the basis for the denial. See page NBM 5407 GP for the Complaint and Grievance Procedures.

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

Medical Examinations

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

Legal Action

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.

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 Preauthorization.

Benefit Advice

Benefit Advice is the Company's toll-free service that can answer questions about an Insured Person's benefit program or specific coverages. The staff provides information on topics such as outpatient surgery, generic drugs, health care alternatives, health care providers and treatment costs in the Insured Person's area.

The staff does not prescribe medical treatment. That is up to the Insured Person's Physician. But they can help the Insured Person understand his or her benefits and how to use them in the most cost-effective manner.

Call the toll-free Health Info Line number (see the ID card or Policyholder for the Health Info Line number) to discuss medical benefits with the Company's Benefit Advice staff. The number is also listed on page NBM 5100 A in this booklet-certificate.

Preauthorization - 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 authorized number of days, the Company will initiate a Continued Stay Review.

- **For Childbirth**

  A Preauthorization is not required for mother and baby for 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated 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 authorized time period if the mother or baby will remain Hospital Inpatient Confined beyond that time period.

  Notification of the number of authorized 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.
- If the Texas Department of Human Services is paying medical assistance benefits on behalf of an insured Dependent Child, the Company will pay all benefits payable under the Group Policy with respect to the child directly to the Texas Department of Human Services, provided the parent, who is insured under the Group Policy:

  - has possession or access to the child pursuant to a court order; or
  - if not entitled to access or possession of the child, is required by a court to pay child support.

  The Company must receive proper Written notice in order to pay the benefits as explained above.

- For a minor child, who otherwise qualifies as a Dependent Child, benefits may be paid on behalf of the child to a person other than the Member if an order issued by a court of competent jurisdiction names such person as the possessory or managing conservator.

  To be entitled to receive benefits, a possessory or managing conservator of the child must submit:

  - Written notice of possessory or managing conservator of the child; and
  - a certified copy of the court order or other acceptable evidence as designated by the state that establishes the person as possessory or managing conservator.

  These requirements will not apply where authorization for payment of benefits has been received from the Member for the unpaid medical bills or the Member has paid any portion of the medical bill that is a Covered Charge under the Group Policy.

- If the Member or a Dependent receives assistance from the Texas Department of Human Resources for any Treatment or Service for which benefits are payable under the Group Policy, the Company will reimburse the Department for the actual amount paid by the Department for the Treatment or Service. The amount of such reimbursement, together with any amount which may otherwise be payable by the Company to the Member or a Dependent, will not exceed the actual benefit payable under the Group Policy.
- Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of the Insured Person.
- Benefits payable to QuestSelect™, a service of Quest Diagnostics, will be paid directly to the laboratory.
- Benefits payable to Transplant Network Providers will be paid directly to the Transplant Network Provider.

Binding Arbitration

Any controversy or claim arising out of or relating to this agreement, or the breach thereof, may be determined by final and binding arbitration administered by the American Arbitration Association ("AAA") under its Commercial Arbitration Rules and Mediation Procedures ("Commercial Rules"). The Company and the Insured Person must mutually agree to binding arbitration post-dispute. The Insured Person has the right to take any other legal remedy action

- **Judgment and Jurisdiction**

  The award rendered by the arbitrator(s) will be final and binding on the parties and may be entered and enforced in any court having jurisdiction, and any court where a party or its assets is located.

- **Selection of Arbitrators**

  There will be three arbitrators. The parties agree that one arbitrator will be appointed by each party within twenty (20) days of receipt by respondent(s) of the request for arbitration or in default thereof appointed by the AAA in accordance with its Commercial Rules, and the third presiding arbitrator will be appointed by agreement of the two party-appointed arbitrators within fourteen (14) days of the appointment of the second arbitrator or, in default of such agreement, by the AAA.

- **Consolidation, Joinder**

  If more than one arbitration is commenced under this agreement and any party contends that two or more arbitrations are substantially related and that the issues should be heard in one proceeding, the arbitrators selected in the first-filed proceeding will determine whether, in the interests of justice and efficiency, the proceedings should be consolidated before those arbitrators. The parties to this agreement are bound to each other by this arbitration clause. Each related party may be joined as an additional party to an arbitration involving other parties under this agreement.

- **Seat of arbitration, Languages**

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

- **Confidentiality**

  Except as may be required by law, neither a party nor the arbitrators may disclose the existence, content or results of any arbitration without the prior Written consent of both parties, unless to protect or pursue a legal right.

- **Remedies**

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

- **Interim Relief**

  The parties also agree that the AAA Optional Rules for Emergency Measures of Protection will apply to the proceedings.

STATEMENT OF RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About the Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce the Member's Rights

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

Under ERISA, there are steps the Member can take to enforce the above rights. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to $110 a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the Member has a claim for benefits which is denied or ignored, 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 Eligible Employees of Riverside Plastics Incorporated, and provided that, for each employee, he or she also meets the definition of a Member as defined in the DEFINITIONS section of this booklet-certificate (page NBM 5136).

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

Employee pays none of Employee's contribution. Employee pays part of Dependent's contribution (if Employee elects to enroll Dependents in plan).

8. **Ending Date of Plan's Fiscal Year:**

December 31

DEFINITIONS

When used in the Group Policy, the terms listed below will mean:

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Insured Person's eligibility under the Group Policy, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an Experimental or Investigational Measure or not medically necessary or appropriate, or due to rescission of coverage.

Ambulatory Surgery Center means a facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility; and
- does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

Average Wholesale Price (AWP) means the published cost of a drug product to the wholesaler.

Birthing Center means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care; and
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a Written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with Written procedures for such transfer being displayed and staff members being aware of such procedures.

Calendar Year means January 1 through December 31 of each year.

Chemical Dependency Treatment Center means a facility that provides a program for the treatment of chemical dependency (alcohol or drug abuse) pursuant to a Written treatment plan approved and monitored by a Physician and which is:

- affiliated with a Hospital under a contractual agreement with an established system for patient referral; or

- accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

- licensed, certified or approved as a chemical dependency treatment program by the proper authority of the state in which it is located.

Community Mental Health Center means a community or county mental health facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

Company means Nippon Life Insurance Company of America.

Copayment; Copay means a specified dollar amount that must be paid by an Insured Person each time certain or specified services are rendered. In no event will the Copay amount exceed:

- for services provided by PPO Providers, the negotiated fee; and
- for services provided by Non-PPO Providers, the actual cost charged to the Insured Person.

Cosmetic Treatment or Service means Treatment or Service intended to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such Treatment or Service:

- is performed primarily to prevent or relieve social, emotional or psychological distress; or
- is not needed to correct or improve a Functional Impairment of an organ or other body part.

Functional Impairment is a direct and measurable reduction of physical performance of an organ or body part.

Cosmetic Treatment or Service includes, but is not limited to, surgery and pharmacological regimens and all their related charges.

Covered Charges means a Treatment or Service that is:

- prescribed by a Physician and required for the screening, diagnosis or treatment of a medical condition;
- consistent with the diagnosis or symptoms;
- not excessive in scope, duration, intensity or quantity;
- the most appropriate level of services or supplies that can safely be provided; and
- determined by the Company to be Generally Accepted.

Crisis Stabilization Unit means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

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, 2024.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges that must be incurred by the Insured Person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the Calendar Year.

Dental Services means any Treatment or Service provided to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); or
- malocclusion (abnormal positioning or relationship of the teeth); or
- ailments or defects of the teeth and supporting tissue and bone (excluding impacted teeth and appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance).

Dependent means:

- The Member's spouse, if that spouse:
    - is not insured under the Group Policy as a Member; and
    - is the Member's lawful spouse.
- The Member's Dependent Child (or Children) 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 the Member becomes a party to a suit in which the Member seeks to adopt the child, 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.

- The Member’s Dependent grandchild, if that child:
  - is not married; and
  - is less than 25 years of age; and
  - is a Dependent of the Member for federal income tax purposes at the time application for insurance of the grandchild is made.

  Insurance for a grandchild may not be terminated solely because the grandchild is no longer a Dependent of the Member for federal income tax purposes.

- The Member’s Dependent Child of any age who is medically certified as disabled and is dependent upon the Member.

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 continuing condition.

Eligible Employee means an employee who works on a full-time basis and who usually works at least 30 hours per week, including a sole proprietor, a partner, and an independent contractor, if included as an employee under a health benefit plan, but excluding any employee who works on a part-time, temporary, seasonal, or substitute basis.

"Eligible Employee" does not include an employee who is covered under:

- another health benefit plan; or

- a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (ERISA); or

- the Medicaid program if the employee elects not to be covered under the Group Policy; or

- another federal program, including the TRICARE or Medicare program, if the employee elects not to be covered under the Group Policy; or

- a benefit plan established in another country if the employee elects not to be covered under the Group Policy.

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 care, (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.

Generally Accepted means Treatment or Service for the particular sickness or injury which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the relevant medical community; and
- is not under scientific testing or research.

Group Health Plan means an employee welfare benefit plan, as defined in ERISA, to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Group Policy means the policy and booklet-certificate of group insurance issued to the Policyholder by the Company which describes benefits and provisions for the Policyholder and Insured Persons.

Health Care Extender means a health care provider who assists in the delivery of covered medical services under the direction and supervision of a Physician. Direction and supervision means the Physician co-signs any progress notes Written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

Health Insurance Coverage means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or Health Maintenance Organization (HMO) contract, offered by an insurance company, insurance service, or insurance organization (including an HMO and stipulated premium company) 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.) or a licensed vocational nurse (L.V.N.), who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency means a Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

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

- is required as the result of a sickness or injury; and
- prevents, delays or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician.

Home Infusion Therapy Services means Treatment or Service required for the administration of intravenous drugs or solutions, which:

- is required as a result of a sickness or injury; and
- prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician.

Hospice means a facility, agency, or service that:

- is licensed by the proper authority of the state in which it is located to establish and manage Hospice Care Programs; and
- arranges, coordinates, and provides Hospice Care Services for dying individuals and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

Hospice Care Program means a program that furnishes palliative or supportive care focused on comfort and not cure and that is:

- managed by a Hospice; and
- established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

Hospice Care Team means a group that provides coordinated Hospice Care Services and normally includes:

- a Physician;
- a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, assisted living facility except as provided under Acquired Brain Injury as described in page NBM 5400, or training center.

For the purpose of Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, the definition of "Hospital" will include each of the following facilities provided it is licensed by the proper authority of the state in which it is located:

- a Psychiatric Hospital; and
- an Inpatient Alcohol or Drug Abuse Treatment Facility; and
- a residential treatment center or facility; and
- any other facility required by state law to be recognized as a treatment facility under the Group Policy.

Hospital Inpatient Confined; Hospital Inpatient Confinement means any period of Treatment or Service in a Hospital in excess of twenty-three consecutive hours for any cause. A Preauthorization as defined in page NBM 5407 CC is required for Hospital Inpatient Confinements.

Hospital Inpatient Confinement Charges means Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia provided while an Insured Person is Hospital Inpatient Confined.

Hospital Room Maximum means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or
- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Immediate Family means an Insured Person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Inpatient Alcohol or Drug Abuse Treatment Facility means an institution that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services; and

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and
- provides 24-hour a day on-site nursing care by licensed registered nurses (R.N.).

Insurance Month means calendar month.

Insured/Insured Person means a Member or Dependent who:

- applied for coverage; and
- meets the eligibility rules set forth in the Group Policy; and
- is approved for insurance by the Company; and
- for whom all applicable premiums are paid, and is therefore insured.

When Insured is used alone, it does not include the Dependent.

When Dependent is used alone, it does not include the Member.

Member means any person who is an Eligible Employee of the Policyholder.

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

Non-Preferred Provider/Non-PPO Provider means a Hospital, Physician, or other provider not contracted with the preferred provider organization (PPO) network identified by the Company to the Group Policy.

Outpatient Alcohol or Drug Abuse Treatment Facility means a facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient alcohol or drug abuse treatment services.

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

Physical Handicap means a Dependent Child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect, or sickness; and
- is diagnosed by a Physician as a 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.

Physician Visit means a face-to-face meeting or an approved form of on-line consultation between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service, except when health care is performed via a Telemedicine Medical Service or Telehealth Service.

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policy Anniversary means January 1, and the same day of each following year.

Policyholder means the business, firm, union, trustee(s), or other entity to whom the Group Policy is issued (see Title Page).

Preferred Provider/PPO Provider means a Hospital, Physician, or other provider contracted with a preferred provider organization (PPO) network identified by the Company to the Group Policy.

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

The Company has the right to terminate the preferred provider organization (PPO) portion of the Group Policy if the Company or the preferred provider organization (PPO) terminates the arrangement.

The Company also has the right to identify different preferred provider organizations from time to time. Preferred provider organizations also have the right, after providing required Written notice to a Preferred Provider, to terminate the designation of any Preferred Provider at any time.

Preferred Provider Organization (PPO) Service Area means the geographic area within which Preferred Provider services are available to persons insured under the Group Policy.

Prevailing Charges means:

- For medical care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.

- For medical care received from Non-Preferred Providers, the amount that is the lesser of:

    - the fee charged under any 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 medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.
- For drugs and medicines requiring a Physician’s prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.

Preventive Health and Wellness Services means the following services:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; or
- immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Persons involved; or
- preventive care and screenings for infants, children, and adolescents, according to guidelines supported by the Health Resources and Services Administration; or
- in addition to the benefits or services listed in the first bullet above, additional preventative care and screening for women according to the guidelines supported by the Health Resources and Services Administration.

Primary Care Physician means a Physician who is a family or general practitioner, internist, obstetrician/gynecologist, pediatrician, or any other licensed or certified health care practitioner who is listed in the Texas Insurance Code §1451.001who is performing primary care services within the scope of their license the same services or procedures of any other practitioner of the healing arts whose services or procedures are covered under the Group Policy. For the purpose of Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, mental and behavioral health and substance use disorder providers, including psychiatrists, clinical psychologists, counselors, therapists, neuropsychologists, social workers, psychiatric nurses, and marriage and family therapists will be considered Primary Care Physicians.

Prior Plan means the group medical expense coverage of the Policyholder for which the Group Policy is a replacement.

Psychiatric Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, and is primarily engaged in providing diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

For the purpose of this definition, a Psychiatric Hospital will also include any inpatient bed in a licensed general Hospital used to provide diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in the absence of a specialized or designated psychiatric or drug treatment unit.

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by the Company.

Skilled Nursing Facility means an institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Skilled Nursing Facility may include Hospitals when the Hospital is providing nursing facility level of services. Skilled Nursing Facility does not include rest homes, homes for the aged, nursing homes, or places which furnish Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

Social Detoxification means a Treatment or Service designed to achieve detoxification without the use of drugs or other medical interventions.

Stabilize means no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the Insured Person from a facility.

Total Disability; Totally Disabled means:

- For a Member, a Member's complete inability due to his or her sickness or injury, to perform all of the substantial and material duties and functions of his or her occupation and any other gainful occupation in which the Member earns substantially the same compensation earned prior to disability.
- 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.

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.

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.

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

Life and Health Insurance Guaranty Association Notice – TX

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects your by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life Insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual Annuities**: Up to $250,000 in present value of benefits, including case surrender and net cash withdrawal values.

- **Other policy types**: Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit**: Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1717 West 6th Street, Suite 230 Austin, Texas 78703-4776 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 12030 Austin, Texas 78711 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Nippon Life Benefits®

Notice of Privacy Practices for Protected Health Information (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how your medical information obtained in connection with your health benefit plan administration may be used and disclosed and how you can access the information. The terms of this Notice apply to current and former plan members and dependents for their group medical expense, group dental expense and/or group vision care expense insurance. This Notice was effective April 14, 2003 and has been revised most recently effective November 1, 2013.

We are required by law to maintain the privacy of our current and former members' and dependents' protected health information, to provide notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all protected health information maintained by us. Copies of any revised Notices will be mailed to plan sponsors for distribution to the members then covered by the plan. You have the right to request a paper copy of the Notice although you may have originally requested a copy of the Notice electronically by e-mail.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Authorization

Except as explained below, we will not use or disclose your protected health information for any purpose unless you have signed an authorization form. You have the right to revoke an authorization by written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to revoke an authorization can be obtained from the Privacy Officer and will be honored upon receipt by us.

Disclosures for Treatment

We may disclose your protected health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your protected health information in our possession to assist in your care.

Uses and Disclosures for Payment

We may use and disclose your protected health information as necessary for payment purposes. For instance, we may use it to process or pay claims, to exercise legal subrogation rights, to perform a Precertification, to determine whether services are for medically necessary care, or to perform prospective reviews. We may also forward information to another insurer in order for them to process or pay claims on your behalf.

Uses and Disclosures for Health Care Operations

We may use and disclose your protected health information as necessary for health care operations. For instance, we may use or disclose your protected health information for quality assessment and quality improvement, premium rating (when allowable by law), conducting or arranging for medical review or compliance. We may also disclose your protected health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with your health plan. Your health plan may have its own privacy practices that are not reflected in this Notice. We may disclose your protected health information to your health plan for its health care operations. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures

We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment

We may request and receive from you and your health care providers protected health information prior to your enrollment under the group policy. When allowable by law, we may use this information to determine rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state privacy laws.

Genetic Information

We will not use or disclose any genetic information we obtain about you in any regard, including underwriting purposes.

Business Associate

Certain aspects and components of our insurance services are performed by outside vendors known as 'Business Associates.' Business Associates are under an independent duty to safeguard your privacy. Additionally we require them to sign a Business Associate Agreement, which is a contract to adhere to our privacy practices.

Plan Sponsor

We may disclose your protected health information to the plan sponsor, provided that the plan sponsor certifies that the information will be used and maintained in a compliant confidential manner and will not be utilized or disclosed for employment-related actions or decisions or in connection with any other benefit plan of the plan sponsor.

Family, Friends and Personal Representatives

With your approval, we may disclose to family members, close personal friends, or another person you identify, your protected health information relevant to their involvement with your health care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your protected health information without your approval. We may also disclose your protected health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures

We are permitted or required by law to use or disclose your protected health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Uses and Disclosures Requiring Authorization

We are required by law to obtain your authorization prior to using or disclosing your protected health information in the following circumstances:

- Uses and disclosures of protected health information for marketing purposes.
- Uses and disclosures that constitute the sale of protected health information.
- Most uses and disclosures of psychotherapy notes.
- Other uses and disclosures not described in this notice will be made only with the individual's written authorization. An individual may revoke an authorization, provided that the revocation is in writing and we have not taken action in reliance upon the authorization.

YOUR RIGHTS

Restrictions on Use and Disclosure of Your Protected Health Information

You have the right to request restrictions on how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951.

A form to request a restriction can be obtained from the Privacy Officer. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Protected Health Information

You have the right to request communications regarding your protected health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request a confidential communication can be obtained from the Privacy Officer.

Access to Your Protected Health Information

You have the right to inspect and/or obtain a copy of your protected health information we maintain in your designated record set, with some exceptions. To request access to your information, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request access to your protected health information can be obtained from the Privacy Officer. A fee may be charged for copying and postage.

Amendment of Your Protected Health Information

You have the right to request an amendment to your protected health information to correct inaccuracies. To request an amendment, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an amendment to your protected health information can be obtained from the Privacy Officer. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Protected Health Information

You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, of your protected health information. To request an accounting, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an accounting of your protected health information can be obtained from the Privacy Officer. The first accounting in any 12-month period will be free; however, a fee may be charged for any subsequent request for an accounting during that same time period.

Complaints

If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may call Nippon Life Insurance Company of America at: English and Non-English (800) 374-1835; Japanese (800) 971-0638; or Korean (877) 827-8713.

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