Nationwide Life Insurance Company

Home Office: Columbus, Ohio

BLANKET ACCIDENT & SICKNESS POLICY

POLICY FACE PAGE

POLICY NUMBER: 302-004-1214

POLICYHOLDER: Greenville College

ADDRESS: 315 East College Street; Greenville, IL 62246

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

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

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

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

You may return this Policy within at least ten (10) days 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.

READ YOUR POLICY CAREFULLY.

RENEWAL

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. Uniform modification to this Policy may occur at the time of Renewal as long as the language is consistent with the laws of Illinois.

BLANKET POLICY PROVIDING
SICKNESS AND INJURY COVERAGE
NON-PARTICIPATING

RIGHTS AND RESPONSIBILITIES

Your responsibilities as a Covered Person include:

- Carrying Your Identification Card with You and presenting it prior to receiving health care services;
- Paying all Deductible, Coinsurance and Copayment amounts, if any, when due;
- Reading the Policy, knowing Your Coverage, and following the procedures outlined in the Policy to receive Maximum Benefits;
- Informing Us of any other health insurance You may have;
- Preventing the dishonest or false use of Your Identification Card by people not eligible for Coverage, and immediately reporting any such use to Us;
- Informing Us of any change in Your address or a Lifestyle Change which may alter Benefits for You or Your Dependents.

Your rights as a Covered Person include:

- Simple information and explanations from Your health plan to help You understand what is covered and what is not covered;
- A current list of Preferred Providers;
- Emergency care at any Hospital for a Condition You believe threatens Your life or seriously affects Your health;
- Information about steps You can take if You think Your health insurance plan has denied You Coverage of a treatment You believe is covered.

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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 necessary 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. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
6. Office infection control charges;
7. Duplicate, provisional and temporary devices, appliances, and services;
8. Plaque control programs, oral hygiene instruction, and dietary instructions;
9. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, full mouth rehabilitation, and restoration for misalignment of teeth;
10. Gold foil restorations;
11. Charges by the provider for completing dental forms;
12. Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
13. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
14. Sealants for teeth other than permanent molars;
15. Precision attachments, personalization, precious metal bases and other specialized techniques;
16. Replacement of dentures that have been lost, stolen or misplaced;

17. Medically Necessary orthodontic services provided to a Covered Person who has not met the twelve (12) month waiting period requirement.
18. Repair of damaged orthodontic appliances;
19. Replacement of lost or missing appliances;
20. Fabrication of athletic mouth guard;
21. Internal bleaching;
22. Topical medicament center
23. 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.

ADDITIONAL BENEFITS

Infertility: Benefits will be provided the same as Your benefits for any other Condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means the inability to conceive a child after one (1) year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The one (1) year requirement will be waived if Your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one (1) year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy. Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when:

- You have been unable to attain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments; however, this requirement will be waived if You or Your partner has a medical condition that makes such treatment useless; and
- You have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.
The maximum number of completed oocyte retrievals that are eligible for coverage under this Policy in Your lifetime is six (6). Following the final completed oocyte retrieval, benefits will be provided for one (1) subsequent procedure to transfer the oocytes or sperm to You. ***Thereafter, you will have no benefits for infertility treatment***.

Special Limitations
Benefits will ***not*** be provided for the following:
1. Services or supplies rendered to a surrogate, except that costs for procedures to obtain eggs, sperm or embryos from You will be covered if You choose to use a surrogate.

2. Selected termination of an embryo; provided, however, termination will be covered where the mother's life would be in danger if all embryos were carried to full term.

3. Expenses incurred for cryo-preservation or storage of sperm, eggs or embryos, except for those procedures which use a cryo-preserved substance.

4. Non-medical costs of an egg or sperm donor.

5. Travel costs for travel within 100 miles of Your home or travel costs not Medically Necessary.

6. Infertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

7. Infertility treatment rendered to Your Dependents under the age of eighteen (18).

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

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 independent of disease or bodily infirmity, 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.

Civil Union: Means a legal relationship between two persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act.

Clinical Trials
We provide Coverage for participation of a Qualified Individual in an Approved Clinical Trial. This includes the routine patient costs for items and services furnished in connection with participation in the Approved Clinical Trial.

"Approved Clinical Trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or a Life-threatening Condition (including Cancer) and is described in any of the following:

(A) The study or investigation is approved or funded, which may include funding through in-kind contributions, by one or more of the following:
(i) The federal National Institutes of Health;
(ii) The federal Centers for Disease Control and Prevention;
(iii) The federal Agency for Health Care Research and Quality;
(iv) The federal Centers for Medicare & Medicaid Services;
(v) A cooperative group or center of any of the entities described in items (i) through (iv) or the U.S. Department of Defense or the U.S. Department of Veteran Affairs;

(vi) A qualified non-governmental research entity identified in the guidelines issued by the federal National Institutes of Health for center support grants; or

(vii) A study or investigation conducted by the U.S. Department of Veteran Affairs, the U.S. Department of Defense, or the U.S. Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of U.S. Department of Health and Human Services determines:

(I) Is comparable to the system of peer review of studies and investigations used by the federal National Institutes of Health; and

(II) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(B) The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration; or

(C) The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

"Qualified Individual" means a participant or Beneficiary who meets the following conditions:

(A) The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or Condition; and

(B)

i. The referring health care professional is a participating Provider and has concluded that the individual's participation in such trial would be appropriate based on the individual meeting the conditions; or

ii. The participant or Beneficiary provides medical and scientific information establishing the individual's participation in such trial would be appropriate based on the individual meeting the conditions.

"Life-threatening Condition" means any disease or Condition from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.

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; (j) hyperemesis gravidarum; or
- When pregnancy is terminated: (a) non-elective cesarean section; (b) ectopic pregnancy that is terminated; and (c) spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will **not** include:

- false labor;
- occasional spotting;
- Physician prescribed rest during the period of pregnancy;
- morning sickness; and
- similar Conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Condition: Sickness, ailment, Injury, or pregnancy of a Covered Person.

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

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

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

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

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

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 Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Emergency Medical Condition 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 an Emergency Medical Condition 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 Medical Condition 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; Drugs; Rehabilitative and Habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

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

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

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

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

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

Generic Drugs: A non-brand name drug, which is a pharmaceutical equivalent to a Brand Name Prescription Drug, sold at a lower cost.

Habilitative Treatment or Therapy: 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 Hospital, Skilled Nursing Facility, Sub-Acute Facility, or other duly licensed, certified and approved health care institution which provides care and treatment for sick or injured persons.

Home Country: The Insured's country of regular domicile.

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

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

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

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 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.

Infection: Bacterial infections, except infections which result from an Accidental Injury, or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance.

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 or bodily infirmity. All injuries sustained in any one (1) Accident, including all related conditions and recurrent symptoms of these injuries, and 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.

Intoxication: Means that which is defined and determined by the laws of the jurisdiction where the loss or cause of the loss was incurred.

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

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

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

Medical Literature:

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

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

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

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

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

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

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

Out-of-Network Benefit Level: The lowest level of payment made by Us for Covered Services under the terms of the Policy. Payment is based on Reasonable and Customary charges unless otherwise indicated.

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

Out-of-Pocket Maximum: The most You pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. This limit will never include Premium, balance-billed charges or health care Your Policy does not cover. Your 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.

"Preventative Physical Therapy" means Physical Therapy that is prescribed by a Physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the Physical Therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

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 has been reserved before the tests are done.

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

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

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

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

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

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

1. Approved for general use by the U.S. Food and Drug Administration (FDA); and
2. Prescribed by a licensed Physician for the treatment of a Life-Threatening Condition, or prescribed by a licensed Physician for the treatment of a Chronic and Seriously Debilitating Condition, the drug is Medically Necessary to treat that Condition, and the drug is on the Formulary, if any; and

3. The drug has been recognized for treatment of that Condition by one of the Standard Medical Reference Compendia or in the Medical Literature as recommended by current American Medical Association (AMA) policies, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Condition.

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

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

(a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

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. **Cardiovascular disease** for adults, early detection and proactive management
6. **Cholesterol screening** for adults of certain ages or at higher risk
7. **Colorectal Cancer screening** - for adults over age 50; all colorectal cancer exams and lab tests for colorectal cancer as prescribed by Physician according to American Cancer Society.
8. **Depression screening** for adults
9. **Diabetes (Type 2) screening** for adults with high blood pressure
10. **Diet counseling** for adults at higher risk for chronic disease
11. **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
12. **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
13. **Obesity screening and counseling** for all adults
14. **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
15. **Syphilis screening** for all adults at higher risk
16. **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;

Covered services include but are not limited to:

1. **Autism screening** for children at 18 and 24 months
2. **Behavioral assessments** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
3. **Blood Pressure screening** for children at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. **Cervical Dysplasia screening** for sexually active females
5. **Depression screening** for adolescents
6. **Developmental screening** for children under age 3
7. **Dyslipidemia screening** for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
8. **Fluoride Chemoprevention supplements** for children without fluoride in their water source

9. **Gonorrhea preventive medication** for the eyes of all newborns
10. **Hearing screening** for all newborns
11. **Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
12. **Hematocrit or Hemoglobin screening** for children
13. **Hemoglobinopathies or sickle cell screening** for newborns
14. **HIV screening** for adolescents at higher risk
15. Hypothyroidism screening for newborns
16. **Immunization vaccines** for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
17. **Iron supplements** for children ages 6 to 12 months at risk for anemia
18. **Lead screening** for children at risk of exposure
19. **Medical History** for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years.
20. **Obesity screening and counseling**
21. **Oral Health risk assessment** for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
22. **Phenylketonuria (PKU) screening** for this genetic disorder in newborns
23. **Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk
24. **Tuberculin testing** for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
25. **Vision screening** for all children

(d) With respect to women (including pregnant 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.

Covered services include but are not limited to:

1. **Anemia screening** on a routine basis for pregnant women
2. **Breast Cancer Genetic Test Counseling (BRCA)** for women at higher risk for breast cancer
3. **Breast Cancer Mammography screenings**
    - Coverage of screening by low-dose mammography for all women over 35; Coverage requires baseline mammogram for women 35-39 and annual mammogram for women 40 years of age and older.
    - For women under 40 with a family history of breast cancer or other risk factors mammograms must be provided at an age and intervals considered Medically Necessary.
    - Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates Medical Necessity as described.
    - Coverage must be provided at no cost to the Insured and shall not be applied to an annual or lifetime maximum benefit.

When coverage is available through contracted providers and such a provider is not utilized, plan provisions specific to the use of those non-contracted providers must be applied without distinction to the coverage required and shall be at least as favorable as for other radiological examinations covered by the Policy or contract.

4. **Breast Cancer Chemoprevention counseling** for women at higher risk
5. **Breastfeeding comprehensive support and counseling** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
6. **Cervical Cancer screening** for sexually active women
7. **Chlamydia Infection screening** for younger women and other women at higher risk
8. **Contraception**: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive

capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."

9. **Domestic and interpersonal violence screening and counseling** for all women
10. **Folic Acid** supplements for women who may become pregnant
11. **Gestational diabetes screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. **Gonorrhea screening** for all women at higher risk
13. **Hepatitis B screening** for pregnant women at their first prenatal visit
14. **HIV screening and counseling** for sexually active women
15. **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older
16. **Osteoporosis screening** for women over age 60 depending on risk factors
17. **Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
18. **Sexually Transmitted Infections counseling** for sexually active women
19. **Syphilis screening** for all pregnant women or other women at increased risk
20. **Tobacco Use screening and interventions** for all women, and expanded counseling for pregnant tobacco users
21. **Urinary tract or other infection screening** for pregnant women
22. **Well-woman visits** to get recommended services for women under sixty-five (65); including but not limited to clinical breast exams, pap tests and pelvic exams.
    The Illinois guidelines for frequency of breast exams is:
    - At a minimum every three (3) years for women over twenty (20) years of age but less than forty (40); and,
    - Annually for women forty (40) years of age and older.

Pap tests includes annual cervical smear or Pap smear, including surveillance tests for ovarian cancer for female Insureds who are at risk for ovarian cancer.

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, 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.

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 use disorder or addiction; and
- Is operated pursuant to law.

Sound Natural Tooth: The major portion of the individual natural tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

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

Standard Medical Reference Compendia: The following publications:

- The "AMA Drug Evaluations", published by the American Medical Association;
- The "American Hospital Formulary Service (AHFS) Drug Information", published by the American Society of Health System Pharmacists; or
- "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 full-time undergraduate students taking twelve (12) or more credit hours per semester are automatically enrolled in the plan and must show proof of other coverage to waive out. Graduate students pursuing a graduate degree are eligible to enroll in the insurance plan. The following courses are excluded from being applied towards the required minimum credit hours: distance learning or internet courses; courses taken as audit; 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 until such child is thirty-one (31) days old. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, the Insured must notify Us in writing within thirty-one (31) days of such birth and pay the required additional Premium, if any, in order to have Coverage for the newborn child continue beyond such thirty-one (31) day period.

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

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

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

Note: ***No Policy that covers the Insured's immediate family or children may exclude or limit coverage of an adopted child or a child not residing with the Insured (foster child). A child residing with an Insured pursuant to an interim court order of adoption is considered an adopted child.***

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 unless the Policyholder does not perform its contractual duties. If We terminate the Policy, notice will be either mailed or delivered to the Policyholder at the last address on file with Us. 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. Ninety (90) days prior to termination, We will provide notice to the Department prior to notifying the plan sponsors, participants, beneficiaries, and covered individuals. We will send the notice by certified mail to the Department ninety (90) days in advance of any notification of Our actions are sent to plan sponsors, participants, beneficiaries, and Covered Persons. The notice shall include: (i) a complete description of the action to be taken, (ii) a specific description of the type of coverage affected, (iii) the total number of covered lives affected, (iv) a sample draft of all letters being sent to the plan sponsors, participants, beneficiaries, or covered individuals, (v) time frames for the actions being taken, (vi) options the plans sponsors, participants, beneficiaries, or covered individuals may have available to them under this Act, and (vii) any other information as required by the Department.

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;
- 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.

EXTENSION OF BENEFITS:
The Coverage provided under this Policy ceases on the Covered Person's Termination Date. However, if a Covered Person is:

- Hospital Confined on the Termination Date from a covered Injury or Sickness for which Benefits were paid before the Termination Date, Covered Expenses for such Injury or Sickness will continue to be paid for a period of ninety (90) days or until date of discharge, whichever is earlier.
- Totally Disabled 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 fifty-two (52) weeks or until the date the disability ends, whichever is earlier.

Totally Disabled means:

- With respect to the Insured, the inability to attend classes at the location where he is enrolled;
- With respect to a Dependent, or the Insured, if such classes are not in session, disability means the inability to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the Covered Person immediately prior to the Injury or Sickness; and
- Under the care of a Physician for period of Total Disability

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

This Extension of Benefits provision is applicable only to the extent the Covered Person will not be covered under this or any other similar health insurance policy in the ensuing term of Coverage.

Dependents that are newly acquired during the Insured's Extension of Benefits period are not eligible for Benefits under the provision.

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

GENERAL EXCLUSIONS AND LIMITATIONS

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

1. Eyeglasses, contact lenses, routine eye refractions, eye examinations except as in the case of Injury, 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 in the case of Accident or Injury.
3. Vaccines and immunizations (except as specifically provided in the Policy): a) required for travel; and b) required for employment.
4. Treatment (other than surgery) of chronic Conditions of the foot including weak feet, fallen arches, flat foot, pronated foot, subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions (except capsular or bone surgery, any type of massage procedure on or to the foot, corrective shoes and shoe inserts. This exclusion does not apply when related to diabetes, Illness or disease, treatment of infections which result from an accidental Injury, or infections which result from an accidental, involuntary, or unintentional ingestion of a contaminated substance.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that are 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; correction of breast size, asymmetry or shape by means of reduction, augmentation, or application of breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections and reductive mammoplasty when Medically Necessary); rhinoplasty. This exclusion does not include Reconstructive Surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part.
6. Sexual/gender reassignment surgery, except as provided when determined to be Medically Necessary or when treatment is otherwise covered under the Policy in the absence of a diagnosis of gender dysphoria. This exclusion does **not** include related mental health counseling or hormone therapy.
7. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved.
8. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications.
9. Custodial Care; long-term care.
10. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, (except as specified herein or when specifically and directly related to the treatment of a Medical Condition.)
11. Injury sustained while (a) participating in any intramural, intercollegiate, professional, semi-professional or club 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.
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.

13. Injury resulting from participation in any hazardous activity, including: travel in or upon a snowmobile, ATV (all terrain or similar type two or three wheeled vehicle and/or off-road four wheeled motorized vehicles motor vehicles not primarily designed and licensed for use on public streets or highways, parachuting, hang gliding, skydiving, parasailing, scuba diving, skin diving, glider flying, sailplaning, racing or speed contests, mountaineering (where ropes or guides are customarily used), rock wall climbing, rodeo or bungee jumping; (except as specifically provided in this Policy).
14. 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.
15. Reproductive/services, unless caused by Injury or Sickness, including but not limited to: family planning, premarital examination; impotence, organic or otherwise; sterilization reversal; and vasectomy reversal.
16. Elective termination of pregnancy.
17. Hospital Confinement or any other services or treatment that are received without charge or legal obligation to pay.
18. Services provided normally without charge by the health service of the Policyholder or services covered or provided by a student health fee.
19. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
20. Any services of a Physician or Nurse who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.
21. Services received before the Covered Person's Effective Date except as specifically provided under the Extension of Benefits provision.
22. Under the Prescription Drug Benefit, any drug or medicine:
    - Obtainable Over the Counter (OTC), except as specifically provided under Preventive Care;
    - for the treatment of alopecia (hair loss) or hirsutism (hair removal);
    - for the purpose of weight control;
    - anabolic steroids used for body building;
    - sexual enhancement drugs;
    - cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in this Policy;
    - treatment of nail (toe or finger) fungus;
    - refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
    - for an amount that exceeds a thirty (30) day supply
    - drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
    - purchased after Coverage under the Policy terminates;
    - consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is:
        i. contraindicated for the treatment of the Condition for which the drug was prescribed; or
        ii. Experimental for any reason.
23. Services for the treatment of any Injury or Sickness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot.
24. Injury or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
25. War or any act of war, declared or undeclared; or while in the armed forces of any country.
26. Modifications made to dwellings, property, or automobiles such as ramps, elevators, stair lifts, swimming pools, spas, air conditioners or air-filtering systems, equipment that may increase the value of the residence, or car hand controls, whether or not their installation is for purposes of providing therapy or easy access, or are portable to other locations.

27. Obesity treatment: Non-Medically Necessary 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:
    - Wiring of the jaw;
    - Appetite suppressants;
    - Surgery for removal of excess skin or fat.
28. General fitness, exercise programs, health club memberships and weight management programs; Exercise machinery or equipment, including but not limited to treadmill, stair steps, trampolines, weights, sports equipment, support braces used primarily for use during any sport or in the course of employment, any equipment obtainable without a Physician's prescription.
29. All services preformed to prepare the mouth for the application, fitting or use of dentures.
30. Elective Treatment, except as specified in the Schedule of Benefits.

PREMIUM

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

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

Please refer to the Schedule of Benefits for Premium information.

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 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 if it is contained in this Policy.

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 partially 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: If the amount of the payment made by Us is more than We should have paid under this Policy, We may recover the excess from one or more of: (a) The person We have paid; (b) The person for whom We have paid; (c) Insurance companies or any other plan; of (d) other organization. The amount of the payments made includes the reasonable cash value of any benefit provided in the form of services.

Right to Subrogation: We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the Benefits We paid for that Sickness or Injury. You are required to furnish any information or assistance, or provide any documents that We may reasonably require in order to exercise Our rights under this provision. This provision applies whether or not the third party admits liability. The refund of Benefits shall be

allowable to the extent the Insured recovers or may recover for the same Injury or Sickness from another plan, including a third party, its insurer, or the Insured's uninsured motorist insurance. Further, We have the right to offset subsequent Benefits payable to the Insured under the Policy against such recovery.

Upon Our request, the Insured must complete the required forms and return them to Us or to Our administrator. The Insured must notify Us of any pending or contemplated claims against third parties. The Insured must cooperate fully with Us in asserting a right to recover. The Insured will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Insured from any third party. If it is necessary for Us to institute legal action against the Insured for failure to repay Us, the Insured will be personally liable for all costs of collection, including reasonable attorney's fees.

We may file a lien in an Insured's action against the third party and have a lien upon any recovery that the Insured receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. We shall have the right to recovery of the full amount of Benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Insured. We will not be responsible for the Insured's attorney's fees or other costs.

Right to Reimbursement: If Benefits are paid under this plan and any person recovers from a third party by settlement, judgment or by operation of primary Coverage, We have a right to recover from that person an amount equal to the amount We paid. However, We will reimburse the Covered Person from any charges on a pro-rata basis for any expense Incurred in securing the settlement, judgment or otherwise.

Limitation to Our Recovery Rights: We may exercise Our Right to Subrogation against third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under this plan. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a third party.

MEDICAL NECESSITY and MEDICAL APPROPRIATENESS DETERMINATION

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

Covered Services are Medically Necessary if they are:

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

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

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

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental/Investigational or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient's family, Physician, Hospital or any other Physician;
- Exceeds in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or Preventive Care;
- Could have been omitted without adversely affecting the patient's Condition or the quality of medical care;
- Involves treatment with or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA). If the prescribed drug is recognized as safe and effective for the

treatment of a Sickness or Injury by one or more of the Standard Medical Reference Compendia or in the Medical Literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Sickness or Injury, Coverage will be provided, subject to the exclusions and limitations of the Policy;

- Involves a service, supply or drug not considered reasonable and necessary by the Centers for Medicare & Medicaid Services; or
- Can be safely provided to the patient on a more cost-effective basis such as Outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

Except for Preventive Care (Wellness Services), all Covered Services must be Medically Necessary except as specified herein.

If You have any questions or concerns about whether a particular service, supply, or treatment is Medically Necessary or Medically Appropriate, contact Us.

CLAIM PROVISIONS

Notice of Claim: Written Notice of Claim must be given to Us or Our authorized representative within ninety (90) 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. Failure to pay within the thirty (30) day period shall entitle the Covered Person to interest at the rate of nine (9) percent per annum from the 30th day after the receipt of such proof of loss to the date of late payment.

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, up to an amount not exceeding $1,000. 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 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 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.

   Illinois Department of Insurance
   122 S. Michigan Ave.
   19th Floor
   Chicago, IL 60603
   312-814-2420 phone
   312-814-5416 fax
   OR

   Illinois Department of Insurance
   320 West Washington Street
   Springfield, IL 62767-0001

   http://insurance.illinois.gov/comlaints/file_complaint.asp
   866-445-5364 toll free
   866-323-5321 TDD
   217-782-4515 phone
   217-782-5020 fax

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.

   Illinois Department of Insurance
   122 S. Michigan Ave.
   19th Floor
   Chicago, IL 60603
   312-814-2420 phone
   312-814-5416 fax

   OR

   Illinois Department of Insurance
   320 West Washington Street
   Springfield, IL 62767-0001

   http://insurance.illinois.gov/comlaints/file_complaint.asp
   866-445-5364 toll free
   866-323-5321 TDD
   217-782-4515 phone
   217-782-5020 fax

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 and within sixty (60) calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to an additional sixty (60) calendar days if additional information is needed. You will be notified in writing of the Appeals Department's decision.

A 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 Representative 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.

You may be eligible for an expedited appeal for urgent care requests if:

- The time frame for making a standard determination could seriously jeopardize the life or health of the Covered Person and with respect to a pregnant woman, includes her unborn child, or the ability to regain maximum function; or
- The request involves an admission, availability of care, continued stay or health care service for which the Covered Person received Emergency services and has not been discharged from a facility; or
- The request involves an Experimental or Investigational determination and the health care Providers certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if no promptly initiated.

Generally, You must exhaust the internal appeal process prior to requesting an external review. This requirement is waived for:

- In certain urgent cases, You may be eligible for an "expedited" external review even if you have not filed and internal appeal;
- You may be eligible for ran external review if you filed and internal appeal but have not received a decision from Us within thirty (30) days for concurrent or prospective review or within sixty (60) days for retrospective, or within forty-eight (48) hours for an expedited internal appeal.

We will provide a form for You to submit a written request for an external review. The form is also available at DOI.externalreview@illinois.gov.

You, an Authorized Representative or a Provider, with Your consent, must submit the request to the Department of insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
866-445-5364 toll free
866-323-5321 TDD
217-782-4515 phone
217-782-5020 fax

Or

122 S. Michigan Ave., 19th Floor
Chicago, IL 60603
312-814-2420 phone
312-814-5416 fax
DOI.externalreview@illinois.gov

External Review Process

You, an Authorized Representative or a Provider, with Your consent, may request an external review within at least one hundred twenty (120) days after the receipt of the notice of an Adverse Determination or final internal adverse benefit determination.

The Department of Insurance will send Your request to Us within one (1) business day to determine if Your request is eligible. We will make an initial eligibility determination within five (5) business days.

Your request will be eligible for external review if:

1) You were covered by the health carrier policy or contract at the time the treatment was requested or provided;
2) The treatment is covered by Your Policy or contract, but health carrier has denied it due to Medical Necessity, Experimental/Investigational; or rescission of health care coverage;
3) You have exhausted the internal appeals to Your health carrier, and the company has upheld its decision to deny payment for the treatment in question;
4) If the treatment is considered "Experimental" or "Investigational" by the health carrier and Your health care Provider (who must be a licensed Physician) has certified that other "standard" treatments are not appropriate for Your Condition due to one of several reasons; and
5) You have provided all required information and forms.

If We determine that Your request is ineligible for an external review, We will provide a written explanation of why Your request is ineligible within one (1) business day. You may appeal Our determination by filing a complaint with the Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL 62767
866-445-5364 toll free
866-323-5321 TDD
217-782-4515 phone
217-782-5020 fax

Or

122 S. Michigan Ave., 19th Floor
Chicago, IL 60603
312-814-2420 phone
312-814-5416 fax
DOI.externalreview@illinois.gov

If Your Request is Eligible for External Review:

Once Your request is determined to be eligible for an external review, the Department will randomly assign a qualified Independent Review Organization ("IRO"), from a list of IROs approved by the Department of Insurance, to review Your case.

How will a decision on my request for external review be reached?

1) After Your case is assigned to an IRO by the Department, that IRO must assign a qualified clinical reviewer to review Your case. A qualified clinical reviewer is a Physician or other appropriate health care Provider who is an expert in the treatment of Your medical Condition, with recent or current actual clinical experience treating patients with the same or similar Condition and, for Physicians, a current specialty certification appropriate to Your Condition. For cases involving Experimental/Investigational determinations, more than one clinical reviewer may be assigned.
2) Within **five (5) business days** after the IRO assignment, We will submit, to the IRO, all the information We used in making Our decision to deny Your treatment, including any information We have received from You or Your health care Provider. You or Your authorized representative also have **five (5) business days**, from the date You receive notice from the Department of the name of the assigned IRO, to submit any additional information directly to the IRO.
3) In addition to the information provided by You, Your authorized representative and Your health carrier, the IRO must consider information including: Your relevant medical records, Your Provider's recommendation, and the most appropriate practice guidelines for Your Condition, which must include any applicable evidence-based standards.
For external reviews involving Experimental or Investigational treatments, the IRO must also consider additional medical and scientific evidence to determine whether the treatment recommended by Your Provider is likely to be

more beneficial to You than any other available "standard" treatment(s), and whether the adverse risks of the recommended treatment would be substantially increased compared to the available standard treatment(s).

4) Within **five (5) days**, but in no event more than **forty-five (45) days** after receiving all necessary information, the IRO must provide written notice of its decision to You, Your health carrier, the Department, and to Your authorized representative, if You have one. If the IRO makes a decision reversing the original denial of treatment, We will immediately approve the coverage.

The written notice from the IRO will include basic information about the external review, including the date the review was initiated and the time period during which it was conducted, a description of the documentation and evidence considered, and the principal reason for the decision, including any applicable evidence-based standards.

For reviews involving Experimental or Investigational treatments, the notice will also include a description and analysis of all medical and scientific evidence considered, and the written opinion of the clinical reviewer(s) as to whether the evidence demonstrates that the recommended treatment would be more beneficial to You than other available standard treatment(s), and whether the adverse risks of the recommended treatment would be substantially increased compared to the available standard treatment(s).

Can I appeal the decision of an IRO?

An external review decision made on or after July 1, 2013 is not eligible for an Appeal to the Director.

What if I have an urgent medical Condition?

In certain urgent circumstances, You may have the right to an "expedited" external review. An expedited external review is similar to the standard external review described above, except that the review must be completed more expeditiously (depending on the reason for denial).

Specifically, the IRO must notify You, Your authorized representative if You have one, the Department and Us of its decision "as expeditiously as Your medical Condition or circumstances require," but in no event more than **seventy-two (72) hours** after the IRO receives all necessary information for all cases **EXCEPT** Experimental/Investigational determinations, which must be made no later than **seven (7) calendar days** after the date the request is received by the IRO.

If You have already filed an expedited internal appeal with Us, and Your appeal was denied (or if You have not received a decision within forty-eight (48) hours), You may request an expedited external review if:

1) You have a medical Condition in which the time it would take to complete a standard external review would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function;

2) The recommended treatment involves an admission, availability of care, continued stay, or health care service for which You have received Emergency Medical Condition but have not yet been released; or

3) For a treatment considered by Us to be Experimental or Investigational, Your health care Provider certifies that the treatment would be significantly less effective if it is delayed.

If You have not yet filed an internal appeal or an expedited internal appeal, You may request an expedited external review in writing if:

1) You have a medical Condition in which the time it would take to complete an expedited internal appeal (forty-eight (48) hours) would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function; or

2) For a treatment considered by Us to be Experimental or Investigational, Your health care Provider certifies that the treatment would be significantly less effective if it is delayed.

To be eligible for an expedited external review, Your request must also meet the eligibility requirements.

NOTE: A request is not eligible for expedited external review if the request relates to a "retrospective" denial, or a case in which We have denied or reduced payment for a treatment after the treatment has already been provided.

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 here to. 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.

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 is incontestable two (2) years from the date of issue, except for fraudulent misstatements made by the applicant in the Application.

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

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

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

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

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

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

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

SCHEDULE OF BENEFITS

Actuarial Value: 81.37%
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 (www.firsthealth.com).

EFFECTIVE DATE: 08/01/2016 **POLICY ANNIVERSARY DATE**: 07/31/2017

PREMIUM:

	Annual
Student Only	$1,000

Policy Year Maximum Benefit		
Insured	unlimited	
	In-Network Benefit	**Out-of-Network Benefit**
Deductible (except as specified herein) per Policy Year per Covered Person; Benefits are subject to Deductible unless otherwise indicated. • The Deductible shall not apply: o In-Network Preventive/wellness exams and immunizations; o To Outpatient Prescription Drugs from a Participating Pharmacy; • Copayments do not apply to Deductibles.	$200	$400
Insured Percent (except as specified herein)	80% of the Preferred Allowance (PA)	60% of the Reasonable and Customary Charges (R&C)
Out-of-Pocket Maximum per Covered Person • Includes Coinsurance, Copayments and Deductibles • Excludes non-covered medical expenses and Elective Treatment; • Any Coinsurance paid by You is applied to the Out-of-Pocket Limit per Policy Year; • Once the In-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% In-Network; • Once the Out-of-Network Out-of-Pocket Maximum level is reached by the Covered Person, the Insured Percent paid by the Company will increase to 100% Out-of-Network.	$6,350	$19,050

Covered Charges for Essential Health Benefits	**In-Network Benefit**	**Out-of-Network Benefit**
Preventive Care (See Definition and page 20 for additional information.)		
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. • Limited to (one) 1 visit per day; • Does not apply when related to surgery; • Includes Consulting Physician/Specialists.	80% of PA after a $20 Copayment per visit	60% of R&C after a $20 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
Bone Density Testing - Covered only for the measurement, diagnosis and treatment of osteoporosis.	80% of PA	60% of R&C
Blood and Blood Components	80% of PA	60% of R&C
CT Scan, MRI, and /or PET Scans	80% of PA	60% of R&C
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
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. • Does not apply when related to surgery; • Includes Specialist/Consultant.	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 one or more incisions at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed. The Benefit for the primary or most expensive procedure is 50% of the Benefit otherwise payable for each subsequent procedure.		
Inpatient Surgical Services		
Surgeon ***Additional Surgical Opinion*** *- Following a recommendation for an Elective Surgery. Covered at 100% of claim charge for one (1) consultation and related diagnostic service by a Physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in Your opinion, is not resolved by the first consultation.*	80% of PA	60% of R&C
Assistant Surgeon	80% of PA	60% of R&C
Anesthetist Services	80% of PA	60% of R&C

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 ***Additional Surgical Opinion*** *- Following a recommendation for an Elective Surgery. Covered at 100% of claim charge for one (1) consultation and related diagnostic service by a Physician. If requested, benefits will be provided for an additional consultation when the need for surgery, in Your opinion, is not resolved by the first consultation.*	80% of PA	60% of R&C
Assistant Surgeon	80% of PA	60% of R&C
Anesthetist Services	80% of PA	60% of R&C
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	60% of R&C
Other Surgical Services (Inpatient/Outpatient)		
General Anesthesia for Dental services	80% of PA	60% of R&C
Reconstructive Surgery - Includes coverage for the correction of congenital deformities or for conditions resulting from accidental injuries, scars tumors or disease, including after mastectomy.	80% of PA	60% of R&C
Organ Transplant Surgery - Coverage provided for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas and pancreas/kidney organ or tissue transplants. ***Note:*** **No Accident and Health Insurer may deny reimbursement for an organ transplant as Experimental or Investigational unless supported by appropriate, required documentation.** Benefits are available to both the recipient and donor of a covered transplant as follows: • If both the donor and recipient have coverage provided by the same Insurer each will have their benefits paid by their own program. • If You are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this Policy will be provided for both You and the donor. In this case, payments made for the donor will be charged against Your benefits. • If You are the donor for the transplant and no coverage is available to You from any other source, the benefits under this Policy will be provided for You. However, no benefits will be provided for the recipient. Benefits will be provided for: • Inpatient and Outpatient Covered Services related to the transplant Surgery. • The evaluation, preparation and delivery of the donor organ. • The removal of the organ from the donor. • The transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada. Benefits will only be provided at in-network approved Human Organ Transplant Coverage Program.	80% of PA	60% of R&C

Organ Transplant Travel When transplant Hospital is located more than fifty (50) miles from the recipient's residence, coverage includes transportation and lodging for the recipient and up to five (5) Family Members, for a single round trip, with a single hotel room, totaling forty-five (45) days. Excludes coverage for meals.	80% of PA	60% of R&C
Bariatric Surgery when Medically Necessary to treat Morbid Obesity - Limited to one (1) surgical procedure per Lifetime.	80% of PA	60% of R&C
Reproductive Services		
Infertility Services - see Additional Benefits section for details.	80% of PA	60% of R&C
Voluntary Sterilization Surgery ***Note:*** Sterilization procedures for women are covered under Preventive Care.	80% of PA	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.		
Outpatient Pre- and Post-Natal Care, except diagnostic services performed and billed by a Physician's office, 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 pre-natal HIV testing, ultrasounds and amniocentesis.	Paid as any other Sickness	Paid as any other Sickness
Mental Conditions and Alcoholism/Substance Abuse Disorder		
Inpatient services - including Alcoholism/Drug detoxification.	Paid as any other Sickness	Paid as any other Sickness
Outpatient Office Visits - Includes, but is not limited to, psychological testing, neuropsychological testing, electroconvulsive therapy, intensive outpatient programs, partial hospitalization treatment programs, if it is an in-network approved program. 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 a $100 Copayment per visit	60% of R&C after a $100 Copayment per visit
Emergency services – visits to an Emergency room for stabilization or the initiation of treatment for an Emergency Condition; Includes Physician's fees, Diagnostic Imaging, Laboratory, Injections, use of emergency room, supplies, and facility charges. Follow-up care at the Emergency room is not covered. **Note:** The Copayment amount for this visit is waived if You are admitted to a Hospital for the same Condition.	80% of PA after a $100 Copayment per visit	80% of R&C after a $100 Copayment per visit
Emergency Medical Transportation services - including ground and air services. Services will not be provided for long distance trips solely because it is more convenient than other transportation.	80% of PA	80% 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
Autism Spectrum Disorders - Includes psychiatric care and diagnostic services, psychological assessments and treatments, Habilitative or rehabilitative treatments, and therapeutic care.	80% of PA	60% of R&C

Habilitative Care - Only when prescribed by the Attending Physician; Includes Outpatient Physical Therapy, Occupational therapy, Speech Therapy, Inhalation therapy, Cardiac therapy, Pulmonary therapy, Chiropractic care for a function that did not previously exist, but would normally be expected to exist. Coverage is provided only for Covered Persons aged eighteen (18) years or younger with congenital, genetic or early acquired disorders. Excludes services that are solely educational in nature.	80% of PA	60% of R&C
Physical Therapy – Outpatient - Includes preventive physical therapy for Covered Persons with Multiple Sclerosis.	80% of PA	60% of R&C
Speech Therapy	80% of PA	60% of R&C
Occupational Therapy	80% of PA	60% of R&C
Cardiac Therapy	80% of PA	60% of R&C
Pulmonary Therapy	80% of PA	60% of R&C
Respiratory Therapy	80% of PA	60% of R&C
Chiropractic care and Osteopathic Manipulation - Includes x-rays, office visits, laboratory services, massage therapy, manipulations and modalities (i.e., hot packs, cold packs and ultrasounds, etc.), regardless of Provider type.	80% of PA	60% of R&C
Dermatology	80% of PA	60% of R&C
Podiatry	80% of PA	60% of R&C
Home Health Care services You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and You must require Skilled Nursing Service on an intermittent basis under the direction of Your Physician. Includes: skilled nursing service by a registered professional nurse, services of physical, occupational and speech therapists, hospital laboratories, and necessary medical supplies. Services do not include and are not intended to provide benefits for Private Duty Nursing Care, or activities of daily living (such as personal hygiene, cleaning, cooking, etc.).	80% of PA	60% of R&C
Private Duty Nursing Care - Coverage is provided only for services that cannot be reasonably be self administered or provided by a Home Health Care agency.	80% of PA	60% of R&C
Hospice - Limited to Covered Persons with a life expectancy of one (1) year or less. Includes respite care for the Family Member primary care giver, coordinated home care, medical supplies and dressings, medication, skilled and non-skilled nursing services, occupational therapy, pain management services, physical therapy, Physician visits, and social and spiritual services.	80% of PA	60% of R&C
Diabetic treatment and education - Includes preventive and routine foot care.	80% of PA	60% of R&C
Durable Medical Equipment (DME) - Includes coverage for osseointegrated auditory implants and hearing aids for Covered Persons under the age of eighteen (18); Includes Prosthetic and Orthotic Devices.	80% of PA	60% of R&C
TMJ - treatment for the dysfunction of the temporomandibular joints, including surgery of the jaw to correct or treat TMJ; Coverage is limited to surgical removal of complete bony impacted teeth; excision of tumors and cysts; excision of exotoses of the jaw or hard palate; treatment of fractures of the facial bone; drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation or, or excision of, the temporomadibular joints. Any services related to preparation of the mouth for dentures are Not Covered.	80% of PA	60% of R&C

Dental treatment due to Injury to a Sound Natural Tooth, not including damage caused by biting or chewing.	80% of PA	80% of R&C
Dietary Counseling - Includes healthy diet counseling and Obesity screening. Excludes weight loss programs, therapies, drugs and classes.	80% of PA	60% of R&C
Amino acid-based elemental formulas ‑ includes reimbursement for amino acid-based elemental formulas, regardless of delivery method, for diagnosis and treatment of a Condition.	80% of PA	60% of R&C
Naprapathic Therapy	80% of PA	60% of R&C
Oxygen and its administration	80% of PA	80% of R&C
Shingles Vaccine - Coverage must include a vaccine for shingles that is approved by the federal Food and Drug Administration if it is ordered by a Physician for an Insured who is sixty (60) years of age or older.	80% of PA	60% of R&C
Pediatric Dental and Vision Services *for under the age of nineteen (19)* – 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; Limited to 1 exam / prophylaxis every 6 month. Includes: • topical fluoride treatment – 1 per 12 months • topical fluoride varnish – 1 per 12 months, ages 3+ (ages 0-2, 3 per 12 months) • x-rays – bitewing – 1 set per 12 months • x-rays - full-mouth and panoramic – 1 per 36 months • sealants (as needed for permanent 1st and 2nd molars only, 1 per tooth per lifetime) • space maintainers - 1 per lifetime per quadrant/arch		100% of R&C
Pediatric Dental – basic restorative services. Includes: • emergency palliative treatment of pain • fillings (amalgam, resin-based composite) - 1 per 12 months per tooth • pre-fabricated stainless steel crown - 1 per primary tooth per lifetime • other crowns - 1 per tooth every 60 months • endodontics - therapeutic pulpotomy • periodontics - scaling and root planning, limited to 1 every 24 months • prosthodontics – denture repair, denture rebase/reline (1 per 24 months; 6 months after initial installation) • simple extractions		70% of R&C
Pediatric Dental – major services. Includes: • prosthodontics - 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; full mouth debridement, limited to 1 per 6 months in office setting • oral surgery • general anesthesia, IV conscious sedation and non-IV conscious sedation – only in conjunction with complex oral surgery • analgesia		50% of R&C
Pediatric Dental – Medically Necessary orthodontia services*, for Covered Persons under the age of nineteen (19) with severe and handicapping malocclusion. Includes: • pre-orthodontic treatment - 1 per lifetime • orthodontic treatment - 1 visit per 45 days • appliance therapy • orthodontic retention - 1 per lifetime *Requires pre-authorization & Subject to 12-month waiting period for services.		50% of R&C

Routine Vision Exam 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 charges up to $150, then 50% thereafter

Outpatient Prescription Drugs

The Pharmacy Benefits Manager (PBM) is: Optum.

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	**Participating Pharmacy Benefit**	**Non-Participating Pharmacy Benefit**
1. Generic Drugs	100% after a $15 Copayment	60% of R&C
2. Preferred Brand Drugs	100% after a $35 Copayment	60% of R&C
3. Non-Preferred Brand Drugs	100% after a $60 Copayment	60% of R&C
4. Specialty Drugs	100% after a $60 Copayment	60% of R&C

- 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.
- Includes prescription contraceptives which have been approved by the FDA, prescribed pre-natal vitamins and smoking deterrent prescription medications.
- Includes medications, equipment and supplies for the management and treatment of diabetes.
- The Deductible does not apply at a Participating Pharmacy.
- The same cost sharing will apply to orally administered cancer drugs as that applied to intravenously or inject cancer drugs.
- Coverage will not be denied or limited for prescription inhalants to Covered Persons suffering from asthma or other life-threatening bronchial ailments based upon any restriction on the number of days before an inhaler refill may be obtained if, contrary to those restrictions, the inhalants have been ordered or prescribed by the treating physician and are Medically Necessary.
- 60 day written or electronic notice will be given to You prior to making any formulary change that alters the terms of coverage if You are receiving immunosuppressant drugs or discontinues coverage for a prescribed immunosuppressant drug that You are receiving. The notification will disclose the formulary change, indicate that the prescribing Physician may initiate an appeal, and include information regarding the procedure for the prescribing Physician to initiate the Plan's appeal process. This notice may be received at the time You request a refill along with a 60-day supply of the immunosuppressant drug.

Covered Charges – Elective Treatment
Note: All services are per Policy Year unless otherwise noted.

Elective Treatment

Non-emergency coverage outside of the United States, if not covered by any other coverage.
Maximum Benefit: $20,000 at 60% of actual charges.

Preventive Services

(a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

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. **Cardiovascular disease** for adults, early detection and proactive management

6. **Cholesterol screening** for adults of certain ages or at higher risk
7. **Colorectal Cancer screening** for adults over age 50; all colorectal cancer exams and lab tests for colorectal cancer as prescribed by Physician according to American Cancer Society.
8. **Depression screening** for adults
9. **Diabetes (Type 2) screening** for adults with high blood pressure
10. **Diet counseling** for adults at higher risk for chronic disease
11. **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
12. **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
13. **Obesity screening and counseling** for all adults
14. **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
15. **Syphilis screening** for all adults at higher risk
16. **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; Covered services include but are not limited to:

1. **Alcohol and Drug Use** assessments for adolescents
2. **Autism screening** for children at 18 and 24 months
3. **Behavioral assessments** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. **Blood Pressure screening** for children at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years.
5. **Cervical Dysplasia screening** for sexually active females
6. **Depression screening** for adolescents
7. **Developmental screening** for children under age 3
8. **Dyslipidemia screening** for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
9. **Fluoride Chemoprevention supplements** for children without fluoride in their water source
10. **Gonorrhea preventive medication** for the eyes of all newborns
11. **Hearing screening** for all newborns
12. **Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
13. **Hematocrit or Hemoglobin screening** for children
14. **Hemoglobinopathies or sickle cell screening** for newborns
15. **HIV screening** for adolescents at higher risk
16. **Hypothyroidism** screening for newborns
17. **Immunization vaccines** for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    a. Diphtheria, Tetanus, Pertussis
    b. Haemophilus influenzae type b
    c. Hepatitis A
    d. Hepatitis B
    e. Human Papillomavirus
    f. Inactivated Poliovirus
    g. Influenza (Flu Shot)
    h. Measles, Mumps, Rubella
    i. Meningococcal
    j. Pneumococcal

k. Rotavirus
l. Varicella

18. **Iron supplements** for children ages 6 to 12 months at risk for anemia
19. **Lead screening** for children at risk of exposure
20. **Medical History** for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years.
21. **Obesity screening and counseling**
22. **Oral Health risk assessment** for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
23. **Phenylketonuria (PKU) screening** for this genetic disorder in newborns
24. **Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk
25. **Tuberculin testing** for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
26. **Vision screening** for all children

(d) With respect to women (including pregnant 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.

Covered services include but are not limited to:

1. **Anemia screening** on a routine basis for pregnant women
2. **Breast Cancer Genetic Test Counseling (BRCA)** for women at higher risk for breast cancer
3. **Breast Cancer Mammography screenings**
4. Coverage of screening by low-dose mammography for all women over 35; Coverage requires baseline mammogram for women 35-39 and annual mammogram for women 40 years of age and older.
5. For women under 40 with a family history of breast cancer or other risk factors mammograms must be provided at an age and intervals considered Medically Necessary.
6. Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates Medical Necessity as described.
7. Coverage must be provided at no cost to the Insured and shall not be applied to an annual or lifetime maximum benefit.
8. When coverage is available through contracted providers and such a provider is not utilized, plan provisions specific to the use of those non-contracted providers must be applied without distinction to the coverage required and shall be at least as favorable as for other radiological examinations covered by the Policy or contract.
9. **Breast Cancer Chemoprevention counseling** for women at higher risk
10. **Breastfeeding comprehensive support and counseling** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
11. **Cervical Cancer screening** for sexually active women
12. **Chlamydia Infection screening** for younger women and other women at higher risk
13. **Contraception**: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt “religious employers.”
14. **Domestic and interpersonal violence screening and counseling** for all women
15. **Folic Acid** supplements for women who may become pregnant
16. **Gestational diabetes screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
17. **Gonorrhea screening** for all women at higher risk
18. **Hepatitis B screening** for pregnant women at their first prenatal visit
19. **HIV screening and counseling** for sexually active women
20. **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older
21. **Osteoporosis screening** for women over age 60 depending on risk factors
22. **Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
23. **Sexually Transmitted Infections counseling** for sexually active women
24. **Syphilis screening** for all pregnant women or other women at increased risk
25. **Tobacco Use screening and interventions** for all women, and expanded counseling for pregnant tobacco users
26. **Urinary tract or other infection screening** for pregnant women

27. **Well-woman visits** to get recommended services for women under sixty-five (65); including but not limited to clinical breast exams, pap tests and pelvic exams.

The Illinois guidelines for frequency of breast exams is:

- At a minimum every three (3) years for women over twenty (20) years of age but less than forty (40); and,
- Annually for women forty (40) years of age and older.

Pap tests includes annual cervical smear or Pap smear, including surveillance tests for ovarian cancer for female Insureds who are at risk for ovarian cancer.

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

ILLINOIS DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION
320 W. Washington Street
Springfield, IL 62767
866-445-5364 toll free
866-323-5321 TDD
217-782-4515 phone
217-782-5020 fax

Or

122 S. Michigan Ave., 19th Floor
Chicago, IL 60603
312-814-2420 phone
312-814-5416 fax
DOI.externalreview@illinois.gov

President

Nationwide Life Insurance Company

NOTICE OF PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or Health Insurance Company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to hospital, medical, and surgical insurance benefits for which the maximum amount of protection is $500,000.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association
1520 Kensington Road, Suite 112
Oak Brook, Illinois 60523-2140
(773) 714-8050

Illinois Department of Insurance
4th Floor 320 West Washington Street
Springfield, Illinois 62767
(217) 782-4515

Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

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?	1-800-525-8669

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