

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.

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.

OHIO HDHP LARGE GROUP

EFFECTIVE MAY 1, 2025

Group Plan Booklet Certificate

Medical Expense Coverage

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

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Member's Signature

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

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

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

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

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

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

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

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

NOTE: IF THE MEMBER OR THE MEMBER'S DEPENDENTS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, THE MEMBER MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE THE MEMBER TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS THE MEMBER OR THE MEMBER'S DEPENDENTS.

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NIPPON LIFE INSURANCE COMPANY OF AMERICA
P.O. Box 4387, Clinton, IA 52733

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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.

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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.

PLEASE 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 May 1, 2025)**

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

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.

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MEDICAL CARE COVERED CHARGES

Benefits payable will be based on four Categories of medical care services as described below. See page NBM 5402 A HDHP 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.

DEDUCTIBLE AMOUNTS

- *- **If medical care is received from PPO Providers, for persons enrolled for Member only coverage, his or her Deductible Amount will be \$1,500 each Calendar Year.**
- *- **If medical care is received from PPO Providers, for persons enrolled for Member and Dependent (family) coverage, the Deductible Amount will be \$3,000 each Calendar Year for all members in the same family. The family Deductible may be satisfied by any one family member or by two or more family members. No benefits will be payable until the entire family Deductible of \$3,000 has been satisfied. No additional Deductible or Out-of-Pocket Expense Limit will be applied to any individual family member in excess of the Federal required annual limit on cost sharing for self-only coverage. After satisfaction of the Deductible, the Company will pay benefits as described in this booklet-certificate.**
- ** **If medical care is received from Non-Preferred Providers, for persons enrolled for Member only coverage, his or her Deductible will be \$3,000 each Calendar Year.**
- ** **If medical care is received from Non-PPO Providers, for persons enrolled for Member and Dependent (family) coverage, the Deductible will be \$6,000 each Calendar Year. The family Deductible may be satisfied by any one family member or by two or more family members. No benefits will be payable until the entire family Deductible of \$6,000 has been satisfied. After satisfaction of the Deductible, the Company will pay benefits as described in this booklet-certificate.**

Covered Charges used to satisfy the individual and family maximum Calendar Year Deductibles that apply when care is received from PPO Providers will not be used to satisfy the individual and family maximums that apply when care is received from Non-PPO Providers and vice versa.

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

	PPO Providers	Non-PPO Providers
Per Person.....	\$1,500	\$5,000
(applies for Member only coverage)		
Per Family.....	\$3,000	\$10,000
(applies if the Member is enrolled for family coverage)		

- Covered Charges used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a PPO Provider will not be used to satisfy the Out-of-Pocket Expense Limits that apply when care is received from a Non-PPO Provider and vice versa.
- If the amount the Insured Person pays for Covered Charges in any one Calendar Year reaches the applicable Out-of-Pocket Expense Limit shown above, the Company will pay 100% of additional Covered Charges.
- The per family Out-of-Pocket Expense Limit shown above may be satisfied by any one family member or by two or more family members.
- The Out-of-Pocket Expense Limit for PPO Providers applied to any individual Insured Person under family coverage will not exceed the Federal required Out-of-Pocket Expense Limit applied to self-only coverage.

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 will not count toward satisfaction of the Out-of-Pocket Expense Limit for medical care received from Non-Preferred Providers.

If a generic equivalent is available and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price will not count toward satisfaction of the Out-of-Pocket Expense Limit, unless the medication is medically necessary and 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.

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
Hospital Services		
- Inpatient Hospital Services		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%
- Deductible	\$1,500* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services – \$3,000** per Calendar Year

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
Hospital Services Covered Charges for Birthing Center Services, Ambulatory Surgery Center Services, and freestanding dialysis center services will be subject to the applicable Calendar Year Deductible Amount.		
- Outpatient Hospital Services		
- Coinsurance	80%	60%
- Deductible	\$1,500* per Calendar Year	\$3,000** per Calendar Year
- Emergency Room Visits/Emergency Services (including outpatient professional services (radiology, pathology, and ER Physician), MRIs, CATs, SPECTs, PETs and other similar imaging tests)		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60% For Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services rendered in an Emergency Room – Same as PPO Providers.
- Deductible	\$1,500* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services – \$3,000** per Calendar Year For Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services rendered in an Emergency Room – Same as PPO Providers.

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
Physician Hospital and Surgery Services		
- Physician Hospital Services (including surgery and surgery performed in an Ambulatory Surgery Center or Physician's office or clinic and Physician Visits on an inpatient or outpatient basis)		
- Coinsurance	80%	60%
- Deductible	\$1,500* per Calendar Year	\$3,000** per Calendar Year
Physician Office or Clinic Services		
- Services at a Physician's office or clinic (other than for Adult Wellness, Well Child Visits and Preventive Health and Wellness Services)		
- Coinsurance	80%	60%
- Deductible	\$1,500* per Calendar Year	\$3,000** per Calendar Year
- Preventive Health and Wellness Services at a Physician's office or clinic		
- Adult Wellness		
- Coinsurance	100%	60%
- Deductible	None	\$3,000** per Calendar Year
- Well-Child Visits		
- Coinsurance	100%	60%
- Deductible	None	\$3,000** per Calendar Year
- Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine as described in page NBM 5400)		
- Coinsurance	80%	No benefits payable
- Deductible	\$1,500* per Calendar Year	No benefits payable

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
All Other Covered Services		
- Ambulance Services		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%
- Deductible	\$1,500* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services – \$3,000** per Calendar Year
- Other Medical Services (including MRIs, CATs, SPECTs, PETs and other similar imaging tests in any outpatient location)		
- Coinsurance	80%	For Emergency Services – Same as PPO Providers. For other than Emergency Services – 60%
- Deductible	\$1,500* per Calendar Year	For Emergency Services – Same as PPO Providers. For other than Emergency Services – \$3,000** per Calendar Year
- Other Preventive Health and Wellness Services		
- Coinsurance	100%	60%
- Deductible	None	\$3,000** per Calendar Year

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
- Contraceptive Methods and Counseling for Women (including FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity).		
- Coinsurance	100%	60%
- Deductible	None	\$3,000** per Calendar Year
- Prescription Drugs for generic and single source contraceptives for women		
- Coinsurance	100%	60%
- Deductible	None	\$3,000** per Calendar Year
- Other Prescription Drugs		
- Coinsurance	80%	60%
- Deductible	\$1,500* per Calendar Year	\$3,000** per Calendar Year
<p>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 subject to Deductible and coinsurance and will be reimbursed up to an amount determined by the Company.</p> <p>Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. If the Physician specifies that the medication must be a Preferred or non-Preferred Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Preferred or non-Preferred Brand Name Drug price. If a generic equivalent is available, and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, the Insured Person will pay the difference between the Generic Drug price and the Preferred or non-Preferred Brand Name Drug price. If a generic equivalent is available, and the Insured Person chooses a Preferred or non-Preferred Brand Name Drug, 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.</p>		

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 payment conditions applicable to Preventive Health and Wellness Services required by Federal law, see page NBM 5400.
- 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 HDHP.
- 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 HDHP.
- For payment conditions applicable to Emergency Room Services, see page NBM 5402 H HDHP.
- For payment conditions applicable to Hearing Aids, see page NBM 5402 J.
- For payment conditions applicable to Traditional East Asian Medicine, see page NBM 5402 N.

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

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.

Hearing Aids.....	\$2,500 per Insured Person/per Calendar Year for hearing aids for one or both ears once every 36
Home Health Care.....	100 visits per Insured Person/per Calendar Year
Skilled Nursing Facility Care.....	60 days for all confinements resulting from the same sickness or injury
Temporomandibular Services	\$1,500 during an Insured Person's lifetime

The Insured Person's Responsibilities

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

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

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

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

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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)(D).

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

I. No Surprises Act

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

Definitions Applicable to the No Surprises Act

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

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

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

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

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

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

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

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

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

Independent Freestanding Emergency Department means a Health Care Facility that:

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

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

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

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

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

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

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

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

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

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

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

The amount is based on one of the following:

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

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

Surprise Medical Bills for Emergency Services

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

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

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

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

Surprise Medical Bills for Non-Emergency Services

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

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

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

Surprise Medical Bills for Air Ambulance Services

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

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

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

II. Dispute Resolution

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

III. Continuity of Care

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

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

Continuing Care Patient means an individual who is:

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

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

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

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

IV. Provider Directories

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

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

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

NIPPON LIFE INSURANCE COMPANY OF AMERICA



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

Katsuhisa Kumasako
President and Chief Executive Officer

HOW TO BE INSURED – MEMBERS

MEDICAL EXPENSE INSURANCE

Eligibility

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

If the person is a Member on May 1, 2025, 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 calendar day notice, if the individual intentionally submitted a claim which included misrepresentation of material fact under the terms of the Group Policy, and that contains false or fraudulent elements under state or federal law;
- in Writing and with 31 calendar day notice, upon finding in a civil or criminal case that an Insured Person has intentionally submitted a claim which included misrepresentation of material fact under the terms of the Group Policy that contain false or fraudulent elements under state or federal law;

- in Writing and with 31 calendar day notice, when an Insured Person has intentionally submitted a claim which included misrepresentation of material fact under the terms of the Group Policy that contains false or fraudulent elements under state or federal law.

The Company will not void an Insured Person's insurance based on a misrepresentation unless the Insured Person (or a person seeking insurance on behalf of the Insured Person) has performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact as prohibited above. The Company will provide notice 30 calendar days before Rescinding the Insured Person's insurance under the Group Policy. See page NBM 5407 GP for the Complaint and Grievance Procedures and page NBM 5407 ER for External Review.

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 May 1.

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

- **Special Enrollment Periods**

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

The Special Enrollment Periods are:

- (1) Loss of Other Coverage. A Special Enrollment Period will apply to a Member or Dependent if all of the following conditions are met:
 - (i) the Member or Dependent was covered under another Group Health Plan or had other Health Insurance Coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and

- (ii) the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, 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 or Placement for Adoption; and
- (iii) enrollment is made within 31 days after the later of the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Medical Expense Insurance is available to the Member under the Group Policy.

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

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

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

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

The enrollment:

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

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

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

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

(4) All Other Court-Ordered Coverage. A Special Enrollment Period will apply to the Member, the Member's 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 is enrolled but failed to enroll the 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 Dependent Child; and
- (iv) enrollment may be made at any time after the issue date of the court or administrative order.

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

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

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

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

Effective Date for Benefit Changes

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

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

Termination

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

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

Termination of Insurance While Outside of the United States

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

Continuation

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

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

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

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

All continuation provisions may run concurrently.

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

Contact the Policyholder with reinstatement questions.

HOW TO BE INSURED - DEPENDENTS

MEDICAL EXPENSE INSURANCE

Eligibility

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

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

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

Effective Date

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

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

Insurance for a Newborn or Newly Adopted Child

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

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

If the child's insurance terminates because the Member fails to enroll for insurance (or pay the required contribution) within the 31-day period following the child's date of birth, adoption or Placement for Adoption, benefits will be payable only for covered expenses incurred by the child during the 31-day period in which insurance was in force.

Individual Incontestability and Eligibility

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

Termination

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

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

- Insurance for any one Dependent will terminate on the earlier of:
 - the last day of the Insurance Month in which he or she ceases to be the Member's Dependent; or
 - for contributory insurance, the end of the Insurance Month desired, if requested by the Member before that date.

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

However, insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on the Member for primary support. The Member must apply for this continuation within 31 days after the date of the child's attainment of the limiting age. After the two year period following attainment of the limiting age, the Company may request further proof that the child remains incapable of self-support, however such requests will not be more frequent than annually.

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.

Termination of Insurance While Outside of the United States

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

Continuation

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

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

Contact the Policyholder with reinstatement questions.

**DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE**

GENERAL PROVISIONS

Payment Conditions

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

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

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

Benefit Qualification

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

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

Benefits Payable

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

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

Benefits Payable – Required by Federal Law

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

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

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

See “Maternity Coverage” under Benefits Payable - State-Required - Ohio 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 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.

- **Preventive Health and Wellness Services**

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

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

Preventive Health and Wellness Services can be found at: www.healthcare.gov/. The Preventive Health and Wellness Services list is subject to change as the federal guidelines are updated.

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

Preventive Health and Wellness Services from PPO Providers will be payable at 100% and no Deductible will apply. Preventive Health and Wellness Services from Non-PPO Providers will be subject to Deductible and coinsurance.

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

- **Contraceptive Methods and Counseling for Women**

Covered Charges from a 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.

Exception: To request an exception for a contraceptive service or item from a Member Pharmacy or PPO Provider, the Insured Person, a designated representative acting on the behalf of the Insured Person, or the prescribing Physician may submit an exception request, either orally or in Writing.

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The Company will review the exception request and make a determination of the claim in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving urgent care. If the Physician determines a particular contraceptive service or FDA-approved item is medically necessary with respect to the Insured Person, that contraceptive service or item from a Member Pharmacy or PPO Provider will be payable at 100%.

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 Cancer Clinical Trial benefit described below under Benefits Payable - State Required – Ohio.

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 – Ohio

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

- **Autism Spectrum Disorder**

Covered Charges will include charges incurred by the Member's Dependent Child who is under 14 years of age for the screening, Diagnosis of Autism Spectrum Disorders and the Treatment for Autism Spectrum Disorders. Prior authorization is required for the Treatment for Autism Spectrum Disorders. Treatment for Autism Spectrum Disorders must be prescribed or ordered by a psychologist trained in autism, a developmental pediatrician, or a clinical nurse specialists or certified nurse practitioner specializing in pediatric health.

Treatment includes, but is not limited to, the following:

- For Speech and language therapy or occupational therapy for a Dependent Child that is performed by a licensed therapist, twenty-visits per Calendar Year for each service;
- For Clinical therapeutic intervention for a Dependent Child that is provided by or Under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of Ohio to perform such services in accordance with a health treatment plan;
- Mental or behavioral health outpatient services for a Dependent Child that are performed by any of the following providing consultation, assessment, development, or oversight of treatment plans:
 - A licensed psychologist;
 - A licensed Physician, including a psychiatrist;
 - A clinical nurse specialist or certified nurse practitioner, including a Psychiatric-Mental Health Advanced Practice Registered Nurse or a clinical nurse specialist or certified nurse practitioner specializing in pediatric or family health.

Except for inpatient services, if a Dependent Child is receiving Treatment for Autism Spectrum Disorders, the Company has the right to request a review of the treatment plan not more than once every twelve (12) months unless the Company and the licensed Physician, clinical nurse specialists, certified nurse practitioner, or licensed psychologist agrees that a more frequent review is necessary. The Company will pay for the cost of obtaining any review or treatment plan.

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

"Applied Behavior Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Autism Spectrum Disorder" means any of the pervasive developmental disorders or Autism Spectrum Disorder as defined by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association available at the time the Dependent Child is first evaluated for suspected developmental delay.

"Clinical Therapeutic Intervention" means therapies supported by empirical evidence, which include, but are not limited to, Applied Behavior Analysis, that satisfy both of the following:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the function of a Dependent Child;
- Are provided by or under the supervision of a certified Ohio behavior analyst; an individual licensed to practice psychology; or an individual licensed to practice professional counseling, social work, or marriage and family therapy.

"Diagnosis of Autism Spectrum Disorder" means medically necessary assessment, evaluations, or tests to diagnose whether a Dependent Child has an Autism Spectrum Disorder.

"Pharmacy Care" means prescribed medications and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

"Psychiatric Care" means direct or consultative services provided by a psychiatrist or Psychiatric-Mental Health Advanced Practice Registered Nurse who is licensed in the state in which the psychiatrist or nurse practices.

"Psychiatric-Mental Health Advanced Practice Registered Nurse" means an advanced practice registered nurse who is either of the following:

- A clinical nurse specialist who is certified as a psychiatric-mental health CNS, or the equivalent of such title, by the American nurses credentialing center;
- A certified nurse practitioner who is certified as a psychiatric-mental health NP, or the equivalent of such title, by the American nurses credentialing center or American academy of nurse practitioners certification board.

"Psychological Care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic Care" means services provided by a speech therapist, occupational therapist, or physical therapist licensed or certified in the state in which the person practices.

"Treatment for Autism Spectrum Disorder" means evidence-based care and related equipment prescribed or ordered for a Dependent Child diagnosed with an Autism Spectrum Disorder by a licensed Physician who is a developmental pediatrician, licensed psychologist trained in autism, clinical nurse specialists or certified nurse practitioner specializing in pediatric health, or clinical nurse specialist or certified nurse practitioner trained in autism who determines the care and related equipment to be medically necessary, including any of the following:

- Clinical Therapeutic Intervention;
- Pharmacy Care;
- Psychiatric Care;
- Psychological Care;
- Therapeutic Care.

- **Cancer Clinical Trial**

Covered Charges will include Routine Patient Care administered to the Insured Person participating in any stage of an Eligible Cancer 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 above under Benefits Payable – Required by Federal Law.

“Eligible Cancer Clinical Trial” means a cancer clinical trial that meets all of the following:

- a purpose of the trial is to test whether the intervention potentially improves the Insured Person’s health outcomes; and
- the treatment provided as part of the trial is given with the intention of improving the Insured Person’s health outcomes; and
- the trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and
- the trial does one of the following:
 - tests how to administer a health care service, item, or drug for the treatment of cancer; or
 - tests responses to a health care service, item, or drug for the treatment of cancer; or
 - compares the effectiveness of health care services, items, or drugs for the treatment of cancer; or
 - studies new uses of a health care service, item, or drug for the treatment of cancer.
- the trial is approved by one of the following entities:
 - the United States Food and Drug Administration; or
 - the United States Department of Defense; or
 - the United States Department of Veteran’s Affairs.

“Routine Patient Care” means all Covered Charges consistent with the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for the Insured Person who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

“Routine Patient Care” does not include coverage for:

- a health care service, item, or drug that is the subject of the cancer clinical trial; or
- any health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the Insured Person; or
- an investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration; or
- transportation, lodging, food, or other expenses for the Insured Person, or a family member or companion of the Insured Person, that are associated with travel to or from a facility providing the cancer clinical trial; or
- an item or drug provided by the cancer clinical trial sponsors free of charge for the Insured Person; or
- a service, item, or drug that is eligible for reimbursement from a source other than the Group Policy, including the sponsor of the cancer clinical trial.

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

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

- **Definitions**

Children's Preventive Pediatric Care Services means the periodic review of a child's physical and emotional status by or under the supervision of a Physician. Benefits are payable for Covered Services as described below.

- **Covered Services**

Covered Services at each visit include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards.

- **Rate of Payment**

Benefits will be payable the same as the Preventive Health and Wellness Services benefit as described in NBM 5102 HDHP.

NOTE: This benefit will be coordinated with the Pediatric Vaccine benefit and the Preventive Health and Wellness Services benefit described above.

- **Cytologic Screening Services**

Covered Charges will include charges incurred by an Insured Person for the detection of cervical cancer and will be coordinated with the Preventive Health and Wellness Services benefit described above under Benefits Payable – Required by Federal Law. Benefits will be payable on the same basis as for any other covered Treatment or Service.

- **Emergency Care**

Covered Charges will include charges for Emergency Services that include a medical screening examination, as required by Federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition.

The medical screening examination and treatment utilized to Stabilize an Emergency Medical Condition must be within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

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

If an Insured Person has an Emergency Medical Condition, an Insured Person should either contact 911 (if available in the Insured Person's area) or seek medical treatment immediately from a Hospital, Physician's office, or some other emergency facility.

- **FDA Approved Drugs**

Covered Charges will include charges for drugs approved by the United States Food and Drug Administration, including those drugs prescribed on the basis that the drug has not been approved for the treatment of the particular indication for which the drug has been prescribed. The drug must have been recognized as safe and effective for treatment of that indication in any one or more of the standard medical reference compendia adopted by the United States department of health and human services under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature that meets all of the following criteria:

- two articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed; and

- no article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; and
- each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services pursuant to Section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395 (x)(t)(2)(B), as amended, as accepted peer-reviewed medical literature.

Benefits payable will not include charges for any experimental drugs not approved for any indication by the United States Food and Drug Administration or any drug which the United States Food and Drug Administration has determined to be contraindicated for the treatment of the particular indication for which it was prescribed. Also, this provision will not be interpreted to do any of the following:

- alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration; and
- require reimbursement or coverage for any drug not included in the Company's drug formulary or list of covered drugs; and
- prohibit this policy from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs required by this section.

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**

Covered Charges for expenses incurred in the purchase of Hearing Aids for an Insured Person less than 22 years of age. Covered Charges include the purchase of a Hearing Aid for each ear for an Insured Person who is verified as being deaf or hearing impaired by a licensed audiologist or by an Otolaryngologist or other licensed Physician. The Hearing Aids must be considered medically appropriate to meet the needs of the Insured Person, according to professional standards established by the state speech and hearing professionals board. Benefits will be payable up to a maximum of \$2,500 per Hearing Aid for each hearing-impaired ear every 48 months.

Covered Charges will also include all Related Services prescribed by an Otolaryngologist or recommended by a licensed audiologist and dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an Otolaryngologist.

Covered Charges will not be included, and no benefits will be paid for the cost of a Hearing Aid if, less than forty-eight months prior to the date of the claim, the Insured Person received coverage for Hearing Aids from any other health benefit plan.

After satisfaction of the Deductible, benefits will be payable at 100%.

"Hearing Aid" means any wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and parts thereof, except batteries and cords, that is dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist.

"Otolaryngologist" means a licensed physician who practices otolaryngology.

"Related Services" means services necessary to assess, select, and appropriately adjust or fit a hearing aid to ensure optimal performance.

- **Mammography Services**

Covered Charges will include charges incurred by an Insured Person for one Screening Mammography every year, including digital breast tomosynthesis.

Covered Charges will also include charges incurred for a Supplemental Breast Cancer Screening for an Insured Person who meets either of the following conditions:

- the Insured Person's Screening Mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the Insured Person has dense breast tissue;
- the Insured Person is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the Insured Person's Physician.

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 will apply. All other mammograms will be payable the same as any other Physician Office or Clinic Service.

Benefits for Screening Mammograms or Supplemental Breast Cancer Screening will be payable the same as for any other covered Physician Office or Clinic Service, except that the maximum benefit will be 130% of the Medicare reimbursement rate for Ohio for Screening Mammography or Supplemental Breast Cancer Screening (the lowest Medicare reimbursement rate in the state, if there is more than one rate). All other mammograms will be payable the same as any other covered Physician Office or Clinic Service.

If services are provided by a Non-PPO Provider, the maximum benefit will be 130% of the Medicare reimbursement rate for Ohio for Screening Mammography or Supplemental Breast Cancer Screening (the lowest Medicare reimbursement rate in the state, if there is more than one rate). Non-PPO Providers may not balance bill for Screening Mammograms or Supplemental Breast Cancer Screening, seek, or receive compensation in excess of the payment described above, except for approved Deductibles.

“Screening Mammography” means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. “Screening Mammography” includes digital breast tomosynthesis. “Screening mammography” includes two views for each breast. The term also includes the professional interpretation of the film. “Screening Mammography” does not include diagnostic mammography.

“Supplemental Breast Cancer Screening” means any additional screening method deemed medically necessary by a treating Physician for proper breast cancer screening in accordance with applicable American college of radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging.

“Medicare reimbursement rate” means the reimbursement rate in Ohio under the Medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

Maternity Coverage

Covered Charges will include Hospital Inpatient Confinement charges incurred by a mother and newborn Dependent Child. Benefits will be payable for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean section. Benefits will be payable the same as for any other covered Hospital confinement; however, the 48-hour and 96-hour minimum will not be subject to the Precertification or Covered Charge requirements described in this booklet-certificate. Any Hospital Inpatient Confinement 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 Hospital confinement.

Covered Charges will also include charges incurred for follow-up care that is determined to be medically necessary by the health care professional responsible for discharging the mother or newborn, when provided in a medical setting or through home health care visits. Coverage for home health care visits will be provided only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Covered Charges will include a Physician-directed source of follow-up care or a source of follow-up care directed by an advanced practice registered nurse. Benefits include, but are not limited to, physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Any decision to shorten the length of stay to less than the minimum period mentioned above may be made by the Physician attending the mother or newborn, except that if a certified nurse midwife is attending the mother in collaboration with a Physician, a certified nurse midwife may make the decision provided the mother or a person responsible for the mother or newborn concurs. When a decision is made to discharge a mother or newborn prior to the expiration of the minimum period mentioned above, the coverage of follow-up care will apply to all follow-up care that is provided within seventy-two hours after discharge from the Hospital.

At the mother's discretion, this visit may occur at the Physician's office.

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

- **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 at a network pharmacy 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 disease or condition 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, opioid analgesic, or benzodiazepine.

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 that is dispensed at a network pharmacy. The Company will determine dispensing fees based exclusively on the total number of prescriptions that are filled or refilled. Dispensing fees will not be based on the days' supply of prescription drugs dispensed.

“Medication Synchronization” means a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month.

- **Opioid Analgesic**

Covered Charges will include an Opioid Analgesic prescribed for the treatment of Chronic Pain. Prior authorization is required except when the drug is prescribed under one of the following circumstances:

- to an Insured Person who is a hospice patient in a Hospice Care program;
- to an Insured Person who has been diagnosed with a Terminal Condition but is not a hospice patient in a Hospice Care program;
- to an Insured Person who has cancer or another condition associated with the Insured Person's cancer or history of cancer.

Prior Authorization requests for opioid treatment will be treated as an expedited service in accordance with applicable state and federal law.

To view information regarding opioid education, visit the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com. Additional educational material is available by clicking the link:

<https://www.cdc.gov/drugoverdose/patients/materials.html>. Insured Persons can also contact their local public health department for more information on initiatives to combat Opioid addiction.

“Chronic Pain” means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months. Chronic Pain does not include pain associated with a Terminal Condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a Terminal Condition.

“Opioid Analgesic” means a controlled substance that has analgesic pharmacologic activity at the opioid receptors of the central nervous system, including the following drugs and their varying salt forms or chemical congeners: buprenorphine, butorphanol, codeine (including acetaminophen and other combination products), dihydrocodeine, fentanyl, hydrocodone (including acetaminophen combination products), hydromorphone, meperidine, methadone, morphine sulfate, oxycodone (including acetaminophen, aspirin, and other combination products), oxymorphone, tapentadol, and tramadol.

"Terminal Condition" means an irreversible, incurable, and untreatable condition that is caused by disease, illness, or injury and will likely result in death. A Terminal Condition is one in which there can be no recovery, although there may be periods of remission.

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

- **Orally Administered Anti-Cancer Medication**

Covered Charges will include orally administered, intravenously administered or injected anti-cancer medication used to kill or slow the growth of cancer cells.

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

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

- **Prior Authorization**

Covered Charges will include prescription drugs for the treatment and management of a Chronic Condition. The Company will honor a prior authorization approval related to a Chronic Condition for an approved prescription drug for the lesser of the following from the date of the approval:

- twelve months;
- the last day of the Insured Person's eligibility under the Group Policy.

The Company will require the health care provider to submit information to the Company indicating that the Insured Person's Chronic Condition has not changed. The request for information by the Company and the response by the health care provider will be in an electronic format, which may be by traditional electronic mail or other electronic communication. The frequency of the submission of requested information will be consistent with medical or scientific evidence and will not be required more frequently than quarterly. If the health care provider does not respond within five calendar days from the date the request was received, the Company will terminate the twelve-month approval.

The twelve-month approval provided above does not apply to and is not required for any of the following:

- Medications that are prescribed for a non-maintenance condition;
- Medications that have a typical treatment of less than one year;
- Medications that require an initial trial period to determine effectiveness and tolerability, beyond which a one-year, or greater, prior authorization period will be given;

- Medications where there is medical or scientific evidence that does not support a twelve-month prior authorization approval;
- Medications that are a schedule I or II controlled substance or any opioid analgesic or benzodiazepine;
- Medications that are not prescribed by an in-network health care provider as part of the care management program.

The twelve-month approval provided above will no longer be valid and will automatically terminate if there are changes to Federal or state laws or Federal regulatory guidance or compliance information prescribing that the prescription drug is no longer approved or safe for the intended purpose.

The approved prescription drug may be substituted with any prescription drug that has received a twelve-month approval when there is a release of a United States food and drug administration approved comparable brand product or a generic counterpart of a brand product that is listed as therapeutically equivalent in the United States food and drug administration's publication titled approved drug products with therapeutic equivalence evaluations.

“Chronic Condition” means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

- **Telemedicine Services**

Covered Charges will include charges for Telemedicine services on the same basis and to the same extent as In-Person Health Care Services.

Covered Charges will not include any costs or fees associated with Telemedicine Services that would be in addition to or greater than the standard reimbursement for comparable In-Person Health Care Services. Telemedicine Services may have different cost sharing from other Physician services.

“In-Person Health Care Services” means health care services delivered by a health care professional through the use of any communication method where the professional and patient are simultaneously present in the same geographic location.

“Recipient” means an Insured Person receiving health care services or a Physician with whom the Physician is consulting regarding the Insured Person.

“Telemedicine Services” means a mode of providing health care services through synchronous or asynchronous information and communication technology by a Physician, within the Physician’s scope of practice, who is located at a site other than the site where the Recipient is located.

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

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DESCRIPTION OF BENEFITS MEDICAL EXPENSE INSURANCE

Benefits Payable

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

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

COVERED CHARGES

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

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

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

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

- **Physician's Hospital and Surgery Services** include charges for:
 - the services of a Physician while receiving treatment at a Hospital, on an inpatient or outpatient basis (including surgery and Physician Visits); and
 - outpatient physical, occupational, and speech therapy, performed in an outpatient Hospital setting, not to exceed 30 visits per Calendar Year, 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; and
 - the services of a Physician for surgery received in a Physician's office, clinic or Ambulatory Surgery Center.

- **Physician's Office or Clinic Services** include:
 - charges for Treatment or Service furnished at the Physician's office or clinic other than charges for surgery or anesthesia. Such services include charges for a Physician Visit, injections, take-home drugs, blood, blood plasma, x-ray and laboratory examinations, x-ray, radium, and radioactive isotope therapy; and
 - the services of a Health Care Extender; and
 - outpatient physical, occupational or speech therapy not to exceed 30 visits per Calendar Year for each Insured Person, except that outpatient physical, occupational, and speech therapy will not be subject to any visit limits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services; and
 - Traditional East Asian Medicine as described in page NBM 5402 N; and
 - Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine as described in page NBM 5400); and
 - Gene-Based, Cellular And Other Innovative Therapies (GCIT) as described in page NBM 5402 F.

- **All Other Covered Services** include:
 - drugs and medicines: (i) requiring a Physician's prescription; and (ii) approved by the Food and Drug Administration for general marketing as described in NBM 5402 R HDHP; and
 - Contraceptive methods and counseling for women as described in page NBM 5400; and

- charges for ambulance services (including air ambulances) provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) or to and from a Hospital when needed to transition to a more cost effective level of care as determined by the Company; and
- surgical dressings, supplies, covered orthotics, casts, splints, braces, crutches and equipment not considered to be Durable Medical Equipment as described in page NBM 5402 J; 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
- anesthesia received in a Physician's office or clinic or an Ambulatory Surgery Center, and
- oxygen (including rental of equipment for its administration) and nebulizers and related charges; and
- the following services performed while the Insured Person is not Hospital Inpatient Confined, or is not in a Hospital emergency room: magnetic resonance imaging (MRIs), computerized axial tomography (CATs), positron emission tomography (PETs), and single photon emission computerized tomography (SPECTs), or other similar imaging tests and all related services (other than evaluation and management services) including but not limited to drugs and supplies; and
- Dental Services to repair damages to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within twelve months after the accident. Covered Charges are limited to the least expensive procedure that would provide professionally acceptable results; and
- Temporomandibular Services, limited to a lifetime maximum benefit of \$1,500 for each Insured Person. These services will not include services for orthodontic procedures or restoration of the dentition, supporting tissues, and bone; and
- unattended (home) sleep studies.

Drug and Medicine Management

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

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

Cosmetic Treatment or Service

Covered Charges will include Cosmetic Treatment or Service resulting from a sickness or an accidental injury, and rendered within 18 months after the date the sickness or accidental injury was first diagnosed. Benefits will be payable the same as any for other covered Treatment or Service.

Covered Charges for Multiple Surgical Procedures

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

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

Covered Charges for an Assistant during Surgical Procedures

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

MENTAL HEALTH, 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, or a psychiatric or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. Benefits will be payable the same as for any other Hospital Inpatient Confinement. Hospital Inpatient Confinements are subject to the Utilization Management Program, including Precertification requirements, as described on NBM 5407 CC.

- **Residential Treatment Services**

Covered Charges include residential Treatment or Services, including individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, and individualized program of rehabilitation, therapy, and education.

- **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.

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.

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DESCRIPTION OF BENEFITS MEDICAL EXPENSE INSURANCE

- **TRANSPLANT SERVICES**

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

- **Covered Transplants**

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

- Heart;
- Heart/lung (simultaneous);
- Lung;
- Liver;
- Kidney;
- Kidney-Pancreas;
- Pancreas;
- Small Bowel;
- Bone marrow transplant or peripheral stem cell infusion for the following conditions when a positive response to standard medical treatment or chemotherapy has been documented. Unless otherwise indicated, coverage is for one transplant or infusion only within a 12-month period.
 - Acute Lymphoblastic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
 - Acute Myelogenous Leukemia - Autologous bone marrow transplant or peripheral stem cell infusion;
 - Acute Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
 - Chronic Lymphocytic Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
 - Chronic Myelogenous Leukemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;
 - Aplastic Anemia - Allogeneic bone marrow transplant or peripheral stem cell infusion;

- Hodgkin's Disease - Autologous bone marrow transplant or peripheral stem cell infusion;
- Hodgkin's Disease - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Non-Hodgkin's Lymphoma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Non-Hodgkin's Lymphoma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Multiple Myeloma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Multiple Myeloma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Pediatric Neuroblastoma - Autologous bone marrow transplant or peripheral stem cell infusion;
- Pediatric Neuroblastoma - Allogeneic bone marrow transplant or peripheral stem cell infusion;
- Primary Amyloidosis – Autologous bone marrow transplant or peripheral stem cell infusion;
- Myelodysplastic 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% in excess of the applicable Deductible Amount, up to a lifetime maximum benefit of \$5,000 for each transplant recipient.

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

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

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

No benefits will be payable for Transplant Services provided by other than a Transplant Network provider.

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

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

For each transplant episode Covered Charges will include:

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

EMERGENCY SERVICES

If an Insured Person requires Emergency Services, either within the PPO Service Area or outside the PPO Service Area, benefits for such treatment received for these Emergency Services will be paid at the PPO level, subject to the provisions described in page NBM 5198 NS.

The Prevailing Charge for Emergency Services provided by a Non-PPO Provider will be the greatest of the following:

- The median amount negotiated with PPO Providers for the Emergency Services furnished;
- The amount for the Emergency Services calculated using the same method the Company generally uses to determine payments for Non-PPO Providers (such as the amount that most health care providers charge within a geographic cost area); or
- The amount that would be paid under Medicare for the Emergency Services.

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

A Preferred Provider may not bill the Insured Person for any part of a charge for Treatment or Service that exceeds the negotiated fee. A Non-Preferred Provider may bill the Insured Person for any part of a charge for Treatment or Service that exceeds Prevailing Charges.

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 PPO level of benefits will be paid subject to the applicable Calendar Year Deductible.
- If the Insured Person goes to a PPO or non-PPO Physician's office or clinic and the Physician sends the x-ray(s) to a non-PPO facility, the level of benefits for Non-Preferred Providers will apply.
- If the Insured Person goes to a PPO freestanding x-ray facility, the PPO level of benefits will be paid subject to the applicable Calendar Year Deductible. If the x-ray facility is not a Preferred Provider, the level of benefits for Non-Preferred Providers will apply.

- OUTPATIENT LABORATORY SERVICES

Benefits payable for outpatient laboratory services will be as follows:

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

EMERGENCY ROOM SERVICES

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

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

If an Insured Person requires Emergency Services, either within the PPO Service Area or outside the PPO Service Area, benefits for such treatment received for these Emergency Services will be paid at the PPO level, subject to the provisions described in page NBM 5198 NS.

The Prevailing Charge for Emergency Services provided by a Non-PPO Provider will be the greatest of the following:

- The median amount negotiated with PPO Providers for the Emergency Services furnished;
- The amount for the Emergency Services calculated using the same method the Company generally uses to determine payments for Non-PPO Providers (such as the amount that most health care providers charge within a geographic cost area); or
- The amount that would be paid under Medicare for the Emergency Services.

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

A Preferred Provider may not bill the Insured Person for any part of a charge for Treatment or Service that exceeds the negotiated fee. A Non-Preferred Provider may bill the Insured Person for any part of a charge for Treatment or Service that exceeds Prevailing Charges.

**DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE**

HOME HEALTH CARE AND HOME INFUSION THERAPY SERVICES

- HOME HEALTH CARE SERVICES

- Covered Charges

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

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

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

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

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

- Benefits Payable

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

- **Limitations**

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

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

- **HOME INFUSION THERAPY SERVICES**

- **Covered Charges**

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

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

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

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

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

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

- **Benefits Payable**

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

- **Limitations**

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

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

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE

DURABLE MEDICAL EQUIPMENT

- **Covered Charges**

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

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

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

- **Benefits Payable**

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

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

- **Limitations**

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

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

HEARING AIDS

- **Covered Charges**

Covered Charges will include charges incurred for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are wearable, non-disposable, electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Treatment or Services are available for a hearing aid that is purchased as a result of a Written recommendation by a Physician and include the hearing aid and the charges for associated evaluation, fitting, testing, adjustments, and supplies, including ear molds. Covered Charges will be limited to a single purchase (including repair and/or replacement) of hearing aids for one or both ears.

- **Benefits Payable**

Benefits will be payable the same as any other covered Treatment or Service subject to a maximum equipment benefit of \$2,500 per Insured Person per Calendar Year and will be limited to one hearing aid per hearing impaired ear every 36 months.

- **Limitations**

The general Comprehensive Medical limitations listed in page NBM 5402 Q will apply to the hearing aid charges under this section. In addition, Covered Charges under this section will not include charges for the following:

- bone anchored hearing aids (i.e., cochlear implants); or
- over-the-counter hearing aids; or
- assistive listening devices such as frequency modulation (FM) systems; or
- batteries and cords.

**DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE**

PROSTHETICS

- **Covered Charges**

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

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

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

- **Benefits Payable**

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

- **Limitations**

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

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

**DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE**

HOSPICE CARE

- **Covered Charges**

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

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

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

Hospice Care Services consist of:

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

- **Benefits Payable**

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

- **Limitations**

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

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

**DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE**

SKILLED NURSING FACILITY CARE

- **Covered Charges**

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

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

either

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

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

- **Benefits Payable**

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

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

of the Hospital in which the Insured Person was confined before the Skilled Nursing Facility confinement. Also, Covered Charges will not include charges for more than 60 days for all Skilled Nursing Facility confinements that result from the same or a related sickness or injury. In addition, Covered Charges will not include any charges after the date the attending Physician stops treatment or withdraws certification.

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

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

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, except as provided under Clinical Trials in page NBM 5400. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure prescribed in the notice of that claim decision); or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is in an Insured Person's Immediate Family; or
- Dental Services or materials, including dental implants, except as described under Covered Charges; or
- eye examinations for the correction of vision or the fitting of glasses, eye refractions; vision materials including but not limited to frames or lenses; or
- acupressure treatment; acupuncture treatment, except as described under Traditional East Asian Medicine; or
- drugs or medicines that do not require a Physician's prescription except as covered under Preventive Health and Wellness Services or drugs or medicines that 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, except as covered under Preventive Health and Wellness Services; or
- nutritional supplements (even if the only source of nutrition), or special diets (whether or not they require a Physician's prescription); or
- drugs that are not included in the formulary; or
- wigs or hair prostheses; or
- Cosmetic Treatment or Service which does not qualify for coverage as described in page NBM 5402 A HDHP, and any complications arising therefrom; or
- personal hygiene, comfort, or convenience items, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, hoier 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; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from the commission of an offense by an Insured Person in which such person is convicted of or pleads guilty or no contest to a felony; 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 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 sterilization; or
- Treatment or Service performed for the purpose of voluntary abortion; or
- Treatment or Service performed for the purpose of reversal of voluntary sterilization; or
- Treatment or Service for routine foot care including the removal of corns and calluses or trimming of toenails, flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary; or
- dietetic counseling, unless provided while the Insured Person is Hospital Inpatient Confined or as provided 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, except as covered under Preventive Health and Wellness Services; or
- Treatment or Service for complications of a non-covered Treatment or Service; or
- Treatment or Service incurred after termination of coverage under this booklet-certificate; 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 Services for standby services; 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 paid by or reimbursed by the Policyholder; or
- Hospital overhead; or
- cosmetic surgery for personal reasons beyond sickness or injury; or
- routine immunizations and inoculations given as preventive measures against disease that are not covered under Preventive Health and Wellness Services; 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.

SAMPLE

SAMPLE

SAMPLE

SAMPLE

DESCRIPTION OF BENEFITS

PRESCRIPTION DRUGS

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 for those drugs and medicines under All Other Covered Services as described in the Summary of Benefits section.

Benefit payment will be limited to:

- Covered Charges as described in this section; and
- for certain qualified Maintenance Drugs and Medicines, a 90-day supply for each prescription and each refill; 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 (see below for Nonmember Pharmacy information); and
- not more than a 90 day supply for each prescription and each refill at a pharmacy designated by the Company to administer its Mail Service Prescription Drugs program.

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

To request benefit payment for a clinically appropriate drug not otherwise covered under the Group Policy, the Insured Person, a designated representative acting on the behalf of the Insured Person, or the prescribing Physician may submit an exception request, either orally or in Writing.

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The Company will provide an exception determination no later than 72 hours after the request is received, or within 24 hours if the Insured Person is suffering from a serious health condition that may seriously jeopardize the Insured Person's life, health, or ability to regain maximum function, or when the Insured Person is undergoing a current course of treatment using a non-formulary drug.

If the Company grants a standard exception request, coverage for the non-formulary drug will continue for the duration of the prescription, including refills. If the Company grants an exception based on exigent circumstances, coverage for the non-formulary drug will continue for the duration of the exigency.

If the Company denies the exception request, the Insured Person, a designated representative acting on the behalf of the Insured Person, or the prescribing Physician may request, either orally or in Writing, a second review, within 60 calendar days of the exception request denial. The independent review organization contracted by the Company to review the exception request denial must make a decision within the same timeframes described above.

Prescription Drugs Utilization Review Program

For Maintenance Drugs and Medicines

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

For all other Drugs and Medicines

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

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

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

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

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

Prescription Drugs Covered Charges

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

Prescription Drugs Covered Charges will include charges for:

- the following diabetic supplies:
 - insulin; and
 - disposable insulin needles/syringes; and
 - disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, and Clinitest tablets; and
 - lancets; and
- compounded medications in which at least one ingredient is a Prescription Legend Drug; and
- legend oral contraceptives or devices and non-oral dosage forms; 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.

Exception: To request an exception for a contraceptive service or item from a Member Pharmacy, the Insured Person, a designated representative acting on the behalf of the Insured Person, or the prescribing Physician may submit an exception request, either orally or in Writing.

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The Company will review the exception request and make a determination of the claim in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving urgent care. If the Physician determines a particular contraceptive service or FDA-approved item is medically necessary with respect to the Insured Person, that contraceptive service or item from a Member Pharmacy will be payable at 100%.

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

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

Maintenance Drugs and Medicines mean a medicinal substance that by law can only be dispensed by a prescription and is taken on a regular or long term basis to treat chronic medical conditions to include: coronary artery disease (angina); diabetes (including, diabetic supplies, e.g., insulin, 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 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.

Limitations

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

- infertility drugs, or
- Levonorgestrel (Norplant); or
- drugs or medicines that are not Covered Charges; or
- drugs or medicines that are Experimental or Investigational, except as provided under Clinical Trials in page NBM 5400. (The denial of any claim on the basis of the exclusion of coverage for Experimental or Investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or
- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or
- drugs or medicines prescribed or dispensed by any person who is in an Insured Person's Immediate Family; or
- vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or
- dietary supplements; or
- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or
- drugs or medicines for which the Insured Person has no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or
- drugs or medicines provided as the result of a sickness or injury that is due to the commission of an offense by an Insured Person in which such person is convicted of or pleads guilty or no contest to a felony; or

- drugs or medicines provided as the result of:
 - an injury arising out of or in the course of any employment for wage or profit, if the Insured Person is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
 - a sickness that is 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, except as covered under Preventive Health and Wellness Services; 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 that are paid for by a Medicare Supplement Insurance Plan; 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.

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 identification card or contact the Company. To file a claim for benefits when utilizing a Nonmember Pharmacy or when an identification card is not utilized at a Member Pharmacy, submit a prescription drug claim form to the Pharmacy Benefit Manager.

Written proof of loss must be sent to the Pharmacy Benefit Manager or the Company within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Pharmacy Benefit Manager or the Company receives proof of loss. Proof of loss includes the patient's name, the Member's name (if different from the patient's name), prescription drug name, and date prescription drug dispensed. Failure to furnish such proof within the specified time will not invalidate or reduce any claim if it was not possible to furnish proof within the specified time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. The Pharmacy Benefit Manager or the Company may request additional information to substantiate the loss or require a Signed unaltered authorization to obtain that information from the provider. Failure to comply with the Company's request or the request of Pharmacy Benefit Manager could result in declination of the claim.

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Pharmacy Benefit Manager or the Company will send a Written explanation prior to the expiration of the 30 calendar days. The claimant is then allowed up to 45 calendar days to provide all additional information requested. The Pharmacy Benefit Manager or the Company will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

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

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

MEDICAL EXPENSE INSURANCE

UTILIZATION MANAGEMENT PROGRAM

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

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

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

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

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

An inpatient confinement facility includes:

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

- For Emergency Services admissions, the Insured Person or a designated patient representative must contact the Company within two business days or as soon as reasonable possible of a Hospital Inpatient Confinement or of a confinement in an inpatient confinement facility. Precertification is not a guarantee that benefits will be payable.
- For selected outpatient non-emergency medical services, the Insured Person or a designated patient representative must contact the Company 15 calendar days before the care is provided, or the Treatment or Service is scheduled. Precertification is not a guarantee that benefits will be payable.

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

- Complex imaging, including but not limited to MRI, MRA, CT-PET SCANS, and IMRT;
- Certain cosmetic and reconstructive surgery, including but not limited to breast related procedures, varicose vein procedures, septoplasty, blepharoplasty, and abdominoplasty;
- Back surgery, including but not limited to artificial discs, laminectomy, lumbar fusion, facet joint injection;
- Certain selective surgery, including but not limited to hysterectomy, bariatric surgery, and stereotactic radiosurgery; and
- Gene-Based, Cellular And Other Innovative Therapies (GCIT) facility/provider.

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

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

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

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

The report (verbal or Written) must include the:

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

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

The report (verbal or Written) must include the:

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

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

The following exception applies to Hospital Inpatient Confinement for childbirth.

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

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

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

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

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

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

Except in cases of fraudulent or materially incorrect information, the Company will not retroactively deny a Precertification for Treatment or Service when all of the following conditions are met:

- The Physician submits a Precertification request to the Company for a Treatment or Service;
- The Company approves the Precertification request after determining that all of the following are true:
 - The Insured Person is eligible for insurance under the Group Policy.
 - The Treatment or Service is a Covered Charge.
 - The Treatment or Service meets the Company's standards for medical necessity and Precertification.
- The Physician renders the Treatment or Service pursuant to the approved Precertification request;
- On the date the Physician renders the prior approved Treatment or Service, all of the following are true:
 - The Insured Person is eligible for insurance under the Group Policy.
 - The Insured Person's condition or circumstances related to the Insured Person's care has not changed.
 - The Physician submits an accurate claim that matches the information submitted by the Physician in the approved Precertification request.

- If the Physician submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the Physician in the approved Precertification request, upon receiving a denial of services from the Company, the Physician may resubmit the claim with the information that matches the information included in the approved Precertification.

- **Electronic Precertification**

If the Physician submits the request for Precertification electronically, the Company will respond to Precertification requests within forty-eight hours for Urgent Care Services, or ten calendar days for any Precertification request that is not for an Urgent Care Service. This provision does not apply to Emergency Services.

The notification will indicate whether the request is approved or denied. If the Precertification is denied, the Company will provide the specific reason for the denial.

If the Precertification request is incomplete, the Company will indicate the specific additional information that is required to process the request.

For the purposes of this provision, "Urgent Care Services" means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the Insured Person or others due to the Insured Person's psychological state;
- In the opinion of a Physician with knowledge of the Insured Person's medical or behavioral condition, would subject the Insured Person to adverse health consequences without the care or treatment that is the subject of the request.

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

Concurrent Review

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

Continued Stay Review

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

Health Professional

An individual who:

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

Initial Clinical Review(er)

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

Notification of Utilization Review Services

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

Ordering Provider

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

Peer Clinical Review(er)

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

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

Precertification

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

Prospective Review

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

Retrospective Review

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

Urgent Review

Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to an Insured Person's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without care or 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. Any claim, that a Physician with knowledge of the Insured Person's medical condition determines is a claim involving urgent care, will be treated as an Urgent Review. An Insured Person's provider should not request an Urgent Review for a situation in which the provider or Insured Person has had adequate time to request standard Precertification.

Utilization Management

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

Utilization Review

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

- **Utilization Review Program**

- **Prospective Review**

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

- **Urgent Prospective Review**

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

- **Concurrent Review**

For a Concurrent Review that does not involve an Urgent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Company will be decided within the timeframes and according to the requirements for Prospective Review. A decision and notification of the decision will be made sufficiently in advance of the reduction or termination to allow the Insured Person to appeal and obtain a decision on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

- **Urgent Concurrent Review**

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

- **Retrospective Review**

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

Upon Written request, the Company will permit a Retrospective Review for a claim that is submitted for a Treatment or Service where Precertification was required but not obtained if the Treatment or Service meets all of the following:

- The Treatment or Service is directly related to another Treatment or Service for which certification was obtained and the Treatment or Service has already been performed.
- The Treatment or Service was not known to be needed at the time the original approved Treatment or Service was performed.
- The need for the Treatment or Service was revealed at the time the original approved Treatment or Service was performed.

Once the Written request and all necessary information is received, the Company will review the claim for medical necessity. The Company will not deny a claim for a Treatment or Service based solely on the fact that Precertification was not received for the Treatment or Service.

- **Request for Reconsideration**

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

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

- **Appeal of Adverse Benefit Determinations**

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

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

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

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

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

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

- **Precertification 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 for a Precertification by Written request to the Company within 180 calendar days of receipt of the notice of Adverse Benefit Determination for a Precertification. 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 decision and notify the Insured Person as expeditiously as the Insured Person's medical condition requires, but in no event more than 48 hours after receipt of the request for the Precertification appeal review for urgent care services. For non-urgent care services, the Company will notify the Insured Person in Writing of the appeal decision within 10 calendar days of receiving the appeal request for the Precertification.

The appeal review of an Adverse Benefit Determination for a Precertification will be between the Physician or other Ordering Provider and a Peer Clinical Reviewer.

If the appeal review does not resolve the difference of opinion regarding a decision not to certify, the Insured Person, attending Physician or other Ordering Provider may request an external review.

Expedited Appeal Review and Voluntary Appeal Review

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

An Insured Person in the process of an expedited internal appeal review may request an expedited external review be conducted simultaneously if:

- the Insured Person's treating Physician certifies in Writing that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function if treated after the time frame of an expedited internal appeal review; or
- in the case of experimental or investigational treatment, the Insured Person's treating Physician certifies in Writing that the recommended Health Care Service or treatment would be significantly less effective if not initiated promptly.

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

If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, attending Physician, or other Ordering Provider can request an external review or a voluntary appeal review. The voluntary appeal review may be requested by telephone, fax or in Writing within 60 calendar days of the receipt of the appeal review Adverse Benefit Determination. The Insured Person, attending Physician or other Ordering Provider may submit Written comments, documents, records and other information relating to the request for the voluntary appeal review. The Company will make a decision within 72 hours of request for a voluntary appeal review.

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

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

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

A standard appeal may be requested in Writing. It must be requested within 180 calendar days of the receipt of an Adverse Benefit Determination. A final decision will be made in Writing to the Insured Person, the attending Physician or other Ordering Provider within 30 calendar days of receiving the request for an appeal for post-service claims and 15 calendar days for pre-service claims.

If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, attending Physician, or other Ordering Provider can request an external review or a voluntary appeal review. The voluntary appeal review may be requested by fax or in Writing within 60 calendar days of the receipt of the appeal review Adverse Benefit Determination. The Insured Person, attending Physician or other Ordering Provider may submit Written comments, documents, records and other information relating to the request for voluntary appeal review. The Company will make a decision within 30 calendar days of request for a voluntary appeal review for post-service claims and 15 calendar days for pre-service claims.

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

- **Notice of Utilization Review**

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

Upon request, the Company must provide copies of all documents considered, relied upon or generated by the Company regarding the claim as well as any new or additional rationale for an Adverse Benefit Determination of an appeal. This documentation will be provided free of charge to the Insured Person. The Insured Person may provide the Company with any additional information the Insured Person deems relevant.

The Company will provide continuation of coverage pending the outcome of appeals.

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

If the Company determines that the Treatment or Service is not covered under the Group Policy and does not involve medical necessity, the Insured Person may contact:

The Ohio Department of Insurance Office of Consumer Affairs
Ohio Department of Insurance
50 West Town Street - Suite 300
Columbus, OH 43215

Phone: 1-800-686-1526

Website: www.ohioinsurance.gov

The Insured Person has the right to an external review if the Company fails to meet all the requirements of the internal appeal process unless the failure:

- was de minimis;
- does not cause or is not likely to cause prejudice or harm to the Insured Person;
- was for good cause and beyond the control of the Company; or
- is not reflective of a pattern or practice of non-compliance.

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

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

COMPLAINT AND GRIEVANCE PROCEDURES

First-Level Appeal Review

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

**Nippon Life Insurance Company of America
P. O. Box 4387
Clinton, IA 52733**

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 15 calendar days for pre-service claims.

Voluntary Appeal Review

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

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

Expedited Appeal Review

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

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

The Company will 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.

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

The Insured Person has the right to an External Review if the Company fails to meet all the requirements of the internal appeal process unless the failure:

- was de minimis;
- does not cause or is not likely to cause prejudice or harm to the Insured Person;
- was for good cause and beyond the control of the Company; or
- is not reflective of a pattern or practice of non-compliance.

For assistance with respect to any claim, grievance, or appeal at any time, an Insured Person has the right to contact the Ohio Department of Insurance Consumer Hotline at 1-800-686-1526 or write to:

Ohio Department of Insurance
50 West Town Street - Suite 300
Columbus, OH 43215

www.insurance.ohio.gov

COMPREHENSIVE MEDICAL EXPENSE INSURANCE

EXTERNAL REVIEW

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code the Company must provide a process that allows an Insured Person to request an independent external review of an Adverse Benefit Determination. This is a summary of that external review process. An Adverse Benefit Determination is a decision by the Company to deny benefits because services are not covered, are excluded, or limited under the plan, or the Insured Person is not eligible to receive the benefit.

The Adverse Benefit Determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny or Rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The Insured Person does not pay for the external review. There is no minimum cost of Health Care Services denied in order to qualify for an external review. However, the Insured Person must generally exhaust the internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the Adverse Benefit Determination. The Insured Person has the right to an external review if the Company fails to meet all the requirements of the internal appeal process unless the failure:

- was de minimis;
- does not cause or is not likely to cause prejudice or harm to the Insured Person;
- was for good cause and beyond the control of the Company; or
- is not reflective of a pattern or practice of non-compliance.

External Review by an IRO - An Insured Person is entitled to an external review by an IRO in the following instances:

- The Adverse Benefit Determination involves a medical judgment or is based on any medical information.
- The Adverse Benefit Determination indicates the requested service is experimental or investigational, the requested Health Care Service is not explicitly excluded in this booklet-certificate, and the treating Physician certifies at least one of the following:
 - Standard Health Care Services have not been effective in improving the condition of the Insured Person.
 - Standard Health Care Services are not medically appropriate for the Insured Person.

- No available standard Health Care Service covered by the Company is more beneficial than the requested Health Care Service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The Insured Person's treating Physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function, if treatment is delayed until after the time frame of an expedited internal appeal.
- The Insured Person's treating Physician certifies that the Final Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the Insured Person received Emergency Services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an Adverse Benefit Determination of experimental or investigational treatment and the Insured Person's treating physician certifies in Writing that the recommended Health Care Service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective Final Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the Insured Person).

External Review by the Ohio Department of Insurance - An Insured Person is entitled to an external review by the Ohio Department of Insurance in either of the following instances:

- The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information; or
- The Adverse Benefit Determination for an Emergency Medical Condition indicates that medical condition did not meet the definition of emergency AND the Company's decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the Insured Person, or an Authorized Representative, must request an external review through the Company within 180 days of the date of the notice of Final Adverse Benefit Determination issued by the Company.

All requests must be in Writing, including by electronic means. Expedited external reviews may be requested orally. The Insured Person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete the Company will initiate the external review and notify the Insured Person in Writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the Insured Person that, within 10 business days after receipt of the notice, he or she may submit additional information in Writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The Company will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete the Company will inform the Insured Person in Writing and specify what information is needed to make the request complete. If the Company determines that the Adverse Benefit Determination is not eligible for external review, the Company must notify the Insured Person in Writing and provide the Insured Person with the reason for the denial and inform the Insured Person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by the Company and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of this booklet-certificate and all applicable provisions of the law.

IRO Assignment

When the Company initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of Health Care Service. An IRO that has a conflict of interest with the Company, the Insured Person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by the Company in making the Adverse Benefit Determination, any information submitted by the Insured Person and other information such as; the Insured Person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under this booklet-certificate, the most appropriate practice guidelines, clinical review criteria used by the Company or the Company's utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a Written notice of its decision within 30 days of receipt by the Company of a request for a standard review or within 72 hours of receipt by the Company of a request for an expedited review. This notice will be sent to the Insured Person, the Company and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review;
- The date the Independent Review Organization was assigned by the Ohio Department of Insurance to conduct the external review;
- The dates over which the external review was conducted;
- The date on which the Independent Review Organization's decision was made;
- The rationale for its decision; and
- References to the evidence or documentation, including any evidence-based standards that were used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care Treatment or Service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the Written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on the Company except to the extent the Company has other remedies available under state law. The decision is also binding on the Insured Person except to the extent the Insured Person has other remedies available under applicable state or federal law.

An Insured Person may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to the Company.

If the Insured Person has Questions About his or her Rights or Needs Assistance

The Insured Person may contact the Company at:

Nippon Life Insurance Company of America
Attn. Grievance Coordinator
P. O. Box 4387
Clinton, IA 52733

Phone: 1-800-374-1835

Fax: (913) 387-5915

The Insured Person may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

Definitions

Independent Review Organization means an entity that is accredited to conduct independent external reviews of Adverse Benefit Determinations.

MEDICAL EXPENSE INSURANCE

COORDINATION WITH OTHER BENEFITS

Applicability

The Coordination of Benefits (“COB”) provision applies when an Insured Person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable Expense.

Definitions

Plan means any of the following that provide benefits or services for medical or dental care Treatment or Service. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits among those separate contracts.

- Plan includes: group and nongroup insurance contracts, health insuring corporation (“HIC”) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
- Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as defined in Ohio statutes; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage above is a separate Plan. If a Plan has two parts and Coordination of Benefit rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing the health care benefits to which the Coordination of Benefit provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one Coordination of Benefit provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another Coordination of Benefit provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the Insured Person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense means a health care expense, including Deductibles, coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment will be the Allowable Expense used by the Secondary Plan to determine its benefits.

- The amount of any benefit reduction by the Primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan means a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent means the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

Order of Benefit Determination Rules

When an Insured Person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

Except as provided below, a Plan that does not contain a coordination of benefits provision that is consistent with the provision described in this section is always primary unless the provisions of both Plans state that the complying Plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base Plan hospital and surgical benefits, and insurance type coverages that are Written in connection with a Closed Panel Plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

- **Non-Dependent or Dependent.** The Plan that covers the person other than as a Dependent, for example as an employee, Member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of Federal law, 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 order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
- **Dependent Child Covered Under More Than one Plan.** Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:
 - For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's Plan is always primary), the Company will follow the rules of that Plan.

- For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of a Dependent Child whose parents are married or are living together, whether or not they have ever been married, will determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of a Dependent Child whose parents are married or are living together, whether or not they have ever been married, will determine the order of benefits; or

- If there is no court decree 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:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-Custodial Parent; and then
- The Plan covering the spouse of the non-Custodial Parent.

- For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Dependent Child, the provisions of a Dependent Child whose parents are married or are living together, whether or not they have ever been married, or a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married, will determine the order of benefits as if those individuals were the parents of the Dependent Child.

- **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Non-Dependent or Dependent above can determine the order of benefits.

- **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other Federal law is covered under another Plan, the Plan covering the person as an employee, Member, subscriber or retiree or covering the person as a Dependent of an employee, Member, subscriber or retiree is the Primary Plan and the COBRA or state or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Non-Dependent or Dependent above can determine the order of benefits.

- **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, Member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan will credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If an Insured Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, Coordination of Benefits will not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Nippon Life Insurance Company of America may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the Insured Person claiming benefits. Nippon Life Insurance Company of America need not tell, or get the consent of, any Insured Person to do this. Each Insured Person claiming benefits under This Plan must give Nippon Life Insurance Company of America any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Nippon Life Insurance Company of America may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Nippon Life Insurance Company of America will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Nippon Life Insurance Company of America is more than it should have paid under this Coordination of Benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If the Insured Person believes that the Company has not paid a claim properly, the Insured Person should first attempt to resolve the problem by contacting the Company. 1-800-374-1835 www.nipponlifebenefits.com If the Insured Person is still not satisfied, the Insured Person may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at <http://insurance.ohio.gov>.

MEDICAL EXPENSE COVERAGE

INTEGRATION WITH MEDICARE

This section will apply to Insured Persons, where permitted by Federal law:

- on the date the Insured Person becomes entitled to Medicare due to their age; and
- who are covered by Medicare Parts A, B and C (or would have been covered if complete and timely application had been made).

Comprehensive Medical benefits payable under the Group Policy for Treatment or Service received will be reduced by:

- the benefits payable for such Treatment or Service by Medicare Parts A, B and C; or
- the benefits that would have been payable for the Treatment or Service by Medicare Parts A, B and C if the Insured Person had been covered by Medicare Parts A, B and C.

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 rights of the Company will be subject to both of the following:

- If less than the full value of the tort action is recovered for comparative negligence, diminishment due to a party's liability, or by reason of the collectability of the full value of the claim for injury, death, or loss to person resulting from limited liability insurance or any other cause, the Company's claim will be diminished in the same proportion as the injured party's interest is diminished.
- If a dispute regarding the distribution of the recovery in the tort action arises, either party may file an action to resolve the issue of the distribution of the recovery.

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, but only to the extent of benefit payments made under the Group Policy.

Insured Person Obligations

To secure the Company's rights under this section, an Insured Person must:

- Complete any applications or other instruments and provide any documents the Company might require, and cooperate with the Company and the Company's agents in order to protect the Company's subrogation rights.
- 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 Insured Person or their legal representative agree to hold all settlement funds in trust until the subrogation and/or reimbursement rights of the Group Policy have been satisfied.

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 - OHIO

State Required Continuation - Ohio Residents

The Member may elect to continue his or her and Dependent Medical Expense Insurance under the Group Policy if active employment ends because of involuntary termination of employment. Insurance may be continued if, on the date coverage would otherwise cease:

- the Member was continuously insured under the Group Policy (or for similar benefits under any group policy which it replaced) for at least the three-month period immediately preceding the termination; and
- the Member or any Dependent is not eligible or covered under any other group medical expense plan (if covered under the other plan on the day before termination); and
- the Member or any Dependent is not eligible for or covered under Medicare.

The Member's and Dependent's insurance may be continued until the earliest of the following dates:

- the date the Member or any Dependent becomes eligible for or covered under any other group medical expense coverage, unless covered under the other plan immediately prior to the termination of employment; or
- the date the Member or any Dependent becomes eligible for or covered under Medicare; or
- the date the Group Policy terminates (the continuation period may be completed under the replacement coverage, if any); or
- the date coverage would otherwise cease as provided in the Group Policy; or
- the end of the period for which contributions are paid, if the Member fails to make timely payment of a required contribution; or
- the date coverage has been continued for twelve months.

State Required Continuation – Ohio Reservists Called to Active Duty

- **Qualification for Continuation**

The Member, the Member's spouse or Dependent Child may elect to continue insurance under the Group Policy for a period of 18 months if insurance terminates due to being called or ordered to active duty.

- **Period of Continuation**

The right to continuation of coverage, or the extension of continuation of coverage, ceases on the date on which any of the following occurs:

- the date the Member, the Member's spouse, or Dependent Child enrolls in another group policy or another group health plan or arrangement that does not contain any exclusion or limitation with respect to any preexisting condition; or
- the period of either 18 months or 36 months for persons eligible for the extension; or
- the end of the premium period for which premium is paid if timely payment of premium has not been made; or
- the date the Group Policy is terminated (the continuation period may be completed under the Policyholder's replacement coverage, if any); or
- the date insurance would otherwise cease as provided in the Group Policy.

- **Extension of Continuation of Coverage**

Insurance may be extended beyond the 18-month continuation period to a 36-month continuation of coverage period if any of the following occurs during the 18-month period:

- the death of the reservist; or
- the divorce or separation of the reservist from the reservist's spouse; or
- the cessation of dependency of a Dependent Child according to Group Policy provisions.

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 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: Ohio HDHP John Doe Health Plan
Contact Name/Area: Ohio HDHP 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. 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. Failure to furnish such proof within the specified time will not invalidate or reduce any claim if it was not possible to furnish proof within the specified time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. 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. If the Company does not deny the claim and requests additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. The Company will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits will be payable sooner, provided the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Company will submit a detailed explanation of the basis for the denial. See page NBM 5407 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 and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

Recoding of Procedures

When a claim contains one or more procedure codes with the same date of service, the Company may review the claim to determine whether it contains, among other things, coding irregularities (including duplicative or combined codes), coding conflicts or coding errors. The Company will base such review on generally recognized and authoritative coding resources, including but not limited to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding Systems (HCPCS).

If the Company determines, at its discretion, that the claim may be more appropriately coded using the same or different codes, the claim will be recoded and processed accordingly to determine the allowable amount and extent of benefits.

Offsetting of Overpayments

If the Company pays benefits under the Group Policy for expenses incurred by an Insured Person which are later determined to have been paid to the Insured Person or a provider in error--for whatever reason, the Company will be entitled within two years from the date the claim was paid to offset the amount of the overpayment from any benefits under the Group Policy which may later become due the Insured Person or the same provider in connection with Treatment or Services rendered to the Insured Person, in order to recoup the Company's overpayment. The Company reserves the right to collect overpayments by other means available.

For Medical Insurance

Preferred Providers

When a person becomes insured, he or she will be issued an identification card. This card should be presented to each Preferred Provider at the time an Insured Person receives needed medical care. The Company will assist the Insured Person with the Precertification for medical care.

Benefit Advice

Benefit Advice is the Company's toll-free service that can answer questions about an Insured Person's benefit program or specific coverages. The staff provides information on topics such as outpatient surgery, generic drugs, health care alternatives, health care providers and treatment costs in the Insured Person's area.

The staff does not prescribe medical treatment. That is up to the Insured Person's Physician. But they can help the Insured Person understand his or her benefits and how to use them in the most cost-effective manner.

Call the toll-free Health Info Line number (see the ID card or Policyholder for the Health Info Line number) to discuss medical benefits with the Company's Benefit Advice staff. The number is also listed on page NBM 5100 A in this booklet-certificate.

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

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

- **For Other than Emergency Services**

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

- **For Emergency Services**

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

- **For a Continued Stay Review**

If the Hospital Inpatient Confinement or confinement in an inpatient confinement facility will exceed the approved number of days, the Company will initiate a Continued Stay Review.

- **For Childbirth**

A Precertification is not required for mother and baby for 48 hours following a vaginal delivery or 96 hours following a cesarean section.

An Insured Person or a designated patient representative must call the Company at the toll-free number shown on the identification card before the end of the automatically approved time period if the mother or baby will remain Hospital Inpatient Confined beyond that time period.

Notification of the number of approval days will be sent to the Insured Person, his or her Physician, and the Hospital.

Facility of Payment For Medical Insurance

The Company will normally pay all benefits to the Member. However, if the claimed benefits result from a Dependent's sickness or injury, the Company may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Company to the full extent of those payments.

- If payment amounts remain due upon the Insured Person's death, those amounts may, at the Company's option, be paid to the Insured Person's estate, spouse, child, parent, or provider of medical services.
- If the Company believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Company may pay whoever has assumed the care and support of the person.
- Reimbursement for covered medical transportation will be made directly to the provider of such service.
- Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of the Insured Person.
- Benefits payable to 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").

- **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**

Arbitration will be conducted in accordance with the rules of the AAA, before a panel of three neutral arbitrators who are knowledgeable in the field of insurance and appointed from a panel list provided by the AAA. 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 in the city or county where the Insured Person resides. 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. The Company will pay the cost of the arbitration and will include any deposits or administrative fee required to commence a dispute in arbitration, as well as any other fee including an arbitrator's fee.

- **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, the Member may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to \$110 a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the Member has a claim for benefits which is denied or ignored, in whole or in part, the Member may file suit in a state or Federal court. In addition, if the Member disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Member may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his or her rights, the Member may seek assistance from the U.S. Department of Labor, or the Member may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees, for example, if it finds the Member's claim is frivolous.

Assistance with Member Questions

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

**SUPPLEMENT
TO THE MEMBER'S BOOKLET-CERTIFICATE**

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

1. **Employer Plan Identification Number:**

EIN: 99-9999999
PN: 501

2. **Type of Administration:**

Medical Expense Coverage: Insurance Contract

3. **Plan Administrator:**

Riverside Plastics Incorporated
900 Washington St
Bonapart USA 52620

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

4. **Plan Sponsor:**

Riverside Plastics Incorporated
900 Washington St
Bonapart USA 52620

A complete list of the employers and/or employee organizations sponsoring the plan may be obtained upon written request to the plan administrator and is also available for examination at the business office of the plan administrator.

Upon Written request, participants may receive from the ERISA Plan Administrator information as to whether a particular employer or employee organization is a sponsor of the ERISA Plan and, if the employer or employee organization is a plan sponsor, their address.

5. **Agent for Service of Legal Process:**

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

Legal process may also be served upon the plan administrator.

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

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

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

Employee pays none of Employee's contribution. Employee pays part of Dependent's contribution (if Employee elects to enroll Dependents in plan).

8. **Ending Date of Plan's Fiscal Year:**

April 30

DEFINITIONS

When used in the Group Policy, the terms listed below will mean:

Adverse Benefit Determination means a decision by the Company:

- to deny, reduce, or terminate a requested Health Care Service or payment in whole or in part, including all of the following:
 - a determination that the Health Care Service does not meet the Company's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
 - a determination of an individual's eligibility for health insurance coverage;
 - a determination that a Health Care Service is not a Covered Charge; and
 - the imposition of an exclusion, including exclusions for source of injury, network, or any other limitation on benefits that would otherwise be covered; or
- to Rescind 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.

Authorized Representative means an individual who represents an Insured Person in an internal appeal or external review process of an Adverse Benefit Determination who is any of the following:

- a person to whom an Insured Person has given express, Written consent to represent that individual in an internal appeals process or external review process of an Adverse Benefit Determination;
- a person authorized by law to provide substituted consent for an Insured Person; or
- a family member or a treating health care professional, but only when the Insured Person is unable to provide consent.

Average Wholesale Price (AWP) means the published cost of a drug product to the wholesaler.

Birth Center means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care; and
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a Written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with Written procedures for such transfer being displayed and staff members being aware of such procedures.

Calendar Year means January 1 through December 31 of each year.

Community Mental Health Center means a community or county mental health facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

Company means Nippon Life Insurance Company of America.

Cosmetic Treatment or Service means Treatment or Service intended to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such Treatment or Service:

- is performed primarily-to prevent or relieve social, emotional or psychological distress; or
- is not needed to correct or improve a Functional Impairment of an organ or other body part.

Functional Impairment is a direct and measurable reduction of physical performance of an organ or body part.

Cosmetic Treatment or Service includes, but is not limited to, surgery and pharmacological regimens and all their related charges.

Covered Charges means a Treatment or Service that is:

- prescribed by a Physician and required for the screening, diagnosis or treatment of a medical condition;
- consistent with the diagnosis or symptoms;
- not excessive in scope, duration, intensity or quantity;
- the most appropriate level of services or supplies that can safely be provided; and
- determined by the Company to be Generally Accepted.

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

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

Date of Issue means the date the Group Policy is placed in force: May 1, 2025.

Deductible; Deductible Amount means a specified dollar amount of Covered Charges that must be incurred by the Insured Person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the Calendar Year.

Dental Services means any Treatment or Service provided to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); or
- malocclusion (abnormal positioning or relationship of the teeth); or
- ailments or defects of the teeth and supporting tissue and bone (excluding impacted teeth and appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance).

Dependent means:

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

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

Emergency Medical Condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- placing the health of the Insured Person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services means the following:

- a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
- such further medical examination and treatment that are required by federal law to Stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

Emergency Services includes the emergency room, complex imaging, lab and radiology services, or any other Treatment or Service needed to treat the Emergency Medical Condition. Complex imaging, lab and radiology services will be covered as Emergency Services if they are billed by the facility as part of the ER visit.

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

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

Final Adverse Benefit Determination means an Adverse Benefit Determination that is upheld at the completion of the Company’s internal appeals process.

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

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

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 Care Services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Insurance Coverage means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or Health Maintenance Organization (HMO) contract, offered by an insurance company, insurance service, or insurance organization (including an HMO) licensed to engage in the business of insurance and subject to state law which regulates insurance.

Health Maintenance Organization (HMO) means an entity that is:

- a federally qualified Health Maintenance Organization as defined by Federal law; or
- an organization recognized under state law as a Health Maintenance Organization; or
- a similar organization regulated under state law for solvency in the same manner and to the same extent as such a Health Maintenance Organization.

Home Health Aide means a person, other than a licensed registered nurse (R.N.), who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency means a Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

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

- is required as the result of a sickness or injury; and
- prevents, delays or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician.

Home Infusion Therapy Services means Treatment or Service required for the administration of intravenous drugs or solutions, which:

- is required as a result of a sickness or injury; and
- prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician.

Hospice means a facility, agency, or service that:

- is licensed by the proper authority of the state in which it is located to establish and manage Hospice Care Programs; and
- arranges, coordinates, and provides Hospice Care Services for dying individuals and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

Hospice Care Program means a program that furnishes palliative or supportive care focused on comfort and not cure and that is:

- managed by a Hospice; and
- established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

Hospice Care Team means a group that provides coordinated Hospice Care Services and normally includes:

- a Physician;
- a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

For the purpose of Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, the definition of "Hospital" will include each of the following facilities provided it is licensed by the proper authority of the state in which it is located:

- a Psychiatric Hospital; and
- an Inpatient Alcohol or Drug Abuse Treatment Facility; and
- a residential treatment center or facility; and
- any other facility required by state law to be recognized as a treatment facility under the Group Policy.

Hospital Inpatient Confined; Hospital Inpatient Confinement means any period of Treatment or Service in a Hospital in excess of twenty-three consecutive hours for any cause. A Precertification as defined in page NBM 5407 CC is required for Hospital Inpatient Confinements.

Hospital Inpatient Confinement Charges means Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia provided while an Insured Person is Hospital Inpatient Confined.

Hospital Room Maximum means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or
- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

Immediate Family means an Insured Person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Inpatient Alcohol or Drug Abuse Treatment Facility means an institution that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services; and

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and
- provides 24-hour a day on-site nursing care by licensed registered nurses (R.N.).

Insurance Month means calendar month.

Insured/Insured Person means a Member or Dependent who:

- applied for coverage; and
- meets the eligibility rules set forth in the Group Policy; and
- is approved for insurance by the Company; and

- for whom all applicable premiums are paid, and is therefore insured.

When Insured is used alone, it does not include the Dependent.

When Dependent is used alone, it does not include the Member.

Member means any person who Resides in the United States and who is a Full-Time Employee of the Policyholder.

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

Non-Preferred Provider/Non-PPO Provider means a Hospital, Physician, or other provider not contracted with the preferred provider organization (PPO) network identified by the Company to the Group Policy.

Outpatient Alcohol or Drug Abuse Treatment Facility means a facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient alcohol or drug abuse treatment services.

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

Physical Handicap means a Dependent Child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect, or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires to be recognized as a Physician under the Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: audiologist, chiropractor, dentist, genetic counselor, occupational therapist, optometrist, physician's assistant, physical therapist, podiatrist, psychologist, social worker, and speech pathologist.

Physician Visit means a face-to-face meeting between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service.

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policy Anniversary means May 1 and the same day of each following year.

Policyholder means the business, firm, union, trustee(s), or other entity to whom the Group Policy is issued (see Title Page).

Preferred Provider/PPO Provider means a Hospital, Physician, or other provider contracted with a preferred provider organization (PPO) network identified by the Company to the Group Policy.

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

The Company has the right to terminate the preferred provider organization (PPO) portion of the Group Policy if the Company or the preferred provider organization (PPO) terminates the arrangement.

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

Preferred Provider Organization (PPO) Service Area means the geographic area within which Preferred Provider services are available to persons insured under the Group Policy.

Prevailing Charges means:

- For medical care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO. A Preferred Provider may not bill the Insured Person for any part of a charge for Treatment or Service that exceeds the negotiated fee.
- 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).

Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from out-of-network providers' surprise bills ("balance billing") for emergency care and other specified items or services. The Company will comply with these new state and federal requirements including how the Company processes claims from certain out-of-network providers.

- 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.

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.

Rescission or to Rescind or Rescinding means to retroactively cancel or discontinue coverage under the Group Policy. “Rescind” does not include canceling or discontinuing coverage under the Group Policy that only has a prospective effect or canceling or discontinuing coverage under the Group Policy that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Reside(s) in the United States means an Insured Person who:

- maintains a home in the United States; and
- lives in that home in the United States; and
- does not leave the United States for more than six consecutive months.

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by the Company.

Skilled Nursing Facility means an institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and

- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Skilled Nursing Facility may include Hospitals when the Hospital is providing nursing facility level of services. Skilled Nursing Facility does not include rest homes, homes for the aged, nursing homes, or places which furnish Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services.

Social Detoxification means a Treatment or Service designed to achieve detoxification without the use of drugs or other medical interventions.

Stabilize means the provision of such medical treatment as may be necessary to assure that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer, if the medical condition could result in any of the following:

- placing the health of the Insured Person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, Stabilize means such medical treatment as may be necessary to deliver, including the placenta.

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

Total Disability; Totally Disabled means:

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

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

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".

Vendor-Supported Telemedicine Services (other than state mandated Telehealth/Telemedicine) as described in page NBM 5400) 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.

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.

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 Insurance Company
of America
P.O. Box 4387
Clinton, IA 52733

**Notice Concerning Coverage
Limitations and Exclusions Under
The Life and Health Insurance
Guaranty Association Act - OH**

TO: All Group Life and/or Medical Expense Policyholders in Ohio
RE: Ohio Life and Health Insurance Guaranty Association

Residents of Ohio who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Ohio Life and Health Insurance Guaranty Association

485 Metro Place S, Ste 270

Dublin, Ohio 43017

Ohio Department of Insurance

50 W. Town Street

Third Floor, Suite 300

Columbus, Ohio 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On Page 2 is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Basic Provisions of the Ohio Life and Health Insurance Guaranty Association Act

Coverage

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, if they are insured under a group insurance contract, issued by a member insurer, or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage

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

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- the insurer was not authorized to do business in that state;
- their policy was issued by a medical, health, or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

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

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

Limits on Amount of Coverage

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provide different types of coverages. The Association will not pay more than \$100,000 in case surrender values, \$500,000 in major medical insurance benefits, \$300,000 in disability or long term care insurance benefits, \$100,000 in other health insurance benefits, \$250,000 in present value annuities, or \$300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the Association will pay a maximum of \$300,000, except for coverages involving major medical insurance benefits, for which the maximum of all coverages is \$500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: For unallocated annuities that fund governmental retirement plans under §§401(k), 403(b) or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net case withdrawal per participating individual. In no event shall the Association be liable to spend more than \$300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

For more information about the Ohio Life and Health Insurance Guaranty Association, visit the website at: www.olhiga.org.

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 4387, Clinton, Iowa 52733. 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 4387, Clinton, Iowa 52733.

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 4387, Clinton, Iowa 52733. 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 4387, Clinton, Iowa 52733. 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 4387, Clinton, Iowa 52733. 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 4387, Clinton, Iowa 52733. 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 4387, Clinton, Iowa 52733 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may call Nippon Life Insurance Company of America at: English and Non-English (800) 374-1835; Japanese (800) 971-0638; or Korean (877) 827-8713.

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

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P.O. Box 4387
Clinton, Iowa 52733