

National Health Insurance Act (Since a part of Act No. 28 will come into force on April 1, 2015, it has not been amended.)

(Act No. 192 of December 27, 1958)

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Chapter I General Provisions

(Purpose of This Act)

Article 1 The purpose of this Act is to ensure the sound administration of national health insurance services, thereby contributing to the improvement of social security and the health of the people.

(National Health Insurance)

Article 2 National health insurance programs shall pay the necessary insurance benefits in relation to an insured persons' illness, injury, childbirth or death.

(Insurers)

Article 3 (1) Municipalities and special wards shall provide National Health Insurance programs pursuant to the provisions of this Act.

(2) National health insurance societies may provide a national health insurance program pursuant to the provisions of this Act.

(National and Municipal Governmental Obligations)

Article 4 (1) The national government must endeavor to ensure the sound administration of national health insurance services.

(2) Each prefectural government must provide guidance necessary to ensure the sound administration of national health insurance services.

Chapter II Municipalities

(Insured Persons)

Article 5 Insured persons covered by the national health insurance program provided by a municipality or special ward (hereinafter simply referred to as a "Municipality") shall be persons domiciled in the area of said Municipality.

(Exclusion from Application)

Article 6 Notwithstanding the provisions of the preceding article, any person who falls under any of the following items shall not be classed as an insured person under any national health insurance program provided by a Municipality:

- (i) an insured person pursuant to the provisions of the Health Insurance Act (Act No. 70 of 1922); provided, however, that this shall not apply to specially-insured day laborers pursuant to the provisions of Article 3, paragraph (2) of the same Act;
- (ii) an insured person pursuant to the provisions of the Seaman's Insurance Act (Act No. 73 of 1939);
- (iii) a member of a mutual aid association pursuant to the National Public Servants Mutual Aid Association Act (Act No. 128 of 1958) or the Local Public Care Service Mutual Aid Association Act (Act No. 152 of 1962);
- (iv) a subscriber to the Private School Personnel Mutual Aid System pursuant to the provisions of the Private School Personnel Mutual Aid Association Act (Act No. 245 of 1953);
- (v) an insured person's dependent pursuant to the provisions of the Health

- Insurance Act; provided, however, that this shall not apply to a dependent pursuant to the provisions of the same Act of a specially-insured day laborer pursuant to Article 3, paragraph (2) of the provisions of the same Act;
- (vi) an insured person's dependent pursuant to the provisions of the Seaman's Insurance Act, the National Public Servants Mutual Aid Association Act (including the cases where applied mutatis mutandis pursuant to other Acts) or the Local Public Care Service Mutual Aid Association Act;
 - (vii) a person whose specially-insured day laborer certificate book received pursuant to the provisions of Article 126 of the Health Insurance Act has not run out of blank space to affix additional health insurance stamps, or such person's dependent pursuant to the provisions of the same Act; provided, however, that this shall not apply to any person for whom a period during which said person shall not be eligible as a specially-insured day laborer pursuant to the provisions of Article 3, paragraph (2) of the same Act is running upon the approval obtained pursuant to the provisions of the proviso of the same paragraph or who has returned such specially-insured day laborer certificate book pursuant to the provisions of Article 126, paragraph (3) of the same Act or such person's dependent pursuant to the provisions of the same Act;
 - (viii) an insured person pursuant to the provisions of the Act on Assurance of Medical Care for Elderly People (Act No. 80 of 1982);
 - (ix) a person who belongs to a household which receives public assistance pursuant to the Public Assistance Act (Act No. 144 of 1950) (excluding a household for which public assistance has been suspended);
 - (x) an insured person of a national health insurance society;
 - (xi) any other person for whom any special reason exists and who is specified as such by Ordinance of the Ministry of Health, Labour and Welfare.

(Time of Acquisition of Eligibility)

Article 7 An insured person under the national health insurance program provided by a Municipality shall become eligible as such on the day on which said person acquires domicile in said Municipality or on the first day on which said person no longer falls under any of the items of the preceding Article.

(Time of Loss of Eligibility)

Article 8 (1) An insured person under the national health insurance provided by a Municipality shall lose eligibility for said health insurance from the day immediately following the day on which said person loses domicile in said Municipality or from the day immediately following the first day on which said person falls under any of the items (excluding items (ix) and (x)) of Article 6; provided, however, that said insured person shall lose eligibility for said health

insurance from the day on which said person loses domicile in said Municipality if said person acquires domicile in the area of another Municipality on the same day.

- (2) An insured person under the national health insurance program provided by a Municipality shall lose eligibility as such from the first day on which said person falls under item (ix) or (x) of Article 6.

(Notification, etc.)

Article 9 (1) The householder of a household to which one or more insured persons belong (hereinafter simply referred to as the " Householder ") must notify the Municipality of particulars regarding the acquisition and loss of eligibility for each insured person belonging to said person's household and other necessary particulars pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare.

- (2) The Householder may request the Municipality to issue a health insurance card for all insured persons belonging to said Householder 's household.

- (3) In cases where a Householder who has become delinquent in the payment of insurance premiums (including any national health insurance tax payable pursuant to the provisions of the Local Tax Act (Act No. 226 of 1950); hereinafter the same shall apply in this paragraph and paragraph (7) of this Article, Article 63-2, item (iv) of paragraph (2) of Article 68-2, item (iii) of paragraph (1) of Article 7 of the Supplementary Provisions and item (iii) of paragraph (3) and item (iii) of paragraph (4) of Article 21 of the Supplementary Provisions) (excluding any Householder, all of whose household members who are insured persons are entitled to the payment of general medical expenses for the treatment of illness under the Act for the Support of Atomic Bomb Victims (Act No. 117 of 1994) or any other benefit for medical services specified by Ordinance of the Ministry of Health, Labour and Welfare (hereinafter referred to as the "Payment, etc. of General Medical Expenses for Atomic Bomb-related Illness" in paragraphs (6) and (8)) fails to pay said insurance premiums after the payment due date for said insurance premiums before the elapse of a period specified by Ordinance of the Ministry of Health, Labour and Welfare, the relevant Municipality shall request said Head of Household to return their health insurance card pursuant to the provisions of Ordinance of the Ministry of Health Labour and Welfare, unless a disaster or any other special circumstances specified by Cabinet Order are deemed to exist under which such insurance premiums failed to be paid.

- (4) Without waiting for the elapse of the period specified by Ordinance of the Ministry of Health, Labour and Welfare as set forth in the preceding paragraph, the Municipality may request the Householder set forth in the same paragraph to return their health insurance card; provided, however, that this shall not

apply if any special circumstances specified by Cabinet Order as set forth in the preceding paragraph are deemed to exist.

- (5) The Householder who was requested to return their health insurance card pursuant to the provisions of the two preceding paragraphs must return said health insurance card to the Municipality.
- (6) When the Householder returns their health insurance card pursuant to the provisions of the preceding paragraph, the Municipality shall issue said Householder with a health insurance certificate for all insured persons belonging to said Householder 's household (excluding any person who is entitled to the Payment, etc. of General Medical Expenses for Atomic Bomb-related Illness and any person who has not yet reached the first March 31 after said person's 18th birthday (or, if any of the insured persons belonging to said household is a person who is entitled to the Payment etc. of General Medical Expenses for Atomic Bomb-related Illness or who has not yet reached the first March 31 after said person's 18th birthday, said health insurance certificate plus a health insurance card for such person) (in the case of a person who has not yet reached the first March 31 after said person's 18th birthday (excluding any person who is entitled to the Payment, etc. of General Medical Expenses for Atomic Bomb-related Illness), a health insurance card valid for 6 months; hereinafter the same shall apply in this paragraph) or, if all insured persons belonging to said household are persons who are entitled to the Payment, etc. of General Medical Expenses for Atomic Bomb-related Illness or who have not yet reached the first March 31 after their respective 18th birthdays, a health insurance card for all of these persons).
- (7) When the Householder to whom a health insurance certificate has been issued makes full payment of delinquent insurance premiums, or when it is found that the delinquent payment amount pertaining to the relevant person has decreased significantly or that a disaster or any other special circumstances specified by Cabinet Order exists, the Municipality shall issue the Householder with a health insurance card for all insured persons belonging to said Householder 's household.
- (8) In cases where a health insurance certificate has been issued to a Householder and when any of the insured persons belonging to said person's household becomes entitled to the Payment, etc. of General Medical Expenses for Atomic Bomb-related Illness, then the relevant Municipality shall issue said Householder with an health insurance card for the relevant insured person.
- (9) When any of the insured persons belonging to a household loses eligibility as such, the Householder must, pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, promptly notify the Municipality thereof as well as returning to the Municipality the health insurance card or

the health insurance certificate, as the case may be, for the relevant insured person.

- (10) A Municipality may set the period of validity for a health insurance card and a health insurance certificate. In this case, a special period of validity may be set for the health insurance card for any Householder who has become delinquent in the payment of insurance premiums payable pursuant to the provisions of this Act (including any national health insurance tax payable pursuant to the provisions of the Local Tax Act) (excluding any person from whom the Municipality requests the return of said person's health insurance card pursuant to the provisions of paragraph (3)) and all insured persons belonging to said person's household and for any Householder who has become delinquent in the payment of insurance premiums payable pursuant to the provisions of the National Pension Act (Act No. 141 of 1959) (including any person who has the obligation to pay insurance premiums pursuant to the provisions of Article 88, paragraph (2) of said Act and limited to a person who has been found by the Minister of Health, Labour and Welfare to satisfy the applicable requirements specified by Ordinance of the Ministry of Health, Labour and Welfare and has been notified by said Minister as such to the relevant Municipality) and all insured persons belonging to said person's household and for other persons specified by Ordinance of the Ministry of Health, Labour and Welfare; provided, however, that in cases where a Municipality intends to set a special period of validity of less than 6 months for the health insurance card for the Householder of a household to which any person who has not yet reached the first March 31 after said person's 18th birthday belongs or for any insured person belonging to said household, the special period of validity for the health insurance card for said person must be not less than 6 months.
- (11) In cases where a Municipality intends to set the period of validity for a health insurance card or a health insurance certificate pursuant to the provisions of the preceding paragraph (including cases where a special period of validity is set for an health insurance card), the same period of validity must be set for all insured persons belonging to the same household (excluding any person who belongs to said household and has not yet reached the first March 31 after said person's 18th birthday in the cases set forth in the proviso of said paragraph and other persons specified by Ordinance of the Ministry of Health, Labour and Welfare).
- (12) All affairs pertaining to the Minister of Health, Labour and Welfare's authority of notification pursuant to the provisions of paragraph (10) shall be conducted by the Japan Pension Organization.
- (13) The provisions of paragraphs (3), (4), (6) and (7) of Article 109 of the National Pension Act shall apply mutatis mutandis to the authority of

notification set forth in the preceding paragraph. In this case, any necessary technical replacement of terms shall be specified by Cabinet Order.

(14) When a notification is received pursuant to the provisions of Articles 22 through 24 or Article 25, 30-46 or 30-47 of the Residential Basic Book Act (Act No. 81 of 1967) (limited to cases when a supplementary note is appended to the document pertaining to said notification pursuant to the provisions of Article 28 of the same Act), a notification pursuant to the provisions of paragraph (1) or (9) shall be considered to have been received for the same reason as that for the above notification.

(15) In addition to what is provided for in each of the preceding paragraphs, necessary particulars concerning notification pertaining to insured persons and pertaining to health insurance cards and health insurance certificates shall be prescribed by Ordinance of the Ministry of Health, Labour and Welfare.

(Special Accounts)

Article 10 Each Municipality must establish a special account for income and expenses related to its national health insurance program pursuant to Cabinet Order provisions.

(Council for the Administration of National Health Insurance)

Article 11 (1) Each Municipality shall have a council for the administration of national health insurance in order to deliberate on important matters concerning the administration of national health insurance services.

(2) In addition to what is provided for in the preceding paragraph, important particulars concerning a council for the administration of national health insurance shall be prescribed by Cabinet Order.

Article 12 Deleted.

Chapter III National Health Insurance Societies

Section 1 General Rules

(Organization)

Article 13 (1) National health insurance societies (hereinafter referred to as a "Society") shall be organized by incorporating those who are engaged in the same kind of business or work and are domiciled in the same district of a Society as its members.

(2) The district of a Society set forth in the preceding paragraph shall consist of the area covered by one, or two or more Municipalities; provided, however, that this shall not apply if any special reason exists for not basing said district on such areas.

(3) Notwithstanding the provisions of paragraph (1), a person shall not be eligible as a Society member if said person falls under any of the items (excluding items (viii) and (x)) of Article 6 or is an insured person under any national health insurance program provided by another Society; provided, however, that this shall not apply if said person's household includes any person who does not fall under any of the items (excluding item (x)) of the same Article and who is not an insured person under any national health insurance program provided by another Society.

(4) Notwithstanding the provisions of paragraph (1), a person shall be eligible as a Society member if said person is employed by said Society, does not fall under any of the items (excluding items (viii) and (x)) of Article 6, and is not an insured person under any national health insurance program provided by another Society.

(Personality)

Article 14 A Society shall be a corporation.

(Name)

Article 15 (1) A Society shall use the characters "国民健康保険組合" (pronounced "kokumin kenko hoken kumiai" (literally meaning "national health insurance society")) in its name.

(2) No person other than a Society may use the name "kokumin kenko hoken kumiai" or any name similar thereto.

(Domicile)

Article 16 The domicile of a Society shall be at the location of its principal office.

(Establishment)

Article 17 (1) The establishment of a Society must be subject to the authorization of the prefectural governor governing the area which is the location of its principal office.

(2) An application for the authorization set forth in the preceding paragraph shall be filed by preparing the Society's constitution, which shall be prepared by at least fifteen founders, and by obtaining consent thereto from at least three hundred persons who will become members of said Society.

(3) In cases where an application for the authorization set forth in paragraph (1) is filed, the prefectural governor shall hear the opinions of the heads of the Municipalities whose area includes any part of the intended district of the relevant Society, and shall not give the authorization set forth in the same paragraph unless said prefectural governor finds that the establishment of said Society will not hinder the operation of the national health insurance services

provided by these Municipalities.

(4) A Society shall be incorporated at the time of authorization of its establishment.

(Particulars to be Included in the Constitution)

Article 18 The constitution of a Society must contain the particulars listed in the following items:

- (i) name;
- (ii) location of the office;
- (iii) district of the Society and the scope of its membership;
- (iv) particulars pertaining to the joining and withdrawal of Society members;
- (v) particulars pertaining to the acquisition and loss of eligibility as an insured person;
- (vi) particulars pertaining to officers;
- (vii) particulars pertaining to Society meetings;
- (viii) particulars pertaining to insurance premiums;
- (ix) particulars pertaining to reserves and other particulars related to property management;
- (x) method for giving public notice;
- (xi) in addition to the particulars listed in the preceding items, particulars specified by Ordinance of the Ministry of Health, Labour and Welfare.

(Insured Persons)

Article 19 (1) A Society member and all persons belonging to said member's household shall be insured persons under the national health insurance program provided by said Society; provided, however, that this shall not apply to any person who falls under any of the items (excluding item (x)) of Article 6 or is an insured person under any national health insurance program provided by another Society.

(2) Notwithstanding the provisions of the preceding paragraph, a Society may, pursuant to the provisions of its constitution, choose not to grant status as an insured person collectively to all persons belonging to the household of a member of such Society.

(Time of Acquisition of Eligibility)

Article 20 An insured person under the national health insurance program provided by a Society shall become eligible as such on the day on which said person becomes a member of said Society or on the first day on which said person belongs to such member's household or on which said person no longer falls under any of the items (excluding item (x)) of Article 6 or on the day on which said person ceases to be an insured person under the National Health

Insurance provided by another Society.

(Time of Loss of Eligibility)

- Article 21 (1) An insured person under the national health insurance program provided by a Society shall lose eligibility as such from the day immediately following the day on which said person ceases to be a member of said Society or ceases to belong to such member's household or from the day immediately following the first day on which said person falls under any of the items (excluding items (ix) and (x)) of Article 6; provided, however, that if said insured person becomes an insured person under any national health insurance program provided by a Municipality or another Society as a result of the fact that said person ceases to be a member of said Society or ceases to belong to such member's household, said person shall lose eligibility as such from the day on which said person ceases to be a member of such Society or ceases to belong to such member's household.
- (2) An insured person under the national health insurance program provided by a Society shall lose eligibility as such from the first day on which said person falls under item (ix) of Article 6.

(Provisions Applied Mutatis Mutandis)

Article 22 The provisions of Article 9 (excluding paragraphs (12) through (14)) shall apply mutatis mutandis to any notification concerning an insured person covered by, and to health insurance cards and certificates of the insured status for, the national health insurance program provided by a Society. In this case, the phrase "The Householder of a household to which one or more insured persons belong" and the term "Householder" in the provisions of paragraphs (1) through (9) of the same Article shall be deemed to be replaced with "A Society member" and "Society member," respectively; the term "Municipality" in the same paragraphs shall be deemed to be replaced with "Society"; the term "Municipality" in paragraph (10) of the same Article shall be deemed to be replaced with "Society," the phrase "any Householder who has become delinquent in the payment of insurance premiums payable pursuant to the provisions of this Act (including any national health insurance tax payable pursuant to the provisions of the Local Tax Act) (excluding any person from whom the Municipality shall request return of said person's health insurance card pursuant to the provisions of paragraph (3)) and all insured persons belonging to said person's household and for any Householder who has become delinquent in the payment of insurance premiums payable pursuant to the provisions of the National Pension Act (Act No. 141 of 1959) (including any person who has the obligation to pay insurance premiums pursuant to the provisions of Article 88, paragraph (2) of said Act and limited to a person who

has been found by the Minister of Health, Labour and Welfare to satisfy the applicable requirements specified by Ordinance of the Ministry of Health, Labour and Welfare and has been notified by said Minister as such to the relevant Municipality)" in the same paragraph shall be deemed to be replaced with "any Society member who has become delinquent in the payment of insurance premiums payable pursuant to the provisions of this Act (including any national health insurance tax payable pursuant to the provisions of the Local Tax Act) (excluding a person from whom the Society shall request return of said person's health insurance card pursuant to the provisions of paragraph (3))"; the phrase " Householder of a household" in the same paragraph shall be deemed to be replaced with "Society member of a household"; and the term "Municipality" in paragraph (11) of the same Article shall be deemed to be replaced with "Society."

Section 2 Management

(Officers)

- Article 23 (1) Each Society shall have directors and auditors as its officers.
- (2) The fixed number of directors shall be five or more and the fixed number of auditors shall be two or more, and each of these fixed numbers shall be specified by the Society's constitution.
- (3) All directors and auditors shall be appointed at a Society meeting from among Society members pursuant to the provisions of the Society's constitution; provided, however, that this shall not preclude directors and auditors from being appointed at a Society meeting from among persons other than Society members if any special circumstances exist.
- (4) The respective terms of office of directors and auditors shall be specified by the Society's constitution within a period not exceeding three years.

(Duties of Officers)

- Article 24 (1) A director shall execute the operations of the Society and shall represent the Society pursuant to the provisions of its constitution.
- (2) Unless otherwise specified by the constitution, a Society's operations shall be determined by the majority of all directors.
- (3) An auditor shall audit the performance of business and the status of the property of the Society.

(Restrictions on Directors' Authority of Representation)

- Article 24-2 Restrictions on directors' authority of representation may not be asserted against a third party without knowledge of such restrictions.

(Delegation of Directors' Authority)

Article 24-3 A director may delegate their authority on a specific action to another person unless such delegation is prohibited by the Society's constitution or a resolution of a Society meeting.

(Provisional Director)

Article 24-4 In cases where there is any vacancy in the position of director and when damage is likely to occur due to a delay in business, the prefectural governor must appoint a provisional director at the request of any interested person or by said person's authority.

(Acts in Conflict of Interest)

Article 24-5 A director shall have no authority of representation as to any matter involving a conflict of interest between the Society and such director. In the event of such a conflict of interest, the prefectural governor must appoint a special agent at the request of any interested person or by said person's authority.

(Matters to be Left Solely to a Directors' Disposal)

Article 25 (1) When a valid Society meeting fails to take place or when a Society meeting fails to make a resolution on any matter on which a resolution needs to be made, the directors may, under the direction of the prefectural governor, handle such matter on which a resolution needs to be made.

(2) In cases where a matter on which a resolution needs to be made at a Society meeting must be implemented temporarily and urgently, when a valid Society meeting fails to take place or when there is no time to convene a Society meeting, then the directors may handle such matter on which a resolution needs to be made.

(3) Any disposition made pursuant to the provisions of the two preceding paragraphs must be reported by the directors at the first Society meeting convened thereafter.

(Society Meetings)

Article 26 (1) A Society shall have Society meetings.

(2) A Society meeting shall be composed of Society council members, whose fixed number shall be specified by its constitution within a range not less than one-twentieth of the total number of Society members; provided, however, that in cases where a Society has more than six hundred members in total, having at least thirty Society council members will suffice.

(3) Society council members shall be elected by Society members from among themselves pursuant to the provisions of the Society's constitution.

(4) The term of office of Society council members shall be specified by the Society's constitution within a period not exceeding three years.

(Matters to be Decided on by a Society Meeting)

Article 27 (1) The matters listed in the following items must be determined through a Society meeting:

- (i) changes to the Society's constitution;
- (ii) obtaining a loan and the method thereof as well as the interest rate and the method of reimbursement of said loan;
- (iii) budget for income and expenditure;
- (iv) settlement of accounts;
- (v) contracts which will place a burden on the Society other than those prescribed by a budget;
- (vi) dispositions of a reserve or any other important property;
- (vii) filing and settling lawsuits;
- (viii) in addition to the matters listed in the preceding items, matters specified by the Society's constitution as those which require resolution by a Society meeting.

(2) A resolution on any of the matters listed in items (i), (ii) and (vi) of the preceding paragraph (in the case of the matters listed in items (i) and (ii) of the same paragraph, excluding changes to the Society's constitution pertaining to an expansion of the district of said Society which will continue to exist after a merger in order to include as part of its district that of another Society which will be dissolved as a result of the merger, and other matters specified by Ordinance of the Ministry of Health, Labour and Welfare) shall not become effective without the authorization of the prefectural governor.

(3) The provisions of Article 17, paragraph (3) shall apply mutatis mutandis to the authorization set forth in the preceding paragraph with respect to changes to the Society's constitution pertaining to an expansion of the district of said Society.

(4) When a Society decides on the matter listed in paragraph (1), item (iii) or any of the matters specified by Ordinance of the Ministry of Health, Labour and Welfare as set forth in paragraph (2), it must promptly notify the prefectural governor thereof.

(Convocation of Society Meetings)

Article 28 (1) Directors must, pursuant to the provisions of a Society's constitution, convene an ordinary Society meeting once annually.

(2) When a Society meeting member requests, upon the consent of no less than one-third of the fixed number of Society council members, the convocation of a Society meeting by submitting a document stating the subject matter of such

meeting and the reasons for such convocation to said Society, the directors must convene an extraordinary Society meeting within twenty days from the day of such request.

(Right to Elect and Voting Rights)

Article 29 Each Society member shall have the right to make a single vote in elections and on resolutions.

(No Voting Rights)

Article 29-2 When voting on the relationship between a Society and a specific Society meeting member, said Society meeting member shall have no voting right.

(Authority of Society Meetings)

Article 30 (1) A Society meeting may inspect documents concerning the Society's affairs, may request reports from directors or auditors, or may inspect the management of affairs, the execution of decisions, or revenue and expenditure of the Society.

(2) A Society meeting may have a person appointed from among the Society council members carry out any of the matters under authority of the Society meeting as set forth in the preceding paragraph.

(Application Mutatis Mutandis of the Act Concerning General Corporations and General Foundations)

Article 31 The provisions of Article 78 of the Act Concerning General Corporations and General Foundations (Act No. 48 of 2006) shall apply mutatis mutandis to a Society.

Section 3 Dissolution and Mergers

(Dissolution)

Article 32 (1) A Society shall be dissolved for any of the reasons listed in the following items:

(i) a decision by the Society meeting;

(ii) the occurrence of a reason for dissolution set forth in the Society's constitution;

(iii) a dissolution order issued pursuant to the provisions of Article 108, paragraph (4);

(iv) a merger.

(2) Dissolution of a Society for the reason listed in item (i) or (ii) of the preceding paragraph must obtain authorization of the prefectural governor pursuant to

the provisions of Ordinance of the Ministry of Health, Labour and Welfare.

(Vesting of Residual Assets)

Article 32-2 (1) The residual assets of a dissolved Society shall be vested in the person, if any, designated by its constitution.

(2) When the Society's constitution fails to designate any person with whom rights should be vested, or fails to provide the means by which to designate such person, the directors may, with the permission of the prefectural governor, dispose of the assets of the Society for any purpose which is similar to that of said Society; provided, however, that this must require a resolution made at a Society meeting.

(3) Any asset which is not disposed of pursuant to the provisions of the two preceding paragraphs shall be vested in the national treasury.

(Capacity of a Society under Liquidation)

Article 32-3 A dissolved Society shall be deemed to continue to exist to the extent of the purpose of its liquidation, until the conclusion of its liquidation procedure.

(Liquidators)

Article 32-4 When a Society has been dissolved, the directors shall become liquidators, except in the cases of a dissolution effected pursuant to a decision for the commencement of bankruptcy proceedings; provided, however, that this shall not apply if it is otherwise specified in the Society's constitution or if persons other than the directors have been appointed as liquidators at a Society meeting.

(Appointment of Liquidators by Court)

Article 32-5 When there are no persons who qualify as liquidators pursuant to the provisions of the preceding Article or when any damage is likely to occur due to a vacancy in the position of liquidators, the court may appoint a liquidator(s) at the request of an interested person or a public prosecutor, or by the court's own authority.

(Dismissal of Liquidators)

Article 32-6 When any material grounds exist, the court may dismiss a liquidator at the request of any interested person or a public prosecutor, or by the court's own authority.

(Notification of Liquidators and Dissolution)

Article 32-7 (1) Except in the case of a decision for the commencement of

bankruptcy proceedings or in the case of a dissolution order issued pursuant to the provisions of Article 108, paragraph (4), a liquidator must provide notification of their name and domicile and the cause and date of said dissolution to the prefectural governor.

- (2) A liquidator who assumes office in the course of liquidation must provide notification of their name and domicile to the prefectural governor.
- (3) The provisions of the preceding paragraph shall apply mutatis mutandis to any liquidator who assumes office as a result of a dissolution order issued pursuant to the provisions of Article 108, paragraph (4).

(Duties and Authority of Liquidators)

Article 32-8 (1) The duties of a liquidator shall be as follows:

- (i) the conclusion of current business;
- (ii) the collection of debts and the performance of obligations;
- (iii) the delivery of residual assets.

- (2) A liquidator may perform any and all acts in order to perform the duties listed in the items of the preceding paragraph.

(Demand for Filing of Claims)

Article 32-9 (1) A liquidator must, within two months from the day of assuming office and by giving public notice on at least three occasions, demand that the relevant creditors file their claims within a stated period. In this case, such notice period may not be less than two months.

- (2) The public notice set forth in the preceding paragraph must include a statement to the effect that any claim of a creditor shall be excluded from the liquidation procedure unless said creditor files such claim within the stated period; provided, however, that the liquidator may not exclude any known creditor.
- (3) The liquidator must make a demand to each known creditor to file said creditor's claim.
- (4) The public notice set forth in paragraph (1) shall be effected by publication in the Official Gazette.

(Filing Claims after Passing of the Stated Period)

Article 32-10 Any creditor who files a claim after the passing of the period set forth in paragraph (1) of the preceding Article shall be entitled to file a claim only with regard to the assets which, after all debts of the Society have been paid off, have not yet been delivered to the persons with vested rights.

(Supervision by the Court)

Article 32-11 (1) The dissolution and liquidation of a Society shall be subject to

supervision of the court.

- (2) The court may, by its own authority, conduct any inspection necessary for the supervision set forth in the preceding paragraph.
- (3) A court supervising the dissolution and liquidation of a Society may seek the opinion of, or commission an investigation from a government agency supervising the operations of such Society.
- (4) The government agency set forth in the preceding paragraph may state its opinion to the court set forth in the same paragraph.

(Notification of the Conclusion of a Liquidation Procedure)

Article 32-12 Upon conclusion of a liquidation procedure, the liquidator must notify the prefectural governor thereof.

(Jurisdiction over Cases Concerning Supervision of Dissolution and Liquidation, etc.)

Article 32-13 Cases concerning the supervision of the liquidation of a Society, and its liquidators, shall be under the exclusive jurisdiction of the district court which has jurisdiction over the location of the principal office of such Society.

(Restrictions on Appeals)

Article 32-14 No appeal may be entered against a judicial decision on the appointment of a liquidator.

(Remuneration for a Liquidator Appointed by the Court)

Article 32-15 In cases where the court has appointed a liquidator(s) pursuant to the provisions of Article 32-5, the court may specify the amount of remuneration to be paid by the Society to such liquidator(s). In this case, the court must hear statements from such liquidator(s) and the auditors.

(Immediate Appeal against a Ruling)

Article 32-16 An immediate appeal against a ruling may be entered against a judicial decision on the dismissal of a liquidator and against a judicial decision made pursuant to the preceding Article.

(Appointment of Inspectors)

- Article 32-17 (1) The court may appoint an inspector(s) to conduct necessary investigations for the supervision of the dissolution and liquidation of a Society.
- (2) The provisions of the preceding three Articles shall apply mutatis mutandis to cases where the court has appointed an inspector(s) pursuant to the provisions of the preceding paragraph. In this case, the phrase "such liquidator(s) and the

auditors" in Article 32-15 shall be deemed to be replaced with "the Society and its inspector(s)"

(Mergers)

Article 33 (1) Any merger of a Society must be subject to a resolution to such effect at a Society meeting.

(2) In cases where Societies have merged together, the Society newly incorporated through the merger or the Society surviving the merger shall succeed to the rights and obligations of the Society or Societies extinguished through said merger (including the rights and obligations which said Society or Societies have in relation to their respective national health insurance services based on the permission, license, approval or any other disposition by an administrative agency).

Article 34 Deleted.

Section 4 Miscellaneous Provisions

(Delegation to Cabinet Order)

Article 35 In addition to what is provided for in this Chapter, necessary matters concerning the management of a Society, retention of its assets and other aspects of a Society shall be prescribed by Cabinet Order.

Chapter IV Insurance Benefits

Section 1 Benefits for Medical Treatment, etc.

(Benefits for Medical Treatment)

Article 36 (1) Municipalities and Societies (hereinafter referred to as "Insurers") shall pay benefits for the types of medical treatment listed in the following items with respect to an insured person's illness and injury; provided, however, that this shall not apply during any period for which a health insurance certificate has been issued to the Householder or Society member of the household to which such insured person belongs:

- (i) medical examinations;
- (ii) provision of medication or materials for medical treatment;
- (iii) treatment, operations or any other medical treatment;
- (iv) in-home medical care management as well as caretaking and any other nursing involved in in-home medical care;
- (v) hospitalization or visiting a clinic, and caretaking and other nursing incidental to medical treatment provided there.

(2) Benefits for the following types of medical treatment shall not be included in

the benefits set forth in the preceding paragraph:

- (i) medical treatment which consists of the provision of meals and is given in combination with the type of medical treatment listed in item (v) of the preceding paragraph (excluding hospitalization in a sanatorium ward as set forth in Article 7, paragraph (2), item (iv) of the Medical Treatment Act (Act No. 205 of 1948) and care and other nursing incidental to the medical treatment there which is provided to an insured person whose 65th birthday is on any month before the month in which said person receives the relevant medical treatment (hereinafter referred to as a "Person Specified as Hospitalized Long-term and Insured")) (hereinafter referred to as "Dietary Treatment");
 - (ii) the following types of medical treatment given in combination with the type of medical treatment listed in item (v) of the preceding paragraph (limited to medical treatment provided to a Person Specified as Hospitalized Long-term and Insured; hereinafter referred to as "Living Support"):
 - (a) medical treatment consisting of the provision of meals;
 - (b) medical treatment consisting of the creation of an appropriate environment for medical treatment in terms of temperature, lighting and water supply;
 - (iii) evaluation treatment (meaning the evaluation treatment as set forth in Article 63, paragraph (2), item (iii) of the Health Insurance Act; hereinafter the same shall apply);
 - (iv) selective treatment (meaning the selective treatment as set forth in Article 63, paragraph (2), item (iv) of the Health Insurance Act; hereinafter the same shall apply).
- (3) When an insured person intends to receive benefit for any of the types of medical treatment set forth in paragraph (1), said person shall submit their health insurance card to the Health Insurance-Covered Medical Institution or health insurance-covered pharmacy (meaning the Health Insurance-Covered Medical Institution or health insurance-covered pharmacy as set forth in Article 63, paragraph (3), item (i) of the Health Insurance Act; hereinafter the same shall apply) of said person's choice and shall receive the relevant medical treatment at or from such Health Insurance-Covered Medical Institution or health insurance-covered pharmacy; provided, however, that when such insured person falls under any of the cases specified by Ordinance of the Ministry of Health, Labour and Welfare, said person shall not be required to submit their health insurance card.

Article 37 Deleted.

Article 38 Deleted.

Article 39 Deleted.

(Responsibilities of Health Insurance-Covered Medical Institutions, etc.)

Article 40 (1) The rules applicable in cases where a Health Insurance-Covered Medical Institution or health insurance-covered pharmacy (hereinafter referred to as a "Health Insurance-Covered Medical Institution, etc.") or a health insurance-covered physician or health insurance-covered pharmacist (meaning the health insurance-covered physician or health insurance-covered pharmacist as set forth in Article 64 of the Health Insurance Act; hereinafter the same shall apply) shall be in charge of benefits for medical treatment under a national health insurance program or shall provide medical care or prescription service under a national health insurance program, shall be governed by the same rules as Ordinance of Ministry of Health, Labour and Welfare set forth in Article 70, paragraph (1) and Article 72, paragraph (1) of the same Act.

(2) In the case referred to in the preceding paragraph, when it is difficult or is not found appropriate for Ordinance of Ministry of Health, Labour and Welfare set forth in the same paragraph to govern such rules, said rules shall be prescribed by another Ordinance of the Ministry of Health, Labour and Welfare.

(Guidance by the Minister of Health, Labour and Welfare or Prefectural Governor)

Article 41 (1) Guidance by the Minister of Health, Labour and Welfare or the prefectural governor must be received by Health Insurance-Covered Medical Institutions, etc. with respect to benefits for medical treatment and by health insurance-covered physicians and health insurance-covered pharmacists with respect to medical care or prescription service provided under a national health insurance program.

(2) In cases where the guidance set forth in the preceding paragraph is provided, the Minister of Health, Labour and Welfare or the prefectural governor shall, when finding it necessary, have a person(s) with knowledge and experience of medical care or prescription service attend such guidance in accordance with the designation by concerned organizations; provided, however, that this shall not apply where such concerned organizations make no such designation or where the person(s) so designated fail to attend.

(Co-payment in Cases Where Benefits for Medical Treatment Are Received)

Article 42 (1) A person who receives benefit for medical treatment in relation to an Health Insurance-Covered Medical Institution, etc. pursuant to the provisions of Article 36, paragraph (3) shall pay, in accordance with the

categories listed in the following items, an amount obtained by multiplying the amount calculated pursuant to the provisions of Article 45, paragraph (2) or (3) with respect to such benefit by the ratio listed in the relevant item below, as said person's co-payment to such Health Insurance-Covered Medical Institution, etc. when receiving such benefit:

- (i) in cases where the first March 31 after said person's 6th birthday has passed and the month in which said person's 70th birthday is has not yet started: 0.3;
 - (ii) in cases where the first March 31 after said person's 6th birthday has not yet passed: 0.2;
 - (iii) in cases where the month in which said person's 70th birthday is has elapsed (excluding the case listed in the following item): 0.2;
 - (iv) in cases where the month in which said person's 70th birthday is has elapsed and where the amount of income calculated pursuant to Cabinet Order provisions with respect to the insured persons (limited to persons whose 70th birthday is in any month before the current month and other persons specified by Cabinet Order) who belong to the household to which the person who receives such benefit for medical treatment belongs is not less than the amount specified by Cabinet Order: 0.3.
- (2) Each Health Insurance-Covered Medical Institution, etc. shall receive the co-payment set forth in the preceding paragraph (or, when the ratio for such co-payment is reduced pursuant to the provisions of Article 43, paragraph (1), the co-payment calculated in accordance with the ratio after such reduction in the case of a Health Insurance-Covered Medical Institution, etc. set forth in paragraph (2) of the same Article or, when the measure set forth in Article 44, paragraph (1), item (i) is taken, the co-payment after the relevant reduction) and, when an insured person fails to make all or part of such co-payment despite efforts of the Health Insurance-Covered Medical Institution, etc. to receive such payment with the same care as due care of a prudent manager, the Insurer may impose a disposition on such insured person pursuant to the same rules as those for the monies to be collected pursuant to the provisions of this Act, at the request of such Health Insurance-Covered Medical Institution, etc.

Article 42-2 In cases where co-payment shall be made pursuant to the provisions of paragraph (1) of the preceding Article, any fraction of less than five yen in the amount of co-payment set forth in the same paragraph shall be rounded down to the nearest ten yen, whereas any fraction of more than five yen and less than ten yen shall be rounded up to the nearest ten yen.

Article 43 (1) An Insurer may, pursuant to Cabinet Order provisions, reduce any

of the ratios for co-payment set forth in Article 42, paragraph (1) by Municipal Ordinance or by its constitution.

- (2) When the applicable ratio for co-payment is reduced pursuant to the provisions of the preceding paragraph, it shall be sufficient for an insured person who receives benefit for medical treatment in relation to one of the Health Insurance-Covered Medical Institutions, etc. designated by the Insurer with the consent of their respective establishers, to pay co-payment calculated in accordance with the applicable ratio after such reduction to such Health Insurance-Covered Medical Institution, etc., notwithstanding the provisions of Article 42, paragraph (1).
- (3) In cases where the applicable ratio for co-payment has been reduced pursuant to the provisions of paragraph (1) and when an insured person has received benefit for medical treatment at or from a Health Insurance-Covered Medical Institution, etc. which is not one of those set forth in the preceding paragraph, the Insurer shall pay to such insured person the difference between the amount of co-payment paid by such insured person to the Health Insurance-Covered Medical Institution, etc. pursuant to the provisions of Article 42, paragraph (1) and the amount of co-payment calculated pursuant to the applicable ratio after the reduction made pursuant to the provisions of paragraph (1).
- (4) The provisions of the preceding Article shall apply *mutatis mutandis* to the making of co-payment in the case set forth in paragraph (2).

Article 44 (1) An Insurer may take any of the measures listed in the following items with respect to any insured person who is under special circumstances and for whom it is found difficult to make co-payment to a Health Insurance-Covered Medical Institution, etc. pursuant to the provisions of Article 42 or the preceding Article:

- (i) to reduce the amount of co-payment;
 - (ii) to exempt such insured person from making co-payment;
 - (iii) to decide to collect co-payment directly from such insured person in lieu of co-payment to the Health Insurance-Covered Medical Institution, etc., and to suspend such collection.
- (2) Notwithstanding the provisions of paragraph (1) of Article 42 and paragraph (2) of the preceding Article, where the measure set forth in item (i) of the preceding paragraph has been taken with respect to an insured person, it shall be sufficient for said person to pay the amount of co-payment so reduced to the relevant Health Insurance-Covered Medical Institution, etc., and where the measure set forth in item (ii) or (iii) has been taken with respect to an insured person, said person shall not be required to make co-payment to the relevant Health Insurance-Covered Medical Institution, etc.

- (3) The provisions of Article 42-2 shall apply mutatis mutandis to the making of co-payment in the case set forth in the preceding paragraph.

(Medical Fees Payable to Health Insurance-Covered Medical Institutions, etc.)

Article 45 (1) Insurers must pay to Health Insurance-Covered Medical Institutions, etc. expenses relating to benefits for medical treatment. The amount of expenses which may be claimed by a Health Insurance-Covered Medical Institutions, etc. from an Insurer in relation to benefits for medical treatment shall be calculated by deducting the amount of any co-payment payable to such Health Insurance-Covered Medical Institution, etc. by the insured person (or the Householder or Society member in the case set forth in Article 57) in relation to the benefits for medical treatment from the amount of expenses incurred in providing said benefits for medical treatment.

- (2) Calculation of the amount of expenses incurred in providing the benefits for medical treatment set forth in the preceding paragraph shall be governed by the same rules as those prescribed by the Minister of Health, Labour and Welfare pursuant to the provisions of Article 76, paragraph (2) of the Health Insurance Act.
- (3) An Insurer may, with the authorization of the prefectural governor, specify otherwise in a contract with a Health Insurance-Covered Medical Institution, etc. with respect to the amount of expenses incurred in providing the benefits for medical treatment set forth in paragraph (1) for the medical treatment to be provided at such Health Insurance-Covered Medical Institution, etc., within the range of the amount calculated pursuant to the provisions of the preceding paragraph.
- (4) Upon receipt of a claim by a Health Insurance-Covered Medical Institution, etc. for expenses incurred in providing benefits for medical treatment, the Insurer shall make payment after conducting an examination according to the rules set forth in Article 40, and according to the method for calculating the amount set forth in paragraph (2), and the provisions of the preceding paragraph.
- (5) An Insurer may entrust affairs concerning the examination and payment pursuant to the provisions of the preceding paragraph to a Federation of National Health Insurance Associations whose jurisdiction covers the area of the relevant prefecture (excluding any such federation the number of whose member Insurers is less than two-thirds of the total number of Insurers located within its jurisdiction) or the Health Insurance Claims Review and Reimbursement Services established under the Health Insurance Claims Review and Reimbursement Services Act (Act No. 129 of 1948).
- (6) Of the affairs concerning the review of medical bills conducted by a Federation of National Health Insurance Associations as entrusted pursuant to

the provisions of the preceding paragraph or those of Article 76, paragraph (5) of the Health Insurance Act, those concerned with the review of such medical bills as specified by the Minister of Health, Labour and Welfare may be entrusted by such Federation of National Health Insurance Associations to any of those general incorporated associations or general foundations designated by the Minister of Health, Labour and Welfare as those meeting the requirements specified by Ordinance of the Ministry of Health, Labour and Welfare in terms of the organization involved in such review and other matters, and as capable of conducting such affairs in a proper and reliable manner.

- (7) An entity to which affairs concerning the review of medical bills as specified by the Minister of Health, Labour and Welfare pursuant to the provisions of the preceding paragraph have been entrusted must have the review of such medical bills conducted by a person who meets the requirements specified by Ordinance of the Ministry of Health, Labour and Welfare.
- (8) In addition to what is provided for in each of the preceding paragraphs, necessary particulars concerning claims for expenses incurred in providing benefits for medical treatment by Health Insurance-Covered Medical Institutions, etc. shall be prescribed by Ordinance of the Ministry of Health, Labour and Welfare.

(Reports, etc. from Health Insurance-Covered Medical Institutions, etc.)

- Article 45-2 (1) When the Minister of Health, Labour and Welfare or a prefectural governor finds it necessary in relation to benefits for medical treatment, said minister or governor may order a Health Insurance-Covered Medical Institution, etc. or any of the persons who were establishers or managers, health insurance-covered physicians, health insurance-covered pharmacists or other employees of a Health Insurance-Covered Medical Institution, etc. (hereinafter referred to as "Former Establishers, etc." in this paragraph) to make a report or submit or present medical records or other books and other documents, may request any of the establishers, managers, health insurance-covered physicians, health insurance-covered pharmacists or other employees of a Health Insurance-Covered Medical Institution, etc. (including Former Establishers, etc.) to appear, or may have personnel question persons involved or inspect any equipment or medical records, the books and other documents or other articles of such Health Insurance-Covered Medical Institution, etc.
- (2) In cases where questions are asked or inspections are conducted pursuant to the provisions of the preceding paragraph, the relevant personnel must carry an identification card and present it at the request of any person concerned.
 - (3) The authority under paragraph (1) must not be construed as being granted for criminal investigation.

- (4) The provisions of Article 41, paragraph (2) shall apply mutatis mutandis to questions asked or inspections conducted pursuant to the provisions of paragraph (1).
- (5) When a prefectural governor finds it necessary that a disposition be made pursuant to the provisions of Article 80 of the Health Insurance Act with respect to a Health Insurance-Covered Medical Institution, etc. in relation to benefits for medical treatment provided under this Act or that a disposition be made pursuant to the provisions of Article 81 of the Health Insurance Act with respect to a health insurance-covered physician or health insurance-covered pharmacist in relation to medical care or prescription service provided under this Act, said governor must notify the Minister of Health, Labour and Welfare thereof, together with the reason therefor.

(Application Mutatis Mutandis of the Health Insurance Act)

Article 46 The provisions of Article 64 and Article 82, paragraph (1) of the Health Insurance Act shall apply mutatis mutandis to benefits for medical treatment provided under this Act. In this case, any technical replacement of terms necessary for these provisions shall be specified by Cabinet Order.

Article 47 Deleted.

Article 48 Deleted.

Article 49 Deleted.

Article 50 Deleted.

Article 51 Deleted.

(Dietary Treatment Expenses for Inpatients)

Article 52 (1) With respect to expenses incurred in Dietary Treatment received by an insured person (excluding a Person Specified as Hospitalized Long-term and Insured) in combination with the medical treatment listed in Article 36, paragraph (1), item (v) at or from the Health Insurance-Covered Medical Institution, etc. of said person's choice, the Insurer shall pay expenses for Dietary Treatment for inpatients to the relevant Householder or Society member; provided, however, that this shall not apply during any period for which a health insurance certificate has been issued in respect of such insured person to the Householder or Society member of the household to which such insured person belongs.

(2) The expenses for Dietary Treatment for inpatients shall be calculated by

deducting the amount of standard co-payment for Dietary Treatment set forth in Article 85, paragraph (2) of the Health Insurance Act (hereinafter simply referred to as "Standard Co-payment for Dietary Treatment") from the amount of expenses calculated for said Dietary Treatment in accordance with the standards set by the Minister of Health, Labour and Welfare pursuant to the provisions of the same paragraph (or, when said amount exceeds the amount of expenses actually incurred for said Dietary Treatment, the amount of expenses actually incurred for said Dietary Treatment).

- (3) When an insured person has received Dietary Treatment at or from a Health Insurance-Covered Medical Institution, the Insurer may, on behalf of the relevant Householder or Society member, pay to said Health Insurance-Covered Medical Institution expenses incurred for said Dietary Treatment payable by such Householder or Society member to said Health Insurance-Covered Medical Institution within the limit of the amount payable to such Householder or Society member as expenses for Dietary Treatment for inpatients.
- (4) When a payment has been made pursuant to the provisions of the preceding paragraph, the Householder or Society member shall be deemed to have received expenses for Dietary Treatment for inpatients.
- (5) Upon acceptance of a payment of expenses incurred for Dietary Treatment, the Health Insurance-Covered Medical Institution must, pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, issue a receipt therefor to the Householder or Society member who makes such payment.
- (6) The provisions of Article 64 of the Health Insurance Act and paragraph (3) of Article 36, Articles 40 and 41, paragraphs (3) through (8) of Article 45 and Article 45-2 of this Act shall apply mutatis mutandis to Dietary Treatment received at or from an Health Insurance-Covered Medical Institution and to the payment of expenses for Dietary Treatment for inpatients associated with such treatment. In this case, any technical replacement of terms necessary for these provisions shall be specified by Cabinet Order.

(Living Expenses for Inpatients)

Article 52-2 (1) With respect to Living Support expenses received by a Person Specified as Hospitalized Long-term and Insured in combination with the medical treatment listed in Article 36, paragraph (1), item (v) at or from the Health Insurance-Covered Medical Institution, etc. of said person's choice, the Insurer shall pay Living Support expenses for inpatients to the Householder or Society member of the household to which such Person Specified as Hospitalized Long-term and Insured belongs; provided, however, that this shall not apply during any period for which a health insurance certificate has been

issued in respect of such Person Specified as Hospitalized Long-term and Insured to the Householder or Society member of the household to which such Person Specified as Hospitalized Long-term and Insured belongs.

- (2) The amount of Living Support expenses for inpatients shall be calculated by deducting the amount of Standard Co-payment for Dietary Treatment set forth in Article 85-2, paragraph (2) of the Health Insurance Act (hereinafter referred to as "Standard Living Expense Co-payment") from the Living Support expenses calculated in accordance with the standards set by the Minister of Health, Labour and Welfare pursuant to the provisions of the same paragraph (or, when said amount exceeds the actual amount of Living Support expenses, such actual amount of Living Support expenses).
- (3) The provisions of Article 64 of the Health Insurance Act and paragraph (3) of Article 36, Articles 40 and 41, paragraphs (3) through (8) of Article 45, Article 45-2 and paragraphs (3) through (5) of the preceding Article of this Act shall apply mutatis mutandis to Living Support received at or from a Health Insurance-Covered Medical Institution and to the payment of Living Support expenses for inpatients associated with such treatment. In this case, any technical replacement of terms necessary for these provisions shall be specified by Cabinet Order.

(Medical Expenses Combined with Treatment Outside Insurance Coverage)

- Article 53 (1) When an insured person has received evaluation treatment or selective treatment at or from a Health Insurance-Covered Medical Institution, etc. of said person's choice, the Insurer shall pay medical expenses combined with treatment outside insurance coverage to the relevant Householder or Society member; provided, however, that this shall not apply during any period for which a health insurance certificate has been issued in respect of such insured person to the Householder or Society member of the household to which such insured person belongs.
- (2) The amount of medical expenses combined with treatment outside insurance coverage shall be the amount specified in item (i) (or the aggregate of such amount and the amount specified in item (ii) or (iii) when such medical treatment includes Dietary Treatment and Living Support, respectively):
 - (i) the amount calculated by deducting, from the amount of expenses calculated for such medical treatment (excluding Dietary Treatment and Living Support) in accordance with the rules prescribed by the Minister of Health, Labour and Welfare pursuant to the provisions of Article 86, paragraph (2), item (i) of the Health Insurance Act (or, when said amount exceeds the amount of expenses actually incurred in such medical treatment, such amount of expenses actually incurred in such medical treatment), the amount obtained by multiplying such amount by the applicable ratio listed in

- the items of paragraph (1) of Article 42, in accordance with the categories listed in the items of the same paragraph (or, where the ratio for co-payment has been reduced pursuant to the provisions of Article 43, paragraph (1), the ratio after such reduction) (or, if any of the measures listed in the items of paragraph (1) of Article 44 needs to be taken with respect to the co-payment set forth in Article 42, paragraph (1) for benefits for medical treatment, the amount calculated as if the relevant measures were taken);
- (ii) the amount calculated by deducting the amount of Standard Co-payment for Dietary Treatment from the amount calculated for such Dietary Treatment in accordance with the standards set by the Minister of Health, Labour and Welfare pursuant to the provisions of the Article 85, paragraph (2) of the Health Insurance Act (or, when said amount exceeds the amount of expenses actually incurred for such Dietary Treatment, such amount of expenses actually incurred for such Dietary Treatment);
- (iii) the amount calculated by deducting the amount of Standard Co-payment for Living Support from the amount calculated for such Living Support in accordance with the standards set by the Minister of Health, Labour and Welfare pursuant to the provisions of the Article 85-2, paragraph (2) of the Health Insurance Act (or, when said amount exceeds the amount of expenses actually incurred in such Living Support, such amount of expenses actually incurred in such Living Support).
- (3) The provisions of Article 64 of the Health Insurance Act and paragraph (3) of Article 36, Articles 40 and 41, paragraphs (3) through (8) of Article 45, Article 45-2 and paragraphs (3) through (5) of Article 52 of this Act shall apply mutatis mutandis to evaluation treatment and selective treatment received at or from a Health Insurance-Covered Medical Institution, etc. and to the payment of medical expenses combined with treatment outside insurance coverage associated with such treatment. In this case, any technical replacement of terms necessary for these provisions shall be specified by Cabinet Order.
- (4) The provisions of Article 42-2 shall apply mutatis mutandis to the payment of the amount calculated by deducting the amount payable as medical expenses combined with treatment outside insurance coverage with respect to expenses incurred in the relevant medical treatment from the amount of expenses calculated for such medical treatment pursuant to the provisions of paragraph (2) in the case set forth in Article 52, paragraph (3) as applied mutatis mutandis pursuant to the preceding paragraph (or, when said amount exceeds the amount of expenses actually incurred in such medical treatment, said amount of expenses actually incurred in such medical treatment).

(Medical Expenses)

Article 54 (1) When an Insurer finds it difficult to pay benefits for medical treatment or expenses for Dietary Treatment for inpatients, Living Support expenses for inpatients or medical expenses combined with treatment outside insurance coverage (hereinafter referred to as a "Benefits for Medical Treatment, etc." in this paragraph and the following paragraph) or finds it unavoidable in cases where an insured person has received any medical care, medication or treatment at or from a hospital, clinic, pharmacy or any other person other than a Health Insurance-Covered Medical Institution, etc., it may pay medical expenses in lieu of Benefits for Medical Treatment, etc.; provided, however, that this shall not apply during any period for which a health insurance certificate has been issued in respect of such insured person to the Householder or Society member of the household to which such insured person belongs.

(2) Where an insured person has received any medical care or medication at or from a Health Insurance-Covered Medical Institution, etc. without submitting their health insurance card and when the Insurer finds that such insured person's failure to submit said health insurance card was due to an emergency or any other unavoidable reason, the Insurer shall pay medical expenses in lieu of Benefits for Medical Treatment, etc.; provided, however, that this shall not apply during any period for which a health insurance certificate has been issued in respect of such insured person to the Householder or Society member of the household to which such insured person belongs.

(3) The amount of medical expenses shall be determined by the Insurer based on: (a) the amount calculated by deducting, from the amount calculated for such medical treatment (excluding Dietary Treatment and Living Support), the amount calculated by multiplying such amount by the applicable ratio listed in the items of paragraph (1) of Article 42, in accordance with the categories listed in the items of the same paragraph; and (b) the amount calculated by deducting, from the amount of expenses calculated for such Dietary Treatment or Living Support, the amount of Standard Co-payment for Dietary Treatment or Standard Co-payment for Living Support, respectively.

(4) In calculating the amount of expenses set forth in the preceding paragraph, the provisions of Article 45, paragraph (2) shall apply mutatis mutandis to cases where benefit for medical treatment shall be received, those of Article 52, paragraph (2) shall apply mutatis mutandis to cases where expenses for Dietary Treatment for inpatients shall be received, those of Article 52-2, paragraph (2) shall apply mutatis mutandis to cases where expenses for Living Support for inpatients shall be received, and those of paragraph (2) of the preceding Article shall apply mutatis mutandis to cases where medical expenses combined with treatment outside insurance coverage shall be received; provided, however, that such amount shall not exceed the amount of

expenses actually incurred in the relevant medical treatment.

(Medical Expenses for Home-Nursing)

- Article 54-2 (1) When an insured person has received any designated home-nursing (meaning the designated home-nursing as set forth in Article 86, paragraph (1) of the Health Insurance Act; hereinafter the same shall apply) at or from a designated home-nursing provider (meaning the designated home-nursing provider as set forth in the same paragraph; hereinafter the same shall apply), the Insurer shall pay a medical expenses for home-nursing with respect to expenses incurred in such designated home-nursing to the relevant Householder or Society member; provided, however, that this shall not apply during any period for which a health insurance certificate has been issued in respect of such insured person to the Householder or Society member of the household to which such insured person belongs.
- (2) The medical expenses for home-nursing set forth in the preceding paragraph shall be paid only if the Insurer finds it necessary pursuant to the provisions of Ordinance of Ministry of Health, Labour and Welfare.
- (3) When an insured person intends to receive designated home-nursing, said person shall submit their health insurance card to the designated home-nursing provider of their choice and shall receive such service at or from such designated home-nursing provider.
- (4) The amount of medical expenses for home-nursing shall be calculated by deducting, from the amount calculated for such designated home-nursing in accordance with the rules prescribed by the Minister of Health, Labour and Welfare pursuant to the provisions of Article 88, paragraph (4) of the Health Insurance Act, the amount calculated by multiplying such amount by the applicable ratio listed in the items of paragraph (1) of Article 42, in accordance with the categories listed in the items of the same paragraph (or, when the ratio for co-payment has been reduced pursuant to the provisions of Article 43, paragraph (1), the ratio after such reduction) (or, when any of the measures listed in the items of paragraph (1) of Article 44 needs be taken with respect to the co-payment set forth in Article 42, paragraph (1) for benefits for the medical treatment, the amount calculated as if the relevant measures were taken).
- (5) When an insured person has received designated home-nursing at or from a designated home-nursing provider, the Insurer may, on behalf of the relevant Householder or Society member, pay to such designated home-nursing provider expenses incurred in such designated home-nursing payable by such Householder or Society member to said designated home-nursing provider, within the limit of the amount payable to such Householder or Society member as medical expenses for home-nursing.

- (6) When a payment is made pursuant to the provisions of the preceding paragraph, the Householder or Society member shall be deemed to have received medical expenses for home-nursing.
- (7) The provisions of Article 42-2 shall apply mutatis mutandis to the payment of the amount calculated by deducting, from the amount of expenses calculated pursuant to the provisions of paragraph (4) in the case set forth in paragraph (5), the amount payable as medical expenses for home-nursing with respect to expenses incurred in the relevant designated home-nursing.
- (8) Upon acceptance of the payment of expenses incurred in designated home-nursing, the designated home-nursing provider must, pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, issue a receipt therefor to the Householder or Society member who makes such payment.
- (9) Upon receipt of a claim by a designated home-nursing provider for a medical expenses for home-nursing, the Insurer shall make payment after conducting an examination according to the method for calculating the amount set forth in paragraph (4) and the rules set forth in the following paragraph.
- (10) The rules for cases where a designated home-nursing provider provides designated home-nursing under a national health insurance program shall be governed by the standards for the operation of a designated home-nursing provider prescribed in Article 92, paragraph (2) of the Health Insurance Act (limited to the provisions concerning the handling of designated home-nursing) and, when it is difficult or is not found appropriate for said standards to govern such rules, said rules shall be prescribed by Ordinance of the Ministry of Health, Labour and Welfare.
- (11) No designated home-nursing shall be included in any of the types of medical treatment listed in the items of paragraph (1) of Article 36.
- (12) The provisions of paragraph (3) of Article 92 of the Health Insurance Act and paragraphs (5) through (8) of Article 45 of this Act shall apply mutatis mutandis to designated home-nursing received at or from a designated home-nursing provider and the payment of medical expenses for home-nursing associated with such service. In this case, any technical replacement of terms necessary for these provisions shall be specified by Cabinet Order.

(Guidance by the Minister of Health, Labour and Welfare and Prefectural Governors)

Article 54-2-2 Guidance by the Minister of Health, Labour and Welfare or prefectural governors must be received by each designated home-nursing provider and nurses and other employees at the office relevant to its designation with respect to designated home-nursing.

(Reports, etc.)

Article 54-2-3 (1) When the Minister of Health, Labour and Welfare or a prefectural governor finds it necessary in relation to the payment of medical expenses for home-nursing, said minister or governor may order a designated home-nursing provider or an entity which was a designated home-nursing provider or any of the persons who were nurses or other employees at the office relevant to such designation (hereinafter referred to as a "Former Designated Home-nursing Business, etc." in this paragraph) to make a report or submit or present the books and other documents, may request a designated home-nursing provider or nurses or other employees at the office relevant to its designation (including Former Designated Home-nursing Businesses, etc.) to appear, or may have personnel question persons involved or inspect the books and other documents or other articles of such designated home-nursing provider at the office relevant to its designation.

(2) The provisions of Article 45-2, paragraph (2) shall apply mutatis mutandis to questions asked or inspections conducted pursuant to the provisions of the preceding paragraph, and the provisions of paragraph (3) of the same Article shall apply mutatis mutandis to the authority under the provisions of the preceding paragraph.

(3) When a prefectural governor finds it necessary that a disposition be made pursuant to the provisions of Article 95 of the Health Insurance Act with respect to a designated home-nursing provider in relation to designated home-nursing provided under this Act, said governor must notify the Minister of Health, Labour and Welfare thereof, together with the reason therefor.

(Special Medical Expenses)

Article 54-3 (1) In cases where a health insurance certificate for an insured person has been issued to the Householder or Society member of the household to which such insured person belongs and where said insured person has received medical treatment at or from a Health Insurance-Covered Medical Institution, etc. or a designated home-nursing provider, the Insurer shall pay to the Householder or Society Member special medical expenses with respect to expenses incurred for such medical treatment.

(2) The provisions of Article 64 of the Health Insurance Act and paragraph (3) of Article 36, Articles 40 and 41, paragraph (3) of Article 45, Article 45-2, paragraph (5) of Article 52, paragraph (2) of Article 53, paragraphs (3), (8) and (10) of Article 54-2, Article 54-2-2 and the preceding Article of this Act shall apply mutatis mutandis to medical treatment covered by special medical expenses received at or from a Health Insurance-Covered Medical Institution, etc. or a designated home-nursing provider and to the payment of special medical expenses associated with such medical treatment. In this case, the

phrase "The amount of medical expenses combined with treatment outside insurance coverage" in Article 53, paragraph (2) shall be deemed to be replaced with "The amount of special medical expenses" and the phrase "Article 86, paragraph (2), item (i) of the Health Insurance Act" in the same paragraph shall be deemed to be replaced with "Article 76, paragraph (2) of the Health Insurance Act if the insured person were eligible for benefits for medical treatment had a health insurance card for said insured person been issued, or those prescribed by the Minister of Health, Labour and Welfare pursuant to the provisions of Article 86, paragraph (2), item (i) of the same Act if the insured person were eligible for payment of medical expenses combined with treatment outside insurance coverage had a health insurance card for said person been issued, or those prescribed by the Minister of Health, Labour and Welfare pursuant to the provisions of Article 88, paragraph (4) of the same Act if the insured person were eligible for payment of medical expenses for home-nursing had a health insurance card for said person been issued," and any technical replacement of terms necessary for the other provisions shall be specified by Cabinet Order.

- (3) In the case set forth in paragraph (1), the Insurer may pay medical expenses if the provisions of Article 54, paragraph (1) were applicable, had a health insurance card for such insured person been issued to such Householder or Society member.
- (4) In the case set forth in paragraph (1), when the insured person has received any medical care or medication at or from a Health Insurance-Covered Medical Institution, etc. without submitting their health insurance certificate and when the Insurer finds that such insured person's failure to submit their health insurance certificate was due to an emergency situation or any other unavoidable reason, the Insurer shall pay medical expenses.
- (5) The provisions of paragraphs (3) and (4) of Article 54 shall apply mutatis mutandis to any medical expenses payable pursuant to the provisions of the two preceding paragraphs. In this case, the phrase "cases where benefit for medical treatment shall be received" in paragraph (4) of the same Article shall be deemed to be replaced with "cases where the insured person is eligible for benefit for medical treatment, had a health insurance card for said insured person been issued," the phrase "cases where Dietary Treatment expenses for inpatients shall be received" in the same paragraph shall be deemed to be replaced with "cases where the insured person is eligible for Dietary Treatment expenses for inpatients, had an health insurance card for said person been issued," the phrase "cases where Living Support expenses for inpatients shall be received" in the same paragraph shall be deemed to be replaced with "cases where the insured person is eligible for Living Support expenses for inpatients, had a health insurance card for said person been issued," the phrase "cases

where a medical expenses combined with treatment outside insurance coverage shall be received" in the same paragraph shall be deemed to be replaced with "cases where the insured person is eligible for medical expenses combined with treatment outside insurance coverage, had a health insurance card for said person been issued".

(Transport Expenses)

Article 54-4 (1) When an insured person has been transported to a hospital or clinic in order to receive medical treatment (including medical treatment covered by a medical expenses combined with treatment outside insurance coverage or by special medical expenses), the Insurer shall pay, as transport expenses, an amount calculated pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare to the relevant Householder or Society member.

(2) The transport expenses as referred to in the preceding paragraph shall be paid only if the Insurer finds it necessary pursuant to the provisions of Ordinance of Ministry of Health, Labour and Welfare.

(Cases Where an Insured Person Has Become a Day Worker or a Dependent Thereof)

Article 55 (1) In cases where an insured person has lost eligibility as such as a result of falling under Article 6, item (vii) and where, at the time of loss of such eligibility, said person actually receives benefit for medical treatment, any medical treatment covered by expenses for Dietary Treatment for inpatients, any medical treatment covered by expenses for Living Support for inpatients, any medical treatment covered by expenses for medical treatment combined with treatment outside insurance coverage, any medical treatment covered by medical expenses for home-nursing or any medical treatment covered by a special medical expenses, or any Designated In-Home Service covered by expenses for In-Home Long-Term Care Service pursuant to the provisions of the Long-Term Care Insurance Act (Act No. 123 of 1997) (meaning the Designated In-Home Service as set forth in Article 41, paragraph (1) of the same Act) (limited to any such service equivalent to medical treatment), any In-Home Service covered by an Exceptional Allowance for In-Home Long-Term Care Service (meaning the In-Home Service as set forth in Article 8, paragraph (1) of the same Act) or any service equivalent thereto (of these services, limited to those equivalent to medical treatment), any Designated Community-Based Service covered by expenses for Community-Based Long-Term Care Service (meaning the Designated Community-Based Service as set forth in Article 42-2, paragraph (1) of the same Act) (limited to any such service equivalent to medical service), any Community-Based Service covered by an Exceptional

Allowance for Community-Based Long-Term Care Service (meaning the Community-Based Service as set forth in Article 8, paragraph (14) of the same Act) or any service equivalent thereto (of these services, limited to those equivalent to medical treatment), any Designated Facility Service, etc. covered by expenses for Long-Term Care Facility Service (meaning the Designated Facility Service, etc. as set forth in Article 48, paragraph (1) of the same Act) (limited to any such service equivalent to medical service), any Facility Service covered by an Exceptional Allowance for Long-Term Care Facility Service (meaning the Facility Service as set forth in Article 8, paragraph (25) of the same Act) (limited to any such service equivalent to medical treatment), any Designated Preventive Service of Long-Term Care covered by expenses for Preventive Service of Long-Term Care (meaning the Designated Preventive Service of Long-Term Care as set forth in Article 53, paragraph (1) of the same Act) (limited to any such service equivalent to medical treatment), or any Preventive Long-Term Care Service covered by an Exceptional Allowance for Preventive Service of Long-Term Care (meaning the Preventive Long-Term Care Service as set forth in Article 8-2, paragraph (1) of the same Act) or any service equivalent thereto (of these services, limited to those equivalent to medical treatment), then such person may receive from the relevant Insurer benefits for medical treatment, expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing, special medical expenses or transportation expenses with respect to the relevant illness or injury and any illness arising therefrom.

(2) Payment of benefits for medical treatment, expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing, special medical expenses or transportation expenses under the provisions of the preceding paragraph shall not be made when any of the events listed in the following items has occurred:

- (i) when the relevant person has become eligible for payment of benefits for medical treatment, expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing, transport expenses, dependent medical expenses, dependent medical expenses for home-nursing or dependent transport expenses pursuant to the provisions of Chapter V of the Health Insurance Act with respect to the relevant illness or injury;
- (ii) when the relevant person has fallen under any of items (i) through (vi) or items (viii), (ix) or (xi) of Article 6;
- (iii) when the relevant person has become an insured person covered by

another Insurer;

(iv) when six months have elapsed since the day on which the relevant person lost eligibility as an insured person.

(3) Payment of benefits for medical treatment, expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing, special medical expenses or transportation expenses under the provisions of paragraph (1) shall not be made during any period in which the relevant person is eligible for payment of a special medical expenses or transport expenses or dependent transport expenses pursuant to the provisions of Chapter V of the Health Insurance Act with respect to the relevant illness or injury.

(4) Payment of benefits for medical treatment, expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing or a special medical expenses under the provisions of paragraph (1) shall not be made in cases where the relevant person is eligible for any benefit corresponding to each of the above benefits pursuant to the provisions of the Long-Term Care Insurance Act with respect to the relevant illness or injury.

(Coordination with Benefits Relating to Medical Services Provided by Other Laws and Regulations)

Article 56 (1) Payment of benefits for medical treatment or expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing, special medical expenses or transportation expenses shall not be made in cases where the insured person is eligible for any benefit relating to medical services pursuant to the provisions of the Health Insurance Act, the Seaman's Insurance Act, the National Public Servants Mutual Aid Association Act (including cases where applied mutatis mutandis pursuant to other Acts or where the same rule governs), the Local Public Care Service Mutual Aid Association Act or the Act on Assurance of Medical Care for Elderly People or where said person is eligible for any benefit corresponding to each of the above benefits pursuant to the provisions of the Long-Term Care Insurance Act, in each case with respect to said person's relevant illness or injury. The same shall apply when such person is eligible for any medical compensation pursuant to the provisions of the Labor Standards Act (Act No. 49 of 1947), any medical compensation benefits or medical treatment benefits under the provisions of the Industrial Accident Compensation Insurance Act (Act No. 50 of 1947), any medical compensation

under the provisions of the National Public Servants Accident Compensation Act (Act No. 191 of 1951; including cases where applied mutatis mutandis pursuant to any other Act), any medical compensation under the provisions of the Local Public Officers Accident Compensation Act (Act No. 121 of 1967) or a Prefectural or Municipal Ordinance under the same Act or any other benefit relating to medical services under any law or regulation as prescribed by Cabinet Order, or when any benefit relating to medical care is provided at the expense of the national or local government pursuant to any law or regulation other than these laws and regulations.

(2) In cases where expenses under any law or regulation set forth in the preceding paragraph shall be provided by way of performance in kind relating to medical services and when any co-payment is made or actual costs are collected in relation to such benefit and when the amount of such co-payment or actual costs collected exceeds the amount of co-payment which would have been required under this Act had such benefit been provided as benefits for medical treatment pursuant to this Act (or, when the applicable ratio for co-payment set forth in Article 42, paragraph (1) has been reduced pursuant to the provisions of Article 43, paragraph (1), the amount of co-payment calculated in accordance with the ratio after such reduction), or in cases where expenses under any law or regulation set forth in the preceding paragraph (excluding the Long-Term Care Insurance Act) shall be provided by way of payment of medical expenses and when the amount of such payment is less than the amount of expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing, special medical expenses or transport allowance which would have been payable had expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing, special medical expenses or transport expenses been required pursuant to this Act with respect to the relevant medical treatment, then the Insurer shall pay to the insured person the difference between the relevant amounts in each case.

(3) In the case referred to in the preceding paragraph, when the insured person has received the relevant medical treatment at or from a Health Insurance-Covered Medical Institution, etc., the Insurer may, on behalf of such insured person, pay to such Health Insurance-Covered Medical Institution, etc. expenses incurred in such medical treatment payable by said insured person to said Health Insurance-Covered Medical Institution, etc. within the limits of the amount payable to said insured person pursuant to the provisions of the same paragraph; provided, however, that when the Insurer has reduced the ratio for

co-payment pursuant to the provisions of Article 43, paragraph (1), the foregoing shall apply only where such insured person has received such medical treatment at or from one of the Health Insurance-Covered Medical Institutions, etc. set forth in paragraph (2) of the same Article.

- (4) When a payment of expenses is made to the relevant Health Insurance-Covered Medical Institution, etc. pursuant to the provisions of the preceding paragraph, the insured person shall, to the extent of such payment, be deemed to have received a payment pursuant to the provisions of paragraph (2).

(Co-payment Relating to an Insured Person Who is Not the Householder or Society Member)

Article 57 In making any co-payment or in paying any difference or medical expenses pursuant to the provisions of paragraph (3) of Article 43 or paragraph (2) of the preceding Article, when the relevant illness or injury is of an insured person who is not the Householder or Society member, the Householder or Society member of the household to which such insured person belongs shall make, or be obligated to make, co-payment and shall receive payment of the difference or medical expenses pursuant to paragraph (3) of Article 43 or paragraph (2) of the preceding Article, notwithstanding the provisions of the respective Articles pertaining to these matters.

(High-Cost Medical Expenses)

Article 57-2 (1) When the amount of co-payment made in relation to the payment of expenses or the amount calculated by deducting, from the amount of expenses incurred in medical treatment (excluding Dietary Treatment and Living Support; hereinafter the same shall apply in the following paragraph), the amount paid as medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing or special medical expenses with respect to expenses incurred in the relevant medical treatment or the amount of difference paid pursuant to the provisions of Article 56, paragraph (2) (in paragraph (1) of the following paragraph referred to as the "Amount of Co-payment, etc.") is extremely large, the Insurer shall pay high-cost medical expenses to the relevant Householder or Society member; provided, however, that this shall not apply if no benefit for medical treatment, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing care or special medical expenses were paid and no difference was paid pursuant to the provisions of Article 56, paragraph (2) with respect to the relevant medical treatment.

- (2) The requirements for payment and the amount of high-cost medical expenses and other necessary matters concerning the payment of high-cost medical

expenses shall be prescribed by Cabinet Order by taking into consideration the impact of the burden of the expenses incurred in the relevant medical treatment on household finances.

(High-Cost Benefits for Medical Treatment Combined with Long-Term Care)

Article 57-3 (1) When the total sum of the Amount of Co-payment, etc. (or, where high-cost medical expenses set forth in paragraph (1) of the preceding Article shall be paid, the amount obtained by deducting the amount so paid from such Amount of Co-payment, etc.) and the amount to be borne by a user of Long-Term Care Service pursuant to the provisions of Article 51, paragraph (1) of the Long-Term Care Insurance Act (or, where expenses for High-Cost Long-Term Care Service set forth in the same paragraph shall be paid, the amount obtained by deducting the amount so paid from such amount to be borne by a user of Long-Term Care Service) and the amount to be borne by a user of Preventive Long-Term Care Service pursuant to the provisions of Article 61, paragraph (1) of the same Act (or, where expenses for High-Cost Preventive Long-Term Care Service set forth in the same paragraph shall be paid, the amount obtained by deducting the amount so paid from such amount to be borne by a user of Preventive Long-Term Care Service) is extremely large, the Insurer shall pay expenses for high-cost medical treatment combined with long-term care to the relevant Householder or Society member; provided, however, that this shall not apply if no benefit for medical treatment, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing care or special medical expenses were paid and no difference was paid pursuant to the provisions of Article 56, paragraph (2) with respect to the medical treatment relevant to such Amount of Co-payment, etc.

(2) The provisions of paragraph (2) of the preceding Article shall apply mutatis mutandis to the payment of medical expenses combined with high-cost long-term care.

Section 2 Other Benefits

Article 58 (1) With respect to an insured person's childbirth or death, the Insurer shall make a childbirth and childcare lump sum payment or pay funeral expenses or grant benefits for funeral services pursuant to the provisions of the applicable Prefectural or Municipal Ordinance or its constitution; provided, however, that all or part of these measures may not be taken when any special reason exists for not doing so.

(2) In addition to the insurance benefits set forth in the preceding paragraph, the Insurer may pay injury and illness benefits or provide any other insurance

benefit pursuant to the provisions of the applicable Prefectural or Municipal Ordinance or its constitution.

- (3) The Insurer may entrust its affairs concerning the payment of the insurance benefits set forth in paragraph (1) and the injury and illness benefits set forth in the preceding paragraph to a Federation of National Health Insurance Associations.

Section 3 Limitation on Insurance Benefits

Article 59 Where a current or former insured person falls under any of the following items, no benefit for medical expenses for Dietary Treatment for inpatients, Living Support expenses for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing, special medical expenses or transport expenses (hereinafter referred to as "Benefits for Medical Treatment, etc." in this Section) shall be provided for the relevant period:

- (1) when such insured person is committed to a juvenile training school or any other institution similar thereto;
- (2) when such insured person is confined to a work facility or any other facility similar thereto.

Article 60 When an insured person suffers illness or injury intentionally, or due to said person committing a criminal act intentionally, no Benefits for Medical Treatment, etc. shall be paid for such illness or injury.

Article 61 When an insured person suffers illness or injury due to a conflict, state of drunkenness or extreme misconduct, Benefits for Medical Treatment, etc. for such illness or injury may not be paid in whole or in part.

Article 62 When a current or former insured person fails to follow instructions concerning medical treatment without a justifiable reason for not doing so, the Insurer may refrain from providing part of the applicable Benefits for Medical Treatment, etc.

Article 63 When a current or former insured person or a person who is to receive insurance benefits fails to comply with an order issued pursuant to the provisions of Article 66 or refuses to answer questions or to undergo a medical examination without a justifiable reason for not doing so, the Insurer may refrain from providing all or part of the applicable Benefits for Medical Treatment, etc.

Article 63-2 (1) In cases where a Householder or Society member who is eligible for insurance benefits (including the payment of a difference pursuant to the provisions of Article 43, paragraph (3) or Article 56, paragraph (2); hereinafter the same shall apply) has become delinquent in the payment of insurance premiums and where said person fails to pay said insurance premiums after the payment due date for said insurance premiums before the elapse of the period specified by Ordinance of the Ministry of Health, Labour and Welfare, the Insurer shall temporarily suspend the payment of insurance benefits in whole or in part pursuant to the provisions of Ordinance of the Ministry of Health Labour and Welfare, unless a disaster or any other special circumstances specified by Cabinet Order are deemed to exist under which such insurance premiums failed to be paid.

(2) In cases where a Householder or Society member who is eligible for insurance benefits has become delinquent in the payment of insurance premiums, the Insurer may, without waiting for the elapse of the period specified by Ordinance of the Ministry of Health, Labour and Welfare as prescribed in the preceding paragraph, temporarily suspend the payment of insurance benefits in whole or in part, unless a disaster or any other special circumstances specified by Cabinet Order are deemed to exist under which such insurance premiums failed to be paid.

(3) In cases where a Householder or Society member to whom a health insurance certificate has been issued pursuant to the provisions of Article 9, paragraph (6) (including cases where applied *mutatis mutandis* pursuant to Article 22) and for whom the payment of insurance benefits has been temporarily suspended in whole or in part pursuant to the provisions of the two preceding paragraphs still fails to pay delinquent insurance premiums, the Insurer may, upon prior notice to such Householder or Society member, deduct the amount of such Householder 's or Society member's delinquent insurance premiums from the amount of insurance premiums whose payment has been so suspended temporarily, pursuant to the provisions of Ordinance of the Ministry of Health Labour and Welfare.

Section 4 Miscellaneous Provisions

(Claims for Damages)

Article 64 (1) When the basis for an expense claim is caused by an act of a third party and an Insurer provides insurance benefits, the Insurer shall obtain, to the extent of the amount of said benefits (or, when such insurance benefits are benefits for medical treatment, the amount calculated by deducting, from the amount of expenses incurred in such benefits for medical treatment, the amount of co-payment to be borne by the insured person with respect to such

benefits for medical treatment; hereinafter the same shall apply in paragraph (1) of the following Article), the right to claim compensation for damages held by an insured person against the third party.

- (2) In the case referred to in the preceding paragraph, when a person to be granted insurance benefit receives compensation for damages for the same reason from a third party, the Insurer shall be exempted from the responsibility to pay said insurance benefit to the extent of the amount of such compensation.
- (3) An Insurer may entrust its affairs concerning the collection or receipt of compensation for damages relating to the right of claim obtained pursuant to the provisions of paragraph (1) to the Federation of National Health Insurance Associations set forth in Article 45, paragraph (5) and prescribed by Ordinance of the Ministry of Health, Labour and Welfare.

(Collection, etc. of Fraudulent Gains)

Article 65 (1) When a person receives any insurance benefit by means of deception or other wrongful conduct, the Insurer may collect all or part of the amount of such benefit from said person.

- (2) In the case referred to in the preceding paragraph, when the insurance benefit is granted because a health insurance-covered physician who is engaged in medical care at a Health Insurance-Covered Medical Institution or an attending physician as set forth in Article 88, paragraph (1) of the Health Insurance Act has made a false entry on the medical certificate which is to be submitted to the Insurer, the Insurer may order said health insurance-covered physicians or attending physicians to pay the money to be collected pursuant to the preceding paragraph jointly and severally with the person who received said insurance benefit.
- (3) When a Health Insurance-Covered Medical Institution or a designated home-nursing provider receives, by means of deception or other wrongful conduct, any payment of expenses relating to benefits for medical treatment or any payment pursuant to the provisions of Article 52, paragraph (3) (including cases where applied mutatis mutandis pursuant to Article 52-2, paragraph (3) and Article 53, paragraph (3)) or Article 54-2, paragraph (5), the Insurer may cause said Health Insurance-Covered Medical Institution, etc. or designated home-nursing provider to refund the amount so paid and to pay, in addition, the amount obtained by multiplying the amount to be refunded by forty hundredths.

(Compulsory Diagnosis, etc.)

Article 66 When an Insurer finds it necessary in relation to an insurance benefit, it may order the relevant current or former insured person or the relevant

person who is to receive said insurance benefit to submit or present a document or any other article or may have its personnel question or diagnose any of the above persons.

(Protection of Rights for Benefits)

Article 67 The right to receive insurance benefits may not be transferred, pledged as collateral, or levied.

(Prohibition of Taxation and Other Public Dues)

Article 68 Taxes and other public dues may not be imposed on the basis of money and goods received as payment of insurance benefits.

Chapter IV-2 Geographic Expansion Support Policy, etc.

(Geographic Expansion Support Policy)

Article 68-2 (1) A prefecture may establish a policy for supporting the Municipalities within its area in order to promote the expansion of geographic coverage of national health insurance services or to promote the financial stability of national health insurance programs (hereinafter referred to as a "Geographic Expansion Support Policy").

(2) Geographic Expansion Support Policies shall generally provide for the following matters:

- (i) basic matters concerning the promotion of the expansion of geographic coverage of national health insurance services or the promotion of the financial stability of national health insurance programs;
- (ii) the current situation and forecast of national health insurance programs;
- (iii) roles to be played by the prefecture in promoting the expansion of geographic coverage of national health insurance services or the financial stability of national health insurance programs, when the current situation and forecast as set forth in the preceding item are taken into account;
- (iv) joint conducting of affairs concerning national health insurance services, appropriate expenses incurred in medical services, improvement of the status of payment of insurance premiums, and other specific measures for promoting the expansion of geographic coverage of national health insurance services or the financial stability of national health insurance programs;
- (v) liaison and coordination between relevant Municipalities necessary for implementing the measures set forth in the preceding item;
- (vi) in addition to what is set forth in the preceding items, matters that the prefecture finds necessary in order to promote the expansion of geographic coverage of national health insurance services or the financial stability of national health insurance programs.

- (3) In cases where there is any Municipality, within the area of the prefecture, whose amount of expenses incurred in medical services is found to be extremely large even after taking into consideration the number and distribution by age group of insured persons and other circumstances pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, the prefecture shall endeavor to ensure appropriate expenses incurred in medical services and to provide other necessary measures in its Geographic Expansion Support Policy as matters listed in item (iv) of the preceding paragraph.
- (4) When intending to establish or change its Geographic Expansion Support Policy, the prefecture must hear the opinions of its Municipalities in advance.
- (5) When a prefecture has established or changed its Geographic Expansion Support Policy, it shall endeavor to announce the same without delay.
- (6) Municipalities shall endeavor to respect the applicable Geographic Expansion Support Policy in providing national health insurance services.
- (7) When a prefecture finds it necessary in relation to the creation of its Geographic Expansion Support Policy or the implementation of the measures provided therein, it may request necessary cooperation from relevant Federations of National Health Insurance Associations and other persons involved.

(Geographical Expansion Support Fund)

Article 68-3 A prefecture may establish a geographical expansion support fund as a fund under Article 241 of the Local Autonomy Act (Act No. 67 of 1947) to be appropriated to expenses incurred in the creation of its Geographic Expansion Support Policy, the implementation of the measures provided therein and other projects contributing to the expansion of geographic coverage of the operation of national health insurance services and to the financial stability of national health insurance programs.

Chapter V Sharing of Costs

(Costs Imposed upon the National Government)

Article 69 Pursuant to Cabinet Order provisions, the national government shall bear the costs incurred by Societies in executing their affairs for national health insurance programs (including affairs concerning the payment of the young-old payment, etc. under the provisions of the Act on Assurance of Medical Care for Elderly People (hereinafter referred to as "Young-Old Payments, etc.") and the old-old aid, etc. under the provisions of the same Act (hereinafter referred to as "Old-Old Aid, etc.") and the payment under the provisions of the Long-Term Care Insurance Act (hereinafter referred to as

"Long-Term Care Payments"))).

Article 70 (1) Pursuant to Cabinet Order provisions, the national government shall bear thirty-two hundredths of the total sum of the amounts listed in the following items, with respect to Municipalities' costs incurred in paying their benefits for medical treatment and their expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing, special medical expenses, transport expenses, high-cost medical expenses and expenses for high-cost medical treatment combined with long-term care (in Article 73, paragraph (1) and Article 104 referred to as "Cost Incurred in Providing Benefits for Medical Treatment, etc.") and the costs incurred in paying the young-old payment under the provisions of the Act on Assurance of Medical Care for Elderly People (hereinafter referred to as "Young-Old Payments") and the old-old aid under the provisions of the same Act (hereinafter referred to as "Old-Old Aid") and the Long-Term Care Payments:

- (i) the amount calculated by deducting the amount equal to one half of the amount to be transferred pursuant to the provisions of Article 72-3, paragraph (1) from the total sum of: (a) the amount calculated by deducting, from the amount of expenses incurred in providing benefits for medical treatment for insured persons, the amount of co-payment relating to such benefits; and (b) the amount of expenses incurred in paying expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing, special medical expenses, transport expenses, high-cost medical expenses and expenses for high-cost medical treatment combined with long-term care;
 - (ii) the amount of expenses incurred in paying Young-Old Payments and Old-Old Aid and Long-Term Care Payments (or, where any young-old subsidy is payable pursuant to the provisions of the Act on Assurance of Medical Care for Elderly People (hereinafter referred to as a "Young-Old Subsidy"), the amount calculated by deducting such Young-Old Subsidy from such amount of expenses).
- (2) With regard to the application of the provisions of the preceding paragraph to a Municipality which has reduced the ratios for co-payment pursuant to the provisions of Article 43, paragraph (1) or to a Municipality for which the prefecture or the Municipality itself has chosen to bear all or part of the amount of the co-payment to be made by all or part of the insured persons, the amount listed in item (1) of the preceding paragraph shall be the amount listed in the same item calculated pursuant to Cabinet Order provisions as if the

relevant measures to reduce the ratios for co-payment or to bear all or part of the amount of co-payment were not taken.

(Reduction of the Share of the National Treasury)

Article 71 (1) In cases where a Municipality unjustly fails to secure its income that it should have secured, the national government may, pursuant to Cabinet Order provisions, reduce the amount of the share of the national treasury payable to such Municipality pursuant to the provisions of the preceding Article.

(2) The amount of reduction permitted pursuant to the preceding paragraph may not exceed the amount of income which unjustly failed to be secured.

(Adjusting Subsidies, etc.)

Article 72 (1) The national government shall provide adjusting subsidies to Municipalities pursuant to Cabinet Order provisions in order to adjust the finances of national health insurance programs.

(2) The total amount of adjusting subsidies to be provided pursuant to the provisions of the preceding paragraph shall be the total sum of the amounts listed in the following items:

(1) the amount equal to nine hundredths of the total estimated sum of the amount listed in Article 70, paragraph (1), item (i) (or, where the provisions of paragraph (2) of the same Article apply, the amount calculated by applying the provisions of the same paragraph) and the amount listed in item (ii) of paragraph (1) of the same Article (in the following Article referred to as the "Amount for Calculation");

(2) the amount equal to one-fourth of the total amount to be transferred pursuant to the provisions of Article 72-3, paragraph (1).

Article 72-2 (1) Each prefectural government shall, by Prefectural Ordinance, provide prefectural adjusting subsidies to the Municipalities within the area of the prefecture pursuant to Cabinet Order provisions, in order to adjust the finances of national health insurance programs provided by such Municipalities.

(2) The total amount of the prefectural adjusting subsidies to be provided pursuant to the provisions of the preceding paragraph shall be equal to nine hundredth of the Amount for Calculation.

(3) In providing prefectural adjusting subsidies, each prefecture shall endeavor to ensure the consistency with its Geographic Expansion Support Policy (or, where such prefecture has issued a recommendation pursuant to the provisions of Article 245-4, paragraph (1) of the Local Autonomy Act in order to implement the measures provided in its Geographic Expansion Support Policy,

said Geographic Expansion Support Policy and the content of such recommendation).

(Transfer, etc. to Special Account for National Health Insurance)

Article 72-3 (1) Each Municipality shall, pursuant to Cabinet Order provisions, transfer from its general fund to a special account for its national health insurance program, an amount calculated, pursuant to Cabinet Order provisions, based on the total amount of insurance premiums relating to insured persons or the national health insurance tax under the provisions of the Local Tax Act, in each case after reductions have been made through reduced assessments of insurance premiums with respect to persons with small income pursuant to the provisions of a Municipal Ordinance or through any reduction of national health insurance tax as set forth in Article 703-5 of the same Act and by taking into consideration the financial condition of the national health insurance program and other circumstances.

(2) Each prefecture shall, pursuant to Cabinet Order provisions, bear an amount equal to three-fourths of the amount to be transferred pursuant to the provisions of the preceding paragraph.

Article 72-4 The national government and each prefecture shall, pursuant to Cabinet Order provisions, bear an amount equal to one-third of the expenses required by each Municipality for the specified health checkups provided pursuant to the provisions of Article 20 of the Act on Assurance of Medical Care for Elderly People and the specified health guidance provided pursuant to the provisions of Article 24 of the same Act (in Article 82, paragraph (1) and Article 86 referred to as "Specified Health Checkups, etc."), to the extent that such expenses are specified by Cabinet Order.

(Assistance to Societies)

Article 73 (1) The national government may, pursuant to Cabinet Order provisions, provide assistance to each Society in the total sum of the amounts listed in the following items with respect to the Cost Incurred in Providing Benefits for Medical Treatment, etc. and the expenses incurred in paying Young-Old Payments and Old-Old Aid and Long-Term Care Payments:

(i) the amount equal to thirty-two hundredths of the total sum of the following amounts:

(a) the amount obtained by deducting, from (1) the total sum of: (i) the amount calculated by deducting, from the expenses incurred in providing benefits for medical treatment, the amount of co-payment relating to such benefits; and (ii) the amount of expenses incurred in paying the expenses for Dietary Treatment for inpatients, Living Support expenses for

inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing, special medical expenses, transport expenses, high-cost medical expenses and expenses for high-cost medical treatment combined with long-term care, (2) an amount calculated pursuant to Cabinet Order provisions as the amount of such portion of said total sum as relating to the Society's Specified Insured Persons (meaning persons who are insured persons covered by such Society as a result of not being eligible as insured persons under the Health Insurance Act upon the approval under the provisions of item (viii) of paragraph (1) of Article 3 or the proviso of paragraph (2) of the same Article of the same Act as well as insured persons covered by such Society who belong to the above insured persons' respective families; the same shall apply in (b)) (hereinafter referred to as the "Specified Benefit Amount" in this Article);

(b) the amount calculated by deducting, from the amount of expenses incurred in paying Young-Old Payments and Old-Old Aid and Long-Term Care Payments (or, where any Young-Old Subsidy is payable, the amount calculated by deducting such Young-Old Subsidy from such amount of expenses), the amount calculated pursuant to Cabinet Order provisions as the amount of such portion of said amount of expenses as relating to the Society's Specified Insured Persons (hereinafter referred to as the "Specified Amount of Payment Cost" in this Article);

(ii) the total sum of the amount obtained by multiplying the Specified Benefit Amount by a specified ratio and the amount obtained by multiplying the Specified Amount of Payment Cost by a specified ratio.

(2) The specified ratio as referred to in item (ii) of the preceding paragraph shall be less than thirty-two hundredths and shall be prescribed by Cabinet Order separately for the Specified Benefit Amount and the Specified Amount of Payment Cost by taking into consideration the proportion of assistance provided by the national government pursuant to the Health Insurance Act with respect to expenses incurred in health insurance services (including expenses incurred in paying Young-Old Payments and Old-Old Aid and Long-Term Care Payments).

(3) With regard to the application of the provisions of paragraph (1) to a Society which has reduced the ratios for co-payment pursuant to the provisions of Article 43, paragraph (1) or to a Society which has chosen to bear all or part of the amount of the co-payment to be made by all or some of its insured persons, the amount listed in (a) of item (1) of the same paragraph and the Specified Benefit Amount shall be the amount listed in (a) of the same item and the Specified Benefit Amount, respectively, calculated pursuant to Cabinet Order provisions as if the relevant measures to reduce the ratios for co-payment or to

bear all or part of the amount of co-payment were not taken.

- (4) In cases where providing assistance as set forth in paragraph (1), the national government may, pursuant to Cabinet Order provisions, increase the amount of assistance set forth in the same paragraph by taking into account the financial capability, etc. of the relevant Society.
- (5) The total amount by which the amount of assistance may be increased pursuant to the preceding paragraph shall be within the amount equal to fifteen hundredths of the total estimated amount of: the amount listed in (a) of item (i) of paragraph (1) and the Specified Benefit Amount (or, where the provisions of paragraph (3) applies to these amounts, the amount calculated by applying the provisions of the same paragraph); and the total sum of the amount listed in (b) of the same item and the Specified Amount of Payment Cost.

(Assistance by the National Government)

Article 74 In addition to what is provided for in Articles 69, 70, 72 and 72-4 and the preceding Article, the national government may, within the limits of its budget, assist with one-third of the expenses for public health nurses and with part of the other expenses for national health insurance services.

(Assistance and Lending by Prefectural and Municipal Governments)

Article 75 In addition to what is provided for in Article 72-2, Article 72-3, paragraph (2) and Article 72-4, a prefectural or municipal government may provide subsidies or loans with respect to expenses incurred in national health insurance services (including expenses incurred in paying Young-Old Payments and Old-Old Aid and Long-Term Care Payments).

(Insurance Premiums)

- Article 76 (1) Each Insurer shall collect from the Householder s or Society members insurance premiums to be allocated to expenses for its national health insurance services (including expenses incurred in paying Young-Old Payments and Old-Old Aid and Long-Term Care Payments and, in the case of a Society set forth in Article 179 of the Health Insurance Act, including expenses incurred in paying day worker contributions collected pursuant to the provisions of the same Act); provided, however, that this shall not apply if any national health insurance tax is imposed pursuant to the provisions of the Local Tax Act.
- (2) Of the insurance premiums collected pursuant to the provisions of the preceding paragraph, those to be allocated to expenses incurred in paying Long-Term Care Payments shall be imposed with respect to insured persons who fall under the category of insured person as set forth in Article 9, item (ii)

of the Long-Term Care Insurance Act.

(Date for Assessment)

Article 76-2 The date for assessment of insurance premiums collected by Municipalities as set forth in the preceding Article shall be the first day of the relevant fiscal year.

(Method of Collection of Insurance Premiums)

Article 76-3 (1) Collection of the insurance premiums set forth in Article 76 by a Municipality must be by means of ordinary collection (meaning that the Municipality collects the insurance premiums by giving payment advice to Householders pursuant to the provisions of Article 231 of the Local Autonomy Act; hereinafter the same shall apply), except in cases where a means of special collection (meaning that the Municipality has a person who shall pay the Old Age, etc. Pension Benefit: collect the insurance premiums from Heads of Households who are insured persons who receive said Old Age, etc. Pension Benefit (excluding those who are prescribed by Cabinet Order); and pay to the Municipality the insurance premiums to be collected by said Municipality; hereinafter the same shall apply) shall be used.

(2) The Old Age, etc. Pension Benefit as referred to in the preceding paragraph means the Old Age Basic Pension under the National Pension Act and other benefits which are provided in the form of a pension due to old age, retirement, disability or death under the same Act, the Welfare Pension Insurance Act (Act No. 115 of 1954), the National Public Servants Mutual Aid Association Act, the Local Public Care Service Mutual Aid Association Act or the Private School Personnel Mutual Aid Association Act and which are prescribed by Cabinet Order as well as benefits which are similar to these benefits provided in the form of a pension and are provided in the form of a pension due to old age, retirement, disability or death and which are prescribed by Cabinet Order.

(Application Mutatis Mutandis of the Long-Term Care Insurance Act)

Article 76-4 The provisions of Articles 134 through 141-2 of the Long-Term Care Insurance Act shall apply mutatis mutandis to any special collection of insurance premiums implemented pursuant to the provisions of the preceding Article. In such a case, any necessary technical replacement of terms shall be specified by Cabinet Order.

(Reduction of and Exemption from Insurance Premiums)

Article 77 An Insurer may, pursuant to the provisions of a Prefectural or Municipal Ordinance or its constitution, reduce insurance premiums or excuse payment or suspend collection thereof with respect to a person subject to

special circumstances.

(Application Mutatis Mutandis of the Local Tax Act)

Article 78 The provisions of Articles 9, 13-2, 20, 20-2 and 20-4 of the Local Tax Act shall apply mutatis mutandis to all insurance premiums and other monies to be collected pursuant to the provisions of this Act (excluding the contributions set forth in Article 10, paragraph (1) of the Supplementary Provisions; the same shall apply in Article 91, paragraph (1)).

(Demand for Payment and Collection of Delinquent Charges)

Article 79 (1) With respect to any person who has become delinquent in the payment of insurance premiums or any other money to be collected pursuant to the provisions of this Act, the Society shall demand payment thereof by designating a due date; provided, however, that this shall not apply if any advanced collection is made pursuant to the provisions of Article 13-2, paragraph (1) of the Local Tax Act as applied mutatis mutandis pursuant to the preceding Article.

(2) When intending to make a demand pursuant to the provisions of the preceding paragraph, the Society must issue a written demand to the person liable for the payment. In this case, the payment due date to be designated in the written demand must be a date at least ten days after the day on which such written demand is issued, except in cases falling under any of the items of paragraph (1) of Article 13-2 of the Local Tax Act.

(3) When demand for payment is made pursuant to the provisions of the preceding paragraph, the Society may collect a delinquent charge pursuant to the provisions of its constitution.

(Delinquency Disposition)

Article 79-2 Insurance premiums collected by Municipalities and other monies collected pursuant to the provisions of this Act shall constitute revenue specified by law as set forth in Article 231-3, paragraph (3) of the Local Autonomy Act.

Article 80 (1) When a person who is liable for payment and has received a demand pursuant to the provisions of Article 79 or notice of advanced collection as a result of falling under any of the items of paragraph (1) of Article 13-2 of the Local Tax Act fails to make, by the designated due date, full payment of the money to be collected, the Society may take action against such person upon the authorization of the prefectural governor or may request the Municipality in which the person liable for payment is domiciled or in which said person's assets are located to take such action.

- (2) In cases where the Society takes action pursuant to the provisions of the preceding paragraph, the provisions of the first sentence of paragraph (3) of Article 231 and paragraph (10) of the same Article of the Local Autonomy Act shall apply mutatis mutandis.
- (3) In cases where the Society requests the Municipality to take action against the relevant person pursuant to the provisions of paragraph (1), said Municipality shall take action against such person pursuant to the same rules as those for insurance premiums collected by such Municipality. In this case, the Society must provide an amount equal to four hundredths of the amount of money so collected to such Municipality.
- (4) Statutory lien assigned to insurance premiums and any other money collected by a Society pursuant to the provisions of this Act shall come after national tax and local tax.

(Entrustment of the Collection of Insurance Premiums)

Article 80-2 A Municipality may, pursuant to Cabinet Order provisions, entrust its affairs for the collection of insurance premiums by means of ordinary collection to a private person where and only where it is found that such entrustment will contribute to the assurance of income and to the promotion of the convenience of insured persons.

(Delegation to Prefectural or Municipal Ordinance or Society's Constitution)

Article 81 In addition to what is provided for in this Chapter, the amount of assessment, rates, due dates, reduced assessment and other matters concerning the assessment, collection, etc. of insurance premiums shall be prescribed by Prefectural or Municipal Ordinance or the Society's constitution in accordance with the standards specified by Cabinet Order.

Chapter VI Healthcare Services

Article 82 (1) An Insurer shall provide Specified Health Checkups, etc. and must also endeavor to provide other services consisting of health education, health counseling, health checkups and other services necessary to maintain and promote the health of insured persons.

- (2) An Insurer may provide on loan tools necessary for the medical treatment of an insured person and other services necessary to improve the medical treatment environment for an insured person, services necessary to provide insurance benefits, and financing for expenses and other necessary services for the medical treatment or childbirth of an insured person.
- (3) A Society may allow persons who are not insured persons to use these services where and only where this does not hinder the services referred to in the two

preceding paragraphs.

- (4) With respect to the services necessary for the maintenance and promotion of health to be provided by Insurers pursuant to the provisions of paragraph (1), the Minister of Health, Labour and Welfare shall publish guidelines necessary for the proper and effective performance of such services.
- (5) The guidelines referred to in the preceding paragraph shall be harmonized with the Health Checkup Guidelines, etc. set forth in Article 9, paragraph (1) of the Health Promotion Act (Act No. 103 of 2002).

Chapter VII Federation of National Health Insurance Associations

(Establishment, Personality and Name)

Article 83 (1) Insurers may establish a Federation of National Health Insurance Associations (hereinafter referred to as a "Federation") in order to jointly achieve their purposes.

(2) A Federation shall be a corporation.

(3) A Federation shall use the characters "国民健康保険団体連合会" (pronounced "kokumin kenko hoken dantai rengo kai" (literally meaning "federation of national health insurance associations")) in its name.

(4) No person other than a Federation may use the name "kokumin kenko hoken dantai rengo kai" or any name similar thereto.

(Authorization for Establishment, etc.)

Article 84 (1) Establishment of a Federation is subject to the authorization of the prefectural governor governing the prefecture whose area includes the district of such Federation.

(2) A Federation shall be incorporated at the time of authorization of its establishment.

(3) When the membership of a Federation whose district covers the area of a prefecture has reached two-thirds or more of all insured persons within such district, all other insured persons within such district shall automatically become members of such Federation.

(Particulars to be Stated in the Constitution)

Article 85 The constitution of a Federation must state the particulars listed in the following items:

(i) services;

(ii) name;

(iii) location of the office;

(iv) district of the Federation;

(v) particulars pertaining to the joining and withdrawal of members;

- (vi) particulars pertaining to the sharing of expenses;
- (vii) particulars pertaining to carrying out business and accounting;
- (viii) particulars pertaining to officers;
- (ix) particulars pertaining to general meetings or the board of representatives;
- (x) particulars pertaining to reserves and other assets;
- (xi) means for giving public notice;
- (xii) in addition to the particulars listed in the preceding items, particulars specified by Ordinance of the Ministry of Health, Labour and Welfare.

(Provisions Applied Mutatis Mutandis)

Article 86 The provisions of Article 16, Articles 23 through 25, Article 26, paragraph (1), Articles 27 through 35 and Article 82 (excluding those relating to Specified Health Checkups, etc.) shall apply mutatis mutandis to a Federation. In this case, the terms "Society member" and "Society members" in these provisions shall be deemed to be replaced with "person representing insured persons who are members" and "persons representing insured persons who are members," respectively; the term "Society meeting" in the same provisions shall be deemed to be replaced with "general meeting or the board of representatives"; and the terms "Society council member" and "Society council members" in these provisions shall be deemed to be replaced with "member of a general meeting or board of representatives" and "members of a general meeting or board of representatives," respectively.

Chapter VIII Medical Fees Review Committee

(Review Committee)

Article 87 (1) In order to review medical bills as entrusted pursuant to the provisions of Article 45, paragraph (5), a Federation whose district covers the area of a prefecture (excluding any such Federation the number of whose member Insurers is less than two-thirds of the total number of Insurers located within its district) shall have a National Health Insurance Medical Fees Review Committee (hereinafter referred to as the "Review Committee").

(2) A Federation may, as far as not hindering the carrying out of the affairs set forth in the preceding paragraph, have the Review Committee conduct the review of medical bills to be conducted as entrusted pursuant to the provisions of Article 76, paragraph (5) of the Health Insurance Act.

(Organization of the Review Committee)

Article 88 (1) The Review Committee shall be composed of committee members representing health insurance-covered physicians and health insurance-covered pharmacists, committee members representing Insurers, and

committee members representing the public interest, each category having the same number of committee members as specified by the prefectural governor.

- (2) Committee members shall be commissioned by the prefectural governor.
- (3) Committee members representing health insurance-covered physicians and health insurance-covered pharmacists and committee members representing Insurers must be commissioned pursuant to the preceding paragraph based on recommendations made by concerned organizations in each category.

(Authority of the Review Committee)

Article 89 (1) When the Review Committee finds it necessary in order to review medical bills, it may, upon the approval of the prefectural governor, request the relevant Health Insurance-Covered Medical Institution, etc. or the relevant office providing designated home-nursing to make a report or submit or present medical records or other the books and other documents, or may request any of the establishers or managers of such Health Insurance-Covered Medical Institution, etc., the designated home-nursing provider, or any of the health insurance-covered physicians or health insurance-covered pharmacists who are in charge of medical treatment at such Health Insurance-Covered Medical Institution, etc. to appear or provide an explanation.

- (2) Federation must pay travel expenses, daily expenses and accommodation expenses to any person who appeared at the Review Committee pursuant to the provisions of the preceding paragraph; provided, however, that this shall not apply to any person who appeared in response to a request for appearance issued due to defective or misleading entries in medical bills or medical records or other the books and other documents submitted by the relevant Health Insurance-Covered Medical Institution, etc. or the relevant office providing designated home-nursing.

(Delegation to Ministerial Ordinance)

Article 90 In addition to what is provided for in this Chapter, necessary particulars concerning the Review Committee shall be prescribed by Ordinance of the Ministry of Health, Labour and Welfare.

Chapter IX Application for Examination

(Application for Examination)

Article 91 (1) A person who is dissatisfied with any action with respect to an insurance benefit (including action with respect to an application for issuance or return of a health insurance card) or any action with respect to insurance premiums or any other money collected pursuant to the provisions of this Act may file an application for examination with the National Health Insurance

Examination Board.

- (2) An application for examination as referred to in the preceding paragraph shall be deemed to be a judicial claim in terms of interruption of prescription.

(Establishment of an Examination Board)

Article 92 Each prefecture shall have a National Health Insurance Examination Board (hereinafter referred to as an "Examination Board").

(Organization)

- Article 93 (1) Examination Boards shall be composed of three committee members representing insured persons, three committee members representing Insurers, and three committee members representing the public interest.
- (2) Committee members shall serve on a part-time basis.

(Term of Office of Committee Members)

- Article 94 (1) The term of office of committee members shall be three years; provided, however, that the term of office of a substitute committee member shall be the remaining term of said member's predecessor.
- (2) Committee members may be reappointed.

(Chairperson)

- Article 95 (1) The Examination Board shall have one chairperson to be elected by the committee members from among the committee members representing the public interest.
- (2) When the chairperson is unable to perform their duties, a person elected in accordance with the provisions of the preceding paragraph shall perform the duties of the chairperson on their behalf.

(Quorum)

Article 96 The Examination Board may not commence proceedings or make any resolution without the attendance of a majority of committee members including one or more committee members representing insured persons, one or more committee members representing Insurers and one or more committee members representing the public interest.

(Voting)

Article 97 Examination Board decisions shall be made by a majority of the committee members present and, in the case of a tie, the chairman shall reach a verdict on said tie.

(Examination Board of Competent Jurisdiction)

Article 98 (1) An application for examination must be filed with the Examination Board of the prefecture governing the location of the Insurer which took the relevant action (or, in the case of action taken pursuant to the provisions of Article 80, paragraph (3), the Municipality which took such action).

(2) When an Examination Board lacks jurisdiction over the matters for which an application for examination has been filed with said Examination Board, it must promptly transfer the case to the Examination Board of the competent jurisdiction and must also notify the person who filed the application for examination of such transfer.

(3) When a case is transferred, the application for examination shall be deemed to have been filed originally with the Examination Board to which such case is transferred.

(Term and Means of Application for Examination)

Article 99 An application for examination must be filed in writing or orally within a period of sixty days from the day following the date that the relevant action was taken, to the applicant's knowledge; provided, however, that this shall not apply if the applicant makes a prima facie showing that an application could not have been filed within such period for a justifiable reason.

(Notice to Insurer)

Article 100 Upon receipt of an application for examination, the Examination Board must give notice to the Insurer who took the original action and other interested persons.

(Disposition for Proceedings)

Article 101 (1) When the Examination Board finds it necessary to conduct proceedings, it may request a report or an opinion from the person who filed the application for examination or any person concerned, may order any of these persons to appear for inquiry, or may direct a physician or dentist to perform a diagnosis or examination.

(2) To any person concerned who appeared at the Examination Board or any physician or dentist who performed diagnosis or examination pursuant to the provisions of the preceding paragraph, the prefecture must pay said person's travel expenses, daily expenses and accommodation expenses or remuneration pursuant to Cabinet Order provisions.

(Delegation to Cabinet Order)

Article 102 In addition to what is provided for in this Chapter and the Administrative Appeal Act (Act No. 160 of 1962), necessary particulars concerning the Examination Board and the procedures for filing an application

for examination shall be prescribed by Cabinet Order.

(Relationship between Application for Examination and Litigation)

Article 103 No action for revocation of the action set forth in Article 91, paragraph (1) may be filed until a determination has been made on an application for examination of such action.

Chapter IX-2 Assistance, etc. for Healthcare Services, etc.

(Assistance, etc. for Healthcare Services, etc.)

Article 104 Each Federation and each association and foundation designated by the Minister of Health, Labour and Welfare as set forth in Article 45, paragraph (6) (hereinafter simply referred to as a "Designated Association") must, in order to promote the stable operation of national health insurance services, endeavor to conduct research and study regarding the services set forth in paragraphs (1) and (2) of Article 82, services to make expenses incurred in providing benefits for medical treatment, etc. reasonable and other services provided by Municipalities (hereinafter referred to as "Healthcare Services, etc." in this Article) and to carry out liaison and coordination among Municipalities involved in the implementation of Healthcare Services, etc., as well as to dispatch persons with specialized skills and knowledge and to provide information and other necessary assistance for Healthcare Services, etc.

(Measures by National and Local Governments)

Article 105 The national and local governments must strive to give advice, provide information and take other measures necessary to promote the services provided by a Federation or Designated Association pursuant to the provisions of the preceding Article.

Chapter X Supervision

(Collection of Reports, etc.)

Article 106 (1) The Minister of Health, Labour and Welfare or the prefectural governor may, when finding it necessary with respect to an Insurer or a Federation, collect a report on the status of services and assets thereof or may have personnel inspect such status on-site.

(2) In cases where an inspection is conducted pursuant to the preceding paragraph, the relevant personnel shall carry an identification card and must present it at the request of any person concerned.

(3) The authority under paragraph (1) must not be construed as granted for criminal investigation.

(Reports on the Status of Services)

Article 107 Each Insurer and Federation must, pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, report the status of its services to the prefectural governor.

(Supervision of Societies, etc.)

Article 108 (1) In cases where a report is collected or an inspection is conducted pursuant to the provisions of Article 106, when the Minister of Health, Labour and Welfare or the prefectural governor finds that the Society's or Federation's management or performance of its services or assets violates any law or regulation, its constitution, or any action of the Minister of Health, Labour and Welfare or the prefectural governor, or that the Society or Federation has unjustly failed to secure the income that it should have secured, has unjustly incurred expenses, has unjustly disposed of its assets or has otherwise significantly failed to perform its services properly, or that the officers of the Society or Federation have evidently failed to manage or perform its services or assets, then the Minister of Health, Labour and Welfare or the prefectural governor may order the Society or Federation or its officers to take measures necessary to correct the violation regarding, or improve, the management or performance of its services or assets within a specified period.

(2) If the Society or Federation or its officers violate the order set forth in the preceding paragraph, the Minister of Health, Labour and Welfare or the prefectural governor may order such Society or Federation to replace all or some of its officers within a specified period.

(3) When the Society or Federation violates the order set forth in the preceding paragraph, the Minister of Health, Labour and Welfare or the prefectural governor may replace the officer(s) relevant to the order set forth in the same paragraph.

(4) When the Society or Federation violates the order set forth in paragraph (1) or finds it difficult to continue its services due to the status of its services or assets, the Minister of Health, Labour and Welfare or the prefectural governor may order such Society or Federation to be dissolved.

Article 109 Deleted.

Chapter XI Miscellaneous Provisions

(Prescription)

Article 110 (1) The right to collect insurance premiums and other monies to be collected pursuant to the provisions of this Act or to receive refunds of such

monies and the right to receive insurance benefits shall be extinguished by prescription after a lapse of two years.

- (2) Notwithstanding the provisions of Article 153 of the Civil Code (Act No. 89 of 1896), any notice of collection of, or any demand for, insurance premiums or any other money to be collected pursuant to the provisions of this Act shall have the effect of interruption of prescription.

(Calculation of a Term)

Article 111 The provisions of the Civil Code concerning the calculation of a term shall apply mutatis mutandis to the calculation of a term prescribed in this Act or in any order issued under this Act.

(Free Certification Relating to Family Registers)

Article 112 The head of a Municipality (or, in the case of a special ward or in the case of a designated city as set forth in Article 252-19, paragraph (1) of the Local Autonomy Act, the head of a ward) may issue, free of charge, a certificate concerning the family register of a current or former insured person to the Insurer or the person who receives insurance benefits, pursuant to the provisions of Ordinance of such Municipality.

(Submission, etc. of Documents)

Article 113 When an Insurer finds it necessary in relation to an insured person's eligibility, insurance benefit or insurance premiums, it may order the current or former Householder or Society member to submit or present a document or any other article or may have its personnel question such Householder or Society member.

(Provision, etc. of Materials)

Article 113-2 (1) When a Municipality finds it necessary in relation to an insured person's eligibility, insurance benefit or insurance premiums, it may request a public agency to provide access to necessary documents or to provide necessary materials or may request a report from a bank, trust company or any other institution or the insured person's employer or any other person involved, concerning the status of assets or income of such insured person or of the Householder of the household to which such insured person belongs or concerning any change in the type of insured person under the National Pension or concerning the status of payment of insurance premiums pursuant to the provisions of the National Pension Act.

- (2) When a Municipality finds it necessary in relation to an insured person's eligibility, it may request another Municipality or any Society or any Insurer or mutual aid association under the provisions of any of the Acts listed in items

(i) through (iii) of Article 6, or the Promotion and Mutual Aid Corporation for Private Schools of Japan, which shall administer the Private School Personnel Mutual Aid System pursuant to the provisions of the Private School Personnel Mutual Aid Association Act, to provide the name and address of an insured person covered by the National Health Insurance provided by such another Municipality or Society, or an insured person covered by health insurance or seaman's insurance or said person's dependent, or a member of a mutual aid association or said member's dependent, or a subscriber to the Private School Personnel Mutual Aid System or said subscriber's dependent, the name and location of the applicable office as set forth in Article 3, paragraph (3) of the Health Insurance Act, or any other necessary materials.

(Presentation, etc. of Medical Records)

Article 114 (1) When the Minister of Health, Labour and Welfare finds it necessary in relation to an insurance benefit, said minister may order any physician, dentist or pharmacist or any person who gave treatment or any person who employs any of the above to make a report or present medical records, the books and other documents or any other article, or may have personnel question any of the above persons, regarding the medical care or medication or treatment provided by the relevant person.

(2) When the Minister of Health, Labour and Welfare or the prefectural governor finds it necessary, said minister or governor may order a current or former insured person who received payment of benefits for medical treatment or expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing or special medical expenses to make a report or may have personnel question such insured person, regarding the content of the medical care, preparation of drugs or designated home-nursing relevant to the payment of said benefit for medical treatment or said expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses for home-nursing or special medical expenses.

(Provisions Applied Mutatis Mutandis)

Article 115 The provisions of Article 106, paragraph (2) and those of Article 106, paragraph (3) shall apply mutatis mutandis to questions asked and the authority granted, respectively, pursuant to the provisions of the two preceding Articles.

(Special Provisions for Insured Persons Attending School)

Article 116 An insured person who is domiciled in the area of a Municipality in

order to attend school and who would, if said person did not so attend school, be found to belong to the same household as another person who is domiciled in the area of another Municipality shall, notwithstanding the provisions of Article 5, be an insured person covered by the national health insurance program provided by said other Municipality and shall be deemed to belong to said household for the purpose of the application of this Act.

(Special Provisions for Insured Persons Hospitalized or Admitted to Hospital or During a Hospital Stay, etc.)

Article 116-2 (1) An insured person whose domicile is found to have been changed to the location of a hospital, clinic or institution listed in the following items (hereinafter referred to as "Hospital, etc." in this Article) due to the fact that said person was hospitalized or admitted to or moved to said place as listed in such items (hereinafter referred to as "Hospitalized, etc." in this Article) and who is found to have been domiciled in the area of another Municipality (meaning any Municipality other than that in which such Hospital, etc. is located) at the time when said person was Hospitalized in such Hospital, etc. shall be an insured person covered by the national health insurance program provided by said other Municipality, notwithstanding the provisions of Article 5; provided, however, that this shall not apply to an insured person who has been Hospitalized, etc. in two or more Hospitals, etc. successively and whose domicile is, due to the fact that said person was Hospitalized, etc. in a different Hospital, etc. immediately before being Hospitalized, etc. in the current Hospital, etc. (hereinafter referred to as the "Current Hospital, etc." in this Article) (hereinafter referred to as the "Last Hospital, etc." in this paragraph) and whose domicile is found to have been sequentially changed to the location Last Hospital, etc. and then to that of the Current Hospital, etc. (in the following paragraph referred to as a "Specified Continuously Hospitalized Insured Person").

(i) hospitalization or admission to a clinic;

(ii) admission to a child welfare institution as set forth in Article 7, paragraph (1) of the Child Welfare Act (Act No. 164 of 1947) (limited to cases where admission measures are taken pursuant to the provisions of Article 27, paragraph (1), item (iii) or Article 27-2 of the same Act);

(iii) admission to support facilities for persons with disabilities as set forth in Article 5, paragraph (12) of the Services and Supports for Persons with Disabilities Act (Act No. 123 of 2005) or the facilities prescribed by Ordinance of the Ministry of Health, Labour and Welfare as set forth in paragraph (1) of the same Article;

(iv) admission to the facilities established by the Nozominosono National Center for Persons with Severe Intellectual Disabilities Incorporated

- Administrative Agency, pursuant to the provisions of Article 11, item (i) of the Act for the Nozominosono National Center for Persons with Severe Intellectual Disabilities Incorporated Administrative Agency (Act No. 167 of 2002);
- (v) admission to a nursing home for the elderly or an intensive care home for the elderly as set forth in Article 20-4 or Article 20-5, respectively, of the Public Aid for the Aged Act (Act No. 133 of 1963) (limited to cases where admission measures are taken pursuant to the provisions of Article 11, paragraph (1), item (i) or (ii) of the same Act);
 - (vi) moving into a Specified Facility as set forth in Article 8, paragraph (11) of the Long-Term Care Insurance Act (excluding a Fee-Based Home for the Elderly as set forth in Article 29, paragraph (1) of the Public Aid for the Aged Act which is rental housing intended for the elderly that has been registered under Article 5, paragraph (1) of the Act on Stable Supply of Residences for the Elderly (Act No. 26 of 2001) (limited to a Fee-Based Home for the Elderly which has not been designated under the main clause of paragraph (1) of Article 41 of the Long-Term Care Insurance Act as a provider engaged in the business of providing Daily Life Long-Term Care Admitted to a Specified Facility as set forth in Article 8, paragraph (11) of the Long-Term Care Insurance Act)) or admission to a Facility Covered by Long-Term Care Insurance as set forth in Article 8, paragraph (24) of the same act.
- (2) Notwithstanding the provisions of Article 5, a Specified Continuously Hospitalized Insured Person who falls under any of the following items shall be an insured person covered by the national health insurance program provided by the Municipality set forth in the relevant item:
- (i) an insured person whose domicile is, due to the fact that said person was Hospitalized, etc. in two or more Hospitals, etc. continuously, found to have been sequentially changed to the locations of the respective Hospitals, etc. and who is found to have been domiciled in the area of another Municipality (meaning any Municipality other than that in which the Current Hospital, etc. is located) at the time when said person was Hospitalized, etc. in the first of such two or more Hospitals, etc.: said other Municipality;
 - (ii) an insured person whose domicile is, in association with the fact that said person was Hospitalized, etc. in one of the two or more Hospitals, etc. in which said person has been continuously hospitalized into another Hospital, etc. with no break (hereinafter referred to as "Continuous Hospitalization, etc." in this item), found to have been changed from a place other than the location of said Hospital, etc. to the location of said other Hospital, etc. (hereinafter referred to as "Specified Change of Domicile" in this item) and who is found to have domiciled in the area of another Municipality (meaning any Municipality other than that in which the Current Hospital, etc. is

located) at the time of the most recent Specified Change of Domicile: said another Municipality.

- (3) A Hospital, etc. in which an insured person to which the provisions of the two preceding paragraphs apply is Hospitalized, etc. must provide the necessary cooperation to the Municipality in which such Hospital, etc. is located and the Municipality which provides a national health insurance program to such insured person.

(Provisions on Replacement of Terms)

Article 117 In this Act, the term "a prefectural governor" or "the prefectural governor" shall be deemed to be replaced with "the Minister of Health, Labour and Welfare" in the case of a Federation whose district extends over the area of two or more prefectures.

(Delegation of Authority)

Article 118 (1) The authority of the Minister of Health, Labour and Welfare provided for in this Act may be delegated to the Director-General of the relevant Regional Bureau of Health and Welfare pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare.

- (2) The authority delegated to the Director-General of such Regional Bureau of Health and Welfare pursuant to the provisions of the preceding paragraph may be delegated to the Director-General of the relevant Regional Branch Bureau of Health and Welfare pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare.

(Coordination between the Minister of Health, Labour and Welfare and Prefectural Governors)

Article 119 When the Minister of Health, Labour and Welfare or a prefectural governor conducts any of the affairs specified in Article 41, paragraph (1) (including cases where applied mutatis mutandis pursuant to Article 52, paragraph (6), Article 52-2, paragraph (3), Article 53, paragraph (3) and Article 54-3, paragraph (2)) and paragraph (2) (including cases where applied mutatis mutandis pursuant to Article 45-2, paragraph (4), Article 52, paragraph (6), Article 52-2, paragraph (3), Article 53, paragraph (3) and Article 54-3, paragraph (2)), Article 45-2, paragraph (1) (including cases where applied mutatis mutandis pursuant to Article 52, paragraph (6), Article 52-2, paragraph (3), Article 53, paragraph (3) and Article 54-3, paragraph (2)), Article 54-2-2 (including cases where applied mutatis mutandis pursuant to Article 54-3, paragraph (2)), Article 54-2-3, paragraph (1) (including cases where applied mutatis mutandis pursuant to Article 54-3, paragraph (2)) and Article 114, paragraph (2) pursuant to these provisions, the relevant affairs

shall be conducted under mutually close coordination.

(Classification of Affairs)

Article 119-2 The affairs which shall be handled by a prefecture pursuant to the provisions of Article 17, paragraph (1) and paragraph (3) (including cases where applied mutatis mutandis pursuant to Article 27, paragraph (3)), Articles 24-4 and 24-5, Article 25, paragraph (1), Article 27, paragraphs (2) and (4), Article 32, paragraph (2), Article 32-2, paragraph (2), Article 32-7, paragraph (1) and paragraph (2) (including cases where applied mutatis mutandis pursuant to paragraph (3) of the same Article), Article 32-12, Article 41, paragraph (1) (including cases where applied mutatis mutandis pursuant to Article 52, paragraph (6), Article 52-2, paragraph (3), Article 53, paragraph (3) and Article 54-3, paragraph (2)) and paragraph (2) (including cases where applied mutatis mutandis pursuant to Article 45-2, paragraph (4), Article 52, paragraph (6), Article 52-2, paragraph (3), Article 53, paragraph (3) and Article 54-3, paragraph (2)), Article 45, paragraph (3) and Article 45-2, paragraphs (1) and (5) (including cases where these provisions shall apply mutatis mutandis pursuant to Article 52, paragraph (6), Article 52-2, paragraph (3), Article 53, paragraph (3) and Article 54-3, paragraph (2)), Article 54-2-2 and Article 54-2-3, paragraphs (1) and (3) (including cases where these provisions shall apply mutatis mutandis pursuant to Article 54-3, paragraph (2)), Article 80, paragraph (1), Article 88 and Article 89, paragraph (1), the affairs which shall be handled by a prefecture pursuant to the provisions of Article 106, paragraph (1) and Articles 107 and 108 and which are relevant to a Society, and the affairs which shall be handled by a prefecture pursuant to the provisions of Article 114 of this Act, Article 44, paragraph (4) and Article 134, paragraph (2) of the Act on Assurance of Medical Care for Elderly People, as applied mutatis mutandis pursuant to Article 16 of the Supplementary Provisions, and Article 152, paragraphs (1) and (3) of the same Act, as applied mutatis mutandis pursuant to Article 19 of the Supplementary Provisions, shall be Type 1 statutory entrusted functions as prescribed in Article 2, paragraph (9), item (i) of the Local Autonomy Act.

(Enforcement Provisions)

Article 120 Unless otherwise specially provided for in this Act, procedures for the enforcement of this Act and other detailed regulations necessary for the execution thereof shall be prescribed by Ordinance of the Ministry of Health, Labour and Welfare.

Chapter XII Penal Provisions

Article 120-2 When a current or former officer or employee of an Insurer divulges, without a justifiable reason, any confidential information obtained in the course of duties in relation to national health insurance services, said person shall be punished by imprisonment with required labor for not more than 1 year or a fine of not more than 1,000,000 yen.

Article 121 (1) When a current or former committee member of a Review Committee or an Examination Board or a current or former officer or employee of a Federation divulges, without a justifiable reason, any confidential information obtained in the course of duties, said person shall be punished by imprisonment with required labor for not more than 1 year or a fine of not more than 1,000,000 yen.

(2) The provisions of the preceding paragraph shall also apply when a person who conducts or used to conduct the review of medical bills as specified by the Minister of Health, Labour and Welfare pursuant to the provisions of Article 45, paragraph (7) (including cases where applied mutatis mutandis pursuant to Article 52, paragraph (6), Article 52-2, paragraph (3), Article 53, paragraph (3) and Article 54-2, paragraph (12)) or a current or former officer or employee of a Designated Association divulges, without a justifiable reason, any confidential information obtained in the course of said person's duties.

Article 122 A person who, without a justifiable reason and in violation of any action taken pursuant to the provisions of Article 101, paragraph (1), fails to appear or to make a statement or report, or makes any false statement or report or fails to perform diagnosis or examination shall be punished by a fine of not more than 300,000 yen; provided, however, that this shall not apply to an Insurer or other interested persons who have received notice pursuant to the provisions of Article 100, paragraph (1).

Article 123 When a current or former insurer fails, without a justifiable reason, to comply with an order to make a report issued pursuant to the provisions of Article 114, paragraph (2) or, without a justifiable reason, fails to reply, or makes a false reply, to any question asked by the relevant personnel pursuant to the provisions of the same paragraph of the same Article, said current or former insurer shall be punished by a fine of not more than 300,000 yen.

Article 124 When a physician, dentist or pharmacist or any person who gave treatment or any person who employs any of the above fails, without a justifiable reason, to comply with an order to make a report or present medical records, the books and other documents or any other article issued pursuant to the provisions of Article 114, paragraph (1) or, without a justifiable reason,

fails to reply, or makes a false reply, to any question asked by the relevant personnel pursuant to the provisions of the same paragraph of the same Article, said person shall be punished by a non-criminal fine of not more than 100,000 yen.

Article 125 When a Society or Federation fails make a notification pursuant to, or makes a false notification under, the provisions of Article 27, paragraph (4) (including the cases where applied mutatis mutandis pursuant to Article 86) or, without a justifiable reason, fails to comply with, or makes a false report in response to, an order issued pursuant to the provisions of Article 106, paragraph (1), or violates an order issued pursuant to the provisions of Article 108, paragraph (1), the officers or liquidators of such Society or Federation shall be punished by a non-criminal fine of not more than 200,000 yen.

Article 126 A person who violates the provisions of Article 15, paragraph (2) or Article 83, paragraph (4) shall be punished by a non-criminal fine of not more than 100,000 yen.

Article 127 (1) A Municipality may, in its Municipal Ordinance, establish provisions to impose a non-criminal fine of not more than 100,000 yen on a person who fails to make a notification pursuant to, or makes a false notification under, the provisions of Article 9, paragraph (1) or (9) or who fails to comply with a request to return said person's health insurance card made pursuant to the provisions of paragraph (3) or (4) of the same Article.

(2) A Municipality may, in its Municipal Ordinance, establish provisions to impose a non-criminal fine of not more than 100,000 yen when a current or former Householder, without a justifiable reason, fails to comply with an order to submit or present a document or any other article issued pursuant to the provisions of Article 113 or fails to reply, or makes a false reply, to any question asked by the relevant personnel pursuant to the provisions of the same Article.

(3) A Municipality may, in its Municipal Ordinance, establish provisions to impose on a person who, by means of deception or other wrongful conduct, evades insurance premiums or any other money to be collected pursuant to the provisions of this Act, a non-criminal fine of not more than the amount equal to five times the amount evaded.

(4) The provisions of Article 255-3 of the Local Autonomy Act shall apply mutatis mutandis to any action of non-criminal fine imposed pursuant to the provisions of the three preceding paragraphs.

Article 128 (1) The provisions of paragraphs (1) through (3) of the preceding

Article shall apply mutatis mutandis to a Society. In this case, the terms "Municipal Ordinance" and "non-criminal fine" in these provisions shall be deemed to be replaced with "constitution" and "penalty," respectively.

(2) A Society or Federation may, pursuant to the provisions of its constitution, collect a penalty of not more than 100,000 yen with respect to the use of its facilities.

Supplementary Provisions

(Effective Date, etc.)

Article 1 This Act shall come into effect as of January 1, 1959.

Article 2 For any Municipality which doesn't actually provide any national health insurance program at the time when this Act comes into effect, it shall be sufficient to commence national health insurance services no later than April 1, 1961, notwithstanding the provisions of Article 3, paragraph (1).

Article 3 Any Municipality as referred to in the preceding Article may, if in special circumstances and upon the approval of the Minister of Health and Welfare, choose to remain with no national health insurance program after April 1, 1961 until otherwise provided for in law, notwithstanding the provisions of Article 3, paragraph (1) and the preceding Article.

Article 4 The provisions of Article 11 shall not apply to any Municipality which provides no national health insurance program pursuant to the provisions of the two preceding Articles.

Article 5 In addition to what is provided for in the three preceding Articles, necessary particulars concerning the enforcement of this Act shall be prescribed by law.

(Special Provisions for Insured Persons Staying at Designated Facility Covered by Long-Term Care Insurance)

Article 5-2 (1) An insured person whose domicile is found to have been changed to the location of a Designated Facility Covered by Public Aid Providing Long-Term Care to the Elderly (meaning a Designated Facility Covered by Public Aid Providing Long-Term Care to the Elderly as set forth in Article 48, paragraph (1), item (i) of the Long-Term Care Insurance Act; hereinafter the same shall apply in this paragraph), due to the fact that said person was admitted thereto, and who is found to have been domiciled in the area of another Municipality (meaning any Municipality other than that in which such

Designated Facility Covered by Public Aid Providing Long-Term Care to the Elderly is located) at the time of admission to such Designated Facility Covered by Public Aid Providing Long-Term Care to the Elderly shall, even if said Designated Facility Covered by Public Aid Providing Long-Term Care to the Elderly becomes a Community-Based Facility for the Elderly Covered by Public Aid Requiring Long-Term Care as set forth in Article 8, paragraph (21) of the same Act (limited to a facility designated under the main clause of paragraph (1) of Article 42-2 of the same Act as a provider engaged in the business of providing Admission to a Community-Based Facility for Preventive Daily Long-Term Care of the Elderly Covered by Public Aid as set forth in Article 8, paragraph (21) of the same Act; hereinafter referred to as the "Converted Community-Based Facility for the Elderly Covered by Public Aid Requiring Long-Term Care" in this Article) due to a decrease in its capacity, be an insured person covered by the national health insurance program provided by such other Municipality notwithstanding the provisions of Article 5, as long as said person continuously stays at such Converted Community-Based Facility for the Elderly Covered by Public Aid Requiring Long-Term Care; provided, however, that this shall not apply to an insured person who has continuously been hospitalized in or stayed or resided at (hereinafter referred to as "Hospitalized, etc." in this Article) two or more Hospitals, etc. (meaning Hospitals, etc. as set forth in Article 116-2, paragraph (1); hereinafter the same shall apply in this Article) which include a Designated Facility Covered by Public Aid Providing Long-Term Care to the Elderly which became a Converted Community-Based Facility for the Elderly Covered by Public Aid Requiring Long-Term Care (hereinafter referred to as the "Former Facility Covered by Public Aid Providing Long-Term Care to the Elderly" in this Article) (limited to an insured person who has continuously stayed at such Converted Community-Based Facility for the Elderly Covered by Public Aid Requiring Long-Term Care and whose domicile is, due to the fact that said person was Hospitalized, etc. in the Hospital immediately before being Hospitalized, etc. in said Former Facility Covered by Public Aid Providing Long-Term Care to the Elderly (hereinafter referred to as the "Last Hospital, etc." in this paragraph) and then in the Former Facility Covered by Public Aid Providing Long-Term Care to the Elderly, found to have sequentially been changed to the location of the Last Hospital, etc. and then to that of the Former Facility Covered by Public Aid Providing Long-Term Care to the Elderly (in the following paragraph referred to as a "Specified Continuously Hospitalized Insured Person").

- (2) Notwithstanding the provisions of Article 5, a Specified Continuously Hospitalized Insured Person who falls under any of the following items shall be an insured person covered by the national health insurance program provided by the Municipality set forth in the relevant item:

- (i) an insured person whose domicile is, due to the fact that said person was Hospitalized, etc. in two or more Hospitals, etc. continuously, found to have been sequentially changed to the locations of the respective Hospitals, etc. and who is found to have been domiciled in the area of another Municipality (meaning any Municipality other than that in which the Former Facility Covered by Public Aid Providing Long-Term Care to the Elderly is located) at the time when said person was Hospitalized, etc. in the first of said two or more Hospitals, etc.: said other Municipality;
 - (ii) an insured person whose domicile is, in association with the fact that said person moved from one of the two or more Hospitals, etc. in which said person has been continuously hospitalized into another Hospital, etc. with no break (hereinafter referred to as "Continuous Hospitalization, etc." in this item), found to have been changed from a place other than the location of said Hospital, etc. to the location of said other Hospital, etc. (hereinafter referred to as "Specified Change of Domicile" in this item) and who is found to have been domiciled in the area of another Municipality (meaning any Municipality other than that in which the Former Facility Covered by Public Aid Providing Long-Term Care to the Elderly is located) at the time of the most recent Specified Change of Domicile: said other Municipality.
- (3) The provisions of Article 116-2 shall apply to an insured person to whom the provisions of the two preceding paragraphs shall apply, as if the Converted Community-Based Facility for the Elderly Covered by Public Aid Requiring Long-Term Care were a Hospital, etc.

(Transitional Measures for Retired Insured Persons, etc.)

Article 6 (1) During the period up to fiscal 2014, an insured person covered by the national health insurance program provided by a Municipality (excluding a person whose 65th birthday falls on any month before the present month) who is eligible for any benefit in the form of a pension provided due to old age or retirement under any of the laws and regulations listed below and: (i) who was an insured person, association member or subscriber pursuant to the provisions of the relevant law or regulation for a period (including any period prescribed by Cabinet Order as equivalent to such period) or total period (hereinafter referred to as "Period During Which the Person was an Insured Person, etc. of Pension Insurance" in this paragraph and Article 20 of the Supplementary Provisions) of twenty years (or, in the case of a person who is eligible for such benefit in the form of a pension and who was an insured person, etc. of pension insurance and was eligible for benefits thereunder for less than twenty years, a period prescribed by Cabinet Order according to the type of such benefit in the form of a pension) or more; or (ii) whose Period During Which the Person was an Insured Person, etc. of Pension Insurance in

and after the month in which such person reached forty years of age is ten years or more, shall be a retired insured person; provided, however, that this shall not apply to any person to whom the payment of such benefit in the form of a pension has been suspended in whole due to said person's age.

- (i) the Welfare Pension Insurance Act;
 - (ii) the Pension Act (Act No. 48 of 1923; including the cases where applied mutatis mutandis pursuant to other Acts);
 - (iii) the National Public Servants Mutual Aid Association Act;
 - (iv) the Act for Enforcement of the National Public Servants Mutual Aid Association Act Concerning Long-Term Benefits (Act No. 129 of 1958);
 - (v) the Local Public Care Service Mutual Aid Association Act;
 - (vi) the Act for Enforcement of the Local Public Care Service Mutual Aid Association Act Concerning Long-Term Benefits, etc. (Act No. 153 of 1962);
 - (vii) the Private School Personnel Mutual Aid Association Act;
 - (viii) Prefectural or Municipal Ordinance concerning retirement pension for local government employees;
 - (ix) the Act on Special Measures for Recipients of Pension from Mutual Aid Associations, etc. under the Former Order (Act No. 256 of 1950).
- (2) An insured person covered by the national health insurance program provided by a Municipality (excluding any person whose 65th birthday falls on any month before the present month) who falls under any of the following items shall be a dependent of the retired insured person:
- (i) the retired insured person's lineal ascendant, spouse (including a person who has not made a notification of marriage but is in a de facto marital relationship with such retired insured person; hereinafter the same shall apply in this paragraph) or any other relative within the third degree of kinship who belongs to the same household as such retired insured person and who is financially supported mainly by said retired insured person;
 - (ii) in cases where the retired insured person's spouse has not made a notification of marriage but is in a de facto marital relationship with such retired insured person, such spouse's father or mother or child who belongs to the same household as said retired insured person and who is financially supported mainly by said retired insured person;
 - (iii) in cases where the spouse as referred to in the preceding paragraph has died, such spouse's father or mother or child who continues to belong to the same household as the retired insured person and who is financially supported mainly by said retired insured person.

(Grants for Medical Treatment Benefit Expenses, etc.)

Article 7 (1) Of the expenses borne by a Municipality in which retired insured persons or their dependents (hereinafter referred to as a "Retired Insured

Persons, etc.") are domiciled (or, in cases where such persons are insured persons covered by the national health insurance program provided by another Municipality pursuant to the provisions of Article 116 or 116-2, said other Municipality; hereinafter referred to as the "Municipality to Which the Retired Insured Persons, etc. Belong"), the amount calculated by deducting the amount listed in item (iii) from the total sum of the amounts listed in items (i) and (ii) (hereinafter referred to as the "Amount for Which Contributions Shall be Made from Employees' Insurance, etc.") shall be, pursuant to Cabinet Order provisions, covered by grants for medical treatment benefit expenses, etc. to be provided by the Health Insurance Claims Review and Reimbursement Services (hereinafter referred to as the "Reimbursement Services") to the Municipality to Which Retired Insured Persons, etc. Belong:

- (i) the total sum of: (a) the amount calculated by deducting, from the amount of expenses incurred in providing benefits for medical treatment relating to Retired Insured Persons, etc., the amount of co-payment relating to said benefits; and (b) the amount of expenses incurred in paying expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing, special medical expenses, transport expenses, high-cost medical expenses and expenses for high-cost medical treatment combined with long-term care;
 - (ii) the amount obtained by multiplying the total sum of the Base Amount for Adjustment and the amount of Old-Old Aid by the ratio calculated pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare as the ratio of the total number of Retired Insured Persons, etc. to the total number of insured persons of the Municipality to Which Retired Insured Persons, etc. Belong (hereinafter referred to as the "Ratio of Retired Insured Persons, etc.");
 - (iii) the amount obtained by deducting, from the total sum of the amounts of insurance premiums relating to Retired Insured Persons, etc., the total sum of the amounts of expenses incurred in paying Long-Term Care Payments relating to said insurance premiums.
- (2) The grants for medical treatment benefit expenses, etc. as referred to in the preceding paragraph (hereinafter referred to as "Grants for Medical Treatment Benefit Expenses, etc.") shall be covered by contributions for medical treatment benefit expenses, etc. collected by the Reimbursement Services pursuant to the provisions of Article 10 of the Supplementary Provisions.
- (3) The Base Amount for Adjustment as set forth in paragraph (1), item (ii) shall be the estimated base amount for adjustment (meaning the estimated base amount for adjustment as set forth in Article 34, paragraph (3) of the Act on Assurance of Medical Care for Elderly People; hereinafter the same shall apply

in this paragraph) for the fiscal year for which the Grants for Medical Treatment Benefit Expenses, etc. are provided; provided, however, that when the estimated base amount for adjustment for the fiscal year before the fiscal year immediately preceding the fiscal year for which the Grants for Medical Treatment Benefit Expenses, etc. are provided exceeds the fixed base amount for adjustment (meaning the fixed base amount for adjustment as set forth in Article 35, paragraph (3) of the same Act; hereinafter the same shall apply in this paragraph) for the fiscal year before the fiscal year immediately preceding the fiscal year for which the Grants for Medical Treatment Benefit Expenses, etc. are provided, said Base Amount for Adjustment shall be the amount obtained by deducting, from the estimated base amount for adjustment for the fiscal year for which the Grants for Medical Treatment Benefit Expenses, etc. are provided, the total sum of the amount of such excess and the base adjustment amount for adjustment (meaning the amount to be calculated for each Municipality to Which Retired Insured Persons, etc. Belong pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, by taking into consideration interest accruing with respect to the amount of difference between the estimated base amount for adjustment and the fixed base amount for adjustment, both for all Municipalities to Which Retired Insured Persons, etc. Belong and for the fiscal year before the fiscal year immediately preceding the fiscal year for which the Grants for Medical Treatment Benefit Expenses, etc. are provided, as well as other circumstances; hereinafter the same shall apply in this paragraph) relating to said amount of such excess, whereas when the estimated base amount for adjustment for the fiscal year before the fiscal year immediately preceding the fiscal year for which the Grants for Medical Treatment Benefit Expenses, etc. are provided falls short of the fixed base amount for adjustment for the fiscal year before the fiscal year immediately preceding the fiscal year for which the Grants for Medical Treatment Benefit Expenses, etc. are provided, said Base Amount for Adjustment shall be the amount obtained by adding, to the estimated base amount for adjustment for the fiscal year for which the Grants for Medical Treatment Benefit Expenses, etc. are provided, the total sum of the amount of such shortfall and the base adjustment amount for adjustment relating to said amount of such shortfall.

(Reduction of Grants for Medical Treatment Benefit Expenses, etc.)

Article 8 (1) When a Municipality to Which Retired Insured Persons, etc. Belong has unjustly failed to secure the income that it should have secured or has unjustly incurred expenses that it should not have incurred, in each case in relation to the carrying out of national health insurance services for Retired Insured Person, etc. of said Municipality to Which Retired Insured Persons, etc.

Belong, the Minister of Health, Labour and Welfare may, pursuant to Cabinet Order provisions, order the Reimbursement Services to reduce the amount of Grants for Medical Treatment Benefit Expenses, etc. to be provided to said Municipality to Which Retired Insured Persons, etc. Belong pursuant to the provisions of paragraph (1) of the preceding Article.

- (2) The amount of reduction permitted pursuant to the preceding paragraph may not exceed the amount of income which unjustly failed to be secured or the amount of expenses which were unjustly incurred.

(Replacement of Terms Concerning Transitional Measures for Costs Imposed upon the National Government, etc.)

Article 9 (1) In a Municipality to Which Retired Insured Persons, etc. Belong, the term "insured persons" in Article 70, paragraph (1), item (i) shall be deemed to be replaced with "General Insured Persons (meaning all insured persons other than retired insured persons or their dependents as set forth in Article 6 of the Supplementary Provisions; the same shall apply in Article 72-3, paragraph (1))," the term "Old-Old Aid" in item (ii) of the same paragraph shall be deemed to be replaced with "the amount calculated by deducting, from the amount of expenses incurred in paying Old-Old Aid, the amount obtained by multiplying the total sum of the Base Amount for Adjustment and the amount of Old-Old Aid as set forth in Article 7, paragraph (1), item (ii) of the Supplementary Provisions by the Ratio of Retired Insured Persons, etc. as set forth in the same item," and the term "insured persons" in Article 72-3, paragraph (1) shall be deemed to be replaced with "General Insured Persons."

- (2) In the case of a Society specified by the Minister of Health, Labour and Welfare pursuant to the provisions of paragraph (3) of the following Article, the term "Insurer" in Article 76, paragraph (1) shall be deemed to be replaced with "Society specified by the Minister of Health, Labour and Welfare pursuant to the provisions of Article 10, paragraph (3) of the Supplementary Provisions," and the phrase "and Long-Term Care Payments and, in the case of a Society set forth in Article 179 of the Health Insurance Act, including expenses incurred in paying day worker contributions collected pursuant to the provisions of the same Act" in the same paragraph shall be deemed to be replaced with ", Long-Term Care Payments, the Contributions collected pursuant to the provisions of paragraph (1) of the same Article, and day worker contributions collected pursuant to the provisions of the Health Insurance Act."

(Collection of and Obligation to Pay Contributions)

Article 10 (1) Reimbursement Services shall, in order cover the expenses incurred in handling the functions set forth in Article 17 of the Supplementary Provisions and of affairs relating to such functions, collect contributions for

medical treatment benefit expenses, etc. and affairs expense contributions (hereinafter referred to as "Contributions" in this Article and Articles 16 and 17 of the Supplementary Provisions) from Insurers of Employees' Insurance, etc. for each fiscal year (meaning the period from April 1 of each year to March 31 of the following year; hereinafter the same shall apply).

(2) Each Insurer of Employees' Insurance, etc. shall have the obligation to pay Contributions.

(3) The Insurers of Employees' Insurance, etc. as referred to in paragraph (1) shall be the Insurers under the provisions of the Health Insurance Act, the Insurers under the provisions of the Seaman's Insurance Act, the mutual aid associations set forth in Article 6, item (iii), the Promotion and Mutual Aid Corporation for Private Schools of Japan, and such Societies as specified by the Minister of Health, Labour and Welfare whose members consist of persons who are not eligible as insured persons under the Health Insurance Act upon the approval under the provisions of Article 3, paragraph (1), item (viii) of the same Act.

(Amount of Contributions for Medical Treatment Benefit Expenses, etc.)

Article 11 (1) The amount of contributions for medical treatment benefit expenses, etc. to be collected from Insurers of Employees' Insurance, etc. pursuant to the provisions of paragraph (1) of the preceding Article shall be the amount of estimated contributions for medical treatment benefit expenses, etc. for the relevant fiscal year; provided, however, that when the amount of estimated contributions for medical treatment benefit expenses, etc. for the fiscal year before the last exceeds the actual amount of fixed contributions for medical treatment benefit expenses, etc. for the fiscal year before the last, the amount of contributions for medical treatment benefit expenses, etc. to be so collected shall be the amount obtained by deducting, from the amount of estimated contributions for medical treatment benefit expenses, etc. for the relevant fiscal year, the total sum of the amount of such excess and the Contribution Adjustment Amount relating to said amount of such excess, whereas when the amount of estimated contributions for medical treatment benefit expenses, etc. for the fiscal year before the last falls short of the amount of fixed contributions for medical treatment benefit expenses, etc. for the fiscal year before the last, the amount of contributions for medical treatment benefit expenses, etc. to be so collected shall be the amount obtained by adding, to the amount of estimated contributions for medical treatment benefit expenses, etc. for the relevant year, the total sum of the amount of such shortfall and the Contribution Adjustment Amount relating to said amount of such shortfall.

(2) The Contribution Adjustment Amount as referred to in the preceding

paragraph shall be the amount to be calculated for each Insurer of Employees' Insurance, etc. pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, by taking into consideration interest accruing with respect to the amount of difference between the estimated contributions for medical treatment benefit expenses, etc. and the amount of fixed contributions for medical treatment benefit expenses, etc., both for all Insurers of Employees' Insurance, etc. and for the fiscal year before the last, as well as other circumstances.

(Estimated Contributions for Medical Treatment Benefit Expenses, etc.)

Article 12 (1) The amount of estimated contributions for medical treatment benefit expenses, etc. as referred to in paragraph (1) of the preceding Article shall be the amount obtained by multiplying the amount calculated pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare as the estimated Total Amount of Standard Remuneration of each Insurer of Employees' Insurance, etc. for the relevant fiscal year (or, in the case of an Insurer under the provisions of the Health Insurance Act or the Seaman's Insurance Act, the estimated total sum, for the relevant fiscal year, of the respective total amounts of the Standard Remuneration as set forth in said Acts (meaning the amount of standard monthly remuneration and the amount of standard bonus) for all insured persons or, in the case of a mutual aid association set forth in Article 6, item (iii), the amount obtained by adjusting, pursuant to Cabinet Order provisions, the estimated total sum, for the relevant year, of respective total amounts of monthly Standard Remuneration and standard end-of-term expenses, etc. or monthly salary and end-of-term expenses, etc. as set forth in the Acts listed in the same item for all Society members or, in the case of the Promotion and Mutual Aid Corporation for Private Schools of Japan, the amount obtained by adjusting, pursuant to Cabinet Order provisions, the estimated total sum, for the relevant year, of respective total amounts of monthly standard salary and of standard bonuses as set forth in the Private School Personnel Mutual Aid Association Act for all subscribers or, in the case of a Society, the amount obtained by adjusting, pursuant to Cabinet Order provisions, the estimated total sum, for the relevant year, of respective total amounts of items specified by Ordinance of the Ministry of Health, Labour and Welfare as corresponding to the above types of remuneration for all Society members; hereinafter the same shall apply) by the Estimated Contribution Rate.

(2) The Estimated Contribution Rate as referred to in the preceding paragraph shall be the rate obtained, pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, by dividing the total sum of the respective estimated Amounts for Which Contributions Shall be Made from

Employees' Insurance, etc. for all Municipalities to Which Retired Insured Persons, etc. Belong for the relevant fiscal year, by the total sum of the estimated Total Amounts of Standard Remuneration for all Insurers of Employees' Insurance for the relevant fiscal year.

(Fixed Contributions for Medical Treatment Benefit Expenses, etc.)

Article 13 (1) The amount of fixed contributions for medical treatment benefit expenses, etc. as referred to in Article 11, paragraph (1) of the Supplementary Provisions shall be the amount obtained by multiplying the Total Amount of Standard Remuneration for the fiscal year before the last for each Insurer of Employees' Insurance by the Fixed Contribution Rate.

(2) The Fixed Contribution Rate as referred to in the preceding paragraph shall be the rate obtained, pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, by dividing the total sum of the respective Amounts for Which Contributions Shall be Made from Employees' Insurance, etc. for all Municipalities to Which Retired Insured Persons, etc. Belong for the fiscal year before the last, by the total sum of the Total Amounts of Standard Remuneration for all Insurers of Employees' Insurance for the fiscal year before the last.

(Amount of Affairs Expense Contributions)

Article 14 The amount of affairs expense contributions to be collected from each Insurer of Employees' Insurance, etc. pursuant to the provisions of Article 10, paragraph (1) of the Supplementary Provisions shall be, pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, the amount obtained by multiplying the estimated amount of expenses incurred in handling affairs concerning the Reimbursement Services' functions performed during the relevant fiscal year pursuant to the provisions of Article 17 of the Supplementary Provisions by the ratio obtained by dividing the Total Amount of Standard Remuneration of each Insurer of Employees' Insurance, etc. for the fiscal year before the last by the total sum of the Total Amounts of Standard Remuneration of all Insurers of Employees' Insurance, etc. for the fiscal year before the last.

(Notification, etc.)

Article 15 (1) Each Municipality to Which Retired Insured Persons, etc. Belong must, pursuant to the provisions of Ordinance of Ministry of Health, Labour and Welfare, notify the Reimbursement Services of its Amount for Which Contributions Shall be Made from Employees' Insurance, etc. for each fiscal year and all other matters prescribed by Ordinance of Ministry of Health, Labour and Welfare.

(2) A Municipality to which Retired Insured Persons, etc. Belong may entrust its affairs concerning the notification to be made pursuant to the preceding paragraph to any of the persons set forth in Article 45, paragraph (5).

(Application Mutatis Mutandis of the Act on Assurance of Medical Care for Elderly People with Respect to Contributions)

Article 16 The provisions of Article 41, Articles 43 through 46, paragraphs (2) and (3) of Article 134 and Article 159 of the Act on Assurance of Medical Care for Elderly People shall apply mutatis mutandis to Contributions. In this case, the terms "Insurer" and "Insurers" in these provisions shall be deemed to be replaced with "Insurer of Employees' Insurance, etc." and "Insurers of Employees' Insurance, etc.," respectively.

(Functions of the Reimbursement Services)

Article 17 In addition to the functions as set forth in Article 15 of the Health Insurance Claims Review and Reimbursement Services Act, the Reimbursement Services shall perform the following functions in order to achieve the purpose of this Act (hereinafter referred to as the "Functions Relating to Medical Services for Retired Persons"):

- (i) to collect Contributions from Insurers of Employees' Insurance, etc.;
- (ii) to provide Municipalities to Which Retired Insured Persons, etc. Belong with Grants for Medical Treatment Benefit Expenses, etc. as set forth in Article 7, paragraph (1) of the Supplementary Provisions;
- (iii) to perform functions incidental to the functions listed in the preceding two items.

(Special Provisions for the Application of the Health Insurance Claims Review and Reimbursement Services Act)

Article 18 An order issued as set forth in Article 8, paragraph (1) of the Supplementary Provisions shall be deemed to constitute an order as set forth in Article 29 of the Health Insurance Claims Review and Reimbursement Services Act for the purpose of the application of Article 11, paragraphs (2) and (3) of the same Act, and the Functions Relating to Medical Services for Retired Persons shall be deemed to constitute the functions set forth in Article 15 of the same Act for the purpose of the application of Article 32, paragraph (2) of the same Act.

(Application Mutatis Mutandis of the Act on Assurance of Medical Care for Elderly People with Respect to the Reimbursement Services' Functions Relating to Medical Services for Retired Persons)

Article 19 The provisions of Articles 140 through 152, Articles 154 and 168 and

Article 170, paragraph (1) of the Act on Assurance of Medical Care for Elderly People shall apply mutatis mutandis to the Reimbursement Services' Functions Relating to Medical Services for Retired Persons. In this case, any necessary technical replacement of terms shall be specified by Cabinet Order.

(Provision, etc. of Materials)

Article 20 When a Municipality to Which Retired Insured Persons, etc. Belong finds it necessary in relation to a retired insured person's eligibility, it may request access to necessary documents or to provide necessary materials concerning said retired insured person's Period During Which the Person was an Insured Person, etc. of Pension Insurance or concerning the status of payment of any benefit in the form of a pension paid to such retired insured person by reason of old age or retirement under any of the laws and regulations listed in the items of paragraph (1), Article 6 of the Supplementary Provisions, from the person who makes payment of said benefit in the form of a pension.

(Transitional Measures for Special Retired Insured Persons, etc.)

Article 21 (1) All insured persons covered by health insurance as set forth in Article 3, paragraph (1) of the Supplementary Provisions of the Health Insurance Act (limited to those who are eligible to become a retired insured person pursuant to the provisions of Article 6, paragraph (1) of the Supplementary Provisions during the period up to fiscal 2014; hereinafter referred to as "Special Retired Insured Persons") and their dependents (excluding those whose 65th birthday falls on any month before the current month or persons who do not belong to the same household as the relevant insured person; hereinafter the same shall apply) shall be deemed to be Retired Insured Persons, etc. for the purpose of calculating: the estimated Total Amount(s) of Standard Remuneration of the Insurer of Employees' Insurance and the estimated Amounts for Which Contributions Shall be Made from Employees' Insurance, etc. for the relevant fiscal year pursuant to the provisions of Article 12 of the Supplementary Provisions; the Total Amount(s) of Standard Remuneration and the Amounts for Which Contributions Shall be Made from Employees' Insurance, etc. for the fiscal year before the last pursuant to the provisions of Article 13 of the Supplementary Provisions; and the Total Amount(s) of Standard Remuneration of the Insurer of Employees' Insurance, etc. for the fiscal year before the last pursuant to the provisions of Article 14 of the Supplementary Provisions.

(2) Each health insurance society set forth in Article 3, paragraph (1) of the Health Insurance Act (hereinafter referred to as a "Specified Health Insurance Society") shall, pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, notify the Reimbursement Services of the

expenses incurred in providing the benefits for medical treatment and other benefits for medical services relating to Special Retired Insured Persons and their dependents for each fiscal year and all other matters prescribed by Ordinance of Ministry of Health, Labour and Welfare.

- (3) The amount of estimated contributions for medical treatment benefit expenses, etc. to be paid by a Specified Health Insurance Society shall be the amount calculated by deducting, from the amount calculated pursuant to the provisions of Article 12, paragraph (1) of the Supplementary Provisions, the amount calculated by deducting the amount listed in item (iii) from the total sum of the amounts listed in items (i) and (ii):
- (i) the total sum of: (a) the amount calculated by deducting, from the estimated amount of expenses incurred in providing benefits for medical treatment relating to Special Retired Insured Persons and their dependents to be borne by such Specified Health Insurance Society, the estimated amount of co-payment relating to said benefits; and (b) the estimated amount of expenses incurred in paying expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing, transport expenses, dependent medical expenses, dependent medical expenses for home-nursing, dependent transport expenses, high-cost medical expenses and expenses for high-cost medical treatment combined with long-term care;
 - (ii) the amount obtained by multiplying the total sum of the Base Amount for Adjustment for such Specified Health Insurance Society and the amount of Old-Old Aid borne by said Specified Health Insurance Society by the ratio calculated pursuant to Cabinet Order provisions as the ratio of the total number of Special Retired Insured Persons and their dependents to the total number of insured persons and their dependents covered by said Specified Health Insurance Society (hereinafter referred to as the "Ratio of Special Retired Insured Persons, etc.");
 - (iii) in cases where Special Retired Insured Persons and their dependents are Retired Insured Persons, etc. and where the amount calculated by deducting, from the amount of average insurance premiums payable by Retired Insured Persons, etc. covered by the national health insurance program covering said Special Retired Insured Persons and their dependents who are Retired Insured Persons, etc., the amount of average expenses incurred in paying Long-Term Care Payments relating to said amount of average insurance premiums, is collected from said Special Retired Insured Persons and their dependents who are Retired Insured Persons, etc., the amount calculated pursuant to Ordinance of the Ministry of Health, Labour and Welfare as the estimated total sum of the amounts so deducted for all Special Retired

Insured Persons and their dependents.

- (4) The amount of fixed contributions for medical treatment benefit expenses, etc. to be paid by a Specified Health Insurance Society shall be calculated by deducting, from the amount calculated pursuant to the provisions of Article 13, paragraph (1) of the Supplementary Provisions, the amount calculated by deducting the amount listed in item (iii) from the total sum of the amounts listed in items (i) and (ii):
- (i) the total sum of: (a) the amount calculated by deducting, from the amount of expenses incurred in providing benefits for medical treatment relating to Special Retired Insured Persons and their dependents borne by such Specified Health Insurance Society, the amount of co-payment relating to said benefits; and (b) the amount of expenses incurred in paying expenses for Dietary Treatment for inpatients, expenses for Living Support for inpatients, medical expenses combined with treatment outside insurance coverage, medical expenses, medical expenses for home-nursing, transport expenses, dependent medical expenses, dependent medical expenses for home-nursing, dependent transport expenses, high-cost medical expenses and expenses for high-cost medical treatment combined with long-term care;
 - (ii) the amount obtained by multiplying the total sum of the Base Amount for Adjustment for such Specified Health Insurance Society and the amount of Old-Old Aid borne by said Specified Health Insurance Society, by the Ratio of Special Retired Insured Persons, etc.;
 - (iii) in cases where Special Retired Insured Persons and their dependents are Retired Insured Persons, etc. and where the amount calculated by deducting, from the amount of average insurance premiums payable by Retired Insured Persons, etc. covered by the national health insurance program covering said Special Retired Insured Persons and their dependents who are Retired Insured Persons, etc., the amount of average expenses incurred in paying Long-Term Care Payments relating to said amount of average insurance premiums, is collected from said Special Retired Insured Persons and their dependents who are Retired Insured Persons, etc., the amount calculated pursuant to Ordinance of the Ministry of Health, Labour and Welfare as the total sum of the amounts so deducted for said Special Retired Insured Persons and their dependents.
- (5) The Base Amount for Adjustment set forth in item (ii) of paragraph (3) and item (ii) of the preceding paragraph shall be the estimated base amount for adjustment (meaning the estimated base amount for adjustment as set forth in Article 34, paragraph (3) of the Act on Assurance of Medical Care for Elderly People; hereinafter the same shall apply in this paragraph) for the relevant fiscal year; provided, however, that when the estimated base amount for adjustment for the fiscal year before the fiscal year immediately preceding the

relevant fiscal year exceeds the fixed base amount for adjustment (meaning the fixed base amount for adjustment as set forth in Article 35, paragraph (3) of the same Act; hereinafter the same shall apply in this paragraph) for the fiscal year before the fiscal year immediately preceding the relevant fiscal year, said Base Amount for Adjustment shall be the amount obtained by deducting, from the estimated base amount for adjustment for the relevant fiscal year, the total sum of the amount of such excess and the base adjustment amount for adjustment (meaning the amount to be calculated for each Specified Health Insurance Society pursuant to the provisions of Ordinance of the Ministry of Health, Labour and Welfare, by taking into consideration interest accruing with respect to the amount of difference between the estimated base amount for adjustment and the fixed base amount for adjustment, both for all Specified Health Insurance Societies and for the fiscal year before the fiscal year immediately preceding the relevant fiscal year, as well as other circumstances; hereinafter the same shall apply in this paragraph) relating to said amount of such excess, whereas when the estimated base amount for adjustment for the fiscal year before the fiscal year immediately preceding the relevant fiscal year falls short of the fixed base amount for adjustment for the fiscal year before the fiscal year immediately preceding the relevant fiscal year, said Base Amount for Adjustment shall be the amount obtained by adding, to the estimated base amount for adjustment for the relevant fiscal year, the total sum of the amount of such shortfall and the base adjustment amount for adjustment relating to said amount of such shortfall.

- (6) The provisions of paragraph (1) through the preceding paragraph shall apply mutatis mutandis to: the Specified Mutual Aid Associations and Special Retired Association Members and their dependents set forth in Article 12 of the Supplementary Provisions of the National Public Servants Mutual Aid Association Act and Article 18 of the Supplementary Provisions of the Local Public Care Service Mutual Aid Association Act; and the Corporation and Special Retired Insured Person and their dependents set forth in Article 12 of the Supplementary Provisions of the National Public Servants Mutual Aid Association Act as applied mutatis mutandis by replacing certain terms pursuant to Article 25 of the Private School Personnel Mutual Aid Association Act.

Article 21-2 (1) For the purpose of applying the provisions of paragraphs (3) and (4) of the preceding Article to the amount of estimated contributions for medical treatment benefit expenses, etc. and the amount of fixed contributions for medical treatment benefit expenses, etc. for each of the fiscal years from fiscal 2010 to 2012, the phrase "Old-Old Aid to be borne by said Specified Health Insurance Society" in item (ii) of paragraph (3) of the same Article shall

be deemed to be replaced with "Old-Old Aid relating to said Specified Health Insurance Society (meaning the amount which would be calculated pursuant to the provisions of Article 119, paragraph (1) of the Act on Assurance of Medical Care for Elderly People if the provisions of the same Article were to apply as if the provisions of Articles 14-3 and 14-4 of the Supplementary Provisions of the same Act did not apply to said Specified Health Insurance Society; hereinafter the same shall apply in item (ii) of the following paragraph)" and the phrase "borne by" in item (ii) of paragraph (4) of the preceding Article shall be deemed to be replaced with "relating to."

(2) For the purpose of applying the provisions of paragraph (5) of the preceding Article to each of the fiscal years 2010 and 2011, the phrase "meaning the estimated base amount for adjustment as set forth in Article 34, paragraph (3) of the Act on Assurance of Medical Care for Elderly People; hereinafter the same shall apply in this paragraph" in the same paragraph shall be deemed to be replaced with "meaning the total sum of the amounts listed in Article 13-2, items (iii) and (iv) of the Supplementary Provisions of the Act on Assurance of Medical Care for Elderly People," the phrase "estimated base amount for adjustment for the fiscal year before the fiscal year immediately preceding the relevant fiscal year" in the same paragraph shall be deemed to be replaced with "estimated base amount for adjustment for the fiscal year before the fiscal year immediately preceding the relevant fiscal year (meaning the estimated base amount for adjustment set forth in Article 34, paragraph (3) of the same Act)," the phrase "from the estimated base amount for adjustment" in the same paragraph shall be deemed to be replaced with "from the estimated base amount for adjustment (meaning the total sum of the amounts listed in Article 13-2, items (iii) and (iv) of the Supplementary Provisions of the same Act)," and the phrase "between the estimated base amount for adjustment" in the same paragraph shall be deemed to be replaced with "between the estimated base amount for adjustment (meaning the estimated base amount for adjustment set forth in Article 34, paragraph (3) of the same Act)."

(3) For the purpose of applying the provisions of paragraph (5) of the preceding Article to fiscal 2012, the phrase "estimated base amount for adjustment as set forth in Article 34, paragraph (3)" in the same paragraph shall be deemed to be replaced with "total sum of the amounts listed in Article 13-2, items (iii) and (iv) of the Supplementary Provisions" and the phrase "fixed base amount for adjustment as set forth in Article 35, paragraph (3)" in the same paragraph shall be deemed to be replaced with "total sum of the amounts listed in Article 13-3, items (iii) and (iv) of the Supplementary Provisions."

(Transitional Measures for Ward Transfer Aid)

Article 22 During the period up to the day specified by Cabinet Order set forth

in Article 2 of the Supplementary Provisions of the Act on Assurance of Medical Care for Elderly People, the phrase "and the old-old aid, etc. under the provisions of the same Act (hereinafter referred to as "Old-Old Aid, etc.")" in Article 69 shall be deemed to be replaced with ", the old-old aid, etc. under the provisions of the same Act (hereinafter referred to as "Old-Old Aid, etc.") and the ward transfer aid, etc. under the provisions of the same Act (hereinafter referred to as "Ward Transfer Aid, etc.)," the phrase "and the old-old aid under the provisions of the same Act (hereinafter referred to as "Old-Old Aid")" in Article 70, paragraph (1) (including the cases where applied mutatis mutandis pursuant to the provisions of Article 9, paragraph (1) of the Supplementary Provisions) shall be deemed to be replaced with ", the old-old aid under the provisions of the same Act (hereinafter referred to as "Old-Old Aid") and the ward transfer aid under the provisions of the same Act (hereinafter referred to as "Ward Transfer Aid)," the phrase "and Old-Old Aid" in item (ii) of the same paragraph (including the cases where applied mutatis mutandis pursuant to the provisions of Article 9, paragraph (1) of the Supplementary Provisions) shall be deemed to be replaced with ", Old-Old Aid and Ward Transfer Aid," the phrase "and Old-Old Aid" in paragraphs (1) and (2) of Article 73 shall be deemed to be replaced with ", Old-Old Aid and Ward Transfer Aid," the phrase "and Old-Old Aid, etc." in Article 75 and Article 76, paragraph (1) (including the cases where applied mutatis mutandis pursuant to the provisions of Article 9, paragraph (2) of the Supplementary Provisions) shall be deemed to be replaced with ", Old-Old Aid, etc. and Ward Transfer Aid, etc.," the phrase "and Old-Old Aid" in Article 7, paragraph (1), item (ii) of the Supplementary Provisions shall be deemed to be replaced with ", Old-Old Aid and Ward Transfer Aid," and the phrase "amount of Old-Old Aid" in item (ii) of paragraph (3) and item (ii) of paragraph (4) of Article 21 of the Supplementary Provisions shall be deemed to be replaced with "amounts of Old-Old Aid and Ward Transfer Aid."

(Special Provisions for Assistance to Societies)

Article 22-2 For the purpose of applying the provisions of Article 73, paragraph (2) to each of the fiscal years from fiscal 2010 to 2012, the phrase "proportion of assistance provided by the national government pursuant to the Health Insurance Act with respect to expenses incurred in health insurance services (including expenses incurred in paying Young-Old Payments and Old-Old Aid and Long-Term Care Payment)" in the same paragraph shall be deemed to be replaced with "proportion of assistance provided by the national government pursuant to the Health Insurance Act with respect to expenses incurred in health insurance services (including expenses incurred in paying Young-Old Payments and Old-Old Aid and Long-Term Care Payments) as well as the

relevant Society's financial capability."

(Special Provisions for the Assessment of Insurance Premiums in Merged Municipalities)

Article 23 In cases where a Merged Municipality set forth in Article 2, paragraph (2) of the Act on Special Provisions on Mergers of Municipalities (Act No. 59 of 2004) finds it extremely unfair to assess uniform insurance premiums across its entire area in the face of an extreme imbalance existing between the Municipalities Involved in a Merger as set forth in paragraph (3) of the same Article in terms of the assessment of insurance premiums, it may, only for the fiscal year to which the date of municipal merger (limited to a municipal merger taking place during the period up to March 31, 2020) belongs and the following five fiscal years, assess non-uniform insurance premiums to and only to the extent of the level of such imbalance.

(Special Provisions for Transfer, etc. to Special Account for National Health Insurance)

Article 24 (1) For each of the fiscal years from fiscal 2010 to 2014, each Municipality must, pursuant to Cabinet Order provisions, transfer from its general fund to a special account for its national health insurance program, an amount calculated, pursuant to Cabinet Order provisions, according to the number of persons with small income by taking into consideration the financial status of the national health insurance program and other circumstances, in addition to the amount to be transferred pursuant to the provisions of Article 72-3, paragraph (1).

(2) For each of the fiscal years from fiscal 2010 to 2014, the national government shall, pursuant to Cabinet Order provisions, bear an amount equal to one half of the amount to be transferred pursuant to the provisions of the preceding paragraph.

(3) For each of the fiscal years from fiscal 2010 to 2014, each prefectural government shall, pursuant to Cabinet Order provisions, an amount equal to one-fourth of the amount to be transferred pursuant to the provisions of paragraph (1).

(Special Provisions on Costs Imposed upon the National Government)

Article 25 For the purpose of applying the provisions of Article 70, paragraph (1), item (i) to each of the fiscal years from fiscal 2010 to 2014, the phrase "amount to be transferred pursuant to the provisions of Article 72-3, paragraph (1)" in the same item shall be deemed to be replaced with "total sum of the amount to be transferred pursuant to the provisions of Article 72-3, paragraph (1) and the amount to be transferred pursuant to the provisions of Article 24, paragraph

(1) of the Supplementary Provisions." For the purpose of applying the provisions of Article 72, paragraph (2), item (i) to each of said fiscal years, the phrase "Article 70, paragraph (1), item (i)" in the same item shall be deemed to be replaced with "Article 70, paragraph (1), item (i) after the replacement of certain terms pursuant to Article 25 of the Supplementary Provisions." For the purpose of applying the provisions of item (ii) of the same paragraph to each of said fiscal years, the phrase "total amount to be transferred pursuant to the provisions of Article 72-3, paragraph (1)" in the same item shall be deemed to be replaced with "aggregate total of the amount to be transferred pursuant to the provisions of Article 72-3, paragraph (1) and the amount to be transferred pursuant to the provisions of Article 24, paragraph (1) of the Supplementary Provisions."

(Subsidy Programs, etc. for High-Cost Medical Services)

Article 26 (1) In order to promote the financial stability of national health insurance programs, each Federation shall, pursuant to Cabinet Order provisions, conduct programs for providing the following subsidies to its member Municipalities during the period from fiscal 2010 to 2014:

- (i) subsidies for the joint sharing by the Municipalities (meaning the Municipalities which are members of the Federation; hereinafter the same shall apply) of the expenses incurred in medical services costing no less than an amount specified by Cabinet Order (or, where a special amount is specified by the prefectural government pursuant to the provisions of paragraph (3), such amount);
- (ii) subsidies for the joint sharing by the national government, the prefectural government and the Municipalities of the expenses incurred in medical services costing no less than an amount specified by Cabinet Order.

(2) In order to cover the expenses incurred in the programs set forth in the preceding paragraph, the Federation shall collect contributions from the Municipalities for each of the programs for providing the subsidies listed in the items of the same paragraph, pursuant to the means specified by Cabinet Order (or, where a special means is specified by the prefectural government pursuant to the provisions of the following paragraph for the program for providing the subsidy listed in item (i) of paragraph (1), said means).

(3) When a prefectural government deems it necessary, it may specify, in accordance with the standards set by Cabinet Order, a special amount or special method for its programs for providing the subsidies listed in item (i) of paragraph (1) in its Geographic Expansion Support Policy, to replace the amount specified by Cabinet Order pursuant to item (i) of paragraph (1) or the method specified by Cabinet Order pursuant to the preceding paragraph, respectively, as part of its specific measures for promoting the financial

stability of national health insurance programs as listed in Article 68-2, paragraph (2), item (iv).

- (4) Each Municipality shall have the obligation to pay the contributions set forth in paragraph (2).
- (5) The national government and the prefectural government shall, pursuant to Cabinet Order provisions, each bear an amount equal to one-fourth of the amount of the contributions collected pursuant to paragraph (2) for the programs for providing the subsidies listed in item (ii) of paragraph (1) (excluding contributions for the expenses incurred in handling affairs concerning said project).
- (6) A Designated Association may conduct programs for providing Federations with subsidies for programs which provide the subsidies listed in item (ii), paragraph (1) and which are related to benefits for high-cost medical services, using, as financial resources, contributions from Federations and other monies disbursed in order to cover expenses necessary for the relevant programs.

(Special Provisions on Adjusted Subsidies)

Article 27 The total amount of adjusted subsidies to be provided pursuant to the provisions of Article 72, paragraph (2) for each of the fiscal years from fiscal 2010 to 2014 shall be, notwithstanding the provisions of the same paragraph, the amount specified in the budget as the amount calculated by taking the amount calculated by deducting, from the amount of expenses to be borne by the national government pursuant to the provisions of paragraph (5) of the preceding Article, an amount not more than one-third of such amount of expenses, and deducting said amount from the amount calculated pursuant to the provisions of the same paragraph.