POLICY FACE PAGE

POLICY NUMBER: 302-900-0414

POLICYHOLDER: The American Academy of Dramatic Arts

ADDRESS: 1336 N La Brea Ave; Los Angeles, CA 90028

Please refer to the Schedule of Benefits for the Policy Effective Date and Termination Date information.

This Policy is issued to the Policyholder by Nationwide Life Insurance Company on the Effective Date at 12:01 a.m. standard time at Policyholder’s address.

This Policy is governed by the laws of the State where it is issued and is a legal contract between the Company and Policyholder.

The Company hereby insures Eligible Persons, as defined by the Policyholder for whom Premium has been timely paid. The Company agrees to pay Benefits set forth in this Policy. Benefit payment is governed by the terms, conditions and limitations of this Policy.

You may return this Policy within at least ten (10) days, thirty (30) days for individuals age 65 or older, of delivery for a full refund of all Premiums paid; and any Coverage returned for a refund of Premium will be null and void from its inception.

To find out whether the care you need is covered, please call Consolidated Health Plans at 2077 Roosevelt Ave, Springfield, MA 01104; at www.chpstudent.com or (800) 633 - 7867.

READ YOUR POLICY CAREFULLY.

ONE YEAR POLICY TERM
This Policy can be renewed on each anniversary date for future terms by payment of the Premium due at the rates agreed upon for each such renewal. If the Policy is not renewed, insurance will terminate as of the date the last Policy Term ends. Coverage may be terminated in accordance with the Policy Termination provision of this Policy.

BLANKET POLICY PROVIDING
SICKNESS AND INJURY COVERAGE
NON-PARTICIPATING
RIGHTS AND RESPONSIBILITIES

Your responsibilities as a Covered Person include:

• Carrying Your Identification Card with You and presenting it prior to receiving health care services;

• Paying all Deductible, Coinsurance and Copayment amounts, if any, when due;

• Reading the Policy, knowing Your Coverage, and following the procedures outlined in the Policy to receive Maximum Benefits;

• Informing Us of any other health insurance You may have;

• Preventing the dishonest or false use of Your Identification Card by people not eligible for Coverage, and immediately reporting any such use to Us;

• Informing Us of any change in Your address or a Lifestyle Change which may alter Benefits for You or Your Dependents.

Your rights as a Covered Person include:

• Simple information and explanations from Your health plan to help You understand what is covered and what is not covered;

• A current list of Preferred Providers;

• Emergency care at any Hospital for a Condition You believe threatens Your life or seriously affects Your health;

• Information about steps You can take if You think Your health insurance plan has denied You Coverage of a treatment You believe is covered.
# TABLE OF CONTENTS

State Mandated Benefits .................................................................................................................. 4
PEDIATRIC DENTAL AND VISION .................................................................................................. 10
General Definitions .......................................................................................................................... 14
CONDITIONS OF INSURANCE ........................................................................................................... 23
  Eligibility ........................................................................................................................................... 23
  Involuntary Loss of Other Coverage ................................................................................................. 23
  Credit Hour Requirements ................................................................................................................ 23
  Dependents Acquired After Effective Date ....................................................................................... 23
  Termination ......................................................................................................................................... 24
  Extension of Benefits ........................................................................................................................ 24
  Reinstatement of Reservist After Release from Active Duty ............................................................... 24
General Exclusions and Limitations .................................................................................................. 25
Premium ............................................................................................................................................... 27
Pre-Certification Process .................................................................................................................... 27
Preferred Provider Benefit .................................................................................................................. 28
Right to Reimbursement ...................................................................................................................... 30
Medical Necessity and Medical Appropriateness Determination ...................................................... 31
Grievance Process .............................................................................................................................. 32
General Provisions ............................................................................................................................. 36
Schedule of Benefits ........................................................................................................................... 39
Important Notice ................................................................................................................................. 46

**INSERTS:**
- Medical Evacuation/Repatriation/AD&D Rider
- Notice of Free Language Assistance
- California Guarantee Association
- Privacy Statement
STATE MANDATED BENEFITS

Benefits subject to applicable Deductible, Coinsurance, and Copayments as outlined in the Schedule of Benefits. Note: Wellness/Preventive Benefits under the Affordable Care Act (ACA) are required to meet federal regulations; no cost sharing will apply to these benefits for In-Network services. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate.

Acupuncture
Coverage is provided for expenses incurred as a result of treatment by a licensed acupuncturist (L.Ac.) who is authorized by law and duly licensed by the appropriate State Regulatory Agency to perform acupuncture, who does not ordinarily reside in the Covered Person’s home, or who is not related to the Covered Person by blood or marriage.

AIDS Vaccine
Coverage is provided for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service.

Alcoholism Treatment
Coverage is provided for the treatment of alcoholism.

Alpha Feto Protein Program
Coverage is provided for participation in the Expanded Alpha Feto Protein (AFP) Program.

Alzheimer’s Disease
Coverage is provided for home-based care for Covered Person’s if they are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including, but not limited to, progressive, degenerative, and dementing illness, including, but not limited to, Alzheimer’s disease.

Behavioral Health Treatment for Pervasive Development Disorder or Autism
Coverage is provided for behavioral health treatment for pervasive development disorder or autism.

"Behavioral health treatment" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

(A) The treatment is prescribed by a licensed Physician and Surgeon.
(B) The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
   (i) A qualified autism service provider.
   (ii) A qualified autism service professional supervised and employed by the qualified autism service provider.
   (iii) A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.
(C) The treatment plan must have measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan will be reviewed no less than once every six (6) months by the qualified autism service provider and modified whenever appropriate. It must be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
   (i) Describes the patient's behavioral health impairments to be treated.
   (ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
   (iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
   (iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
(D) The treatment plan cannot be used to provide or reimburse respite, day care, or educational services, or to reimburse a parent for participating in the treatment program. The treatment plan must be made available to the insurer upon request.
Breast Cancer Screening, Diagnosis and Treatment
Coverage is provided for screening, diagnosis, and treatment of breast cancer. Screening and diagnosis of breast cancer shall be consistent with generally accepted medical practice and scientific evidence upon the referral of the Covered Person's Physician. Treatment shall include Coverage for prosthetic devices or reconstructive surgery, including surgery on the healthy breast, to restore and achieve symmetry after a mastectomy. Coverage for initial and subsequent prosthetic devices and reconstructive surgery shall be subject to the Deductible and Coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other Benefits.

Blood Lead Level Screening
Coverage is provided for screening for blood lead levels in covered children.

Cancer Clinical Trials
Coverage is provided for:
(a) A Covered Person diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer, if the Covered Person's treating Physician, who is providing covered health care services, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Covered Person. For purposes of this section, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

(b)(1) "Routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:
(A) Health care services typically provided absent a clinical trial.
(B) Health care services required solely for the provision of the investigational drug, item, device, or service.
(C) Health care services required for the clinically appropriate monitoring of the investigational item or service.
(D) Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
(E) Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

(b)(2) For purposes of this section, "routine patient care costs" does not include the costs associated with the provision of any of the following:
(A) Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
(B) Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that an insured may require as a result of the treatment being provided for purposes of the clinical trial.
(C) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
(D) Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from Coverage under the insured's health plan.
(E) Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

(c) The treatment shall be provided in a clinical trial that either (1) involves a drug that is exempt under federal regulations from a new drug application or (2) that is approved by one of the following:
(A) One of the National Institutes of Health.
(B) The federal Food and Drug Administration, in the form of an investigational new drug application.
(C) The United States Department of Defense.
(D) The United States Veterans' Administration.

(d) In the case of health care services provided by a contracting Provider, the payment rate shall be at the agreed-upon rate. In the case of a non-contracting Provider, the payment shall be at the negotiated rate the insurer would otherwise pay to a contracting Provider for the same services, less applicable Copayments and Deductibles. Nothing in this section shall be construed to prohibit a disability insurer from restricting Coverage for clinical trials to Hospitals and Physicians in California unless the protocol for the clinical trial is not provided for at a California Hospital or by a California Physician.

(e) The provision of services when required by this section shall not, in itself, give rise to liability on the part of the insurer.
(f) Nothing in this section shall be construed to prohibit, limit, or modify an insured's rights to the independent review process available under Section 10145.3 or to the Independent Medical Review System available under Article 3.5 (commencing with Section 10169).

(g) Nothing in this section shall be construed to otherwise limit or modify any existing requirements under the provisions of this chapter or to prevent application of Deductible or Copayment provisions contained in the Policy.

(h) Copayments and deductibles applied to services delivered in a clinical trial shall be the same as those applied to the same services if not delivered in a clinical trial.

Cancer Screening
Coverage is provided for all generally medically accepted cancer screening tests.

Cervical Cancer Screening
Coverage is provided for an annual cervical cancer screening test upon the referral of a Covered Person’s Physician or Surgeon, a nurse practitioner, or a certified nurse midwife. Covered tests include the conventional Pap test, and the option of any other cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the patient’s health care Provider.

Contraceptives
Coverage is provided for all of the following services and contraceptive methods for women:

(A) All FDA-approved contraceptive drugs, devices, and products available by prescription only or over the counter, as prescribed by the Covered Person’s Provider;
(B) Voluntary sterilization procedures;
(C) Patient education and counseling on contraception; and
(D) Follow-up services related to drugs, devices, products, and procedures covered including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

If the Food and Drug Administration (FDA) has approved at least one therapeutic equivalent of a contraceptive drug, device, or product, and coverage is provided at no cost sharing, requirements for coverage are met.

Coverage will not be excluded for contraceptive supplies as prescribed by a Provider, acting within the scope of his or her practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of a Covered Person.

Diabetes
Coverage is provided for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as Medically Necessary, even if the items are available without a prescription:

• Blood glucose monitors and blood glucose testing strips;
• Blood glucose monitors designed to assist the visually impaired;
• Insulin pumps and all related necessary supplies;
• Ketone urine testing strips;
• Lancets and lancet puncture devices;
• Pen delivery systems for the administration of insulin;
• Podiatric devices to prevent or treat diabetes-related complications;
• Insulin syringes;
• Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Coverage is provided for the following prescription items if the items are determined to be Medically Necessary:

• Insulin;
• Prescriptive medications for the treatment of diabetes; and
• Glucagon.

Diabetic Daycare Self-Management and Education Programs
Coverage is provided, as agreed upon by the Policyholder and Us, for diabetic daycare self-management education programs. Coverage applies only to programs directed and supervised by a licensed Physician who is board certified in internal medicine or pediatrics. Diabetic daycare self-management and education programs includes instruction which enables diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy thereby avoiding frequent hospitalizations and complications.
Diethylstilbestrol (DES) Exposure
Coverage is provided for Conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

General Anesthesia for Dental Procedures
Coverage is provided for general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical Condition of the insured requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or surgery setting. This shall apply only to general anesthesia and associated facility charges for only the following Insureds:
- Insureds who are under seven (7) years of age;
- Insureds who are developmentally disabled, regardless of age; and
- Insureds whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

HIV Testing
Coverage is provided, subject to any limitations specified in the Schedule of Benefits, for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

Home Health Care
Coverage is provided for Home Health Care provided by a licensed home health agency, as specified in the Schedule of Benefits. Home health care benefits may be subject to a Policy Year Deductible of not more than fifty dollars ($50) for each Covered Person under the Policy, and may be subject to a Coinsurance provision which provides coverage of not less than 80 percent of the reasonable charges for such services.

Jawbone Surgery
Coverage is provided, as agreed upon by the Policyholder and Us, for the surgical procedure for those Covered Persons with covered conditions directly affecting the upper and lower jawbone, or associated bone joints, if the procedure is Medically Necessary.

Laryngectomy (Prosthetics)
Coverage is provided under this Policy for the removal of the larynx, also known as a laryngectomy, for Medically Necessary reasons as determined by a Physician and Surgeon. Coverage shall also include initial and subsequent prosthetic devices, including installation accessories, ordered by the Covered Person’s Physician and Surgeon to restore a method of speaking for the Covered Person incident to the laryngectomy. Prosthetic devices do not include electronic voice producing machines.

Coverage for such prosthetic devices shall be subject to the Deductible and Coinsurance conditions applied to the laryngectomy, and all other terms and conditions applicable to other Benefits.

Mammography
Coverage will be provided for mammograms upon the referral of a Physician, nurse practitioner, certified nurse-midwife, or physician assistant and in accordance with the following guidelines:
- A baseline mammogram for women age thirty-five (35) to thirty-nine (39);
- A mammogram for women age forty (40) to forty-nine (49), every two (2) years or more frequently based on the woman’s Physician’s recommendations; and
- A mammogram every year for women age fifty (50) and over.

Mastectomy and Reconstructive Surgery
Coverage for mastectomies and lymph node dissections is provided as follows:
- The length of the Hospital stay associated with the mastectomies and/or lymph node dissection to be determined by the Attending Physician and Surgeon in consultation with the patient, consistent with sound clinical principles and processes;
- Coverage for prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy; and
- Cover all complications for a mastectomy, including lymphedema.
Maternity and Postpartum Care
Coverage is provided for expenses incurred in pregnancy and childbirth. Benefits provided for a minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of Inpatient care following a cesarean section for a mother and her newly born child in a health care facility. Any decision to shorten the length of the inpatient stay to less than forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a cesarean delivery must be made by the Physician after conferring with the mother.

Benefits will be provided for a follow-up visit within forty-eight (48) hours of discharge when prescribed by the treating Physician. Follow-up services include, but are not limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any Medically Necessary physical assessments of the mother and newborn. The follow-up visit may take place in the mother’s home, in a Physician’s office, or at a facility as determined by the treating Physician, in consultation with the mother, based on factors including, but not limited to, the transportation needs of the family, and environmental and social risks.

Nicotine Treatment
Coverage is provided under this Policy for the treatment of nicotine use, and the treatment may take place in facilities licensed to provide chemical dependency services.

Off-Label Prescription Drug Use
Coverage is provided for Prescription Drugs when prescribed for a use that is different from the use for which the drug has been approved for marketing by the federal Food and Drug Administration under this bill.

Oral Anti-Cancer Medication
Coverage is provided for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells. The total amount of Copayment and Coinsurance a Covered Person is required to pay shall not exceed two hundred dollars ($200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medical covered by the Policy.

Orthotic and Prosthetic Devices and Services
Coverage is provided, as agreed upon by the Policyholder and Us, for Medically Necessary orthotic and prosthetic devices and services. Coverage for Prosthetic Devices shall include original and replacement devices, as prescribed by a Physician, Surgeon, or Doctor of Podiatric Medicine (DPM) acting with the scope of his license.

Coverage for Orthotic Devices shall provide for coverage when the devices, including original and replacement devices, are prescribed by a Physician and Surgeon or Doctor of Podiatric Medicine (DPM) or other licensed health care provider acting within the scope of his license.

Osteoporosis
Coverage is provided for services related to the diagnosis, treatment, and appropriate management of osteoporosis. Services, include, but are not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Pediatric Asthma Management
Coverage is provided Medically Necessary equipment and supplies for the management and treatment of pediatric asthma. Coverage includes inhaler spacers, outpatient prescription drugs, nebulizers including face masks and tubing, peak flow meters. Additional or replacement inhaler spacers, nebulizers, and peak flow meters will be provided when Medically Necessary for the Covered Person to maintain compliance with his or her treatment regimen.

Coverage is also provided for education, including the proper use of any prescribed device, consistent with current professional medical practice.

Phenylketonuria
Coverage is provided for the testing and treatment of Phenylketonuria (PKU), including those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease, provided the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Formula means an enteral product or enteral products for use at home that are prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon referral by a Physician authorized to prescribe dietary treatments, as Medically Necessary for the treatment of phenylketonuria (PKU).
Special Food Product means a food product that is both of the following: (a) prescribed for the treatment of phenylketonuria (PKU) and is consistent with the recommendations of best practices of qualified health professionals with expertise to, and experience in the treatment and care of PKU. It does not include food that is naturally low in protein, but may include a food product that is specially formulated to have less than one (1) gram of protein per serving; and (b) used in place of normal food products, such as grocery store foods, used in the general population.

**Prenatal Diagnosis of Genetic Disorders of Fetus**
Coverage is provided for the prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy.

**Prostate Cancer Screening**
Coverage is provided for the screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.

**Reconstructive Surgery**
Coverage is provided for surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
- To improve function; or
- To create a normal appearance, to the extent possible.

In the case of breast cancer, this includes surgery on the healthy breast, to restore and achieve symmetry after a mastectomy.

**Second Opinion**
Coverage is provided for a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:
- If the insured questions the reasonableness or necessity of recommended surgical procedures;
- If the insured questions a diagnosis or plan of care for a Condition that threatens Loss of life, Loss of limb, Loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic Condition;
- If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the Condition and the Insured requests an additional diagnosis;
- If the treatment plan in progress is not improving the medical Condition of the insured within an appropriate period of time given the diagnosis and plan of care, and the insured requests a second opinion regarding the diagnosis or continuance of the treatment;
- If the Insured has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

**Severe Mental Illness at Any Age and Serious Emotional Disturbance of a Child**
Coverage is provided for the diagnosis and Medically Necessary treatment of Severe Mental Illnesses of a person of any age, and of serious emotional disturbances of a child. The Benefits shall include, but are not limited to, the following:
- Outpatient services;
- Inpatient Hospital services;
- Residential treatment;
- Partial Hospital services;
- Prescription Drugs, if the Policy or contract includes coverage for Prescription Drugs.

Serious Emotional Disturbance of a Child: A child under the age of eighteen (18) who:
- has one (1) or more Mental Illness as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child’s age according to expected developmental norms; and
- as a result of the Mental Illness, has substantial impairment in at least two (2) of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur: (1) the child is at risk of removal from home or has already been removed from the home; or (2) the Mental Illness and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment; or
the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Illness; or
the child meets the state’s special education eligibility requirements.

Severe Mental Illness: Schizophrenia; schizoaffective disorder; bipolar disorder (manic-depressive Illness and delusional depressions); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa.

Special Footwear for Persons Suffering from Foot Disfigurement
Coverage is provided, as agreed upon by the Policyholder and Us, for special footwear needed by persons who suffer from foot disfigurement. Foot disfigurement shall include, but not be limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, and diabetes, and foot disfigurement caused by Accident and developmental disability.

Transplantation Services for Persons with HIV
Coverage is provided under this Policy for the costs of solid organ or other tissue transplantation services, and such Coverage will also apply to services provided to an Insured infected with human immunodeficiency virus (HIV).

PEDIATRIC DENTAL AND VISION

PEDIATRIC VISION SERVICES
Please refer to the Schedule of Benefits section of this Policy for cost-sharing requirements, day or visit limits. We cover emergency, preventive and routine vision care for Covered Persons up to age nineteen (19).

This Benefit terminates on the first of the month following the Covered Person’s 19th birthday.

Exclusions for this Pediatric Vision Services Benefit
We will not pay Benefits for:
1. any charges for failure to keep a scheduled appointment;
2. any service charges for personalization or characterization of prosthetic appliances;
3. office infection control charges;
4. medical treatment of eye disease or injury;
5. visual therapy;
6. special lens designs or coatings;
7. replacement of lost/stolen eyewear;
8. non-prescription (Plano) lenses;
9. two pairs of eyeglasses in lieu of bifocals;
10. optometric prosthetic devices and services;
11. insurance of contact lenses against loss or damage.

All other terms, provisions, limitations and general exclusions listed within this Policy still apply.

PEDIATRIC DENTAL SERVICES
Please refer to the Schedule of Benefits section of this Policy for cost-sharing requirements and any applicable pre-authorization or waiting period requirements. We cover preventive and diagnostic, basic restorative, major and Medically Necessary orthodontia services for Covered Persons up to age nineteen (19). Medically Necessary orthodontia services are those necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

The qualifying conditions for Medically Necessary orthodontia services are:
- Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts, written documentation from a credentialed specialist shall be submitted on their professional letterhead, with the prior authorization request;
- Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request;
- Deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate;
- A crossbite of individual anterior teeth causing destruction of soft tissue;
- An overjet greater than 9 mm or reverse overjet greater than 3.5 mm;
• A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

This Benefit terminates on the first of the month following the Covered Person’s 19th birthday.

IMPORTANT: If You opt to receive dental services that are not Covered Services under this Policy, a participating dental provider may charge you his or her Reasonable and Customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call member services at 1-800-633-7867 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this evidence of coverage document.

Alternative Benefits
There is often more than one Service that Providers can use to treat a dental problem or disease. In determining the Benefits payable on a claim, We will consider different materials and methods of treatment. The amount payable will be limited to the Covered Expense for the least costly service, which meets broadly accepted standards of dental care. The Covered Person and his or her Provider may decide on a more costly procedure or material than We have determined to be satisfactory for the treatment of the condition, referred to below as “optional” benefits. We will pay a benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits payable for Covered Expenses for the least costly Service. We will not pay the excess amount.

Covered Services and Limitations

Preventive and Diagnostic Services
• initial and periodic oral examinations
• consultations, including specialist consultations
• topical fluoride treatment
• preventive dental education and oral hygiene instruction
• Roentgenology (x-rays)
  o Bitewing x-rays in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis
  o Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months
  o Panoramic film x-rays are limited to once every twenty-four (24) consecutive months
• prophylaxis services (cleanings) - limited to two (2) in a twelve (12)-month period
• dental sealant treatments - limited to permanent first and second molars only
• space maintainers, including removable acrylic and fixed band type

Basic Restorative Services
• restorations, including replacement only when defective, as evidenced by conditions such as recurrent caries or fracture:
  o Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
    (Note: composite resin or acrylic restorations in posterior teeth must be Medically Necessary.)
  o Micro filled resin restorations which are non-cosmetic
  o Replacement of a restoration
  o Use of pins and pin build-up in conjunction with a restoration
  o Sedative base and sedative fillings
• Endodontics
  o Pulpotomy or vital pulpotomy
• Periodontics
  o scaling and root planning, and subgingival curettage, limited to five (5) quadrant treatments every 12 months
• **Prosthodontics**
  - acrylic and prefabricated stainless steel crowns. Crowns for children under twelve (12) years of age are limited to acrylic or stainless steel. If other materials are used, the Covered Benefit will be that of an acrylic crown. Crowns will only be covered if there is not enough retentive quality left in the tooth to hold a filling.
  - denture rebase/reline, limited to 1 per arch every 12 months
  - denture adjustment
  - recementation of crowns, bridges, inlays and onlays
  - repair and replacement of crowns, fixed bridges, abutments, pontics, and dentures; crown replacement is limited to 1 per 36 months except when the crown is no longer functional; replacement of fixed bridges is only provided when it cannot be made satisfactory by repair; denture replacement is limited to 1 per 36 months unless Medically Necessary

• **Oral surgery, except as otherwise Covered in the Policy**
  - Extractions, including surgical extractions
  - Removal of impacted teeth, only when evidence of pathology exists
  - Biopsy of oral tissues
  - Alveolectomies
  - Excision of cysts and neoplasms
  - Treatment of palatal torus
  - Treatment of mandibular torus
  - Frenectomy
  - Incision and drainage of abscesses
  - Post-operative services, including exams, suture removal and treatment of complications
  - Root recovery (separate procedure)

• **Other**
  - Emergency palliative treatment of pain

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**Major Services**

• **Endodontics**
  - direct pulp capping
  - Apexification filling with calcium hydroxide
  - Root amputation
  - Root canal therapy, including culture canal. Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
  - Apicoectomy
  - Vitality tests

• **Periodontics**
  - Gingivectomy
  - Osseous or muco-gingival surgery
  - Emergency treatment, including treatment for periodontal abscess and acute
  - periodontitis

• **Prosthodontics**
  - Crowns – acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay, or three quarter crown, limited to five (5) units of crownwork per arch; related dowel pins and pin build-up. Crowns will only be covered if there is not enough retentive quality left in the tooth to hold a filling. Veneers posterior to the second bicuspid are considered optional; an allowance will be made for a cast full crown.
  - Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, limited to five (5) units of bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional. Fixed bridges are Covered only when a partial cannot satisfactorily restore the case; fixed bridges used when a partial could satisfactorily restore the case are considered optional. For children under age sixteen (16), fixed bridges are considered optional and the Covered Person will be responsible for the difference in cost between the fixed bridge and a space maintainer. Fixed bridges used to replace missing posterior teeth are considered optional, as are fixed bridges when provided in connection with a partial denture on the same arch.
o Removable prosthetics, including dentures, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers; tissue conditioning, limited to two (2) per denture; denture duplication; stayplates (only when used as anterior space maintainers for children), space maintainer (except as otherwise covered under Preventive & Diagnostic Services). When teeth are missing on both sides of the dental arch, a removable partial denture will be considered adequate restoration of a case. Other treatment will be considered optional.
  o Implants are considered an optional benefit.

• Other
  o general anesthesia and IV sedation” – in conjunction with complex oral surgery
  o analgesia (nitrous oxide) or non-IV sedation (not in conjunction with general anesthesia or IV sedation)

**Orthodontia Services**
- pre-orthodontic treatment
- orthodontic treatment
- appliance therapy
- orthodontic retention

**Exclusions for this Pediatric Dental Services Benefit**
We will not pay Benefits for:
1. Services which are not Medically Necessary.
2. Cosmetic dental care.
3. Experimental procedures.
4. Dental conditions arising out of and due to a Covered Person’s employment for which Worker’s Compensation or an employer’s Liability Law is payable.
5. Services which were provided without cost to the Covered Person by the State government or an agency thereof, or any municipality, county or other subdivisions.
6. Hospital charges of any kind.
7. Major surgery for fractures and dislocations.
8. Loss or theft of dentures or bridgework.
9. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Covered Person became eligible for such services.
10. Any service that is not specifically listed as a covered benefit.
11. Malignancies.
12. Dispensing of drugs not normally supplied in a dental office.
13. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist’s office due to the general health and physical limitations of the Covered Person.
14. The cost of precious metals used in any form of dental benefits.
15. The surgical removal of implants.

All other terms, provisions, limitations and general exclusions listed within this Policy still apply.
GENERAL DEFINITIONS

The terms listed below, if used, have the meaning stated.

Accident: An event that is sudden, unexpected, and unintended, and over which the Covered Person has no control.

Accidental Injury: A specific, sudden, unforeseeable, external event resulting in Injury.

Ambulatory Surgical Center: A facility which meets licensing and other legal requirements and which:
- Is equipped and operated to provide medical care and treatment by a Physician;
- Does not provide services or accommodations for overnight stays;
- Has a medical staff that is supervised full time by a Physician;
- Has full-time services of a licensed Registered Nurse (R.N.) at all times when patients are in the facility;
- Has at least one operating room and one recovery room and is equipped to support any surgery performed;
- Has x-ray and laboratory diagnostic facilities;
- Maintains a medical record for each patient; and
- Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

Anesthetist: A Physician duly licensed according to state law, who administers the anesthesia agent during a surgical procedure.

Assistant Surgeon: A Physician who assists the Surgeon who actually performs a surgical procedure.

Attending Physician: A Physician who is charged with the overall care of the patient and who is responsible for directing the treatment program.

Benefit(s): The extent of those services listed in the Covered Charges.

Brand Name Prescription Drugs: Drugs for which the drug manufacturer’s trademark registration is still valid, and who’s trademarked or proprietary name of the drug still appears on the package label. See also Preferred Brand Drug and Non-Preferred Brand Drug.

Chronic and Seriously Debilitating: Diseases or Conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

Coinsurance: The percentage of the expense for which the Covered Person is responsible for a Covered Service. The Coinsurance is separate and not a part of the Deductible and Copayment.

Company: Nationwide Life Insurance Company. Also hereinafter referred to as We, Our and Us.

Complications of Pregnancy: A Condition which:
- When pregnancy is not terminated, requires medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) missed abortion; (e) preeclampsia/eclampsia; (f) puerperal infection; (g) R.H. Factor problems; (h) severe loss of blood requiring transfusion; (i) and other similar medical and surgical Conditions of comparable severity related to pregnancy; or
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include:
- false labor;
- occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- morning sickness; and
- similar Conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.
**Condition:** Sickness, ailment, Injury, or pregnancy of a Covered Person.

**Confinement/Confined:** An uninterrupted stay following admission to a Health Care Facility. The re-admission to a Health Care Facility for the same or related Condition, within a seventy-two (72) hour period, will be considered a continuation of the Confinement. Confined/Confinement does **not** include observation, which is a review or assessment of eighteen (18) hours or less, of a person's Condition that does not result in admission to a Hospital or Health Care Facility.

**Copayment:** A specified dollar amount a Covered Person must pay for specified Covered Charges. The Copayment is separate from and not a part of the Deductible or Coinsurance.

**Coverage:** The right of the Covered Person to receive Benefits subject to the terms, conditions, limitations and exclusions of the Policy.

**Covered Charge(s) or Covered Expense:** As used herein means those charges for any treatment, services or supplies:

- For Preferred Providers, not in excess of the Preferred Allowance;
- For Out-of-Network Providers not in excess of the Reasonable and Customary expense; and
- Not in excess of the charges that would have been made in the absence of this insurance; and
- Not otherwise excluded under this Policy; and
- Incurred while this Policy is in force as to the Covered Person except with respect to any Covered Expense payable under the Extension of Benefits Provision.

**Covered Person:** A person:

- Who is eligible for Coverage as the Insured;
- Who has been accepted for Coverage or has been automatically added;
- Who has paid the required Premium; and
- Whose Coverage has become effective and has not terminated.

**Covered Services:** Means the services and supplies, procedures and treatment described herein, subject to the terms, conditions, limitations, and exclusions of the Policy.

**Custodial Care:** Care that is primarily for the purpose of meeting non-medical personal needs, such as help with the activities of daily living and taking medications. Activities of daily living include, but are not limited to, bathing, dressing or grooming, eating, toileting, walking, and getting in and out of bed. Custodial Care can usually be provided by someone without professional medical skills or training.

**Deductible:** The amount of expenses for Covered Services and supplies which must be incurred by the Covered Person before specified Benefits become payable.

**Dermatology:** The diagnosis and treatment of skin disorders. Covered expenses do not include cosmetic treatment and procedures.

**Durable Medical Equipment:** A device which:

- is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
- is used exclusively by the patient;
- is routinely used in a Hospital but can be used effectively in a non-medical facility;
- can be expected to make a meaningful contribution to treating the patient's Sickness or Injury; and
- is prescribed by a Physician to
  1. Treat a Condition; or
  2. Improve or restore the functional ability of a malformed body part; or
  3. Prevent worsening of the Covered Person’s Condition.

Durable Medical Equipment does not include: 1) comfort and convenience items; 2) equipment that can be used by Family Members other than the patient; 3) health exercise equipment; and 4) equipment that may increase the value of the patient’s residence. Such items that do not qualify as Durable Medical Equipment include, but are not limited to: modifications to the patient’s residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.
Effective Date: The date Coverage becomes effective at 12:01 a.m. on this date.

Elective Treatment: Those services that do not fall under the definition of Essential Health Benefits. Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person’s Effective Date of Coverage. Elective Benefits is shown on the Schedule of Benefits, as applicable.

Eligible Person: The person who meets the eligibility criteria of the Policyholder.

Emergency: A Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency does not include the recurring symptoms of a chronic Condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

Emergency Medical Transportation Services: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide ground and air transportation to a Hospital for Emergency care or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care, if a Physician specifies in writing that such transport is Medically Necessary. Charges are payable only for transportation from the site of an Emergency to the nearest available Hospital that is equipped to treat the Condition.

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of Covered Services: ambulatory patient services; Emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; Rehabilitative and Habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

Evaluation and Management: Professional services provided by a Physician in the Physician’s office or in an out patient or other ambulatory facility.

Expense Incurred: The charge made for a service, supply, or treatment that is a Covered Service under the Policy. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.

Experimental/Investigational: The service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see of Medically Necessary/Medical Necessity provision.

Family Member: A person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member includes an individual who normally lives in the Covered Person’s household.

Formulary: A list of Generic, Brand Name, and/or Specialty Prescription Drugs that are Covered under the Policy.

Generic Drugs: A non-brand name drug, which is a pharmaceutical equivalent to a Brand Name Prescription Drug, sold at a lower cost.
**Habilitative Treatment or Therapy:** Health care services and devices that help a Covered Person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient or Outpatient settings, or both.

**Health Care Facility:** A Hospital, Skilled Nursing Facility, Sub-Acute Facility, or other duly licensed, certified and approved health care institution which provides care and treatment for sick or injured persons.

**Home Country:** The Insured’s country of regular domicile.

**Home Health Care:** Services and supplies that are Medically Necessary for the care and treatment of a covered Illness or Accidental Injury and are furnished to a Covered Person at the Covered Person’s residence.

Home Health Care consists of, but shall not be limited to, the following:

- Physician-directed Home Health Care follow-up visits provided to a mother or newborn child within seventy-two (72) hours after the mother’s or newborn child’s early discharge from an Inpatient stay. The Provider conducting the visit must have knowledge and experience in maternity and newborn care.
- Care provided in a Covered Person’s home by a licensed, accredited Home Health Care agency. This care must be under the direction of a Physician and in conjunction with the need for Skilled Nursing Care and includes, but is not limited to:
  - Skilled nursing (L.P.N., R.N.) part-time or intermittent care;
  - medical social services;
  - Infusion services;
  - Part-time or intermittent certified nurse assistant services or home health aide services, which provide support in the home under the supervision of an R.N. or a physical, speech or occupational therapist. A visit of four (4) hours or less by a certified nurse assistant or home health aide will count as one (1) Home Health Care visit. Each visit by any other home health agency representative will count as one (1) Home Health Care visit;
  - Physical Therapy;
  - occupational therapy;
  - Speech Therapy.
- Medical supplies, drugs and medicines prescribed by a Physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the Policy if the Covered Person had remained in the Hospital.

**Home Infusion Therapy:** The continuous Infusion of prescribed blended drugs, as prescribed by the Attending Physician, representing direct treatment of a specific covered Illness or Accidental Injury. The treatment is provided in the Covered Person’s home.

**Hospice:** A coordinated plan of home and Inpatient care which treats the terminally ill patient and family as a unit. Care is provided by a team of trained medical personnel, homemakers, and counselors. Care is provided in a Covered Person’s home by a licensed, accredited Home Health Care, home Infusion, or Hospice agency, or provided in a Health Care Facility. This care must be under the direction of a Physician in conjunction with the need for Skilled Nursing Care and includes:

- Skilled nursing (L.P.N., R.N.) part-time or intermittent care;
- medical social services;
- nutrition counseling;
- Physical Therapy;
- Infusion therapy, injectables and related supplies, including site care supplies;
- certified nurse assistant services and home health aid services;
- occupational therapy
- Restorative Speech Therapy
- Medical equipment, supplies, drugs and medicines prescribed by a Physician
- Bereavement services for the family unit
Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center, and a birthing facility certified and licensed as such under the laws where located. It shall also include Rehabilitative facilities if such is specifically required for treatment of physical disability.

Facilities primarily treating drug addiction or Alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include an institution, or part thereof, which is, other than incidentally, a place for rest, the aged, a place for educational or Custodial Care or Hospice.

Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least eighteen (18) hours or greater for which a room and board charge is made by reason of Sickness or Injury for which Benefits are payable. The readmission for the same or related Sickness or Injury, within a seventy-two (72) hour period, will be considered a continuation of Confinement. See Confined/Confinement.

Identification Card: Your Identification Card identifies You as a Covered Person.

Illness: Sickness or disease.

Infusion Services: Services provided in an office or Outpatient facility, or by a licensed Infusion or health care agency, including the professional fee and related supplies.

Injectable Drugs: Means a drug when an oral alternative drug is not available.

Injection Services: Services provided in an office or Outpatient facility, including the professional fee and related supplies. Injection Services does not include self-administered Injectable Drugs.

Injury: Bodily Injury due to a specific, sudden, unforeseeable, external event. All injuries sustained in any one (1) Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

In-Network Benefit: The level of payment made by Us for Covered Services received by a Preferred Provider under the terms of the Policy. Payment is based on the Preferred Allowance unless otherwise indicated.

Inpatient/Inpatient Admission: A Confinement of eighteen (18) hours or greater. See Confined/Confinement.

Insured: The Covered Person who is enrolled at and meets the eligibility requirements of the Policyholder’s school.

Insured Percent: That part of the Covered Charge that is payable by the Company after the Deductible and/or Copayment has been paid, and subject to the Policy Year Maximum or Maximum Benefit, as applicable.

Lifestyle Change: A change in Your or Your Dependent’s status due to marriage, divorce, dissolution of Domestic/Civil Union Partnership, age, birth, death, adoption, change in Spouse’s or Domestic/Civil Union Partner’s employment or health insurance or health plan Coverage, eligibility for Medicare, change in student status or any other event which impacts eligibility for Coverage under the Policy.

Life-Threatening Condition: Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted; or with potentially fatal outcomes, where the end point of clinical intervention is survival.

Maximum Benefit: The maximum payment We will make under the Policy for each Covered Person for Covered Services. This amount is shown on the Schedule of Benefits, as applicable.

Medical Literature:
- Two (2) (articles from major peer-reviewed professional medical journals which have recognized, based on scientific or medical criteria, the drug’s safety and effectiveness for treatment of the Condition for which it has been prescribed; and
- No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug’s safety and effectiveness cannot be determined for the treatment of the Condition for which it has been prescribed; and
• Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services pursuant to federal law, as accepted peer-reviewed Medical Literature.

**Medically Necessary/Medical Necessity:** Refer to the Medical Necessity provision of this Policy.

**Mental Illness:** A Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Expense.

**Morbid Obesity:** A body mass index that is greater than 40 kilograms per meter squared; or, equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

**Non-Preferred Brand Drug:** A Brand Name Prescription Drug that is on the Formulary and is available at a higher cost than Preferred Brand Drugs.

**Nurse:** A licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who: (a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and (b) provides medical services which are within the scope of the nurse’s license or certificate who does not ordinarily reside in the Covered Person’s home or is not related to the Covered Person by blood or marriage.

**Orthopedic Appliance:** A supportive device or appliance used to treat a Sickness or Injury (e.g., a crutch, cane, splint, brace, supportive bandage, etc.).

**Orthotic Device:** A mechanical device, such as braces (but not dental) or shoes, that:

1. is directly related to the treatment of an Injury or Sickness of the foot; and
2. is prescribed by the Insured Person’s Physician who documents the necessity for the item.

**Out-of-Network Benefit Level:** The lowest level of payment made by Us for Covered Services under the terms of the Policy.

Payment is based on Reasonable and Customary charges unless otherwise indicated.

**Out-of-Network Provider:** Physicians, Hospitals and other Providers who have not agreed to any pre-arranged fee schedules. See the definition of Out-of-Network Benefit Level.

**Out-of-Pocket Maximum:** The most You pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. This limit will never include Premium, balance-billed charges or health care Your Policy does not cover. Your other non-covered expenses and Elective Treatment do not count toward this limit.

**Outpatient:** Not Confined in a Hospital, Skilled Nursing facility or Hospice as a registered bed patient.

**Outpatient Office Visit** – a patient encounter with a health care provider in an office, clinic or ambulatory care facility as an Outpatient.

**Outpatient Other Services** – medical and other services provided to a non-admitted patient by a Hospital or other qualified facility such as mental health clinic, rural health clinic, mobile x-ray unit, free standing dialysis unit. Examples include Physical Therapy, diagnostic x-ray, lab tests and any Ambulatory service.

**Physical Therapy:** Any form of the following:

- Physical or mechanical therapy;
- Diathermy;
- Ultra-sonic therapy;
- Heat treatment in any form; or
- Manipulation or massage.
Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:

1. the Insured Person;
2. a Family Member of the Insured Person; or
3. a person employed or retained by the Policyholder.

Policy: The agreement between Us and the Policyholder which states the terms, conditions, limitations and exclusions regarding Coverage.

Policy Year: The period of twelve (12) months following the Policy’s Effective Date.

Policyholder: The entity shown as the Policyholder on the Policy face page.

Pre-admission Testing: Tests done in conjunction with a scheduled surgery where an operating room has been reserved before the tests are done.

Preferred Allowance (PA): The amount a Preferred Provider has agreed to accept as payment in full for Covered Charges.

Preferred Brand Drug: A Brand Name Prescription Drug that is on the Formulary and is available at a lower cost than Non-Preferred Brand or Specialty Drugs.

Preferred Providers: Physicians, Hospitals and other healthcare Providers who have contracted to provide specific medical care at negotiated prices. See the definition of In-Network Benefit.

Preferred Provider Organization or PPO: The entity named in the Schedule of Benefits.

Premium: The amount required to maintain Coverage for each Covered Person in accordance with the terms of this Policy.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law and is:

1. Approved for general use by the U.S. Food and Drug Administration (FDA); and
2. Prescribed by a licensed Physician for the treatment of a Life-Threatening Condition, or prescribed by a licensed Physician for the treatment of a Chronic and Seriously Debilitating Condition, the drug is Medically Necessary to treat that Condition, and the drug is on the Formulary, if any; and
3. The drug has been recognized for treatment of that Condition by one of the Standard Medical Reference Compendia or in the Medical Literature as recommended by current American Medical Association (AMA) policies, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Condition.

The Drugs must be dispensed by a licensed pharmacy Provider for out of Hospital use, except as specifically provided under Preventive Care including over-the-counter drugs for smoking cessation. Prescription Drug Coverage shall also include Medically Necessary supplies associated with the administration of the drug.

Preventive Care: Provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations, as specified in the Schedule of Benefits. Well Baby and Child Care, and Well Adult Care Benefits will be considered based on the following:

(a) Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
(b) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
(c) With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
(d) With respect to women, such additional Preventive Care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
Provider: A Physician, dentist, Health Care Facility, or Urgent Care Facility that is licensed or certified to provide medical services or supplies.

Prosthetic Device: A device, or artificial appliance, that:
1. Maintains or replaces the body part of a Covered Person whose covered Injury or Sickness has required the removal of that body part; and
2. Is prescribed by the Covered Person’s Physician who documents the necessity for the item.

Reasonable and Customary (R&C): The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:
- The actual amount charged by the Provider;
- The negotiated rate, if any; or
- The fee often charged for in the geographical area where the service was performed.

The Reasonable Charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 90th percentile of Fair Health Inc. schedules. The Insured Person may be responsible for the difference between the Reasonable Charge and the actual charge from the Provider.

For a Provider who has a reimbursement agreement, the Reasonable Charge is equal to the Preferred Allowance under any reimbursement agreement with Us, either directly or indirectly through a third party, as described in the Preferred Provider Benefit provision. If a Provider accepts as full payment an amount less than the rate negotiated under the reimbursement agreement, the lesser amount will be the maximum Reasonable Charge.

Restorative Speech Therapy: Therapy after an Injury, including stroke, and treatment of a speech abnormality resulting from surgery or trauma to anatomical structures affecting speech.

Review Organization: Entity named in the Schedule of Benefits.

Sickness: Illness, disease or Condition, including pregnancy and Complications of Pregnancy, that impairs a Covered Person’s normal functioning of mind or body and which is not the direct result of an Injury or Accident. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Skilled Nursing Care: Services that are certified as Medically Necessary by a Physician and are not intermediate, domiciliary, custodial or retirement care.

Skilled Nursing Facility: A place (including a separate part of a Hospital) which:
- Regularly provides room and board for person(s) recovering from Illness or Accidental Injury;
- Provides continuous twenty-four (24) hour nursing care by or under the supervision of a Registered Nurse;
- Is under the supervision of a duly licensed Physician;
- Maintains a daily clinical record for each patient;
- Is not, other than incidentally, a place for rest, the aged, place of treatment for Alcoholism or drug and/or substance abuse or addiction; and
- Is operated pursuant to law.
Sound Natural Tooth: The major portion of the individual natural tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Specialty Drugs: Means a Prescription Drug including Injectable Drugs, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis, and which are listed in the specialty care drug list.

Standard Medical Reference Compendia: The following publications:
- The “AMA Drug Evaluations”, published by the American Medical Association;
- The “American Hospital Formulary Service (AHFS) Drug Information”, published by the American Society of Health System Pharmacists; or

Sub-Acute Facility: A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of Rehabilitative and Skilled Care Nursing.

Substance Use Disorder: A Sickness that is listed as an alcoholism and substance use disorder in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Expense.

Surgeon: A Physician who actually performs surgical procedures.

Telemedicine: The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Neither a telephone conversation nor an electronic mail message between a Physician and patient constitutes “Telemedicine”.

Termination Date: The date a Covered Person’s Coverage under this Policy ends. Coverage ends at 11:59 p.m. on this date.

Urgent Care: Means short-term medical care performed in an Urgent Care Facility for non-life threatening Conditions that can be mitigated or require care within forty-eight (48) hours of onset.

Urgent Care Facility: A Hospital or other licensed facility which provides diagnosis, treatment, and care of persons who need acute care under the supervision of Physicians.

Vision Screening: A screening to determine if there are underlying medical Conditions or if a refractive exam needs to be performed. Vision Screening does not include refractive exams, which are not covered as specified in the General Exclusions and Limitations.

We, Our and Us: Nationwide Life Insurance Company.

You and Your: The Covered Person or Eligible Person as applicable.

Male pronouns whenever used include female pronouns.
CONDITIONS OF INSURANCE

ELIGIBILITY:
You are eligible for Coverage if You meet the definition of Eligible Person as determined by the Policyholder and Us.

Any Insured voluntarily withdrawing from school during the first thirty-one (31) days of the period for which Coverage is purchased, will not be covered under this Policy and a full refund of Premium will be made minus the cost of any claim Benefits made by Us. Insureds withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed except as otherwise specified herein.

We maintain the right to investigate eligibility status and attendance records to verify that the Policy eligibility requirements have been met. If We discover that the Policy eligibility requirements have not been met, Our only obligation is refund of Premium less any claims paid.

Eligibility requirements must be met each time Premium is paid to renew Coverage.

INCOMPULSORY LOSS OF OTHER COVERAGE:
If You are eligible for Coverage but do not enroll in Coverage under this Policy when You first meet the definition of Eligible Person as a result of coverage under another Policy, You may be eligible to enroll in Coverage under this Policy provided enrollment and Premium are received within thirty-one (31) days of Involuntary Loss of Other Coverage.

For purposes of this section, Involuntary Loss of Other Coverage means that prior coverage is involuntarily terminated due to no fault of the Eligible Person, which includes coverage that terminates due to a loss of employment by the Eligible Person or the Eligible Person’s spouse or parent. This definition does not include coverage that has a predetermined termination date, or expiration of COBRA eligibility, and does not apply to coverage that has been voluntarily terminated.

Coverage is effective upon enrollment and receipt of Premium by Us or Our authorized representative.

CREDIT HOUR REQUIREMENTS:
All registered domestic and international students are automatically enrolled in the Policy. The following courses are excluded from being applied towards the required minimum credit hours: distance learning or internet courses; home study and correspondence; and TV courses.

DEPENDENTS ACQUIRED AFTER EFFECTIVE DATE:
Newborn Children: An Insured’s newborn child is automatically covered from the moment of birth until such child is thirty-one (31) days old. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, the Insured must notify Us in writing within thirty-one (31) days of such birth and pay the required additional Premium, if any, in order to have Coverage for the newborn child continue beyond such thirty-one (31) day period.

Step-Child: Coverage for a Step-Child is effective on the date the Insured marries or enters into a Domestic/Civil Union Partnership with the child’s parent. However, the Insured must notify Us in writing within thirty-one (31) days of the marriage and pay the required additional Premium, if any, in order to have Coverage for the child continue beyond such thirty-one (31) day period.

Foster Child: Coverage for a Foster Child is effective upon the date of placement with the Covered Person. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage will continue unless the placement is disrupted and the child is removed from placement. However, the Insured must notify Us in writing within thirty-one (31) days of such placement and pay the required additional Premium, if any, in order to have Coverage for the Foster Child continue beyond such thirty-one (31) day period.
Adopted Child: Coverage for an adopted child is effective upon the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, the Insured must notify Us in writing within thirty-one (31) days of such adoption and pay the required additional Premium, if any, in order to have Coverage for the adopted child continue beyond such thirty-one (31) day period.

This Policy does not have Dependent Coverage, therefore Benefits will not be extended beyond the thirty-one (31) day period.

TERMINATION:
Policyholder: The termination of the Policy by the mutual consent of the Policyholder and Us, terminates the entire contract, including the Grace Period uniform provision (see General Provisions section of this Policy).

The Policyholder may terminate coverage any time after the First Policy Term. Such notice must be provided at least thirty-one (31) days in advance of the Termination Date. If the Policyholder terminates the Policy, termination will become effective at 12:01 a.m. local time, based on the Policyholder’s address, on the date We receive notice or the date specified in the notice, whichever is later.

We may not terminate the Policy unless the Policyholder does not perform its contractual duties. If We terminate the Policy, notice will be either mailed or delivered to the Policyholder at the last address on file with Us. A copy of such notice may also be sent to the Policyholder’s agent, if any, at his or her last address on file with us. Termination will become effective on the date stated in the notice or the 31st day after we mail or deliver the notice, whichever is later.

In either event, We will promptly return any unearned Premium paid or the Policyholder will promptly pay any earned Premium which has not been paid.

Covered Person: Coverage will terminate at 11:59 p.m. standard time at the Policyholder’s address on the earliest of:

- The Termination Date of the Policy;
- The last day of the Policy term for which Premium is paid;
- The date the Covered Person departs the Policyholder’s school for their Home Country. No Benefits will be payable for any medical treatment received in the Covered Person’s Home Country.
- The date a Covered Person enters full time active military service. Upon written request within ninety (90) days of leaving school, We will refund the unearned pro-rata Premium (minus any claims paid) to such person upon request.

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS:
The Coverage provided under this Policy ceases on the Covered Person’s Termination Date. However, if a Covered Person is: Hospital Confined on the Termination Date from a covered Injury or Sickness for which Benefits were paid before the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of ninety (90) days or until date of discharge, whichever is earlier.

The total payments made in respect of the Insured for such Condition both before and after the Termination Date will never exceed the Maximum Benefit. After this Extension of Benefits provision has been exhausted, all Benefits cease to exist and under no circumstances will further Benefits be made.

This Extension of Benefits provision is applicable only to the extent the Covered Person will not be covered under this or any other similar health insurance policy in the ensuing term of Coverage. Dependents that are newly acquired during the Insured’s Extension of Benefits period are not eligible for Benefits under the provision.

REINSTATEMENT OF RESERVIST AFTER RELEASE FROM ACTIVE DUTY:
If Your insurance ends due to Your being called or ordered to active duty, such insurance will be reinstated without any waiting period when You return to school and satisfy the eligibility requirements defined by the Policyholder.
GENERAL EXCLUSIONS AND LIMITATIONS

Unless specifically included, no Benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. Eyeglasses, contact lenses, routine eye refractions, eye examinations except as in the case of Injury or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.
2. Hearing aids and the fitting or repairing or replacement of hearing aids, except in the case of Accident or Injury.
3. Vaccines and immunizations (except as specifically provided in the Policy): a) required for travel; and b) required for employment;
4. Treatment (other than surgery) of chronic Conditions of the foot including weak feet, fallen arches, flat foot, pronated foot, subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions any type of massage procedure on or to the foot, corrective shoes, shoe inserts and Orthotic Device; except for treatment of Injury, infection or disease.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease except as provided herein or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections). This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part.
6. Sexual/gender reassignment surgery, except as provided when determined to be Medically Necessary or when treatment is otherwise Covered under the Policy in the absence of a diagnosis of gender dysphoria. This exclusion does not include related mental health counseling or hormone therapy.
7. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved.
8. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications. Upon written request, claims denied under this provision may be reviewed by an independent medical review entity if You or Your Dependent has a terminal Condition that, according to the Physician’s current diagnosis, has a high probability of causing death within two (2) years from the date of the request for medical review.
9. Custodial Care; long-term care; Care provided in a: rest home, home for the aged, halfway house, health resort, college infirmary or any similar facility for domiciliary or Custodial Care, or that provides twenty-four (24) hour non-medical residential care or day care (except as provided for Hospice care).
10. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, (except as specified herein).
11. Reproductive/Infertility services, including but not limited to: treatment of infertility (male or female) including diagnosis, diagnostic tests, medication, surgery, supplies, and fertilization procedures rendered for the purpose or with the intent of inducing conception, premarital examination; impotence, organic or otherwise; sterilization reversal; vasectomy reversal. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, artificial insemination, embryo transfer or similar procedures that augment or enhance Your reproductive ability.
12. Hospital Confinement or any other services or treatment that are received without charge or legal obligation to pay.
13. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee.
14. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
15. Services received before the Covered Person’s Effective; Services received after the Covered Person’s Coverage ends, except as specifically provided under the Extension of Benefits provision.

16. Under the Prescription Drug Benefit shown in the Schedule of Benefits, any drug or medicine:
   • Obtainable Over the Counter (OTC), except as specifically provided under Preventive Care;
   • for the treatment of alopecia (hair loss) or hirsutism (hair removal);
   • for the purpose of weight control;
   • anabolic steroids used for body building;
   • for the treatment of infertility;
   • cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in this Policy;
   • treatment of nail (toe or finger) fungus;
   • refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
   • for an amount that exceeds a thirty (30) day supply
   • drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
   • purchased after Coverage under the Policy terminates;
   • consumed or administered at the place where it is dispensed;
   • if the FDA determines that the drug is:
     i. contraindicated for the treatment of the Condition for which the drug was prescribed; or
     ii. Experimental for any reason.

17. Services for the treatment of any Injury or Sickness incurred while committing or attempting to commit a felony.

18. War or any act of war, declared or undeclared, while on active duty in the armed forces of any country.

19. Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations.

20. Nutrition counseling services (except as specifically provided in the Policy), including services by a Physician for general nutrition, weight increase or reduction services, except as specifically provided in the Policy; general fitness, exercise programs, health club memberships and weight management programs; exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Physician’s prescription.

21. Treatment received outside of the United States of America, except when Medically Necessary for an Emergency Confinement in a Hospital or as specified herein.

22. Non-cystic acne.

23. Acupressure, aroma therapy, hypnosis, rolfing, hyperhidrosis, psychosurgery and biofeedback except as specified in the Schedule of Benefits

24. Elective Treatment, except as specified in the Schedule of Benefits.
PREMIUM

Payment of Premium/Due Date: The Premium rates, and the method and timing of Premium/fee payments, are as agreed upon by the Policyholder and Us. In no event will Coverage become effective prior to the date of enrollment and before required Premium is received at Our home office or by Our authorized representative.

Returned or Dishonored Payment: If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to the Policyholder which will not exceed the maximum specified under state law. A dishonored check shall be considered a failure to pay Premium and Coverage shall not take effect.

Please refer to the Schedule of Benefits for Premium information.

PRE-CERTIFICATION PROCESS

The Schedule of Benefits identifies medical Covered Services which must be Pre-Certified by the Review Organization. Advising the Review Organization before You receive such medical Covered Services allows the Review Organization to determine Medical Necessity and Medical Appropriateness. Medical care that is not necessary and appropriate adds to the cost of care and exposes You to unnecessary risk.

You are responsible for calling the Review Organization at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services, the call should be made prior to Hospital Confinement. In the case of an Emergency, the call should take place as soon as reasonably possible.

Pre-Certification is not required for Medical Emergency or Urgent Care or Hospital Confinement for maternity care. The Pre-Certification process will not be used to determine the length of stay after a mastectomy or lymph node dissection.

The following Inpatient and Outpatient services or supplies require Pre-Certification:

- All Inpatient admissions, including length of stay, to a Hospital, convalescent facility, Skilled Nursing Facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility;

Pre-certification is not a guarantee that Benefits will be paid.

Your Physician will be notified of the Review Organization’s decision as follows:

- For elective (non-Emergency) admissions to a Health Care Facility, the Review Organization will notify Your Physician and the Health Care Facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
- For Confinement in a Health Care Facility longer than the originally approved number of days, Your treating Physician or the Health Care Facility must contact the Review Organization before the last approved day. The Review Organization will review the request for continued stay to determine Medical Necessity and notify the Physician or the Health Care Facility of its decision in writing or by telephone;

Our Review Organization agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non urgent requests following receipt of all necessary information for review. Notice of an adverse determination made by the Review Organization agent will be in writing and will include:

- The reasons for the adverse determination including the clinical rationale, if any.
- Instructions on how to initiate standard or urgent appeal.
- Notice of the availability, upon request of the Covered Person, or the Covered Person’s designee, of the clinical review criteria relied upon to make the adverse determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, the Review Organization Agent in order to render a decision on any requested appeal.

Failure by the Review Organization agent to make a determination within the time periods prescribed shall be deemed to be an adverse determination subject to appeal. If You have questions about Your Pre-Certification status, You should contact Your Provider.
PREFERRED PROVIDER BENEFIT

We encourage Covered Persons to use Preferred Providers by providing benefit incentives when Preferred Providers are used.

In the event of an Emergency, services rendered by any Hospital are covered as if the service had been provided by a Preferred Hospital. In the case of an Emergency, if an Out-of-Network Provider is used, the In-Network percentage in the Schedule of Benefits will be applied.

A Covered Person is not required to seek treatment from a Preferred Provider. Each Covered Person is free to elect the services of a Provider and Benefits payable will be made in accordance with the terms and Conditions of this benefit.

We do not make any representation or warranty as to the medical competence or ability of a Preferred Provider or to their respective staff or Physicians. We shall not have any liability or responsibility, direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the Preferred Provider, their staff or Physicians.

Out-of-Network Provider: Any Provider that is not a member of the Preferred Provider network arrangement that has contracted with Us.

Preferred Provider: Any Provider that has contracted with Us to provide services, as described in this Policy, through a Preferred Provider network arrangement, to be reimbursed at discounted fees.

If You are undergoing an active course of treatment with a Preferred Provider for an acute Condition, a serious chronic Condition, a pregnancy, a terminal Illness, the care of a newborn child between birth and age thirty-six (36) months or performance of a surgery or other procedure that has been recommended and documented by the Preferred Provider to occur within one hundred eighty (180) days of the Preferred Provider’s contract Termination Date, You may request continuation of treatment by such Preferred Provider in the event the Preferred Provider’s contract has terminated with the Preferred Provider Organization.

- An acute Condition is a medical Condition that involves a sudden onset of symptoms due to an Illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute Condition or until the Covered Person’s Coverage terminated, whichever occurs first.
- A serious chronic Condition is a medical Condition due to a disease, Illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by the health insurer in consultation with the Insured and the terminated Preferred Provider and consistent with good professional practice. Completion of Covered Services under this paragraph shall not exceed twelve (12) months from the Preferred Provider’s contract Termination Date or until the Covered Person’s Coverage terminated, whichever occurs first.
- A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy or until the Covered Person’s Coverage terminated, whichever occurs first.
- A terminal Illness is an incurable or irreversible Condition that has a high probability of causing death within one or two years or less. Completion of Covered Services shall be provided for the duration of a terminal Illness or until the Covered Person’s Coverage terminated, whichever occurs first.
- The care of a newborn child between birth and age thirty-six (36) months will not exceed twelve (12) months from the Preferred Provider’s contract Termination Date.

COORDINATION OF BENEFITS

Read this section with care. It applies to all sections of the Policy that pay Benefits for Covered Charges, except the Prescription Drug Benefit.

The intent of this section is to help control Your Premium costs by preventing financial gain by persons Insured under more than one plan. All plans will be taken into account for this section, even plans, which do not have a coordination of Benefits provision.

Benefits received from this Policy are coordinated with Benefits, which the Covered Person may receive from certain other plans. The Covered Person is urged to file any claims as early as possible with all insurance companies under which he or she has health Coverage. This will help Us to provide the Maximum Benefit due as soon as possible.
The total benefit received from all plans may not exceed 100% of Allowable expenses.

DEFINITIONS APPLICABLE TO COORDINATION OF BENEFITS SECTION:
"Covered Person" means the person for whom a claim is being made.

"Plan" means any plan that provides Benefits or services for or by reason of medical or dental care or treatment. These are:
1. Group, blanket, or franchise insurance Coverage whether Insured or uninsured but not including:
   • A contract covering elementary, junior high, high school and or college students for accidents only, including athletic injuries, on a twenty-four hour basis or on a "to and from school" basis; or
   • Hospital indemnity Benefits of $100 per day or less so long as they are the indemnity-type Benefit as opposed to the reimbursement-type benefit. (Any amount of Hospital indemnity Benefits of either type which exceed $100 per day will be included); or
2. Group or group-type Coverage through health maintenance organizations, Hospital or medical service organizations, group practice and other prepayment Coverage; or
3. Labor-management trusteed plans, union welfare plans and employer or employee Benefit plans; or
4. Any Coverage required or provided by a government except Medicaid; or
5. No-fault vehicle insurance.

"This Policy" means the sections of this Policy that pay Benefits for Covered Charges.

"Allowable expenses" means any needed, reasonable item of expense which is at least partly covered under one of the plans covering the Covered Person.

When Benefits are reduced under the primary plan because the Covered Person did not comply with the plan provisions, the amount of such reduction will not be considered an Allowable expense. However, the secondary plan cannot refuse to pay Benefits because a Health Maintenance Organization (HMO) member has elected to have health care services provided by a non-HMO Provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services. When a plan provides services rather than cash payments, the reasonable cash value of the service will be considered as both an Allowable expense and a Benefit paid.

EFFECT ON BENEFITS:
The Policy Year is the basis for consideration of claims. This provision will be used when the Benefits the Covered Person would receive under this Policy plus those received under all other Plans would exceed the total Allowable expense. If the Benefits provided under all Plans exceed the Allowable expense, We will reduce Our Benefits so that the total is not exceeded. However, if the Covered Person is Insured under another Plan containing a coordination of Benefits provision, the following rules will be used to determine which Plan may reduce Benefits.

1. That plan which insures the Covered Person as an employee (that is, other than as a Dependent) are determined before those of the plan which covers the Covered Person as a Dependent, except that, if the Covered Person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   • Secondary to the plan covering the person as a Dependent; and
   • (Primary to the plan covering the person as other than a Dependent, then the Benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.

2. The Benefits of a plan which insures the Covered Person as a Dependent child of a person whose date of birth, excluding the year of birth, occurs earlier in the calendar year, shall be determined before the Benefits of a plan which covers such person as a Dependent of a person whose date of birth, excluding the year of birth, occurs later in the calendar year. If both such persons have the same date of birth, the Benefits of the plan of the person who has been Insured under his or her plan for the longer period of time shall be determined first. If the other plan does not have the provisions of this paragraph regarding Dependents, which results in the plans not agreeing on the order of Benefits, the rule set forth in the other plan will determine the order of Benefits.

However, if the Covered Person is a Dependent child with separated or divorced parents, Benefits for the child are determined in this order:
• First, the plan of the parent with custody of the Dependent child;
• Then the plan of the spouse of the parent with custody of the Dependent child; and
• Finally the plan of the parent not having custody of the Dependent child.
However, if there is a court decree, which gives financial responsibility to a particular parent for the health care expenses of the child, statements above do not apply. In this case, any other plan, which covers the child as a Dependent may reduce before the plan which, covers the child as a Dependent of the parent with financial responsibility.

3. If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the Dependent child shall follow the order of Benefits set forth in rule two (2).

4. The Benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule four (4) is to be ignored.

5. Continuation Coverage. If a person whose Coverage is provided under a right of continuation pursuant to federal law, namely COBRA, or state law, also is covered under another plan, Benefits are determined in the following order:
   • First, the Benefits of the plan covering the person as an employee (or as that employee's Dependent);
   • Second, the Benefits under the continuation of Coverage.
   If the other plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule (5) shall be ignored.

6. When none of the rules above determines the order of Benefits, the plan that has Insured the Covered Person for a shorter period of time may reduce Benefits if another plan has Insured that Covered Person for a longer period of time.
   If Benefits are reduced under this section and later in the same Policy Year the total Allowable expense exceeds the Benefits paid under all plans, We will pay additional Benefits. These Benefits will not exceed the lesser of:
   • The amount of the earlier reduction; or
   • The amount which would cause total Benefits under all plans to exceed total Allowable expenses.

   If the total amount of benefit is reduced under this section, each benefit will be reduced proportionately and only the reduced amount will be charged against each benefit limit.

RIGHT TO RECEIVE AND RELEASE INFORMATION:
To carry out this provision:
   • The Covered Person must furnish to Us any necessary information; and
   • We may, without asking for consent, obtain necessary information from any source; and
   • We may release information to other plans.

FACILITY OF PAYMENT/RIGHT OF RECOVERY:
If another plan pays an amount that this Policy should have paid, We have the right to pay the benefit to that plan. This ends Our duty for payment of that claim. If this Policy pays an amount that another plan should have paid, We have the right to recover the excess amount from the person or organization to whom it was paid.

RIGHT TO REIMBURSEMENT
If Benefits are paid under this plan and any person recovers from a third party by settlement, judgment or by operation of primary Coverage, We have a right to recover from that person the sum of the reasonable costs actually paid by Us, and any amount that We paid pursuant to this Policy to any Provider. However, If You hire an attorney, then We can recover the lesser of: the amount described above; or one-third of the monies due to You under any final judgment, compromise, or settlement agreement. Any recovery by Us will be subject to pro rata reduction in relation to any attorney's fees and costs You incurred. If you did not use an attorney, then Our amount of recovery may not exceed the amount We may recover pursuant to this Policy, or one-half of the monies due to You under any final judgment, compromise, or settlement agreement. Where a final judgment includes a special finding by a judge, jury, or arbitrator that You were partially at fault, then Our recovery shall be reduced by the same comparative fault percentage by which Your recovery was reduced.
MEDICAL NECESSITY and MEDICAL APPROPRIATENESS DETERMINATION

We reserve the right to review claims and establish standards and criteria to determine if a Covered Service is Medically Necessary and/or Medically Appropriate. Benefits will be denied by Us for Covered Services that are not Medically Necessary and/or Medically Appropriate. In the event of such a denial, You will be liable for the entire amount billed by that Provider. You do have the right to appeal any adverse decision as outlined in the Appeals and Complaint Section of this Policy. You may have the right to an external independent review as outlined in the Appeals and Complaint Section of this Policy.

Covered Services are Medically Necessary if they are:
- Required to meet the health care needs of the Covered Person; and
- Consistent (in scope, duration, intensity and frequency of treatment) with current scientifically based guidelines of national medical or research organizations or governmental agencies; and
- Consistent with the diagnosis of the Condition; and
- Required for reasons other than the comfort or convenience of the Covered Person or Provider; and
- Of demonstrated medical value and medical effectiveness.

A Covered Service is Medically Appropriate if it is rendered in the most cost-effective manner and type of setting appropriate for the care and treatment of the Condition.

When specifically applied to Hospital Confinement, it means that the diagnosis or treatment of symptoms or a Condition cannot be safely provided on an Outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:
- Is Experimental/Investigational or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient’s family, Physician, Hospital or any other Physician;
- Exceeds in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or Preventive Care;
- Could have been omitted without adversely affecting the patient’s Condition or the quality of medical care;
- Involves treatment with or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA). If the prescribed drug is recognized as safe and effective for the treatment of a Sickness or Injury by one or more of the Standard Medical Reference Compendia or in the Medical Literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Sickness or Injury, Coverage will be provided, subject to the exclusions and limitations of the Policy;
- Involves a service, supply or drug not considered reasonable and necessary by the Centers for Medicare & Medicaid Services; or
- Can be safely provided to the patient on a more cost-effective basis such as Outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

Except for Preventive Care (Wellness Services), all Covered Services must be Medically Necessary except as specified herein. If You have any questions or concerns about whether a particular service, supply, or treatment is Medically Necessary or Medically Appropriate, contact Us.
GRIEVANCE PROCESS

The grievance process includes complaints, internal and external review.

Definitions:
Adverse Benefit Determination: Means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Appeal or Internal Appeal: Review by a plan or issuer of an adverse benefit determination.

Authorized Representative: An individual who by law or by the consent of a person may act on behalf of the person.

Complaint: An inquiry to Nationwide about Covered Services, a Covered Person’s rights or other issues or the communication of dissatisfaction about the quality of service or Benefit or other issue which is not an Adverse Benefit Determination.

Grievance: A request submitted by an enrollee or an authorized representative.

Expedited (Urgent Care) Appeal: An appeal that must be reviewed under an expedited process because the application of non-expedited appeal time frames could seriously jeopardize a Covered Person’s life or health or the Covered Person’s ability to regain maximum function. In determining whether an appeal involves urgent care, Nationwide must apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving (a) care that the treating Physician deems urgent in nature; (b) the treating Physician determines that a delay in the care would subject the Covered Person to severe pain that could not adequately be managed without the care or treatment that is being requested; or (c) the Covered Person is a cancer patient and the delay would subject the Covered Person to pain. Such appeal may be made by telephone, facsimile or other available similarly expeditious method. An Expedited Appeal is not available for services already incurred.

Independent External Review: If the Covered Person receives a final Adverse Decision of an appeal, the Covered Person or the Covered Person’s authorized representative who may include the treating Provider may appeal the Adverse Decision to the Bureau of Insurance for an Independent External Review.

Independent Review Organization: An entity that conducts independent external reviews of adverse determinations and final adverse determinations.

Post-service Appeal: An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

Reconsideration: A review of a not Medically Necessary Adverse Decision, by either Nationwide’s Medical Director, an independent Physician advisor, or a peer of the treating Provider who is licensed in the Provider’s same or similar specialty. The Covered Person, a Provider, or a Covered Person's authorized representative may request reconsideration. Reconsiderations are a voluntary and optional step in Nationwide’s appeal process. A Covered Person is not required to go through the reconsideration process before filing an appeal.

Complaint Resolution
1. Administrative Complaints
   Complaints due to the denial of services or payment of a claim must be reported no later than twelve (12), months from the date of service. Most complaints can be resolved by calling, or writing to, Our Customer Service Department. The telephone number and address are on Your Identification Card.
   If an informal review does not resolve the reported complaint, You will be notified of Your right to appeal.

2. Quality of Care or Service Complaint
   Quality of care complaints will be forwarded to the unit responsible for such investigations immediately upon receipt by Customer Service. We will send You a written acknowledgment within five (5) working days of receipt of the complaint. All quality of care complaints will be investigated and corrective action taken where problems and/or deficiencies are verified.
3. If We cannot provide You with a satisfactory solution to Your complaint, You may file a standard or urgent (if applicable) appeal for internal review by contacting Us at the address or phone number on the back of Your ID card or write to or call the Department of Insurance, whose information is located in the Important Notice section of this Policy.

4. If We deny a claim as “not Medically Necessary” and cannot provide You with a satisfactory solution to Your complaint, You may request an Independent External Review by writing to or calling the department of insurance in Your state.

**Internal Appeal Review Process**

**Standard Appeals**
You, an authorized person, or a Provider, with Your consent, may submit a written appeal to Us if Coverage is denied, reduced or terminated. Appeals must be received within one hundred eighty (180) days of the date the Covered Person receives written notification of the denial. Appeals should be sent to:

**Nationwide Life Insurance Company**
**Attention: Consolidated Health Plans**
2077 Roosevelt Ave.
Springfield, MA 01104
Toll Free Number: 1-800-633-7867
Fax Number: 413-733-4612

The receipt of the grievance or appeal will be acknowledged in writing within seven (7) days. The appeals staff will review all of the information. A decision will be made within thirty (30) calendar days of receipt for a Pre-Service Claim Appeal and within sixty (60) calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to an additional sixty (60) calendar days if additional information is needed. You will be notified in writing of the Appeals Department’s decision.

A Pre-Service Claims Appeal is an appeal of any claim for Benefits under the terms of the Policy, which must be Pre-Certified (in whole or in part) before medical care is obtained.

A Post-Service Claims Appeal is an appeal of a decision to deny or reduce Benefits for claim that has already been incurred.

**Expedited (Urgent Care) Appeal**
You, an authorized person or a Provider, with Your consent, may request an Expedited Appeal. This request may be verbal or written. A decision will be made within seventy-two (72) hours of receipt for an Expedited Appeal.

An Expedited Appeal is an appeal for which the medical Condition, in the absence of immediate medical attention, may result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, severe pain that cannot be managed adequately, or places in serious jeopardy the health of an individual, and with respect to a pregnant woman, includes her unborn child.

For urgent health situations, You may ask for an external review request at the same time as Your internal appeal request.

The types of denials that can go to external review are:
- Any denial that involves medical judgment (such as Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered Benefit) where You or Your Provider may disagree with the health insurance plan.
- Any denial that involves a determination that a treatment is Experimental or Investigational.

**External Review Process**
Under certain circumstances, You have a right to an external appeal of a denial of coverage. Specifically, if We denied Coverage on the basis that the service does not meet the plan’s requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an Experimental or Investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

You, an authorized person or a Provider, with Your consent, may request the external review by an Independent Review Organization (IRO) within at least one hundred eighty (180) days after the receipt of the notice of adverse determination or final internal adverse benefit determination, provided you have exhausted the internal appeal.
review process. We will provide an external appeal application with the final adverse determination issued through the internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal request form from the California Department of Insurance at 800-927-4357. Submit the completed application as indicated on the form. You must agree and provide written consent to participate in the Independent Medical Review. If You satisfy the criteria for an external appeal, the California Department of Insurance will forward the request to a certified external appeal (utilization review) agent. Requests for external review should be sent to:

State of California
Department of Insurance
Health Claims Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
www.insurance.ca.gov

FAX: 213-897-9641
PHONE: 1-800-927-HELP (4357)
TDD: 800-482-4TDD (4833)

There is no charge to You for the external review.

You will have an opportunity to submit additional documentation with Your request. If the external appeal agent determines that the information You submit represents a material change from the information on which We based Our denial, the external appeal agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision.

In general, the external appeal agent must make a decision within thirty (30) days of receipt of the necessary information to make a determination, or within twenty (20) days of the date the external appeal agent receives a request that the determination be made. The external appeal agent may request additional information from You, Your Physician, or from Us. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify You in writing of its decision within two (2) business days.

**Expedited Review:** If Your Attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your Attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the external appeal agent must try to notify You and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify You in writing of its decision within forty-eight (48) hours after oral notice is given to You and the Plan.

**External Review Decision:** If the external appeal agent overturns the Our decision that a service is not Medically Necessary or approves Coverage of an Experimental or Investigational treatment, We will provide Coverage subject to the other terms and conditions of the Policy. Please note that if the external appeal agent approves Coverage of an Experimental or Investigational treatment that is part of a clinical trial, We will only cover the costs of services required to provide treatment to You according to the design of the trial. We will not cover the costs of Investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Policy for non-Experimental or non-Investigational treatments provided in such clinical trial.

The external appeal agent’s decision is binding for both parties. The external appeal agent’s decision is admissible in any court proceeding.

1. **Your Right to Appeal a Determination that a Service is Not Medically Necessary**
   You may request an Independent Medical Review (IMR) of Medical Necessity denial, if You believe that We have improperly denied, modified, or delayed health care services. A Medical Necessity denial is any health care service eligible for Coverage and payment under the Policy that has been denied, modified, or delayed by Us, in whole or in part, because the health care service is not Medically Necessary.
The IMR process is in addition to any other procedures or remedies that may be available to You. Costs associated with the independent external review are the responsibility of the nonprevailing party. You have the right to provide information in support of the request for IMR. You may contact Customer Service for assistance.

Eligibility:
We will review Your application for IMR if it is filed within six (6) months of any of the following qualifying periods or events. All of the following Conditions must be met:

a. Your Provider has recommended a health care service as Medically Necessary; or
b. You have received Urgent Care or Emergency services that a Provider determined was Medically Necessary; or
c. In the absence of (a) or (b) You have been seen by a Participating Provider for the diagnosis or treatment of the medical Condition for which You seek independent review; and
   • The claim has been denied, modified, or delayed by Us based in whole or in part on a decision that the health care service is not Medically Necessary; and
   • You have filed an appeal with Us and the disputed decision is upheld or the appeal remains unresolved after thirty (30) days. If Your appeal requires expedited review You may bring it immediately to Our attention. We may waive the requirement that You follow the appeal process in unusual cases; or
   • We waive the exhaustion requirement.

If Your case is eligible for an IMR, the dispute will be submitted to an IMR organization, meeting the requirements of Section 1152 of the Social Security Act, that will make an independent determination of whether or not the care is Medically Necessary. A determination made by the external reviewer is binding on the parties. You will receive a copy of the assessment made by the independent reviewer. If the IMR determines the service is Medically Necessary, We will provide Benefits for the health care service.

For non-urgent cases, the IMR organization, independent of the Company, must provide its determination within thirty (30) days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

You have the right to submit, to the IRO, additional information in writing that the IRO must consider when conducting the external review. The IRO will allow You at least five (5) business days to submit any additional information and any additional information submitted by You will be sent to Us, from the IRO, within one (1) business day.

Please call Our Customer Service Department at the phone number on the back of Your Identification Card if You have any questions or need additional information.

2. Independent Medical Review (IMR) - Experimental or Investigational Denials Eligibility:
You may request an Independent Medical Review (IMR) from an organization independent of the Company if all of the following criteria are met:

a. You have a Life Threatening or Seriously Debilitating Condition, as certified by Your Physician.
   (i) “Life Threatening” means either or both of the following:
   • Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted;
   • Diseases or Conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
   (ii) “Seriously Debilitating Condition” means diseases or Conditions that cause major irreversible morbidity.

b. Your Physician certifies that one of the following situations applies:
   • standard therapies have not been effective in improving the Condition;
   • standard therapies are not Medically Necessary for You;
   • there is no standard therapy covered under the Policy that will benefit You more than the requested therapy;

c. Your Physician has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to benefit You more than standard therapies; or You or Your Physician have requested a therapy that based on two (2) documents from the Medical and Scientific Evidence as defined below, is likely to be more beneficial for You than any available standard therapy.
d. The Physician’s certification includes a statement of the evidence relied upon when certifying the recommendation. We will not pay for services of a Non-Participating Provider that are not otherwise covered.

e. You have been denied Benefits/Covered Services for services requested in (2) above, unless Coverage for the specific therapy is excluded by this Policy;

f. The drug, device, procedure or other therapy would be covered under the Policy if it were not considered to be Experimental or Investigational.

For the purposes of this section, “Medical and Scientific Evidence” means the following sources:

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

2. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline and MEDLARS database Health services Technology Assessment Research (HSTAR).

3. Medical journals recognized by the Secretary of Health and Human services, under Section 1861(t) (2) of the Social Security Act.

4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.

5. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

3. External Exception Process – Non-Formulary Prescription Drugs

You, an authorized person, or a Provider may request an external exception review when a non-formulary drug request has been denied.

For non-urgent cases, the IMR organization, independent of the Company, must provide its determination within seventy-two (72) hours of receipt of Your external exception review request. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within twenty-four (24) hours of receipt of Your external exception review request.

Please call Our Customer Service Department at the phone number on the back of Your Identification Card if You have any questions or need additional information.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy and the Application of the Policyholder constitute the entire contract between the parties, and any statement made by the Policyholder shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under this Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void this Policy after it has been in force for two (2) years from the date of its issue.

No change in this Policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit on Certain Defenses (Incontestability): After two (2) years from the date of issue of this Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in the application shall be used to void the Policy.

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**Grace Period:** A grace period of thirty-one (31) days will be granted for the payment of Premiums accruing after the first premium, during which grace period the Policy shall continue in force, but the Policyholder shall be liable to Us for the payment of the premium accruing for the period the policy continues in force.

**Reinstatement:** We do not permit reinstatement of the Policy after lapse because of default in the payment of Premium. If any renewal Premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of Premium by Us or by any agent duly authorized by Us to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if We or Our agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Policy will be reinstated upon approval of such application by Us, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the Policyholder in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such Accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after such date. In all other respects We and the Policyholder shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

**Notice of Claim:** Written Notice of Claim must be given to Us within ninety (90) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Covered Person to Us at Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield, MA 01104 (1-800-633-7867) or to any authorized agent of the insurer, with information sufficient to identify the Covered Person, shall be deemed notice to Us.

**Claim Forms:** We, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

**Proof of Loss:** Written proof of loss must be furnished to Us, in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within ninety (90) days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

**Time of Payment of Claims:** Benefits payable under this Policy for any loss other than loss for which this policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:** Benefits will be payable to the Covered Person or the medical services Provider if We have received a valid assignment by the Covered Person.

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, Hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.
Physical Examination and Autopsy: We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending. We, at Our own expense, may also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Legal Actions: A legal action may not be brought to recover on this Policy within sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of three (3) years from the time written proof is required to be furnished.

Non-Participating: The Policy is non-participating. It does not share in Our profits or surplus earnings.

Nonduplication of Benefits: If any item of expense is payable under more than one provision of the Policy, payment will be made only under the provision providing the greater Benefit.

Conformity with State Statutes: If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Workers' Compensation: This Policy is not in lieu of and does not affect any requirement for Coverage by Workers' Compensation Insurance.

Clerical Error: If a clerical error is made so that an otherwise Eligible Person’s Coverage does not become effective, Coverage may be in effect if: (a) the Policyholder makes a written request for Coverage on a form approved by Us; and (b) any Premium not paid because of the error is paid in full from the Effective Date of Coverage. Company reserves the right to limit retroactive Coverage to two months preceding the date the error was reported.

If a clerical error is made so that the Coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

Information and Records: We shall have the right to inspect, at reasonable times, any of the Policyholder's records for the Policy. The Policyholder shall provide Us with information necessary to administer Coverage and set Premium under the Policy. Information is required when an Eligible Person becomes covered, when changes in amounts of Coverage occur, and when a Covered Person's Coverage terminates.
SCHEDULE OF BENEFITS

Actuarial Value: 81.18%
Equivalent or next lowest coverage level: Gold

Please note, while this plan provides an actuarial value of at least 60% in accordance with the Patient Protection and Affordable Care Act, it may not provide an actuarial value on parity with those of the same metal tier currently offered in the health insurance marketplace in your state. The metal tier coverage level noted above indicates the actual or next lowest corresponding metal tier based on the referenced actuarial value of this plan.

Your Coverage provides for the utilization of Preferred Providers in a Preferred Provider Organization (PPO). Certain Benefits are paid at different rates if the service is not provided by a Preferred Provider. See the Definitions page for the definition of Preferred Provider Organization, Preferred Provider, Out-of-Network Provider, In-Network Benefit and Out-of-Network Benefit. The Preferred Provider Organization(s) & Review Organization for Your Coverage is: Cigna (www.cigna.com).

EFFECTIVE DATE: 8/25/2016
TERMINATION DATE: 08/24/2017

PREMIUM:

<table>
<thead>
<tr>
<th></th>
<th>Annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Only</td>
<td>$1,137</td>
</tr>
</tbody>
</table>

Policy Year Maximum Benefit

<table>
<thead>
<tr>
<th></th>
<th>Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Deductible (except as specified herein) per Policy Year per Covered Person:
- Benefits are subject to Deductible unless otherwise indicated.
- The Deductible shall not apply:
  - In-Network Preventive/wellness exams and immunizations
  - To Outpatient Prescription Drugs
  - In-Network Office Visits
- Copayments do not apply to Deductibles

<table>
<thead>
<tr>
<th></th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$250</td>
<td>$500</td>
</tr>
</tbody>
</table>

Insured Percent (except as specified herein)

<table>
<thead>
<tr>
<th></th>
<th>80% of Preferred Allowance (PA)</th>
<th>60% of Reasonable &amp; Customary (R&amp;C)</th>
</tr>
</thead>
</table>

Out-of-Pocket Maximum

- Includes Coinsurance, Copayments and Deductibles
- Out-of-Network Emergency Services (including Emergency Transportation Services) apply to the In-Network Out-of-Pocket maximum;
- Excludes non-covered medical expenses and Elective Treatment;
- Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year;
- Once the In-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network;
- Once the Out-of-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% Out-of-Network.

<table>
<thead>
<tr>
<th></th>
<th>$6,600 per Covered Person</th>
<th>$13,200 per Covered Person</th>
</tr>
</thead>
</table>

Covered Charges – Essential Health Benefits

Preventive Care (See Definition for additional information.)

<table>
<thead>
<tr>
<th></th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>100% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Deductible &amp; Copayment waived</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Outpatient Services - Other than Surgery or Maternity

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment</th>
<th>R&amp;C Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits performed and billed by a Physician’s office, including Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician. Includes Specialists.</td>
<td>100% of PA after a $50 Copayment per visit + waiver of Deductible</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Consulting Physician - Does not apply when related to surgery.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic Imaging - Includes x-ray services which are diagnostic or therapeutic.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>CT Scan, MRI, and/or PET Scans</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Infusions (done in an Outpatient Health Care Facility or Physician’s office)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Injections (done in an Outpatient Health Care Facility or Physician’s office)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Radiation</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Dialysis (hemodialysis and peritoneal) and Filtration Procedures in office or home setting, for acute or chronic renal failure - Includes administration and supplies.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

### Inpatient Services - Other than Surgery or Maternity

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment</th>
<th>R&amp;C Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous Hospital Services - Includes meals and prescribed diets, Diagnostic Imaging, Laboratory, pharmaceuticals administered while an Inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical event, Pre-Admission Testing and Inpatient Rehabilitation.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Room and Board expense - daily semi-private room rate and general nursing care provided by the Hospital.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
</tbody>
</table>

**Note:** Only one (1) Copayment amount, if any, for Room and Board, and Intensive Care Room applies to each admission for the same Condition.

### Surgical Services

When multiple surgeries are performed through the same incision at the same operative session, We will pay an amount not to exceed 50% of the Benefit otherwise payable for the secondary procedure and 25% of the Benefit otherwise payable for each subsequent procedure.

### Inpatient Surgical Services

<table>
<thead>
<tr>
<th>Role</th>
<th>Copayment</th>
<th>R&amp;C Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Service Description</td>
<td>PA Coverage</td>
<td>R&amp;C Coverage</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Inpatient Surgical Miscellaneous - Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Outpatient Surgical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Outpatient Surgical/Day Surgery Miscellaneous Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Other Surgical Services (Inpatient/Outpatient) ^</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Anesthesia for Dental services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Major Oral or Dental procedures to prepare the jaw for radiation treatment of oral or throat cancers.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Obesity Surgery for the treatment of Morbid Obesity ^</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>• The Covered Person must complete pre-surgical education in order to qualify for benefits under this Policy.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>• Limited to one (1) bariatric surgical procedure per lifetime.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Reconstructive Surgery - Includes Medically Necessary breast reduction and varicose vein removal; Post-mastectomy reconstruction of the impacted and non-impacted breast to achieve a symmetrical appearance.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Organ Transplant Surgery ^ - Limited to heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas and autologous bone marrow transplants only.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Donor Services ^ - Covered only for services not covered by the donor’s own plan. Excluded for a Covered Person donating to a recipient not covered by this Policy.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Reproductive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Sterilization Surgery</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Note: Sterilization procedures for women are covered under Preventive Care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective Termination of Pregnancy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Maternity Care ^ – Includes forty-eight (48) hours of Inpatient care following a normal delivery and ninety-six (96) hours of Inpatient care following a cesarean delivery, unless after conferring with the mother or a person responsible for the mother or newborn, the Attending Physician or a certified nurse-midwife who consults with a Physician, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits will be provided.</td>
<td>100% of PA Deductible &amp; Copayments waived after a $50 Copayment per visit + waiver of Deductible</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Routine prenatal exams, the first postnatal exam, routine tests and ultrasounds</td>
<td>100% of PA Deductible &amp; Copayments waived after a $50 Copayment per visit + waiver of Deductible</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Delivery and Inpatient Physician visits for mother and baby.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic services performed and billed by a Physician’s office, including diagnostic ultrasounds and amniocentesis.</td>
<td>100% of PA after a $50 Copayment per visit + waiver of Deductible</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Mental Illness and Substance Use Disorder (including Severe Mental Illness or Serious Emotional Disturbance of a Child – see State Mandated Benefits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services ^ including Alcoholism/Drug detoxification</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Outpatient Office Visits (Includes partial, residential or day treatment)</td>
<td>100% of PA after a $50 Copayment per visit + waiver of Deductible</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Other Outpatient treatment (anything outside of an Office Visit, Emergency Services or Prescription drugs)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Urgent Care and Emergency Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Facility (non Emergency) services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Service Description</td>
<td>Cost Sharing</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Emergency services - visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition; Includes Physician’s fees, Diagnostic Imaging, Laboratory, Injections, use of emergency room, supplies, and facility charges. Including Emergency services for Mental Illness & Substance Use Disorder.  
  - Copayment waived if admitted to Hospital  
  - Follow-up care at the Emergency room is not covered | 80% of PA after a $100 Copayment per visit | 80% of PA after a $100 Copayment per visit |
<p>| Emergency Medical Transportation Services (Including non-emergency licensed ambulance and psychiatric transport van services). | 80% of R&amp;C |
| Other Services                                                                       |                       |
| Allergy Testing                                                                      | 80% of PA 60% of R&amp;C |
| Allergy injections/treatment - Includes treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual treatments. Also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy. | 80% of PA 60% of R&amp;C |
| Clinical Trials - Includes coverage for routine patient costs associated with a Covered Person’s participation in a clinical trial. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care of the Covered Person. | 80% of PA 60% of R&amp;C |
| Habilitative Care - Only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy for a function that did not previously exist, but would normally be expected to exist. | 80% of PA 60% of R&amp;C |
| Rehabilitative Care - only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, Occupational Therapy, and Restorative Speech Therapy; Outpatient Physical Therapy is limited to twelve (12) visits per Condition. | 80% of PA 60% of R&amp;C |
| Pulmonary Therapy                                                                    | 80% of PA 60% of R&amp;C |
| Cardiac Therapy                                                                      | 80% of PA 60% of R&amp;C |
| Respiratory Therapy                                                                  | 80% of PA 60% of R&amp;C |
| Acupuncture typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. | 80% of PA 60% of R&amp;C |
| Dermatology (not including treatment of acne)                                         | 80% of PA 60% of R&amp;C |
| Podiatry                                                                             | 80% of PA 60% of R&amp;C |
| Home Health Care services – no more than $50 Deductible for In-Network services will apply per Policy Year. | 80% of PA 60% of R&amp;C |
| Hospice - Includes bereavement counseling and respite care.                           | 80% of PA 60% of R&amp;C |
| Diabetic treatment and education                                                     | 80% of PA 60% of R&amp;C |
| Prosthetic and Orthotic Devices - Includes replacement, repair, fitting and adjustment. | 80% of PA 60% of R&amp;C |
| Durable Medical Equipment (DME)                                                      | 80% of PA 60% of R&amp;C |
| Formulas and Low Protein Modified Foods - prescribed Enteral formulas and services and supplies provided to Covered Persons suffering from an inherited metabolic disorder (such as PKU). | 80% of PA 60% of R&amp;C |
| TMJ – treatment for the dysfunction of the temporomandibular joints, including surgical treatment of the jaw, to correct or treat TMJ. | 80% of PA 60% of R&amp;C |
| Hearing Screenings for Covered Persons nineteen (19) years of age and older (under age nineteen (19) covered under Preventive Services). | 80% of PA 60% of R&amp;C |</p>
<table>
<thead>
<tr>
<th>Specialty Lenses – special contact lenses for aniridia when prescribed by an optometrist or other Physician are limited to two (2) Medically Necessary contact lenses per eye (including fitting and dispensing) in any Policy Year to treat aniridia; and up to six (6) Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per Policy Year to treat aphakia for Covered Persons through age nine (9).</th>
<th>80% of PA</th>
<th>60% of R&amp;C</th>
</tr>
</thead>
</table>

**Pediatric Dental and Vision Services – Refer to the Pediatric Vision Services and Pediatric Dental Services provisions in the Policy and Certificate for additional details, including applicable limitations and exclusions.**

<table>
<thead>
<tr>
<th>Pediatric Dental – preventive &amp; diagnostic services, for Covered Persons under age nineteen (19); Limited to 1 exam / prophylaxis every 6 months. Includes:</th>
<th>100% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Topical fluoride treatment – 2 per 12 months</td>
<td></td>
</tr>
<tr>
<td>• x-rays – bitewing – 1 set per 6 months</td>
<td></td>
</tr>
<tr>
<td>• x-rays - full-mouth and panoramic – 1 per 24 months</td>
<td></td>
</tr>
<tr>
<td>• sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months)</td>
<td></td>
</tr>
<tr>
<td>• space maintainers, including removable acrylic and fixed band type</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Dental – basic restorative services, for Covered Persons under age nineteen (19); Includes:</th>
<th>70% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>• emergency palliative treatment of pain</td>
<td></td>
</tr>
<tr>
<td>• fillings (amalgam, resin-based composite, acrylic, synthetic or plastic) including Medically Necessary replacement</td>
<td></td>
</tr>
<tr>
<td>• endodontics - pulpotomy or vital pulpotomy</td>
<td></td>
</tr>
<tr>
<td>• periodontics - scaling and root planning and subgingival curettage, limited to five (5) quadrant treatments every 12 months</td>
<td></td>
</tr>
<tr>
<td>• prosthodontics – acrylic and prefabricated stainless steel crowns; denture and crown repair, denture rebase/reline (1 per arch every 12 months) recementation of crowns, bridges, inlays and onlays; replacement of crowns and dentures (1 per 36 months unless Medically Necessary)</td>
<td></td>
</tr>
<tr>
<td>• Oral surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Dental – major services, for Covered Persons under age nineteen (19); Includes:</th>
<th>50% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>• prosthodontics – crowns, bridges, and dentures</td>
<td></td>
</tr>
<tr>
<td>• endodontics</td>
<td></td>
</tr>
<tr>
<td>• periodontics – gingivectomy; osseous or muco-gingival surgery; emergency treatment, including treatment for periodontal abscess and acute periodontitis</td>
<td></td>
</tr>
<tr>
<td>• general anesthesia and IV sedation – in conjunction with complex oral surgery</td>
<td></td>
</tr>
<tr>
<td>• analgesia (nitrous oxide) or non-IV sedation (not in conjunction with general anesthesia or IV sedation)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Dental – Medically Necessary orthodontia services*, for Covered Persons under age nineteen (19). Includes:</th>
<th>50% of R&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>• pre-orthodontic treatment</td>
<td></td>
</tr>
<tr>
<td>• orthodontic treatment</td>
<td></td>
</tr>
<tr>
<td>• appliance therapy</td>
<td></td>
</tr>
<tr>
<td>• orthodontic retention</td>
<td></td>
</tr>
<tr>
<td>Subject to 12-month waiting period for services</td>
<td></td>
</tr>
<tr>
<td>*Requires pre-authorization</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine Vision Exam for Covered Persons under age nineteen (19); Includes:</th>
<th>100% up to $150, then 50% thereafter</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1 exam/fitting per Policy Year, including dilation if professionally indicated</td>
<td></td>
</tr>
<tr>
<td>• prescription eyeglasses (lenses and frames), or one (1) year supply of contact lens in lieu of eyeglasses</td>
<td></td>
</tr>
<tr>
<td>• Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes. Low vision aid devices are limited to one (1) per year.</td>
<td></td>
</tr>
</tbody>
</table>
Outpatient Prescription Drugs

Retail Prescription Drugs - per prescription or refill, subject to dispensing limits.

The Pharmacy Benefits Manager (PBM) is: Cigna at www.cigna.com

Note: Retail Prescription Drugs will be considered an Essential Health Service unless prescribed drug is related to an Elective Treatment, subject to exclusions and other limitations of the Policy.

<table>
<thead>
<tr>
<th>3 Tier Plan</th>
<th>In-Network Pharmacy Benefit: 100% after</th>
<th>Out-of-Network Pharmacy Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Generic Drugs</td>
<td>$15 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>2. Preferred Brand Drugs</td>
<td>$35 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>3. Non-Preferred Brand and Specialty Drugs</td>
<td>$70 Copayment</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

You must show Your Identification Card to the pharmacist. Normally there are no claims to file. If You forget Your Identification Card, You may be asked to file a claim form for reimbursement. Save Your receipt and call Our customer service department to request a form.

- Only a thirty (30) day supply can be dispensed at any time (certain exceptions apply as specified by the retail pharmacy);
- One (1) Copayment per thirty (30) day supply.
- No cost sharing applies to Generic Contraceptives or other Preventive Services drugs; Includes FDA approved prescription and over-the-counter contraceptives and contraceptive devices for women, preventive over-the-counter drugs when prescribed by a Physician on the USPSTF A&B recommendations list, and FDA approved smoking deterrent prescription and over-the-counter medications for a 90-day treatment regimen when prescribed by a Provider;
- Sexual enhancement drugs are limited to a maximum of 8 doses in any 30-day period or 27 doses in any 100-day period;
- Includes medications, equipment and supplies for the management and treatment of diabetes;
- The Deductible does not apply;
- The Covered Person will be responsible for the cost difference between Brand and Generic, in addition to the Tier 2, 3 Copayment for a Brand drug when there is a Generic equivalent available, unless “Do Not Substitute” or “Dispense as Written” is indicated on the prescription.
- Cost sharing for oral anticancer medication will be capped at $200 per 30-day supply.
- Coverage will include Medically Necessary disposable devices for administering a covered outpatient Prescription Drug, such as spacers and inhalers for aerosol drugs and syringes for drugs that are not dispensed in pre-filled syringes.
- Coverage is provided for appropriately prescribed pain management medications for terminally ill patients when Medically Necessary.
- For coverage of drugs that are not included on the formulary drug list, You may contact Cigna at www.cigna.com or call CHP at 800.633.7867 to determine if the benefits are available. For non-urgent cases, the PBM must provide its determination within seventy-two (72) hours of receipt of Your exception review request. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the PBM must provide its determination within twenty-four (24) hours of receipt of Your exception review request.

Mail Service Prescription Drugs - per prescription or refill, (In-Network Benefit only)

<table>
<thead>
<tr>
<th>3 Tier Plan</th>
<th>Participating Pharmacy Benefit: 100% after</th>
<th>Non-Participating Pharmacy Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Generic Drugs</td>
<td>$30 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>2. Preferred Brand Drugs</td>
<td>$70 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>3. Non-Preferred Brand Drugs</td>
<td>$140 Copayment</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Prescription Drugs covered under the Retail Prescription Drug benefit, as described above, may be ordered by mail through Our Pharmacy Benefits Manager. There is no Out-of-Network mail service Prescription Drug Coverage. The Copayment and/or Coinsurance amounts, whichever applies, shown above must be sent with each prescription or refill. You may call Our customer service department for determination of the dollar amount for each prescription or refill. If You have mail service prescription drug Coverage, the Pharmacy Benefits Manager will send You information on how to order Drugs through the mail.

- Only a ninety (90) day supply can be dispensed at any time.
<table>
<thead>
<tr>
<th>Covered Charges</th>
<th>In-Network Benefit</th>
<th>Out-of-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental treatment due to Injury to a Sound Natural Tooth</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Repair or replacement of eye glasses, contact lenses or hearing aids when required as a direct result of an Injury.</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Non-emergency out-of-country, if not covered by any other coverage.</td>
<td></td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Evacuation Services</td>
<td></td>
<td>100% of charges</td>
</tr>
<tr>
<td>Repatriation Services</td>
<td></td>
<td>100% of charges</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment Benefit Amount:</td>
<td></td>
<td>$5,000</td>
</tr>
</tbody>
</table>
IMPORTANT NOTICE

Nationwide Life Insurance Company
Attention: Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104
Toll Free Number: 1-800-633-7867
Fax Number: 413-733-4612

If You continue to remain unsatisfied, You may contact the California Department of Insurance with any complaint. To contact the Department of Insurance, You may write or call them at:

CALIFORNIA DEPARTMENT OF INSURANCE
Consumer Services Division
300 S. Spring St., South Tower
Los Angeles, CA  90013
800-927-HELP (4357)
TDD: 800-482-4TDD (4833)

[Signature]

President

Nationwide Life Insurance Company
ADDITIONAL BENEFITS RIDER
NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Issues this rider to: THE POLICYHOLDER REFERRED TO ON THE COVER PAGE OF THE POLICY/CERTIFICATE TO WHICH THIS RIDER IS ATTACHED AND MADE A PART THEREOF.

The Effective Date of this rider is the Effective Date of the Policy to which this rider is attached. The Policy/Certificate is amended as described below. All other terms, provisions, limitations and exclusions remain unchanged except as specifically noted within this Benefit Rider.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

This benefit applies only with respect to Accidents that occur on or after the Rider Effective Date.

Benefit:

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>Benefit Amount Insured:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$5,000</td>
</tr>
<tr>
<td>Both hands or both feet or the entire sight of both eyes</td>
<td>$5,000</td>
</tr>
<tr>
<td>One (1) hand and one (1) foot</td>
<td>$5,000</td>
</tr>
<tr>
<td>One (1) hand or one (1) foot or the entire sight of one (1) eye</td>
<td>$2,500</td>
</tr>
<tr>
<td>More than one (1) of the above losses due to one (1) Accident</td>
<td>$5,000</td>
</tr>
<tr>
<td>Thumb or Index Finger</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

Note: Loss shall mean, with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint, and with regard to eyes, entire or irrecoverable loss of sight. Only the largest benefit will be paid if more than one (1) loss results from any one (1) Accident.

If the Eligible Person, within one hundred eighty (180) days from the date of an Accident which occurs while Coverage is in force, dies as the result of Injury from such Accident, We will pay the Eligible Person’s beneficiary the amount for loss of life as shown on the Schedule of Benefits. If the Eligible Person, within one hundred eighty (180) days from the date of an Accident, which occurs while Coverage is in force, suffers dismemberment as the result of Injury from such Accident, We will pay the Eligible Person the amount set opposite such loss, as shown on the Schedule of Benefits. If more than one (1) such loss is sustained as the result of one (1) Accident, We will pay only one (1) amount, the largest to which the Eligible Person or his or her beneficiary would be entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight must be entire and irrecoverable. Loss of a thumb and index fingers means loss by severance at or above the metacarpophalangeal joints, which are the joints between the fingers and the hand. This Benefit is subject to all the terms, Conditions and exclusions of this Policy.

Beneficiary Information

The Eligible Person’s beneficiary is the person or persons who will receive his or her Accidental Death and Dismemberment Benefit if the Eligible Person dies.

The Eligible Person will be required to name a beneficiary when he or she enrolls. The Covered Person may later change his or her beneficiary. This change must be made on forms We provide and must be received in Our home office. Any change will be effective on the date he or she signs proper forms. We will not be responsible for a change received after his or her claim has been paid. When the beneficiary is changed, any previous choice of beneficiary will be void.

More than one (1) beneficiary may be named. We will pay the amount the Eligible Person specifies for each person. If he or she does not specify amounts, We will divide the Benefit equally. If one (1) of the beneficiaries dies before the Covered Person dies, We will divide the Benefit equally among the others, unless the Covered Person specifies otherwise.

If the Eligible Person fails to name a beneficiary or if there is no beneficiary surviving when the Covered Person dies, We will, at Our option, pay in successive order, the spouse, children, parents, brothers, sisters, or the Eligible Person’s estate.

The Following Language Amends the Claims Provisions Section of the Policy

Payment of Claims: Unless instructed by You otherwise, Benefits payable under this Policy for Loss of life are payable to the first surviving classes of the Covered Person: spouse; child or children; mother or father; sisters or brothers; or estate. All other Benefits will be payable to the Covered Person or the medical services Provider if We have received a valid assignment by the Covered Person.
If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Subject to any written direction of the Covered Person or of the legal or natural guardian of the Covered Person, if the Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, Hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

**MEDICAL EVACUATION AND REPATRIATION EXPENSE BENEFIT**

This benefit applies only with respect to Medical Evacuation (Family Travel) and Repatriation that occur on or after the Rider Effective Date.

**Maximum Benefit per Policy Year, per Covered Person:** Unlimited

**Emergency Medical Evacuation** - If the Covered Person sustains an Accidental Injury or Emergency Sickness while Insured under the Policy, We will pay for the actual charges Incurred for an emergency medical evacuation of the Covered Person to or back to the Covered Person’s home state, country or country of regular domicile, subject to the maximum Benefit limit shown above, and the Exclusions and Limitations provisions. Before We make any payment, We require written certification by the Attending Physician that the evacuation is Medically Necessary. Any expense for medical evacuation requires Our prior approval and coordination. For international students, Once evacuation is made outside the country, Coverage terminates. This Benefit does not include the transportation expense of anyone accompanying the Covered Person or visitation expenses.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured’s Injury or Emergency Sickness warrants his Emergency Evacuation. All transportation arrangements made must be by the most direct and economical conveyance and route possible.

No Benefits are payable for expenses Incurred after the date the Insured Person’s Coverage under the Policy terminates. However, if on the date of termination the Insured is Inpatient Confined in a Hospital, then Coverage under this Benefit provision continues until the earlier of the date such Confinement ends or the end of the 31st day after the date of termination.

**Definitions for this Medical Evacuation Benefit**

**Children:** Includes natural children, stepchildren, adopted children, children placed in the Insured's custody for the purpose of adoption, children appointed to the Insured’s custody by court order, or foster children who are dependent upon the Insured for support.

**Covered Evacuation Expenses:** Expenses for Medically Necessary transportation, including Reasonable and Customary Charges for medical services and supplies Incurred in connection with the Insured’s Emergency Evacuation.

**Emergency Evacuation:** The Insured Person’s medical Condition warrants immediate transportation from the place where the Insured is injured or sick to the nearest Hospital where appropriate medical treatment can be obtained. Transportation means any land, sea or air conveyance required to transport the Insured during an Emergency Evacuation.

**Emergency Sickness:** An Illness or disease, diagnosed by a legally licensed Physician, which meets all of the following criteria:

1. There is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of Your Condition or place the Insured's life in jeopardy; and
2. The severe or acute symptom occurs suddenly and unexpectedly.
Repatriation - If the Covered Person dies while Insured under the Policy, We will pay for the actual charges incurred for embalming, and/or cremation and returning the body to his place of permanent residence in his home country or country of regular domicile, subject to the maximum Benefit limit shown above, and the Exclusions and Limitations provisions. Expenses for repatriation of remains require the Policyholder’s and Our prior approval. If You are a United States citizen, Your Home Country is the United States. This Benefit does not include the transportation expense of anyone accompanying the body, visitation or lodging expenses or funeral expenses.

Signed for Nationwide Life Insurance Company

[Signature]
Secretary

[Signature]
President
NOTICE OF FREE LANGUAGE ASSISTANCE

No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or 1-800-468-4343. For more help call the CA Dept. of Insurance at 1-800-927-4357.

English

Arabic 1-800-927-4357

Armenian

Chinese 1-800-468-4343

Czech 1-800-927-4357

Japanese 1-800-927-4357

Korean 1-800-927-4357

Kherman 1-800-927-4357

Persian 1-800-927-4357

Russian 1-800-927-4357

Spanish 1-800-927-4357

Tagalog 1-800-927-4357

Vietnamese 1-800-927-4357
NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association (“the Association”). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers’ care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations or the rights or obligations of the Association.

**COVERAGE**

- **Persons Covered**
  Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payee or assignees, whether or not they live in California.

- **Amounts of Coverage**
  The basic coverage protections provided by the Association are as follows.

  - **Life Insurance, Annuities and Structured Settlement Annuities**
    For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

    - **Life Insurance**
      80% of death benefits but not to exceed $300,000
      80% of cash surrender or withdrawal values but not to exceed $100,000

    - **Annuities and Structured Settlement Annuities**
      80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

  The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**
  The maximum amount of protection provided by the Association to an individual, as of January 1, 2015 is $519,764. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.
COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

• A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.

• A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society

• If the person is provided coverage by the guaranty association of another state.

• Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual

• Employer and association plans, to the extent they are self-funded or uninsured

• A policy or contract providing any health care benefits under Medicare Part C or Part D

• An annuity issued by an organization that is only licensed to issue charitable gift annuities

• Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract

• Any policy of reinsurance unless an assumption certificate was issued

• Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either the following:

<table>
<thead>
<tr>
<th>California Life and Health Insurance Guarantee Association</th>
<th>California Department of Insurance Consumer Communications Bureau</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O Box 16860, Beverly Hills, CA 90209-3319</td>
<td>300 South Spring Street, Los Angeles, CA 90013</td>
</tr>
<tr>
<td>(323) 782-0182</td>
<td>(800) 927- 4357</td>
</tr>
</tbody>
</table>

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.
WHEN DOES NATIONWIDE DO WITH YOUR PERSONAL INFORMATION?

Why?
Financial companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?
The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number, government issued identification, and contact information
- Policy, account, and contract information
- Credit reports and other consumer reports

How?
All financial companies need to share customers’ personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers’ personal information; the reasons Nationwide chooses to share; and whether you can limit this sharing.

<table>
<thead>
<tr>
<th>Reasons we can share your personal information</th>
<th>Does Nationwide share?</th>
<th>Can you limit this sharing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For our marketing purposes— to offer our products and services to you</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For joint marketing with other financial companies</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For our affiliates’ everyday business purposes— information about your transactions and experiences</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>For our affiliates’ everyday business purposes— information about your creditworthiness</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>For our affiliates to market to you</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>For nonaffiliates to market to you</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

To limit our sharing:
- Call us toll free at 1-866-280-1809 and our menu will prompt you through your choices.
- If you have previously opted out, your preference remains on file and you do not need to opt out again.
- Please have your account or policy number handy when you call.

Please note: If you are a new customer, we can begin sharing your information 30 days from the date we sent this notice. When you are no longer our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.

Questions? 1-800-633-7867

Who we are
Who is providing this notice? Nationwide Life Insurance Company

What we do
How does Nationwide protect my personal information?
To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state law. These measures include computer safeguards and secured files and buildings. We limit access to your information to those who need it to do their job.
How does Nationwide collect my personal information?

We collect your personal information, for example, when you:
- Apply for insurance
- Make a payment or file a claim
- Conduct business with us
We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.

Why can’t I limit all sharing?

Federal and state law gives you the right to limit only:
- Sharing for affiliates’ everyday business purposes—information about your creditworthiness;
- Affiliates from using your information to market to you; and
- Sharing for nonaffiliates to market to you.
State laws and individual companies may give you additional rights to limit sharing. See below for more information.

Definitions

Affiliates
Companies related by common ownership or control. They can be financial and nonfinancial companies. These companies include Nationwide Life Insurance Company, Nationwide Bank, and Nationwide Property and Casualty Insurance Company. Visit nationwide.com for a list of affiliated companies.

Nonaffiliates
Companies not related by common ownership or control. They can be financial and nonfinancial companies.

Joint marketing
A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

Other important information

California Residents: We currently do not share information we collect about you with affiliated or nonaffiliated companies for their marketing purposes. Therefore, you do not need to opt out.

Nevada Residents: You may request to be placed on our internal Do Not Call list. Send an email with your phone number to privacy@nationwide.com. You may request a copy of our telemarketing practices. For more on this Nevada law, contact Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; Phone number: 1-702-486-3132; email: BCPINFO@ag.state.nv.us.

Vermont Residents: For Vermont customers only. We will not share your personal information for marketing purposes with the Nationwide family of companies without your authorization, except as permitted by law.

AZ, CA, CT, GA, IL, ME, MA, MT, NV, NJ, NM, NC, ND, OH, OR, and VA Residents: When we refer to “Information” we mean information we collect during an insurance transaction (not including medical record information). We will not use your medical information for marketing purposes without your consent. We share personal information with nonaffiliates without your prior authorization as permitted or required by law. They may use it to investigate fraud, respond to court orders, and conduct actuarial studies. We share it with insurance regulatory authorities and law enforcement. We share it with consumer reporting agencies. They may retain it or disclose it to other companies with which you do business. These other companies use and disclose it to others as permitted by law. We obtain reports prepared by an insurance-support organization. The insurance-support organization keeps copies and discloses them to others. You have a right to access and correct your Information as described below.

Accessing your information

You can ask us for a copy of your personal information. Please send your request to the address below and have your signature notarized. This is for your protection so we may prove your identity. Please include your name, address, and policy number. You can change your personal information at Nationwide.com or by calling your agent. We can’t change information that other companies, like credit agencies, provide to us. You’ll need to ask them to change it.

Consolidated Health Plans
Attn: Privacy Officer
2077 Roosevelt Ave
Springfield, MA 01104