Nationwide Life Insurance Company

Home Office: Columbus, Ohio

BLANKET STUDENT ACCIDENT & SICKNESS POLICY

Non-Renewable One Year Term Insurance - This Policy will not be renewed.

POLICY FACE PAGE

POLICY NUMBER: 302-039-3710

POLICYHOLDER: LEHIGH UNIVERSITY

ADDRESS: Bethlehem, PA

EFFECTIVE DATE: 8/8/2012 **TERMINATION DATE:** 8/8/2013

Premium for each Insured person:

	Annual (8/8/12 – 8/8/13)	**Fall (8/8/12 – 1/9/13)**	**Spring (1/9/13 – 8/8/13)**
Student	$2,116*	$941*	$1,392*
Optional Supplemental			
	$365**	$365**	$365**

*An administration fee is added to the student premium.

**The Optional Supplemental must be purchased at the time of initial enrollment.

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.

NOTICE: Your Student Accident and Sickness Insurance coverage, offered by Nationwide Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits for health insurance plans other, than student health insurance coverage for the 2012/2013 policy year. Minimum restrictions for policy year dollar limits for student health insurance coverage are $100,000 for the 2012/2013 policy year. Your Student Accident and Sickness Insurance Plan has a coverage limit of $100,000 per policy year. Be advised that you may be eligible for coverage under your parents' plan if you are under the age of 26. If you have any questions or concerns about this notice, contact Consolidated Health Plans at 800-633-7867.

READ YOUR POLICY CAREFULLY

This Policy is excess only. See the excess provision section of this Policy. Benefits payable under this Policy are subject to reduction if a Covered Person is entitled to Benefits, whether on an indemnity basis or on a provision-of-service basis, for Hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group, or blanket insurance Policy or contract, Hospital or medical service program, or group-practice prepayment plan, except for automobile medical payments insurance.

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 Doctors, Health Care Practitioner, and facilities;
- Emergency care at any Hospital for a Condition You believe threatens Your life or seriously affects Your health;
- Information about steps You can take if You think Your health insurance plan has denied You Coverage of a treatment You believe is covered.

TABLE OF CONTENTS

	Page Number:
Schedule of Benefits	**1-3**
General Definitions	**4-10**
Conditions of Insurance	
Eligibility	**11**
Dependents Acquired After Effective Date	**11**
Termination	**11**
Extension of Benefits	**12**
Reinstatement of Reservist after Release from Active Duty	**12**
Covered Services	
Wellness Covered Services	**13**
Outpatient Covered Services	**13**
Inpatient Covered Services	**13**
Surgical Services	**14**
Reproductive Covered Services	**14**
Mental Disorders/Alcohol Abuse and Dependency	**14**
Severe Mental Illness (and Serious Emotional Disturbances of a Child)	**14**
Emergency Covered Services	**15**
Other Covered Services	**15**
Prescription Drugs	**17**
General Exclusions and Limitations	**19-20**
Student Health Services Referral	**21**
Coordination of Benefits	
Definitions Applicable to Coordination of Benefits Section	**22**
Effect on Benefits	**22**
Right to Receive and Release Information	**23**
Facility of Payment/Right of Recovery	**23**
Claim Provisions	
Notice of Claim	**24**
Claim Forms	**24**
Proof of Loss	**24**
Time of Payment of Claims	**24**
Payment of Claims	**24**
Physical Examination and Autopsy	**24**
Physical Examination	**24**
Legal Actions	**24**
Medical Necessity and Medical Appropriateness Determinations	**25**
Premium: Payment of Premium/Due Date	**25**
Returned or Dishonored Payment	**25**
General Provisions	
Entire Contract; Changes	**26**
Grace Period	**26**
Incontestability	**26**
Non-Participating	**26**
Conformity with State Statutes	**26**
Workers' Compensation	**26**
Clerical Error	**26**
Information and Record	**26**
Excess Provision	**27**
Complaint and Appeal Process	**28-30**
Mandated Benefits	**31-33**
Important Notice	**34**
Sports Rider	**Insert**
Organ transplant rider	**Insert**
Privacy Statement	**Insert**

SCHEDULE OF BENEFITS

BASIC MEDICAL EXPENSE BENEFIT	
Deductible: Per Sickness or Injury (waived if referred by the Student Health Center)	$50
Insured Percent: 100% of Preferred Allowance (PA) for In-network services and 100% of Reasonable & Customary (R&C) for Out-of-network services, up to the Basic Aggregate Maximum Amount	
Basic Aggregate Maximum Amount Per Sickness or Injury: $1,000	

MAJOR MEDICAL EXPENSE BENEFIT	
Deductible: Per Sickness or Injury (waived if referred by the Student Health Center)	$50
Insured Percent: 80% of Preferred Allowance (PA) for In-network services and 80% of Reasonable & Customary (R&C) up to $5,000; then 100% of Preferred Allowance (PA) for In-network services and 100% of Reasonable & Customary (R&C) up to the Major Medical Aggregate Maximum Amount	
Major Medical Aggregate Maximum Amount: $100,000 (minus the Basic Benefits already paid)	

OPTIONAL ENHANCED SUPPLEMENTAL BENEFIT
Insured Percent: 100% of Preferred Allowance (PA) for In-network services and 100% of Reasonable & Customary (R&C) in excess of $100,000.
Optional Enhanced Supplemental Maximum Amount: $200,000

Out-of-Network claim payment - The methodology for calculating Reasonable and Customary is based in accordance with data provided by Fair Health Inc. and the prevailing rate in the community based upon zip code.
This Policy is excess, We will pay an initial amount of $100 for charges incurred for an Injury or Sickness and then We are secondary.

PLEASE NOTE: ALL BENEFITS ARE PER POLICY YEAR UNLESS OTHERWISE NOTED.

SCHEDULE OF BENEFITS (continued)

Covered Services	In-Network Provider	Out-of-Network Provider
Wellness Services (See Covered Services for more details)		
Well baby and child care – only available for the first thirty-one (days). No Dependent Coverage on this Policy.	100% of PA + waiver of Deductible	Not covered
Well adult care	100% of PA + waiver of Deductible	Not covered
Immunizations – Including but not limited too: Tetanus, Diptheria, Pertussis, TdaP; Measles-Mumps-Rubella; Hepatitis A; Hepatitis B; Herpes Zoster; HPV; Flu; Pneumonia; Varicella; Meningococcal; Twinrix (combo Hepatitis A and B).	100% of PA + waiver of Deductible	Not covered
Outpatient Services		
Doctor office visits (limited to one (1) visit per day)	PA	R&C
Diagnostic Imaging and Laboratory Procedures	PA	R&C
CAT Scan, MRI, and /or PET Scans	PA	R&C
Infusions and/or Injections done in an Outpatient Health Care Facility or Doctor's office	PA	R&C
Miscellaneous Outpatient Services	PA	R&C
Radiation and Chemotherapy	PA	R&C
Dialysis and Filtration Procedures	PA	R&C
Inpatient Services		
Hospital Services a. Room & Board expense, daily semi-private room rate and general nursing care provided by the Hospital; b. Intensive Care Room; c. Pharmaceuticals administered while an Inpatient; d. Inpatient rehabilitation; e. Miscellaneous benefits; f. Consulting Physician; g. Preadmission testing	PA	R&C
Physical therapy – up to thirty (30) days per Condition.	PA	R&C
Doctor visits – limited to one (1) visit per day and does not apply when related to surgery.	PA	R&C
Registered Nurse expense & private duty nursing.	PA	R&C
Surgical Services (Inpatient & Outpatient)		
Anesthesia Services (Inpatient coverage is limited to 30% of surgeon allowance for Out-of-network; Outpatient coverage is limited to 25% of surgeon allowance) for Out-of-network.	PA	R&C
Surgeon	PA	R&C
Assistant Surgeon	PA	R&C
Outpatient Hospital/Health Care/Surgical Facility fee	PA	R&C
Office Surgery performed in a Doctor's office	PA	R&C
Reconstructive Surgery	PA	R&C
When Injury or Sickness requires multiple Surgical Procedures through the same incision, at 50%.		
Reproductive Services		
Maternity Care - Pre and Post Natal Care, including delivery and In-Hospital Doctor visits for mother and baby.	PA	R&C
Elective Abortion - up to $400 maximum per Policy Year.	PA	R&C
Mental Disorder		
Inpatient - up to sixty (60) days per Policy Year.	PA	R&C
Outpatient - up to fifteen (15) visits per Policy Year.	50% of PA	50% of R&C
Severe Mental Illness		
Inpatient	Paid as any other Sickness	
Outpatient	Paid as any other Sickness	

SCHEDULE OF BENEFITS (continued)

Covered Services	In-Network Provider	Out-of-Network Provider
Alcohol Abuse and Dependency (see mandated benefits for details)		
Inpatient	Paid as any other Sickness	
Outpatient	Paid as any other Sickness	
Emergency services		
Urgent Care Expenses	PA	R&C
Medical Emergency Expenses	PA	R&C
Emergency Medical Transportation Services	PA	R&C
Other Services		
Allergy testing and treatment	PA	R&C
Rehabilitative Care (limited to one (1) visit per day) a. Physical Therapy (up to fifteen (15) visits maximum per condition); b. Speech Therapy c. Occupational Therapy d. Cardiac/Pulmonary	PA	R&C
Home Health Care services	PA	R&C
Hospice	PA	R&C
Diabetic treatment & education	PA	R&C
PKU Testing & treatment	PA	R&C
Durable Medical Equipment	PA	R&C
Prosthetic appliances	PA	R&C
Eye Refractions, when performed in conjunction with a chronic or acute medical Condition. Note: Must be associated with an Illness code.	PA	R&C
Dental treatment due to Injury to Sound Natural Teeth.	PA	R&C
Intercollegiate Sports – up to $2,000 per Policy Year. See rider for details.	PA	R&C
Retail Prescription Drugs	100% after a $10 Copayment for Generic and $20 Copayment for Brand Name Prescription Drugs per 30 day supply; $0 Copayment for Generic Contraceptives.	
Cancer Chemotherapy and Hormone Therapy - We will pay the expenses incurred for cancer chemotherapy and cancer hormone treatments and services which have been approved by the United States Food and Drug Administration for general use in the treatment of cancer. Benefits will be provided for treatments and services performed in a Physician's office, in an outpatient department of a Hospital, as a Hospital inpatient or in any other medically appropriate treatment setting.		

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.

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

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

Basic Medical Benefits: The maximum lifetime benefit amount payable by the Company for incurred Covered Charges for each Injury or Sickness. When Injury or Sickness requires treatment, payment shall be made for Covered Charges incurred.

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.

Coinsurance: The percentage of the expense for which the Company is responsible for a covered service. The Coinsurance is separate and not a part of the Deductible and Copayment.

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

Complications of Pregnancy: A Condition which:

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

Complications of Pregnancy will **not** include:

- False labor;
- Occasional spotting;
- Doctor 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: Disease, Illness, ailment, malfunction, 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 72 hour period, will be considered a continuation of the Confinement. Confined/Confinement does **not** include observation, which is a review or assessment of 23 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 charges. The Copayment is separate from and not a part of the Deductible or Coinsurance or out-of-pocket maximum.

Cosmetic Surgery or Plastic Surgery: Surgery intended primarily to alter normal structures of the body to improve appearance and that will result in only minimal functional improvement, except for Reconstructive Surgery as defined in this Policy**.**

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

Covered Charge or Covered Expense: As used herein means those charges for any treatment, services or supplies: (a) for Network Providers not in excess of the Preferred Allowance; (b) for Non-Network Providers not in excess of the charges of the Reasonable and Customary expense therefore; and (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Covered Person except with respect to any covered expense payable under the Extension of Benefits Provision.

GENERAL DEFINITIONS (continued)

Covered Person: A person:

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

Covered Services: The services and supplies, procedures and treatment described under Covered Services, subject to the terms, Conditions, limitations, and exclusions of the Policy.

Doctor: Any of the following to the extent they are authorized by law and duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy: Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage**.**

Drug Abuse: Any chemical component that one inhales, ingests, injects, or applies to one's body for purposes of non-therapeutic use. Drug Abuse does not include alcoholism or alcohol abuse.

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 Doctor and the device is Medically Necessary for rehabilitation.

Effective Date: The first date a Student or a covered Dependent becomes covered under this Policy.

Eligible Person: The Covered Person who is enrolled, attending class and meets the eligibility requirements of the Policyholder's school.

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

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

Emergency Medical Transportation Services: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital 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.

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 definition of Medically Necessary/Medical Necessity.

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.

Formula: Enteral products for use at home that are prescribed by a Doctor, Health Care Practitioner upon referral by a health care Provider authorized to prescribe dietary treatments, as medically necessary for the treatment of phenylketonuria (PKU).

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

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

Health Care Practitioner: Includes but is not limited to: A Doctor of Dentistry (D.D.S. or D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), Doctor of Chiropractic (D.C.), Doctor's Assistant (P.A..), Psychologists (Ph. D.), Nurse (R.N. or L.P.N), which may include Nurse Midwife, Nurse Anesthetist, and Nurse Practitioner, a Licensed Clinical Social Worker (L.C.S.W.), Physical Therapist (P.T. or R.P.T.), Occupational Therapist (O.T.R.), Speech Pathologist, Audiologist, Marriage and Family Therapist (M.F.T. or M.S.W.), Respiratory Care Practitioner, or Registered Dietitian (R.D.) all of whom are (a) properly licensed or certified to provide medical care under the laws of the state of practice; (b) provide medical services within the scope of the license or certificate:, and (c) does not ordinarily reside in the Covered Person's home or is not related to the Covered Person by blood or marriage.

Home Health Care: Services and supplies that is Medically Necessary for the care and treatment of a covered Illness or Accidental Injury that 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:

- Part-time or intermittent skilled nursing services provided by a Registered Nurse or licensed Vocational Nurse;
- Part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a Registered Nurse or a Physical Therapist; and
- Physical 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 Doctors. 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.

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 nursing home, a convalescent Hospital, or a place for rest or the aged.

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.

Illness: Sickness or disease.

Infusion/Injectable 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. Infusion/Injectable Services does include self-administered Injectable Drugs.

Injury: Bodily Injury due to a sudden, unforeseeable, external event which:

- Results solely, directly and independently of disease, bodily infirmity or any other causes;
- Occurs while Coverage is in force.

All injuries sustained in any one Accident, including all related Conditions and recurrent symptoms of these injuries, and are considered a single Injury.

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

GENERAL DEFINITIONS (continued)

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.

Lifestyle Change: A change in Your or Your Dependent's status due to marriage, divorce, dissolution of Domestic Partnership, age, birth, death, adoption, change in Spouse's or Domestic 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.

Loss: Medical expenses covered by this Policy as a result of Injury or Sickness as defined in this Policy.

Major Medical Aggregate Maximum Amount: The maximum amount of Benefits we will pay for any one Sickness or Injury under the Major Medical expense Benefit while a Covered Person is covered under this Policy or any other Policy issued to the Policyholder by Us and is inclusive and cumulative of any and all periods of Coverage regardless of gaps in participation. The Major Medical Aggregate Maximum Amount is shown in the Schedule of Benefits.

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.

Medical Emergency: The unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective surgery, elective treatment or routine care.

Medically Necessary/Medical Necessity: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. 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, Doctor, Hospital or any other Provider;
- 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 Healthcare Financing Administration Medicare Coverage Issues Manual; 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.

We reserve the right to determine whether a service, supply or drug is Medically Necessary.

Mental Disorder: Nervous, emotional, and mental disease, Illness, syndrome or dysfunction classified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a Mental Disorder on the date of medical care or treatment is rendered to a Covered Person.

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.

GENERAL DEFINITIONS (continued)

Office Surgery (ies): An invasive procedure to repair, replace, remove or add tissue or fluid. The procedural coding represents that found under the surgical codes as outlined in the Current Procedural Terminology Manual (CPT).

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

Partial Hospital Mental Health Confinement: A structured program of active treatment for psychiatric care for Mental Disorders, alcoholism and/or Drug Abuse and/or addiction received on an Outpatient basis at a Hospital. Such program may include, but is not limited to, Doctor or Other Medical Care Practitioner visits, dietary counseling, physical activities, and room and meal services. This includes day treatment or residential treatment centers.

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

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

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

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

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

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the U.S. Food and Drug Administration (FDA). The Drugs must be dispensed by a licensed pharmacy Provider for out of Hospital use. Coverage for a Prescription Drug will not be excluded for a particular indication on the grounds that the drug has not been approved by the FDA for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Prescription Drug Coverage shall also include Medically Necessary supplies associated with the administration of the drug.

Preventive Care: Comprehensive Preventive Care of Dependent children:
- That is consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Doctors; and
- Provides for periodic health evaluations, immunizations and laboratory services in connection with periodic health evaluations.

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

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.

Reasonable and Customary expense: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:
- The actual amount charged by the Provider;
- The negotiated rate, if any; or
- The charge which would have been made by the Provider of medical services for a comparable service or supply made by other Providers in the same geographic area, as reasonably determined by Us for the same service or supply.

Geographic area means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

GENERAL DEFINITIONS (continued)

Reasonable charges, fees or expenses as used herein to describe expense, will be considered to mean the percentile of the payment system in effect on the Effective Date as shown on the face page of this Policy.

No payment will be made under this Policy for any expenses incurred which in the judgment of the Company are in excess of Reasonable and Customary expense.

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

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.

Screening Mammography: A radiological examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray or digital radiography examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast and includes the professional interpretation of the films. Screening Mammography does not include diagnostic mammography. Screening Mammography must be performed in a facility or mobile mammography screening unit that is accredited under the American College of Radiology Mammography Accreditation Program or in a Hospital.

Serious Emotional Disturbance of a Child: A child under the age of eighteen (18) who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms.

Serious Mental Illness: Any of the following Mental Illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

Sickness: Illness, disease, pregnancy and Complications of Pregnancy. 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 Doctor 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 Doctor;
- Maintains a daily clinical record for each patient;
- Is not, other than incidentally, a place for rest, the aged, place of treatment for alcoholism or drug and/or substance abuse or addiction; and
- Is operated pursuant to law.

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

Special Food Product: A food product that is both of the following: (a) prescribed for the treatment of phenylketonuria (PKU) and is consistent with the recommendations of best practices of qualified health professionals with expertise to, and experience in the treatment and care of PKU. It does not include food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and (b) used in place of normal food products, such as grocery store foods, used in the general population.

Surgeon: A Doctor who actually performs surgical procedures.

GENERAL DEFINITIONS (continued)

Surgical Services: Surgical Services include both facility and Provider fees associated with any surgery, whether done as an Inpatient, Outpatient or in a Doctor's office. Benefits are paid at the Surgical Services Benefit shown on the Schedule of Benefits services include:

- Surgeon and Assistant Surgeon
- Anesthesia
- Facility fees
- Supplies, drugs, and miscellaneous items used in association with the surgical event.

We, Our and Us: Nationwide Life Insurance Company.

You and Your: the Covered Person.

Male pronouns whenever used include female pronouns.

CONDITIONS OF INSURANCE

ELIGIBILITY

We maintain the right to investigate Student 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.

All registered Students who actively attend class or have matriculated at the Policyholder's school for at least the first thirty-one (31) days of the Policy Term are eligible to enroll in the Policy for the term enrolled. Except in the case of medical withdrawal due to Sickness or Injury, any Student 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. Students withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed.

Each Student, as determined by the school and the Company, is eligible for Coverage under this Policy.

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. **After the thirty-one (31) days, Dependent coverage is not available.**

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. **After the thirty-one (31) days, Dependent coverage is not available.**

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. **After the thirty-one (31) days, Dependent coverage is not available.**

Adopted Child: Coverage for an adopted child is effective upon the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, the Insured must notify Us in writing within thirty-one (31) days of such adoption and pay the required additional Premium, if any, in order to have Coverage for the adopted child continue beyond such thirty-one (31) day period. **After the thirty-one (31) days, Dependent coverage is not available.**

TERMINATION

Policyholder: The Policy is issued for the Policy term stated on the face page of this Policy on the Effective Date of the Policy. If the Policyholder desires to continue Coverage, We will issue a new Policy for a new Policy term, subject to the then current underwriting requirements.

Covered Person: Coverage will terminate at 12:01 a.m. standard time at the Covered Person's residence on the earliest of:

- The termination date of the Policy;
- The date the Insured ceases to be an Eligible Person;
- The last day of the Policy term for which Premium is paid;
- The date a Covered Person enters full time active military service.

Termination is subject to the Extension of Benefits provision.

EXTENSION OF BENEFITS

The Coverage provided under this Policy ceases on the termination date, shown on the face page. However, if an Insured is Hospital Confined on the termination date from a covered Injury or Sickness for which Benefits were paid before the termination date, Covered expenses for such Injury or Sickness will continue to be paid for a period not to exceed twelve (12) months after the Termination Date.

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.

REINSTATEMENT OF RESERVIST AFTER RELEASE FROM ACTIVE DUTY

If Your insurance or Your eligible Dependent's 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.

COVERED SERVICES

Subject to the terms, Conditions, limitations, and exclusions of the Policy, payment will be considered for expenses Incurred for the Covered Services described in this section. All Benefits are per Policy Year/per Injury or Sickness unless otherwise indicated. All Covered Services must be Medically Necessary (except as provided for wellness/preventive services). For details on Benefit limits, Deductible, Copayment, and Coinsurance amounts please refer to the Schedule of Benefits.

Preventive/Wellness Covered Services

1. Well baby and child care – only available for the first thirty-one (days). (No Dependent Coverage on this Policy). Benefits will be considered based on the following:
   a. The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics;
   b. The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Doctors.

   The Covered Services include, but are not limited to:
   - Periodic health evaluations;
   - Immunizations;
   - Laboratory services in connection with periodic health evaluations;
   - Hearing screening as recommended by the American Academy of Pediatrics;
   - One (1) Vision Screening per Policy Year;
   - Screening for blood lead levels.
2. Well adult care - Benefits will be considered based on the following, Covered Services include, but are not limited to:
   - Routine physical examinations;
   - Routine gynecological care, including an annual cervical cancer screening;
   - One prostate specific antigen test (PSA) and one digital rectal exam per Policy Year, for men;
   - One (1) Screening Mammography per Policy Year;
   - The most current version of the Recommended Adult Immunization/vaccines as recommended by the Centers for Disease Control, the Advisory Committee on Immunization Practices, and the American Academy of Family Doctors.

   Note: Sterilization procedures for women are covered under the Well Adult Care Benefit.

Outpatient Covered Services

1. Doctor office visits limited to one (1) visit per day for the diagnosis, medical advice, care or treatment of a Condition.
2. Diagnostic services performed and billed by a Doctor's office, including ultrasounds and amniocentesis;
3. Diagnostic Imaging and Laboratory procedures;
4. CAT Scan, MRI, and /or PET Scans;
5. Infusions and/or Injections done in an Outpatient Health Care facility or Doctor's office;
6. Miscellaneous Outpatient services;
7. Radiation and Chemotherapy;
8. Dialysis and Filtration Procedures.

Inpatient Covered Services

1. Hospital Facility services:
   - Semi-private room and board;
   - Intensive care units;
   - Meals and prescribed diets;
   - X-ray and lab services which are diagnostic or therapeutic and Doctor services;
   - Therapeutic services and supplies;
   - General nursing services;
   - Pharmaceuticals administered while an Inpatient
   - Rehabilitative services.
2. Doctor services:
   - Doctor visits limited to one (1) visit per day during Confinement in a Hospital;
   - Medical services including radiology and laboratory services ordered by or provided by a Doctor while Confined.

Surgical Services

1. Surgical services include both facility and Provider fees associated with any surgery, whether done as an Inpatient, Outpatient or in a Doctor's office. Benefits are paid at the Surgical Services Benefit shown on the Schedule of Benefits. Services include: Surgeon and Assistant Surgeon; Anesthesia; Facility fees; Supplies, Drugs, and miscellaneous items used in association with the surgical event.
2. Reconstructive Surgery:
   - Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or diseases to either improve function or to create a normal appearance;
   - Reconstructive Surgery to restore or correct a Loss of function resulting from surgery, or trauma, infection or other disease, including initial implantation of prosthesis, such as following cancer surgery;
   - Reconstructive breast surgery following a mastectomy for breast cancer. Coverage is provided for all complications from a mastectomy, including lymphedema. Surgery and reconstruction of the unaffected breast to produce a symmetrical appearance is also covered when performed as part of the same procedure.

Reproductive Covered Services

1. Maternity Care:
   Coverage for maternity care, including Complications of Pregnancy, starts with the date the Covered Person's Coverage becomes effective under the Policy and ends when the Covered Person's Coverage terminates, unless the Covered Person is Confined in a Hospital on that date. If a Covered Person is Confined on that date, Coverage will terminate when the Covered Person has been discharged. See Extension of Benefits. Benefits for Outpatient maternity services will be paid at the Reproductive services Benefit shown on the Schedule of Benefits and not at the Outpatient Services Benefit level.

   The following are Covered Services:
   - 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 Doctor or a certified nurse-midwife who consults with a Doctor, decides to discharge the mother or newborn child sooner. In the event of early discharge, Home Health Care visits may be provided;
   - Pre-natal and post-natal visits to a Doctor. The Policy will not pay for pre-natal visits which occur prior to the date Your Coverage takes effect;
   - Delivery charges;
   - In-Hospital Doctor visits;
   - In-Hospital care for a newborn child, subject to the enrollment and Premium payment requirements;
   - Rooming in for maternity care;
2. Elective termination of pregnancy.

Mental Disorder/Drug Abuse and Alcoholism (including Severe Mental Illness and Serious Emotional Disturbance of a Child) Covered Services

A separate Benefit limit is shown on the Schedule of Benefits for alcoholism Covered Services. Benefits for Outpatient Mental Disorder/Drug Abuse and Outpatient alcoholism services will be paid at the mental health/Drug Abuse/alcoholism Benefit level shown on the Schedule of Benefits and not at the Outpatient services Benefit level.

1. **Outpatient Mental Disorder services (including Severe Mental Illness and Serious Emotional Disturbance of a Child)**: Outpatient Mental Disorder services provided by a Doctor, Health Care Practitioner, or psychologist. The programs must be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by the State Department of Health or the State Department of Mental Health. The services must be provided in one of the following:
   - The Provider's office;
   - A Hospital-related program;
   - A free-standing unit;
   - A day or night treatment unit; or
   - A community mental health center.

2. **Inpatient Mental Disorder services (including Severe Mental Illness and Serious Emotional Disturbance of a Child)**: Inpatient mental disorder care while Confined in a Hospital, or Skilled Nursing/Sub-Acute Facility, including day treatment and partial hospitalization. Care includes room and board, services and supplies.
    - Inpatient and Outpatient Drug Abuse detoxification;
    - Evaluation and medical treatment of acute detoxification.
3. **Inpatient and Outpatient Drug Abuse services** rendered in a Health Care facility or Doctor's office.
4. **Inpatient and Outpatient Alcoholism services:** Alcoholism treatment, including rehabilitation and detoxification, provided by or under the clinical supervision of a Doctor or licensed psychologist. The services must be provided in one of the following:
    - The Doctor's or psychologist's office;
    - A Hospital;
    - A community mental health center or alcoholism treatment facility approved by the Joint Commission on Accreditation of Hospitals or certified by the State Department of Health.

Emergency Covered Services - visits to an Emergency room for stabilization or the initiation of treatment for Emergency Medical Conditions requiring Emergency services.

Other Covered Services

1. Allergy testing/therapy and injections – includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.
2. Radiation Therapy and Chemotherapy.
3. Rehabilitative Care:
    - Inpatient physical therapy, occupational therapy, and restorative speech therapy which is expected to result in significant return of function;
    - Outpatient physical therapy, occupational, and restorative therapy which is expected to result in significant return of function. Each therapy treatment is considered one (1) visit.
    - Restorative speech therapy means therapy after an Injury, including stroke, and treatment of a speech abnormality resulting from surgery or trauma to anatomical structures affecting speech.
    - Cardiac and pulmonary therapy which is expected to result in significant return of function.
4. Home Health Care services:
    - Doctor-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 Doctor and in conjunction with the need for Skilled Nursing Care and includes:
    - Skilled nursing (L.P.N., R.N.) part-time or intermittent care;
    - Medical social services;
    - Infusion services;
    - Certified nurse assistant services and home health aide services, which provide support in the home under the supervision of an R.N., physical, occupational or speech 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 Care agency representative will count as one (1) Home Health Care visit;
    - Physical, Occupational and Restorative Speech therapy.
5. Hospice Care: Care provided in a Covered Person's home by a licensed, accredited Home Health Care, home Infusion, or Hospice agency, or provided in a Health Care facility. This care must be under the direction of a Doctor in conjunction with the need for Skilled Nursing Care and includes: Skilled nursing (L.P.N., R.N.) part-time or intermittent care; Medical social Services; Nutrition counseling; Physical, Occupational and Restorative Speech therapy; Infusion therapy, injectables and related supplies, including site care supplies; Certified nurse assistant services and home health aid services; and Bereavement services for the family unit for up to the maximum number of days shown on the Schedule of Benefits.

COVERED SERVICES (continued)

6. Oral Surgery for Accidental Injuries: Dental services are limited to immediate care to stabilize Conditions due to accidental Injury and include:
   - Services provided by a dentist within seventy-two (72) hours of accidental Injury to sound natural Teeth;
   - treatment of Injury to jawbone or surrounding tissues;
   - Correction of a non-dental physiological Condition which has resulted in severe functional impairment.
7. Prosthetic Appliances: Examples include: prescribed external prosthetic appliances, including artificial limbs and eyes; breast prosthesis following surgery to control breast disease.
8. Diabetic Education: The purpose of Diabetic self-management education is to educate and enable diabetics to understand and practice daily management of diabetic therapy.
9. Testing and treatment of phenylketonuria (PKU), including Formulas and special food products prescribed by and under the supervision of a Doctor. Charges for Formulas or special food products are covered to the extent that the costs of the Formulas and special food products exceed the costs of a normal diet.
10. Durable Medical Equipment and Medical Supplies: Durable Medical Equipment eligibility will be based on Medical Necessity. Durable Medical Equipment and medical supplies must be prescribed by a Doctor. The Durable Medical Equipment and medical supplies must be designed for repeated use and must be Medically Necessary to:
    a. Treat a Condition; or
    b. Improve or restore the functional ability of a malformed body part; or
    c. Prevent worsening of the Covered Person's Condition.

    Durable Medical Equipment and medical supplies include, but are not limited to, the following:
    a. Braces, including necessary adjustments to shoes to accommodate braces (dental braces are excluded);
    b. Mechanical equipment and monitors necessary for the treatment of chronic or acute respiratory failure, (environmental items are excluded);
    c. Manual Hospital-type beds and mattresses;
    d. Canes, crutches, walkers or standard wheelchairs;
    e. Oxygen and equipment for its administration;
    f. Commode items, i.e. - bedside handrails, shower bench;
    g. Electronic larynx and voice prosthesis buttons;
    h. Insulin pumps and all related necessary supplies;
    i. Podiatric devices to prevent or treat diabetes-related complications;
    j. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin;
    k. Ostomy/ileostomy supplies;
    l. Special pressure pads;
    m. Medical elastic stockings (limited to two (2) per year);
    n. Pumps and supplies to deliver an external product;
    o. Prosthetic Bra and/or Q-Breast insert (limited to two (2) per year); and
    p. Wigs as a result of cancer Therapy (limit one (1) per year).
11. Emergency Medical Transportation services:
    - Transportation by a licensed ambulance to the nearest Hospital for Emergency Care;
    - Transportation for inter-Health Care facility transfers;
    - Emergency Medical Transportation services through the 911 Emergency response system.

COVERED SERVICES (continued)

12. Eye refractions, performed by a Doctor or optometrist, when used as a diagnostic tool in conjunction with a chronic or acute medical Condition.
13. Dialysis (hemodialysis and peritoneal dialysis) and filtration procedures for acute or chronic renal failure, including administration and supply expenses.
14. Prescription Drugs: A written prescription by a Doctor or Health Care Practitioner is required. Benefits for expenses Incurred are subject to the applicable Copayments or Coinsurance amounts, as shown on the Schedule of Benefits. A Co-payment or Coinsurance is required each time a thirty (30) day supply prescription drug is dispensed. The following drugs and medicines are eligible for Benefits:
    - Federal Legend Drugs;
    - Specialty Drugs - Benefits are payable under the Non-Formulary Brand Benefit;
    - Injectable/insulin, prescriptive medications for the treatment of diabetes, Glucagon and the following equipment and supplies for the management and treatment of diabetes. For the following, Benefits will not be paid under the Durable Medical Equipment Benefit:
        a. Blood glucose testing device, including those designed to assist the visually impaired (one (1) every three (3) years)
        b. Blood glucose testing strips
        c. Ketone urine testing strips
        d. Lancets and lancet puncture devices
        e. Pen delivery systems for the administration of insulin
        f. Insulin syringes
    - Compounded drugs of which at least one (1) ingredient is a Federal Legend Drug;
    - Any other drug which due to state law may only be dispensed when prescribed by a Provider;
    - Prescribed drugs and Medically Necessary services needed to administer the drug which are otherwise eligible for Benefits, if the drug is:
        a. Approved by the U.S. Food and Drug Administration (FDA); and
        b. Recognized as safe and effective for the treatment of a Condition by one (1) 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 Condition; and
        c. Prescribed for the treatment of a Life-Threatening Condition; or
        d. Prescribed for the treatment of a Chronic and seriously debilitating Condition, is Medically Necessary to treat that Condition, and is on Our formulary.

In this section:

"Life-threatening" means either or both of the following:

a. Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted.
b. Diseases or Conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Chronic and seriously debilitating" means diseases or Conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

"Standard Medical Reference Compendia" means the following publications:

a. The "AMA Drug Evaluations", published by the American Medical Association;
b. The "American Hospital Formulary Service (AHFS) Drug Information", published by the American Society of Health System Pharmacists; or
c. "Drug Information for the Health Care Provider", published by the U.S. Pharmacopoeia Convention.

"Medical Literature" means all of the following:

a. 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

b. 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

c. 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.

"Brand Name" means a trademark name of a drug appearing on the package label.

"Federal Legend Drugs" means any drug or medicine whose label must bear the legend "CAUTION: Federal Law Prohibits Dispensing without a Prescription" or similar warning.

"Formulary" means a list of Brand Name Drugs that are available at a lower cost than Non-Formulary Brand Drugs.

"Formulary Brand Drug" means a Brand Name drug that is on the Formulary.

"Generic Drug" means a non-brand name drug, which is a pharmaceutical equivalent to a Brand Name drug, sold at a lower cost.

"Non-Formulary Brand Drug" means a Brand Name drug that is not on the Formulary.

RETAIL PRESCRIPTION DRUGS

You must show Your Identification Card to the pharmacist. A Copayment must be paid for each thirty (30) day supply of a prescription.

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

GENERAL EXCLUSIONS AND LIMITATIONS

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

1. Treatment, service, or supply which is not Medically Necessary (except wellness/preventive benefits required under the Affordable Care Act (ACA) to meet federal regulations); treatment, services or supplies which as determined by Nationwide Life Insurance for the diagnosis, care or treatment of the Sickness or Injury involved.
2. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA), and resulting complications. Upon written request, claims denied under this provision may be reviewed by an independent medical review entity if You or Your Dependent has a terminal Condition that , according to the health care Provider's current diagnosis, has a high probability of causing death within two years from the date of the request for medical review.
3. Services provided normally without charge by the health service of the Policyholder, or services covered or provided by a Student health fee.
4. Any services of a Doctor, Nurse, or Health Care Practitioner who lives with You or Your Dependent(s) or who is related to You or Your Dependent(s) by blood or marriage.
5. War or any act of war, declared or undeclared; or while in the armed forces of any country.
6. Accident or Sickness for which Benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation.
7. Injury occurring in consequence of riding 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.
8. Cosmetic surgery, Plastic surgery, resulting complications, consequences and after effects or other services and supplies that We determine to be furnished primarily to improve appearance rather than a physical function or control of organic disease except as provided herein or for treatment of an Injury that is covered under the Policy. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts, rhinoplasty, sagging eyelids, prominent ears, skin scars, baldness, and correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction or deformity resulting from mastectomies or lymph node dissections), gynecomastia;
9. Surgery and/or treatment for; acupuncture; alopecia; biofeedback-type services; and circumcision.
10. Services for the treatment of any Injury or Illness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot; or fighting, except in self-defense.
11. Injuries sustained as a result of suicide or any attempt at suicide or intentional self-inflicted Injury.
12. Weight management services and supplies related to weight reduction programs, weight management programs, and related nutritional supplies.
13. Obesity treatment: Services and associated expenses for the treatment of obesity and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to: gastric or intestinal bypasses; gastric balloons; stomach stapling; wiring of the jaw; panniculectomy; appetite suppressants; and surgery for removal of excess skin or fat.
14. Treatment on or to the Teeth or gums (except as provided herein).
15. TMJ.
16. Eyeglasses, contact lenses, including but not limited to routine eye refractions, eye exams except as in the case of Injury. Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided herein.
17. Treatment in a government Hospital, unless there is a legal obligation for the Covered Person to pay for such treatment.
18. Treatment (other than surgery) of chronic Conditions of the foot including, but not limited to, weak or fallen arches, flat or pronated foot ,subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions, any type of massage procedure on or to the foot, corrective shoes, shoe inserts and orthotics.
19. Reproductive/Infertility services including but not limited to: fertility tests, infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception except as specifically provided in this Policy. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; artificial insemination; premarital examination; impotence, organic or otherwise; vasectomy.

20. For Injury resulting from travel in or upon a parachuting, hang gliding, skydiving, parasailing, glider flying, sail planing or bungee jumping.
21. Hearing Screenings or hearing examinations or hearing aids and the fitting or repairing of hearing aids; except in the case of Accident or Injury.
22. For an 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;
23. Sexual reassignment surgery.
24. Under the Prescription Drug Benefit, when included, any drug or medicine:
    - Obtainable Over the Counter (OTC);
    - For the treatment of alopecia (hair Loss) or hirsutism (hair removal);
    - For the purpose of weight control;
    - Anabolic steroids used for body building;
    - For the treatment of infertility;
    - 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;
    - 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.
25. Sleep disorders, including supplies, treatment and testing thereof.
26. Nasal and sinus surgery, unless Medically Necessary.
27. Patient controlled analgesia (PCA).

STUDENT HEALTH SERVICES REFERRAL

The Student must first seek services of the Student Health Center (SHC). If the SHC cannot provide the service needed, the Student must obtain an initial referral that verifies that the services were not available at the SHC. The Student is then free to seek services without penalty with a Provider outside of the SHC. Expenses incurred for treatment rendered outside of the SHC for which no referral is obtained will be excluded from Coverage.

A SHC referral for outside care is necessary except under the following Conditions:

- Medical Emergency;
- When the SHC is closed;
- When service is rendered at another facility during break or vacation periods;
- Medical care received when the Student is more than twenty (20) miles from campus;
- Medical care obtained when the Student is no longer able to use the SHC due to change in Student status; or
- Maternity;
- Treatment of Mental or Nervous Disorders.

A written referral from the SHC is required for any follow-up care, with a Provider other than SHC, after Emergency services.

A SHC referral does not constitute a guarantee of Benefits when treatment is provided outside the SHC. We reserve the right to determine the Medical Necessity of treatment for services provided outside the SHC.

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 partly covered under one of the plans covering the Covered Person.

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

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

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

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

   However, if the Covered Person is a Dependent child with separated or divorced parents, Benefits for the child are determined in this order:
   - First, the plan of the parent with custody of the Dependent child;
   - Then the plan of the spouse of the parent with custody of the Dependent child; and
   - Finally the plan of the parent not having custody of the Dependent child.

   However, if there is a court decree, which gives financial responsibility to a particular parent for the health care, expenses of the child, statements above do not apply. In this case, any other plan, which covers the child as a Dependent may reduce before the plan which, covers the child as a Dependent of the parent with financial responsibility.
3. If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the Dependent child shall follow the order of Benefits set forth in rule two (2).
4. The Benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule four (4) is to be ignored.
5. Continuation Coverage. If a person whose Coverage is provided under a right of continuation pursuant to federal law, namely COBRA, or state law, also is covered under another plan, Benefits are determined in the following order:
   - First, the Benefits of the plan covering the person as an employee (or as that employee's Dependent);
   - Second, the Benefits under the continuation of Coverage.
     If the other plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule (5) shall be ignored.
6. When none of the rules above determines the order of Benefits, the plan that has Insured the Covered Person for a shorter period of time may reduce Benefits if another plan has Insured that Covered Person for a longer period of time.

   If Benefits are reduced under this section and later in the same Policy Year the total Allowable expense exceeds the Benefits paid under all plans, We will pay additional Benefits. These Benefits will not exceed the lesser of:
   - The amount of the earlier reduction; or
   - The amount which would cause total Benefits under all plans to exceed total Allowable expenses.

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

RIGHT TO RECEIVE AND RELEASE INFORMATION:

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

FACILITY OF PAYMENT/RIGHT OF RECOVERY:

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

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 thirty (30) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the Loss for which claim is made.

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

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

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

If any indemnity of this Policy shall be payable to the estate of the Covered Person or to a Covered Person who is a minor or otherwise not competent to give a valid release, We may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

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

Physical Examination and Autopsy: We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending. We, at Our own expense, may also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Physical Examination: 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.

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.

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 Medically Appropriate. Benefits will be denied by Us for Covered Services that are not Medically Necessary and Medically Appropriate. In the event of such a denial, You will have to pay the entire amount billed by that Provider. You do have the right to appeal any adverse decision as outlined in the Appeals and Compliant 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.

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

PREMIUM

Payment of Premium/Due Date: All Premium, charges or fees (hereinafter “Premium”) must be paid to Us at Our home office prior to the start of the term for which Coverage is selected. In no event will Coverage become effective prior to the date of enrollment and required Premium are 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.

GENERAL PROVISIONS

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

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

We have full, exclusive and discretionary authority to determine all questions arising in connection with the Policy, including its interpretation.

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.

Incontestability: 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.

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

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.

EXCESS PROVISION

Our liability for medical expense Benefits payable on account of Covered Charges incurred shall be limited to that part of the expense, if any, which is in excess of the total Benefits payable for the same Sickness or Injury, on a provision of service basis or on an expense Incurred basis under any Other Medical Insurance. If Other Medical Insurance provides Benefits on an excess insurance or an excess Coverage basis, Benefits will be paid first by the insurer or services plan whose Policy or service contract has been in effect for the longer period of time at the date of such Sickness or Injury. For purposes of the Policy, a Covered Person's entitlement to Other Medical Insurance will be determined as if the Policy did not exist and shall not depend upon whether timely application for Benefits from Other Medical Insurance is made by or on behalf of the Covered Person.

Primary Benefit Amount: If a Primary Benefit Amount is shown in the Schedule of Benefits, We will pay the Covered Charges incurred for a Sickness or Injury up to the Primary Benefit Amount. Such Covered Charges will be paid according to the terms of the Policy. Subsequent claims received for the same Sickness or Injury which are in excess of the Primary Benefit Amount, will subject the entire claim to the Excess Provision.

Other Medical Insurance: Any reimbursement for or recovery of any element of Covered Charges, incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

- Any individual, group, blanket, or franchise Policy of accident, disability or health insurance.
- Any arrangement of Benefits for members of a group, whether Insured or uninsured.
- Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
- Any amount payable for Hospital, medical or other health services for accidental bodily Injury arising out of a motor vehicle accident to the extent such Benefits are payable under any medical expense payment provision (by whatever terminology used including such Benefits mandated by law) of any motor vehicle insurance Policy.
- Any amount payable for services or injuries or diseases related to the Covered Person's job to the extent that he actually received Benefits under a Worker's Compensation Law. If the Covered Person enters into a settlement to give up his rights to recover future medical expenses that would have been payable except for that settlement.
- Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after he becomes disabled while insured hereunder.
- Any Benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.
- Any Policy containing Coverage which provides Benefits for medical expenses on a 1st or 3rd party basis.

COMPLAINT AND APPEAL PROCESS

Complaint Resolution

1. Administrative Complaints
   Complaints due to the denial of services or payment of a claim must be reported no later than twelve (12) months from the date of service. Most complaints can be resolved by calling, or writing to, Our Customer Service Department. The telephone number and address are on Your Identification Card.

   If an informal review does not resolve the reported complaint, You will be notified of Your right to appeal.

2. Quality of Care or Service Complaint
   Quality of care complaints will be forwarded to the unit responsible for such investigations immediately upon receipt by Customer Service. We will send You a written acknowledgment within fifteen (15) working days of receipt of the complaint. All quality of care complaints will be investigated and corrective action taken where problems and/or deficiencies are verified.

3. If We cannot provide You with a satisfactory solution to Your complaint, You may file a standard or urgent (if applicable) appeal for internal review by contacting Us at the address or phone number on the back of your ID card or write to or call the Department of Insurance, whose information is located in the Important Notice section of this Policy.

4. If We deny a claim as "not Medically Necessary" and cannot provide You with a satisfactory solution to Your complaint, You may request an Independent Medical Review (IMR) by writing to or calling Us or the Department of Insurance, whose information is located in the Important Notice section of this Policy.

Internal Appeal Review

1. 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. The appeal must be requested no later than one hundred eighty (180) calendar days from the date of receipt of the denial letter.

   The appeals staff will review all of the information. A decision will be made within thirty (30) calendar days of receipt for a Pre-Service Claim Appeal and within sixty (60) calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to an additional sixty (60) calendar days if additional information is needed. You will be notified in writing of the Appeals Department's decision. If the appeal involves a medical necessity determination, an independent peer reviewer, who is in the same or a similar specialty, as the Provider who will perform or performed the service will review the file.

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

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

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

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

External Appeal Process

After exhausting the Internal Appeal Process, You, an authorized person or a Provider, with Your consent, may request a review from an external independent entity as described below.

1. Department of Insurance Review - Coverage Decision Denials
   If We deny Benefits because the service is not a Covered Service, a review of the Coverage Decision may be requested by contacting the:

   Department of Insurance at the address located in the Important Notice section of this Policy.

2. Independent Medical Review –Medical Necessity Denials

   You may request an Independent Medical Review (IMR) of medical necessity denial from the Department of Insurance if You believe that We have improperly denied, modified, or delayed health care services. A medical necessity denial is any health care service eligible for Coverage and payment under the Policy that has been denied, modified, or delayed by Us, in whole or in part, because the health care service is not Medically Necessary.

   The IMR process is in addition to any other procedures or remedies that may be available to You. You pay no fees of any kind for IMR. You have the right to provide information in support of the request for IMR. You may contact the Department of Insurance for an IMR application or Customer Service for assistance.

Eligibility:

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

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

If Your case is eligible for an IMR, the dispute will be submitted to an IMR organization that will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made by the independent reviewer. If the IMR determines the service is Medically Necessary, We will provide Benefits for the health care service.

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

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

3. Independent Medical Review (IMR) - Experimental or Investigational Denials

Eligibility:

Your may request an Independent Medical Review (IMR) from an organization independent of the Company or designated by the Department of Insurance if all of the following criteria are met:

a. You have a Life Threatening or Seriously Debilitating Condition, as certified by Your Doctor.
   (i) "Life Threatening" means either or both of the following:
   - Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted;
   - Diseases or Conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

   (ii) "Seriously Debilitating Condition" means diseases or Conditions that cause major irreversible morbidity.
b. Your Doctor certifies that one of the following situations applies:
   - standard therapies have not been effective in improving the Condition;
   - standard therapies are not Medically Necessary for You;
   - there is no standard therapy covered under the Policy that will benefit You more than the requested therapy;

c. Your Doctor has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to benefit You more than standard therapies; or You or Your Doctor have requested a therapy that based on two (2) documents from the Medical and Scientific Evidence as defined below, is likely to be more beneficial for You than any available standard therapy.
d. The Doctor's certification includes a statement of the evidence relied upon when certifying the recommendation. We will not pay for services of a Non-Participating Provider that are not otherwise covered.
e. You have been denied Benefits/Covered Services for services requested in (2) above, unless Coverage for the specific therapy is excluded by this Policy;
f. The drug, device, procedure or other therapy would be covered under the Policy if it were not considered to be Experimental or Investigational.

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

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health services Technology Assessment Research (HSTAR).
3. Medical journals recognized by the Secretary of Health and Human services, under Section 1861(t) (2) of the Social Security Act.
4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.
5. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Requesting an Independent Review:

1. Within five (5) business days of Our decision to deny, delay or modify treatment that is Experimental or Investigational therapy, We will notify You, in writing, and include your appeal rights, which include your right to appeal to the Department of Insurance. You may request an Independent Medical Review (IMR) by writing to or calling the Department of Insurance, whose information is located in the Important Notice section of this Policy.
2. The panel of experts, supplied by the Independent Medical Review agency, will complete its review within thirty (30) calendar days of receiving the request for review. If Your Provider certifies, in writing, that an imminent and serious threat to Your health may exist the review will be expedited and completed within three (3) days of the request for the expedited review.
3. The Independent Medical Review panel of experts will provide [the Department of Insurance], the Company, You and Your Doctor with copies of the review upon completion of the review and analysis. [The Department of Insurance will immediately adopt the decision of the Independent Medical Review agency and will issue a written decision to all concerned parties.

There is no expense to You for the Independent Medical Review.

MANDATED BENEFITS

(**Note:** Wellness/preventive benefits under the Affordable Care Act (ACA) are required to meet federal regulations. Under ACA, states retain the ability to mandate benefits beyond those established by the federal mandate. Please see the Schedule of Benefits for coverage details.)

Benefits for Alcohol Abuse and Dependency

Outpatient Care

(a) Minimal additional treatment shall be provided in a facility appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Before a Covered Person qualifies to receive benefits under this section, a licensed physician or licensed psychologist must certify the Covered Person as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment.
(b) The following services will be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
(2) Rehabilitation therapy and counseling.
(3) Family counseling and intervention.
(4) Psychiatric, psychological and medical laboratory tests.
(5) Drugs, medicines, equipment use and supplies.

(c) Outpatient care is subject to policy limitations with a minimum of thirty (30) outpatient, full-session visits or equivalent partial visits per year.
(d) Outpatient care is subject to policy limitations with a minimum of thirty (30) separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a two-to-one basis to secure up to fifteen (15) additional non-hospital, residential alcohol treatment days.

Inpatient Detoxification

(a) Coverage for Inpatient detoxification will be provided for services either in a hospital or in an inpatient non-hospital facility which has a written affiliation agreement with a hospital for emergency, medical and psychiatric or psychological support services, meets minimum standards for client-to-staff ratios and staff qualifications which shall be established by the Department of Health and is licensed as an alcoholism and/or drug addiction treatment program.
(b) The following services will be covered under inpatient detoxification:

(1) Lodging and dietary services.
(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
(3) Diagnostic X-ray.
(4) Psychiatric, psychological and medical laboratory testing.
(5) Drugs, medicines, equipment use and supplies.

(c) Treatment is may be limited to seven (7) days of treatment per admission.

Non-hospital Residential Care

(a) Minimal additional treatment as a covered benefit under this article shall be provided in a facility which meets minimum standards for client-to-staff ratios and staff qualifications which shall be established by the Office of Drug and Alcohol programs and is appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Before a Covered Person qualifies to receive benefits under this section, a licensed physician or licensed psychologist must certify the Covered Person as a person suffering from alcohol or other drug abuse or dependency and refer the Covered Person for the appropriate treatment.
(b) The following services will be covered under this section:

(1) Lodging and dietary services.
(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services.
(3) Rehabilitation therapy and counseling.
(4) Family counseling and intervention.
(5) Psychiatric, psychological and medical laboratory tests.
(6) Drugs, medicines, equipment use and supplies.

(c) Non Hospital Residential Care is subject to policy limitations with a minimum of thirty (30) days per year for residential care.

Periodic Health Maintenance

The benefits to be provided under the policy include coverage for periodic health maintenance to include:
(1) Annual gynecological examination, including a pelvic examination and clinical breast examination.
(2) Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

Diabetes

Diabetes diagnosis and treatment expense for treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. This benefit includes expense for blood glucose monitors; blood glucose monitoring strips for home use; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; prescribed oral diabetes medications that influence blood sugar levels; laboratory tests, including glycosylated hemoglobin, or HbAlc tests; urinary/protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens, so-called; therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy.

Licensed Certified Nurse Midwife

Provides for reimbursement for any health care service which is within those areas of practice for which a midwife may be licensed whether the service is performed by a duly licensed certified nurse midwife practicing within those areas for which the certified nurse midwife is licensed in the state where the licensed certified nurse midwife is practicing. When payment is made for health care services performed by a licensed certified nurse midwife, no payment or reimbursement shall be payable to a physician or osteopath for the service performed by the licensed certified nurse midwife.

Coverage for Cost of Nutritional Supplements/Medical Foods

Provides coverage for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician.

Coverage provided for formulas that are equivalent to a prescription drug, medically necessary for the therapeutic treatment of such rare hereditary genetic metabolic disorders and administered under the direction of a physician. Phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria are aminoacidopathies that are rare hereditary genetic metabolic disorders.

Immunization Coverage for Children

Provides for coverage for Medically Necessary booster doses of all immunizing agents used in child immunizations.

Mammography Coverage

The minimum coverage includes all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age.

Mastectomy Coverage

Provides coverage for inpatient care following a mastectomy for the length of stay that the treating physician determines is necessary to meet generally accepted criteria for safe discharge.

Provides coverage for a home health care visit that the treating physician determines is necessary within forty-eight hours after discharge when the discharge occurs within forty-eight hours following admission for the mastectomy.

Provides coverage for the surgical procedure known as mastectomy shall also include coverage for:

(i) Prosthetic devices;
(ii) Physical complications including lymphedemas; and
(iii) Reconstructive surgery incident to any mastectomy in a manner determined in consultation with the attending physician and the patient. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.

Serious Mental Illness

Provides coverage for Serious Mental Illnesses that meet, at a minimum, the following standards:

(1) At least thirty (30) Inpatient and sixty (60) Outpatient days annually;
(2) Ability to convert coverage of Inpatient days to Outpatient days on a one-for-two basis;
(3) There shall be no difference in either the annual or lifetime dollar limits in coverage for Serious Mental Illnesses and any other Illnesses.

Coverage for Serious Mental Illnesses shall be subject to the Deductible and Coinsurance and all other terms and conditions applicable to other benefits.

Diabetes Equipment, Supplies and Service

Diabetes diagnosis and treatment expense for treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. This benefit includes expense for blood glucose monitors; blood glucose monitoring strips for home use; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; prescribed oral diabetes medications that influence blood sugar levels; laboratory tests, including glycosylated hemoglobin, or HbAlc tests; urinary/protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens, so-called; therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy.

IMPORTANT NOTICE

NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE SPECIALTY HEALTH DEPARTMENT
2077 ROOSEVELT AVENUE
SPRINGFIELD, MA 01104
1-800-633-7867

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

Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120
Phone: 1-717-787-7000

SPORTS ACCIDENT RIDER

NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Issues this rider to

THE INSURED REFERRED TO ON THE COVER PAGE OF THE POLICY TO WHICH THIS RIDER IS ATTACHED AND MADE A PART THEREOF

The effective date of this rider is the effective date of the Policy to which this rider is attached.

The Policy is amended as described below. All other terms remain unchanged.

Subject to the Benefits and Limitations in the Policy, this Rider provides benefits for injuries sustained while (a) participating in any intercollegiate; (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;

No Benefits will be paid for:

1. Room and Board expenses, which exceed the semi-private room rate;
2. Outpatient Physical Therapy in excess of $1,000 maximum per Policy Year;
3. Prescription Drugs in excess of $750;
4. Infections, except pyogenic infections caused wholly by a Covered Injury;
5. Cysts, blisters, or blisters;
6. Overexertion, heat exhaustion; fainting;
7. Hernia, regardless of how caused; or
8. Artificial aids such as crutches, braces, appliances and artificial limbs.

Intercollegiate Sports Injury Benefit for any medical expense incurred which has been paid or is payable by other valid and collectible insurance. This Excess Provision will not be applied to the first $100 of medical expenses incurred. The Deductible Provision will also not be applied to the first $50 of medical expenses incurred. Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as the result of the Insured's failure to comply with Policy provisions or requirements.

The maximum benefit under this rider is $2,000 per Injury.

NATIONWIDE LIFE INSURANCE COMPANY

President

ORGAN TRANSPLANT POLICY RIDER

NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Issues this rider to

THE INSURED REFERRED TO ON THE COVER PAGE OF THE POLICY TO WHICH THIS RIDER IS ATTACHED AND MADE A PART THEREOF

The effective date of this rider is the effective date of the Policy to which this rider is attached.

The Policy is amended as described below. All other terms remain unchanged.

Subject to the Benefits and Limitations in the Policy, this Rider provides an organ transplant benefit.

Organ Transplant: The following transplants, including organ acquisitions, hospital services, related services and supplies which are determined to be Medically Necessary for the treatment of a Condition are covered: Solid organs, including but not limited to: autologous and allogenic bone marrow transplants, autologous and allogenic stem cell transplants. In addition, coverage is provided for anything caused by, contributed to, or resulting from an organ transplant, including complications thereof.

NATIONWIDE LIFE INSURANCE COMPANY

President

Nationwide® Privacy Statement

Thank you for choosing Nationwide
Our privacy statement explains how we collect, use, share, and protect your personal information. So just how do we protect your privacy? In a nutshell, we respect your right to privacy and promise to treat your personal information responsibly. It's as simple as that. Here's how.

Confidentiality and security
We follow all data security laws. We protect your information by using physical, technical, and procedural safeguards. We limit access to your information to those who need it to do their jobs. Our business partners are legally bound to use your information for permissible purposes.

Collecting and using your personal information
We collect personal information about you when you ask about or buy one of our products or services. The information comes from your application, business transactions with us, consumer reports, medical providers, and publicly available sources. Please know that we only use that information to sell, service, or market products to you.

We may collect and use the following types of information:

- Name, address, and Social Security number
- Assets and income
- Account and policy information
- Credit reports and other consumer report information
- Family member and beneficiary information
- Public information

Sharing your information for business purposes
We share your information with other Nationwide companies and business partners. When you buy a product, we share your personal information for everyday purposes. Some examples include mailing your statements or processing transactions that you request. You cannot opt out of these. We also share your information where federal and state law requires.

Sharing your information for marketing purposes
We don't sell your information for marketing purposes. We have chosen not to share your personal information with anyone except to service your product. So there's no reason for you to opt out. If we change our policy, we'll tell you and give you the opportunity to opt out before we send your information.

Using your medical information
We sometimes collect medical information. We may use this medical information for a product or service you're interested in, to pay a claim, or to provide a service. We may share this medical information for these business purposes if required or permitted by law. But we won't use it for marketing purposes unless you give us permission.

Nationwide®
On Your Side

Accessing your information
You can ask us for a copy of your personal information. Please call the number on your insurance ID card if applicable, contact your customer service representative, or send a letter to the address below and have your signature notarized. This is for your protection so we may prove your identity. We don't charge a fee for giving you a copy of your information now, but we may charge a small fee in the future.

We can't update information that other companies, like credit agencies and third parties, provide to us. So you'll need to contact these other companies to change and correct your information.

Send your privacy inquiries to the address below. Please include your name, address, and policy number. If you know it, include your agent's name and number.

Nationwide Specialty Insurance
Administered by Consolidated Health Plans
Jed Proujansky, Privacy Officer
2077 Roosevelt Avenue
Springfield, MA 01104

A parting word …
These are our privacy practices. They apply to all current and former clients of Nationwide Specialty Insurance. They also apply to joint policy or contract holders. This includes the following companies:

Nationwide Life Insurance Company
Nationwide Mutual Insurance Company
National Casualty Company
Allied Property and Casualty Insurance Company