Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Accident & Sickness Policy

POLICY FACE PAGE

POLICY NUMBER: 302-001-2214

POLICYHOLDER: Bethel University

ADDRESS: 3900 Bethel Drive; St. Paul, MN 55112

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.

READ YOUR POLICY CAREFULLY.

You may return this Policy within at least ten (10) days 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. The refund will be made within ten (10) days after We receive notice of cancellation. The Policy must be returned to the Company. Cancellation becomes effective upon return of the Policy.

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.

ACCIDENT & SICKNESS POLICY PROVIDING
SICKNESS AND INJURY COVERAGE
NON-PARTICIPATING
NON-QUALIFIED

Notice of Non-Discrimination and Accessibility Requirements

Bethel University complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Bethel University does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

Bethel University:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

- Interpreters
- information translated into other languages

If you need these services, contact Cara Wald, Human Resources Director.

If you believe that Bethel University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Cara Wald, Human Resources Director
3900 Bethel Drive
St Paul MN 55112
651-638-8657 (phone)
651-635-1469 (fax)
c-wald@bethel.edu

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, Cara Wald, Human Resources Director is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or fax at:

Celeste Davis
Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Bethel University complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

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.

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INSERTS:

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

No Benefit will be paid 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.

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, day or visit limits, 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 limited to Covered Persons with severe and handicapping malocclusion. This Benefit terminates on the first of the month following the Covered Person's 19th birthday.

Alternative Benefits

There is often more than one Service that can be used to treat a dental problem or disease. In determining the Benefits payable on a claim, different materials and methods of treatment will be considered. 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. 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.

Exclusions for this Pediatric Dental Services Benefit

No Benefit will be paid for:

1. Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
2. Services and treatment resulting from your failure to comply with professionally prescribed treatment;
3. Any charges for failure to keep a scheduled appointment;
4. Any service charges for personalization or characterization of prosthetic dental appliances;
5. Office infection control charges;
6. Duplicate, provisional and temporary devices, appliances, and services;
7. Plaque control programs, oral hygiene instruction, and dietary instructions;
8. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
9. Gold foil restorations;
10. Charges by the provider for completing dental forms;
11. Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
12. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
13. Sealants for teeth other than permanent molars;
14. Precision attachments, personalization, precious metal bases and other specialized techniques;

15. Replacement of dentures that have been lost, stolen or misplaced;
16. Medically Necessary orthodontic services provided to a Covered Person who has not met any applicable waiting period requirement.
17. Repair of damaged orthodontic appliances;
18. Replacement of lost or missing appliances;
19. Fabrication of athletic mouth guard;
20. Internal bleaching;
21. Nitrous oxide;
22. Oral sedation;
23. Topical medicament center
24. Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible 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 unforeseen event, which directly, and from no other cause, results in an 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.

Contraceptives: All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a Provider, including, but not limited to, barrier methods, hormonal methose, and implanted devises. For hormonal contraceptive methods, coverage includes, but is not limited to all three (3) oral contraceptive methods (combined, progestin-only, and extended/continuous use), injectables, implants, the vaginal contraceptive ring, the contraceptive patch, emergency contraception (Plan B/Plan B One Step/Next Choice), emergency contraception (Ella), and IUDs with progestin.

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

Covered Person: A person:

- Who is eligible for Coverage as the Insured;
- Who has been accepted for Coverage or has been automatically added;
- For whom the required Premium has been paid; 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 and the device is Medically Necessary for rehabilitation.

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: An Illness, Sickness or Injury manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

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.

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: Treatment or therapy that develops or attempts to develop a function that did not previously exist, but would normally be expected to exist. Treatment or therapy is considered habilitative if the function has achieved maximal or optimal improvement or is static, showing no progressive improvement with additional treatment.

Health Care Facility: A Student Health Center, 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 ninety-six(96) 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;
    - Private duty nursing services, when Medically Necessary;
    - 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.
    - Respiratory Therapy

Hospice: A coordinated plan of home and Inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with physical, psychological, spiritual, social, and economic stresses.

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 includes a medical facility owned or operated by, or on behalf of, the state or any unit of local government. 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 sudden, unforeseeable, external event which results independently of disease, bodily infirmity or any other causes. 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, death, 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, 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.

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.

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 Out-of-Network payments or 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.

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.

Policy Year Maximum: The maximum amount of Benefits we will pay for all Conditions under this Policy each Policy Year for each Covered Person. This amount is shown on the Schedule of Benefits.

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

Pre-admission Testing: Tests done in conjunction with a scheduled surgery where a operating room was 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 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
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. 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 or when ordered or provided by a Physician in

accordance with the standard practice of medicine. Well Baby and Child Care, and Well Adult Care Benefits will be considered based on the following:
(a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, 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;

Covered Services include but are not limited to:

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have never smoked;
2. Alcohol Misuse screening and counseling;
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages;
4. Blood Pressure screening for all adults;
5. Cholesterol screening for adults of certain ages or at higher risk;
6. Colorectal Cancer screening for adults over age fifty (50);
7. Depression screening for adults;
8. Diabetes (Type 2) screening for adults with high blood pressure;
9. Diet counseling for adults at higher risk for chronic disease;
10. HIV screening for everyone ages fifteen (15) to sixty-five (65), and other ages at increased risk;
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    a. Hepatitis A
    b. Hepatitis B
    c. Herpes Zoster
    d. Human Papillomavirus
    e. Influenza (Flu Shot)
    f. Measles, Mumps, Rubella
    g. Meningococcal
    h. Pneumococcal
    i. Tetanus, Diphtheria, Pertussis
    j. Varicella
12. Obesity screening and counseling for all adults;
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
14. Syphilis screening for all adults at higher risk;
15. Tobacco Use screening for all adults and cessation interventions for tobacco users.

(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;
(d) Child health supervision services, which means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six (6), and appropriate immunizations from ages six (6) to eighteen (18), as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to twelve (12) months, three (3) child health supervision visits from twelve (12) months to twenty-four (24) months, once a year from twenty-four (24) months to seventy-two (72) months.
(e) 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.
(f) Additional information can be found at https://www.healthcare.gov/preventive-care-benefits/ or by calling 1-800-318-2596 / TTY: 1-855-889-4325.

Provider: A Physician, dentist, Health Care Facility, or Urgent Care Facility that is licensed or certified to provide medical services or supplies.

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 80th 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.

Reconstructive Surgery: Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, disease, or Accidental Injury to either: (1) improve function or (2) create a normal appearance.

Rehabilitative: The process of restoring a person's ability to live and work after a disabling Condition by:

- Helping the person achieve the maximum possible physical and psychological fitness;
- Helping the person regain the ability to care for himself or herself;
- Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance and with psychological readjustment.

Reservist: A member of a reserve component of the Armed Forces of the United States. Reservist also includes a member of the State National Guard and the State Air National Guard.

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.

Special Providers: The student health center (SHC) system**.**

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
- "Drug Information for the Health Care Provider", published by the U.S. Pharmacopoeia Convention.

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.

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.

INVOLUNTARY 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 College of Arts & Sciences students registered for at least one (1) credit hour and all student athletes are automatically enrolled and subject to the waiver requirements defined by the Policyholder. All other students taking six (6) or more credit hours are eligible to enroll. The following courses are excluded from being applied towards the required minimum credit hours: Distance learning or internet courses; Courses taken as audit; Courses taken as Pass/Non-Pass; Courses taken Grad Non-Degree; Home Study; Correspondence and TV courses.

DEPENDENTS ACQUIRED AFTER EFFECTIVE DATE:
Newborn Children: An Insured's newborn child is automatically covered from the moment of birth and thereafter. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care.

Step-Child: Coverage for a Step-Child is effective on the date the Insured marries the child's parent.

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.

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.

Notification of Newborn, Step-Child, Foster and Adopted Children: Notification is not required, however, the Insured will be responsible to pay the required additional Premium, if any, and We will be entitled to all premiums that would have been collected had We been aware of the additional Dependent. We may withhold payment of any health Benefits for the new Dependent until We have been compensated with the applicable premium, which would have been owed if We had been informed of the additional Dependent immediately.

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

TERMINATION:
Policyholder: 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 before its first anniversary, unless the Policyholder does not perform its contractual duties. We may terminate coverage any time after the First Policy Term. 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 term of Coverage for which Premium is paid for the Insured;
- The date the Covered Person departs the Policyholder's school for their Home Country permanently. We will refund the unearned pro-rata Premium (minus any claims paid) to such person upon written request from the Policyholder.
- The date a Covered Person enters full time active military service. Upon written request, We will refund any unearned pro-rata Premium (minus any claims paid) with respect to such person.

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 an Insured, 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.

REINSTATEMENT
If We accept payment of premium without requiring an application for reinstatement, after the time period in which the Covered Person must pay the renewal premium, the Policy will be reinstated. If We require an application for reinstatement from the Covered Person and issue a conditional receipt of the premium, the Policy will be reinstated upon approval of the application, or upon the forty-fifth (45) day following the conditional receipt of the premium, unless We have previously notified the Covered Person, in writing, that the application was disapproved.

The reinstated Policy shall cover only loss resulting from accidental injury sustained by the Covered Person after the date of reinstatement and loss due to such sickness that begins more than ten (10) days after the date of reinstatement. Under the reinstated policy, The Company and the Covered Person shall have the same rights under the Policy immediately before the due date of the defaulted premium, subject to any provisions 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.

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, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery or Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.
2. Hearing Screenings (except as specifically provided in the Policy) or hearing examinations or hearing aids and the fitting or repairing or replacement of hearing aids (except as provided herein or in the case of an 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 (except capsular or bone surgery), any type of massage procedure on or to the foot, corrective shoes and shoe inserts. 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 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; warts, non-malignant moles and lesions; hair growth; hair removal; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants including gynecomastia (except for correction or deformity resulting from mastectomies or lymph node dissections); lipectomy services and supplies related to surgical suction assisted lipectomy; rhinoplasty; nasal and sinus surgery; and deviated nasal septum, including submucous resection except when Medically Necessary treatment of acute purulent sinusitis. 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. This applies even if they are prescribed, recommended or approved by the Student Health Center or by the person's Attending Physician or dentist.
8. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications.
9. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, (except as specified herein).
10. Injury sustained while (a) participating in any professional or semi-professional sport, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition.
11. Long term care.
12. Injury sustained by reason of a motor vehicle Accident to the extent that Benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such Benefits or if the Insured is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place. This exclusion will not apply to passengers if they are insured under the Policy.
13. Injury occurring in consequence of riding as a passenger or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline or as a passenger in a Policyholder owned leased chartered or operated aircraft or as a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.
14. Reproductive/Infertility services, unless caused by Injury or Sickness, including but not limited to: family planning; 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; 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.

15. Elective termination of pregnancy.
16. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee.
17. Services for the treatment for any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.
18. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
19. War or any act of war, declared or undeclared; or while in the armed forces of any country.
20. Obesity treatment: Services and associated expenses for the treatment of obesity, except nutrition counseling specifically provided in the Policy, and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to:
    - Gastric or intestinal bypasses;
    - Gastric balloons;
    - Stomach stapling;
    - Wiring of the jaw;
    - Panniculectomy;
    - Appetite suppressants;
    - Surgery for removal of excess skin or fat.
21. Acupuncture.
22. Diagnosis and treatment of sleep disorders including but not limited to apnea monitoring, sleep studies, and oral appliances used for snoring, except treatment and appliances for documented obstructive sleep apnea.
23. Elective Treatment or Surgery, 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.

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 co-ordination 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 co-ordination 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.

SUBROGATION AND RECOVERY RIGHTS

Right of Recovery: This clause applies only after the Covered Person has received a full recovery from another source.

Right to Subrogation: Our subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the Covered Person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the We are separately represented by an attorney.

If We are separately represented by an attorney, the Covered Person and Us, by respective attorneys, may enter into an agreement regarding allocation of the Covered Person's costs, disbursements, and reasonable attorney fees and other expenses. If We and the Covered Person cannot reach agreement on allocation, We and Covered Person shall submit the matter to binding arbitration. Nothing in this section shall limit Our right to recovery from another source which may otherwise exist at law. For the purposes of this section, full recovery does not include payments made by a health plan to or for the benefit of a Covered Person.

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.

If You have other insurance and pre-certification is required, this Coverage will consider the services authorized by the primary carrier as Medically Necessary and process Your claim accordingly unless otherwise excluded under the plan. 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.

CLAIM PROVISIONS

Notice of Claim: Written Notice of Claim must be given to Us or Our authorized representative within sixty (60) days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: Upon Our receipt of written Notice of Claim, We will furnish to the claimant such forms as are usually furnished by Us 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 this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: If it is necessary to file a claim, a written claim form must be given to Us within ninety (90) days of such claim. If it was not possible for the claim form to be given within ninety (90) days, We will not deny the claim because of late filing, provided proof was given as soon as reasonably possible. In any case, the claim form must be sent no later than one (1) year from the date of service, unless the Covered Person is legally incapacitated.

Time of Payment of Claims: Benefits payable under this Policy for any loss, other than loss for which this Policy provides any periodic payment, will be paid immediately upon, or within thirty (30) days after, receipt of due written proof of such loss. Subject to due written Proof of Loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination 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 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.

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 given as required. No such action may be brought after three (3) years from the time written proof was required to be given.

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, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be 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 fifteen (15) 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 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 Post-Service Claims Appeal is an appeal of a decision to deny or reduce Benefits for claim that has already been incurred.

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

An Urgent 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), or is an out-of-network treatment, 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 within at least one hundred twenty (120) days after the receipt of the notice of adverse determination or final internal adverse benefit determination. 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 review form from the Department of Insurance in Your state.

Minnesota Department of Commerce
Attn: Consumer Protection & Education Division
85 7th Place East, Suite 500
St. Paul, MN 55101
Call Toll Free: 1-800-657-3602

There is no charge to You for the external review.

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 non-prevailing 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 five (5) 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 Medicus (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. Your Right to Appeal a Determination that a Service is Out-of-Network

If the Plan has denied Coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an external appeal agent if You satisfy the following three (3) criteria:

- The service must otherwise be a Covered Service under this Subscriber Contract;
- You must have requested pre-authorization for the out-of-network treatment; and
- You must have received a final adverse determination through the first level of the Plan's internal appeal process and the Plan must have upheld the denial or You and the Plan must agree in writing to waive any internal appeal or You apply for an expedited external appeal at the same time as You apply for an expedited internal appeal or the Plan fails to adhere to claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and the violation occurred during an ongoing, good faith exchange of information between You and the Plan).

In addition, Your Attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your Attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

You do not have a right to an external appeal for a denial of a referral to an out-of-network Provider on the basis that a health care Provider is available in-network to provide the particular health service requested by You. The independent external reviewer will either uphold or overturn Our decision to deny payment. If the external reviewer overturns Our decision, We will provide Benefits for the health care service.

You may also request an external appeal request form from the State Department of Insurance at 1-800-657-3602. Submit the completed application to the State Department of Insurance at the address indicated on the application. If You satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

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 Your completed application. 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.

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.

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 or an out-of-network 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.

If You need help filing an internal appeal or external review, Your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help You. To find help in Your state, go to www.HealthCare.gov/consumerhelp and click on Your state. The HealthCare.gov website also has information about other consumer protections and health care coverage options created by the Affordable Care Act.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy, including the Certificate, if any, Policyholder Application, Amendments, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

Failure by Us to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

Time Limit on Certain Defenses: After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such two (2) year period.

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 Covered Person shall be liable to Us for the payment of the Premium accruing for the period the Policy continues in force.

Statements in the Application: All statements made in an application by the Policyholder are, in the absence of fraud, representations and not warranties. No statement shall be used to contest the Policy, the validity of Coverage or reduce Benefits, unless it is in writing, signed by the Policyholder, and a copy of such statement is furnished to the Policyholder. The Policy shall become incontestable as to statements contained in the application after a period of two (2) years.

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.

Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

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.

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 **Minnesota Department of Insurance** with any complaint. To contact the Department of Insurance, You may write or call them at:

Minnesota Department of Commerce
Attn: Consumer Protection & Education Division
85 7th Place East, Suite 500
St. Paul, MN 55101
Call Toll Free: 1-800-657-3602

Secretary

President

Nationwide Life Insurance Company

SCHEDULE OF BENEFITS
Actuarial Value: 78.83%
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) for Your Coverage is: First Health at www.firsthealthlbp.com.

EFFECTIVE DATE: 08/10/2016 **TERMINATION DATE**: 08/09/2017

PREMIUM:

	Annual
Student Only	$1,323

Policy Year Maximum Benefit	
Insured	unlimited

	In-Network Benefit	**Out-of-Network Benefit**
Deductible* (except as specified herein) per Condition per Covered Person.	$200	$400

***Deductible:**
• Benefits are subject to Deductible unless otherwise indicated.
• The Deductible shall not apply:
  o In-Network Preventive/wellness exams and immunizations
  o To Covered Services performed at the Student Health Center.
• Copayments do not apply to Deductibles.		

Insured Percent (except as specified herein)	80% of Preferred Allowance (PA)	60% of Reasonable & Customary (R&C)
Student Health Center	100% of charges incurred; In-Network Deductible waived	
Out-of-Pocket Maximum**		
Covered Person	$4,500	None
****Out-of-Pocket Maximum:** • Includes Coinsurance, Copayments and Deductibles; • Excludes Out-of-Network and 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.		

Covered Charges – Essential Health Benefits	**In-Network Benefit**	**Out-of-Network Benefit**
Preventive Care (See Definition for additional information. Also refer to Reproductive Services below.)		
Preventive Services	100% of PA Deductible waived	60% of R&C
Outpatient Services - Other than Surgery or Maternity Services		
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, including services provided via Telemedicine.	80% of PA after $25 Copayment per visit	60% of R&C after $25 Copayment per visit
Specialist visits	80% of PA after $25 Copayment per visit	60% of R&C after $25 Copayment per visit

Consulting Physician (other than Family or General Practice, Pediatrician, Internal Medicine or OB/GYN when acting as a primary care Physician). Limited to (one) 1 visit per day, Injury, Sickness, Condition Does not apply when related to surgery or Physical Therapy	80% of PA after $25 Copayment per visit	60% of R&C after $25 Copayment per visit
Diagnostic Imaging - Includes x-ray services which are diagnostic or therapeutic.	80% of PA	60% of R&C
Laboratory Services - Includes laboratory services which are diagnostic or therapeutic.	80% of PA	60% of R&C
CT Scan, MRI, and /or PET Scans	80% of PA after a $500 Copayment per Procedure	60% of R&C after a $500 Copayment per Procedure
Infusions (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	60% of R&C
Injections (done in an Outpatient Health Care Facility or Physician's office)	80% of PA	60% of R&C
Diagnostic Procedures for Cancer Including but not limited to: • Prostate Cancer Screening • Ovarian Cancer Surveillance Tests for women at risk for ovarian cancer. At risk for ovarian cancer" means: (1) having a family history: (i) with one or more first or second-degree relatives with ovarian cancer; (ii) of clusters of women relatives with breast cancer; or (iii) of nonpolyposis colorectal cancer; or (2) testing positive for BRCA1 or BRCA2 mutations. (b) "Surveillance tests for ovarian cancer" means annual screening using: (1) CA-125 serum tumor marker testing; (2) transvaginal ultrasound; (3) pelvic examination; or (4) other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.	80% of PA	60% of R&C
Radiation	80% of PA	60% of R&C
Chemotherapy	80% of PA	60% of R&C
Dialysis (hemodialysis and peritoneal) and Filtration Procedures, for acute or chronic renal failure - Includes administration and supplies.	80% of PA	60% of R&C
Inpatient Services – Other than Surgery or Maternity Services		
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	80% of PA	60% of R&C
Room and Board expense, daily semi-private room rate and general nursing care provided by the Hospital.	80% of PA	60% of R&C
Intensive Care Room	80% of PA	60% of R&C
Physician visit, during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility. Limited to one (1) visit per day and Does not apply when related to surgery	80% of PA	60% of R&C
Specialist visit	80% of PA	60% of R&C
Consulting Physician, when requested and approved by the Attending Physician. Limited to one (1) visit per Consulting Physician per day	80% of PA	60% of R&C
Skilled Nursing Facility and Sub-Acute Care Facility - Includes semi-private room and board, general nursing services, meals and prescribed diets, supplies, Diagnostic Imaging, laboratory, Rehabilitation.	80% of PA	60% of R&C

Inpatient Rehabilitation Facility - Includes Physical Therapy, Occupational Therapy, Restorative Speech Therapy, Cardiac therapy, and Pulmonary Therapy which is expected to result in significant return of function.	80% of PA	60% of R&C
Surgical Services		
When multiple surgeries are performed through the same incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. When multiple surgeries are performed through more than one (1) incision at the same operative session, We will pay an amount not to exceed the benefit for the primary or most expensive procedure and 50% of the Benefit otherwise payable for each subsequent procedure.		
Inpatient Surgical Services		
Surgeon	80% of PA	60% of R&C
Assistant Surgeon	25% of Surgeon's payment	25% of Surgeon's payment
Anesthetist Services	25% of Surgeon's payment	25% of Surgeon's payment
Inpatient Surgical Miscellaneous - Includes supplies, drugs, facility fee, and miscellaneous items used in association with the surgical event.	80% of PA	60% of R&C
Outpatient Surgical Services		
Surgeon	80% of PA	60% of R&C
Assistant Surgeon	25% of Surgeon's payment	25% of Surgeon's payment
Anesthetist Services	25% of Surgeon's payment	25% of Surgeon's payment
Outpatient Surgical/Day Surgery Miscellaneous **-** Includes supplies, drugs, facility fee, anesthesia, Diagnostic Imaging, laboratory and miscellaneous items used in association with the surgical event.	80% of PA after $500 Copayment per surgical event	60% of R&C after $500 Copayment per surgical event
Other Surgical Services (Inpatient/Outpatient)		
General Anesthesia for Dental services	80% of PA	60% of R&C
Reconstructive Surgery – Including, but not limited to: • Surgery to correct a congenital defect, disease or anomaly that improves physical function; • Nevus flammeus or "port-wine stain" removal • Post mastectomy reconstructive surgery on the impacted breast, as well as surgery on the second breast to achieve symmetrical appearance and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient	80% of PA	60% of R&C
Organ Transplant Surgery - Includes kidney, cornea, heart, lung, heart/lung, liver, bone marrow, pancreas and kidney/pancreas transplants; Donor expenses related to the recipient Covered Person are covered. **Note:** Excludes treatment of medical complications of the donor.	80% of PA	60% of R&C
Reproductive Services		
Infertility Services - Includes diagnostic procedures and tests, office visits and consultations to diagnosis infertility, Excludes infertility treatment.	80% of PA	60% of R&C
Contraceptives, including devices and related procedures, except as provided under the Prescription Drug Benefit.	100% of PA waiver of Deductible	60% of R&C

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.		
Routine Prenatal Care Services and tests. "Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.	100% of PA Deductible & Copayments waived	Paid as any other Sickness
Delivery and Inpatient Physician visits for mother and baby.	Paid as any other Sickness	Paid as any other Sickness
Diagnostic services performed and billed by a Physician's office, including ultrasounds and amniocentesis.	Paid as any other Sickness	Paid as any other Sickness
Mental Conditions and Alcoholism/Drug Abuse		
Inpatient services - including Alcoholism/Drug detoxification.	Paid as any other Sickness	Paid as any other Sickness
Outpatient Office Visits - Includes partial, residential or day treatment.	Paid as any other Sickness	Paid as any other Sickness
Urgent Care and Emergency Services		
Urgent Care Facility services	80% of PA after $150 Copayment per visit	80% of R&C after $150 Copayment per visit
Emergency services– visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition. Emergency services includes an immediate response service available on a 24-hour, seven-day-a-week basis for each child, or person, having a psychiatric crisis, a mental health crisis, or a mental health emergency. Includes Physician's fees, Diagnostic Imaging, Laboratory, Injections, use of emergency room, supplies and facility charges. • ***Copayment is waived if admitted to Hospital;*** • Follow-up care at the Emergency room is not covered.	80% of PA after $150 Copayment per visit	80% of R&C after $150 Copayment per visit
Emergency Medical Transportation services	80% of PA	60% of R&C
Other Services		
Allergy Testing	80% of PA	60% of R&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&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&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. Limited to one (1) visit per day	80% of PA	60% of R&C
Rehabilitative Care - Only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, Occupational therapy and Restorative Speech Therapy which is expected to result in significant return of function. Limited to one (1) visit per day	80% of PA	60% of R&C
Pulmonary Therapy	80% of PA	60% of R&C
Cardiac Therapy	80% of PA	60% of R&C
Respiratory Therapy	80% of PA	60% of R&C

Chiropractic care - Only when prescribed by the Attending Physician to diagnose or treat acute neuromuscular-skeletal conditions; Includes x-rays, office visits, laboratory services, manipulations and modalities (i.e., hot packs, cold packs and ultrasounds, etc.), regardless of Provider type. Limited to one (1) visit per day.	80% of PA	60% of R&C
Dermatology - Only when prescribed by the Attending Physician.	80% of PA	60% of R&C
Podiatry - Only when prescribed by the Attending Physician.	80% of PA	60% of R&C
Home Health Care services - Includes services for Covered Persons dependent on a ventilator.	80% of PA	60% of R&C
Hospice - Limited to Covered Persons with a life expectancy of six (6) months or less.	80% of PA	60% of R&C
Diabetic treatment and education	80% of PA	60% of R&C
Durable Medical Equipment (DME) Including, but not limited to: • Prosthetic and orthotic devices (foot orthotics are limited to Covered Persons with diabetes); • One (1) hair prosthesis per Policy Year for Covered Persons who's hair loss is related to chemotherapy or radiation therapy for the treatment of cancer or those with alopecia areata; • Prosthetics to address a congenital defect; • Prosthetic breast post mastectomy; • Diabetic supplies and equipment. Coverage excludes repair or replacement if the items are damaged by misuse, are lost or are stolen and excludes sales tax, mailing and delivery fees.	80% of PA after $50 Copayment per Prescription	60% of R&C after $50 Copayment per Prescription
Nutritional Services - Coverage is provided for dietary counseling and treatment for Covered Persons with an inherited metabolic disorder, such as PKU; Includes oral amino acid based elemental formulas.	80% of PA	60% of R&C
Hearing Aids - limited to one (1) hearing aid per ear every thirty-six (36) months and limited to Covered Persons through eighteen (18) years of age.	80% of PA	60% of R&C
TMJ/CMJ - treatment for the dysfunction of the temporomandibular joint disorder and craniomandibular disorder including surgery of the jaw to correct or treat TMJ.	80% of PA	60% of R&C
Lyme Disease Treatment	80% of PA	60% of R&C
Dental treatment due to Injury to a Sound Natural Tooth, not including broken fillings or damage caused by biting or chewing; Treatment must be initiated within six (6) months of Injury and received within twenty-four (24) months.	80% of PA	60% of R&C
Private Duty Nursing Care or personal care assistant to a ventilator-dependent Covered Person in the Covered Person's home, coverage is provided for up to 120 hours of services provided by a private duty nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.	80% of PA	60% of R&C
Scalp Hair Prostheses for hair loss as a result of alopecia areata.	80% of PA	60% of R&C
Routine Eye Exam for Covered Person aged nineteen (19) and older	80% of PA	60% of R&C

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.	
Pediatric Dental – preventive & diagnostic services, for Covered Persons under nineteen (19); Limited to 1 exam / prophylaxis every 6 month. Includes: • Topical fluoride treatment – 2 per 12 months • x-rays – bitewing – 1 set per 6 months • x-rays - full-mouth and panoramic – 1 per 60 months • sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth every 36 months) • space maintainers	100% of R&C
Pediatric Dental – basic restorative services, for Covered Persons under nineteen (19). Includes: • emergency palliative treatment of pain • fillings (amalgam, resin-based composite) • prefabricated stainless steel crown – 1 per tooth per 60 months • endodontics - therapeutic pulpotomy • periodontics - scaling and root planning, limited to 1 every 24 months • prosthodontics – denture repair, denture rebase/reline (1 per 36 months; 6 months after initial installation) • Oral surgery	70% of R&C
Pediatric Dental – major services, for Covered Persons under nineteen (19). Includes: • prosthodontics - crowns, bridges, and dentures - 1 per tooth/arch every 60 months • endodontics (root canals on permanent teeth limited to one per tooth per lifetime) • periodontics – gingivectomy or gingivoplasty, limited to 1 every 36 months for four or more teeth • general anesthesia and IV sedation – in conjunction with complex oral surgery	50% of R&C
Pediatric Dental – Medically Necessary orthodontia services *, for Covered Persons under nineteen (19) with severe and handicapping malocclusion. Includes: • pre-orthodontic treatment • orthodontic treatment • appliance therapy • orthodontic retention *Requires pre-authorization	50% of R&C
Routine Vision Exam for Covered Persons under nineteen (19). Includes: • 1 exam/fitting per Policy Year, including dilation if professionally indicated • prescription eyeglasses (lenses and frames), or one (1) year supply of contact lens in lieu of eyeglasses, limited to once per Policy Year • 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.	100 % of actual charges up to $150, then 50%

Outpatient Prescription Drugs	In-Network Pharmacy Benefit	Out-of-Network Pharmacy Benefit
Retail Prescription Drugs - per prescription or refill, subject to dispensing limits. **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.		
4 Tier Plan		
1. Generic Drugs	80% of R&C after $25 Copayment	
2. Preferred Brand Drugs	80% of R&C after $50 Copayment	
3. Non-Preferred Brand Drugs	80% of R&C after $50 Copayment	
4. Specialty Drugs	80% of R&C after $50 Copayment	
You will need 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. • No cost sharing applies to: 1) Contraceptives which have been approved by the FDA and prescribed by a Provider as Medically Necessary; and 2) other Preventive Services drugs. • Includes prescribed pre-natal vitamins and smoking deterrent prescription medications. • Includes medications, equipment and supplies for the management and treatment of diabetes. • The Deductible does apply. • The Covered Person will be responsible 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.		

COVERED CHARGES - ELECTIVE TREATMENT
PLEASE NOTE: ALL BENEFITS ARE PER POLICY YEAR UNLESS OTHERWISE NOTED.

Covered Charge	In-Network Benefit	Out-of-Network Benefit
Elective Treatment		
Intercollegiate, Club and Intramural Sports	Paid as any other Injury	
Non-emergency out of Country Coverage **Maximum Benefit:** $20,000 per Policy Year	60% of actual charges	

NATIONWIDE LIFE INSURANCE COMPANIES
P.O. Box 182835
Columbus, Ohio 43218-2835
1-800-882-2822

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life & Health Insurance Guaranty Association
4760 White Bear Parkway
Suite 101
White Bear, Minnesota 55110
(651)-407-3149

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

FACTS	WHAT 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.

Reasons we can share your personal information	Does Nationwide share?	Can you limit this sharing?
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	Yes	No
For our marketing purposes— to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes— information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	Yes	Yes

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 or third parties 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