Nationwide Life Insurance Company

Home Office: One Nationwide Plaza, Columbus, Ohio 43216
(Called We, Us or Our in this Certificate)

GROUP LIFE & LIMITED BENEFIT MEDICAL CERTIFICATE OF COVERAGE

INSURING AGREEMENT

The Nationwide Life Insurance Company has issued a Group Policy covering certain Eligible Classes of the Policyholder. The benefits of the Group Policy are described in this Certificate.
Final interpretation is governed by the Policy. This Certificate replaces any and all Certificates previously issued for the eligible classes under the Policy. This Certificate describes the Group Policy in effect as of the Effective Date shown in the Schedule of Benefits.

NOTICE CONCERNING YOUR POLICY

THIS CERTIFICATE IS NOT VALID UNLESS IT HAS A SCHEDULE OF BENEFITS ATTACHED SHOWING ALL OF THE FOLLOWING:

- **The Policyholder's Name.**
- **The Policy Number.**
- **The Effective Date of the Policy.**

The benefits and provisions of the Policy are described in this Certificate. Additional benefits and provisions may apply based on the requirements of the state where Your Policyholder is located. These state benefits and provisions are described in separate Amendments. See the Policyholder for details.

YOU DO NOT HAVE COVERAGE FOR THE BENEFITS DESCRIBED IN THIS CERTIFICATE UNLESS THEY ARE LISTED IN YOUR SCHEDULE OF BENEFITS.

Please read Your Certificate carefully. Keep it in a safe place.

John Carter
President and COO
Nationwide Life Insurance Company

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SCHEDULE OF BENEFITS

Policy Holder: EmployBridge Holding Company
Policy Number: FV1301
Effective Date: 12/27/2021
Policy Anniversary: 12/26/2022
Program Manager: Fringe Benefit Group, Inc.

This product is (a) not a substitute for minimum essential health coverage under the Affordable Care Act (ACA); and (b) does not qualify as minimum essential coverage under the ACA.

Who Pays For the Coverage

- The coverage under this policy is contributory. This means you make contributions towards its cost.

We will provide the benefits shown. Any change in amount is subject to the Change in Amounts of Benefits provision.

LIFE INSURANCE BENEFITS FOR YOU

Amount of Life Insurance $20,000

Benefits Reduce Due to Age
The Life Insurance Benefits reduce 35% of the original amount upon attainment of Age 65, and by an additional 35% each five year period thereafter.

LIFE INSURANCE BENEFITS FOR YOUR DEPENDENTS

Maximum Amounts of Dependent Life Insurance are:

Spouse	Child from 10 days to 6 months	Child from 6 months to 26 years
$2,500	$200	$1,250

Benefits Reduce Due to Age
The Life Insurance Benefits reduce 35% of the original amount upon attainment of Age 65, and by an additional 35% each five-year period thereafter.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR YOU

Principal Sum- Same as amount of Life Insurance.
The Principal Sum for Accidental Death, Dismemberment will be reduced in the same manner and at the same time as the Life Insurance.

CHANGE IN AMOUNTS OF BENEFITS

Any change in the amount of benefits due to a change in Your Eligible Class will be effective on the Policy Anniversary Date provided:

- You are actively at work, and
- You make any required payment for the change to be effective.

If You are not actively at work, such change will be effective on the first day on which You return to work. If You or Your Policyholder do not make the required payment within 31 days of the change, any increased benefits will not be effective until You give Proof of Good Health satisfactory to Us. Such increased benefits will be effective on a date set by Us.
Changes in benefits due to an Amendment to the Policy will take effect:

- **For You:**
  - On the Amendment date, if You are actively at work performing all the normal duties of Your job for a full work day:
    - While physically present at Your normal place of employment; or
    - At some other place of business that the Policyholder requires You to go; or
    - On the day You return to work, if You are not actively at work on the Amendment date.
- **For Your Dependent** (if applicable):
  - On the Amendment date, if the Dependent is not confined to a Hospital; or
  - On the day after the Dependent is released from a Hospital, if Hospital confined on the Amendment date.

Payment will be based on the benefits in effect at the time of death, loss, or the service is rendered.
Any reduction in the amount of benefits due to Your reaching an Age specified in the Schedule of Benefits will be made if You are actively at work or not.

ADDITIONAL INDEMNITY BENEFITS 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 Additional Indemnity Benefits.

President

CHANGE IN AMOUNTS OF BENEFITS

Any change in the Amount of Benefits due to a change in Your class will be effective on the first of the month following Your having worked and been paid for the minimum required hours, provided You make any required payment for the change to be effective.

Changes in Amounts of Benefits due to an Amendment to the Policy will take effect for You and Your Dependents on the Amendment date.

Payment will be based on the benefits in effect at the time of death, loss, or when the service is rendered.

ELIGIBILITY FOR YOU

Who is Eligible?

You are eligible if You are included in an Eligible Class in the Schedule of Benefits and You are:

- performing all the normal duties of Your job at the normal place of business of the Policyholder; and
- working in an Eligible Class shown in the Schedule of Benefits; and
- working the minimum required hours at the normal place of business of the Policyholder.

The minimum required hours, elected by the Policyholder, is shown in the Schedule of Benefits.

When Will You Become Covered?
If You are eligible, You will become covered on the day following the completion of any Waiting Period shown in the Schedule of Benefits.

You must complete an Enrollment Form giving the information We require. If You are required to pay all or part of the Premium for Coverage, You must acknowledge Your permission to Your Policyholder to withhold such Premium from Your pay.

You will be required to provide Proof of Good Health, at Your cost, if:

1. You apply for Coverage more than 31 days after You become eligible; or
2. You become covered for the Life, Accidental Death and Dismemberment, and, if applicable, Non-Occupational Weekly Disability Income Benefits when You become eligible, but apply for other benefits more than 31 days after You become eligible; or
3. You apply for Reinstatement of Coverage that was cancelled at Your request; or
4. Your amount of Life Insurance is in excess of the guarantee issue limit as determined by Us.

This requirement will continue even if Your job with the Policyholder ends and You are later rehired.

You will become covered on a date set by Us.

Reinstatement

If You have ceased to be eligible for Coverage, You may qualify for Reinstatement within 90 days from the date You were last eligible. You will be reinstated and eligible for Coverage on the first day of the calendar month following a month in which You are working the minimum required hours as elected by the Policyholder shown in the Schedule of Benefits.

If You do not qualify for Reinstatement within 90 days from the date You were last eligible, You shall be treated as a new hire.

When Do You Cease to be Eligible?

You shall cease to be eligible on the first day of the month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder in the Schedule of Benefits.

ELIGIBILITY FOR DEPENDENTS

Who is Eligible?

Your Dependents are eligible if:
- You are in a class that qualifies for Dependent benefits; and
- You make a written request giving any information We may require; and
- The Dependent is not in an Eligible Class as shown in the Schedule of Benefits.

A person may not be covered more than once under the Policy at the same time. If both husband and wife are covered under the Policy, either, but not both, may elect to cover their eligible Dependent children.

When is the Dependent Eligible?

A Dependent is eligible on the later of:
- The date You qualify for coverage if You have one or more Dependents at that time; or
- The date You acquire Your first Dependent if You have no Dependents on the date You become eligible; or
- The first date coinciding with or next following the date the Dependent first meets the definition of Dependent.

How Will a Dependent Become Covered?

You must complete an Enrollment Form giving the information We require for all Dependents and authorizing the Policyholder to make payroll deductions toward the cost of Your Dependent's Coverage (if applicable).
This Enrollment Form must be completed prior to the expected birth of a child.

If You did not elect Dependent's Coverage before the birth of a child, Coverage on that child will not be denied, with respect to Limited Medical Benefits, if You notify Us in writing of the birth of such child and authorize the Policyholder to make the required payroll deductions toward the cost of Dependent's Coverage, within 31 days of the date of birth.
If You already have Dependent Coverage for one Dependent, more Dependents later acquired will be added without Proof of Good Health. However, We require You to notify Us of additional Dependents to assure accurate claims handling.

When Will a Dependent Become Covered?

A Dependent will become covered:
- <u>Automatically:</u>
  a. On the date You become covered if You apply for Dependent Coverage before this date; or
  b. On the date You apply for Dependent Coverage, if You make the request within 31 days after You become eligible.

  Your newborn child will automatically be covered from the moment of birth for the first 31 days, provided You notify Us of such in writing and pay any required Premium within 31 days of the date of birth.

- <u>After Proof of Good Health</u>
  a. On a date set by Us if You apply more than 31 days after he or she becomes eligible; or
  b. On a date set by Us if You apply for Reinstatement of Coverage that was cancelled at Your request.

  You must furnish to Us, at Your cost, adequate Proof of Good Health for each Dependent before the Dependent can become covered. This requirement will continue even if Your job with the Policyholder ends and You are later rehired.

A Dependent confined to a Hospital or at home during the 6 days prior to the date they would otherwise be eligible to become covered will become covered on the first day after a period of 6 consecutive days during which all of the following requirements are met:
- The Dependent has not been so confined.
- The Dependent has received no medical care or services.
- The Dependent has engaged in their Normal Daily Activities.

DEFINITIONS

Throughout this Policy, You will find many terms in capital letters.

These terms have special meaning in the Policy. When You find a term which has been capitalized, its meaning may be found in this section.

ACCIDENT.
An unforeseen, unexpected and involuntary event which causes the Covered Person to suffer an Injury while covered under the Policy.

ACCIDENTAL BODILY INJURY/INJURY.
Physical pain or impairment of a physical condition to a Covered Person that is:

- Unforeseen;
- Unexpected;
- Involuntary; and
- Due to violent and external means

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

AGE.
Age at last birthday.

AMENDMENT.
A document that modifies this Policy and becomes part of this Policy.

APPLICATION.
A form completed by Policyholder in applying for Coverage under the Policy.

BENEFICIARY.
The one who will receive benefits payable upon Your death. You may designate or change your Beneficiary at any time by filing written notice on a form We provide and sending it back to the Policyholder.

BENEFIT.
The dollar amount payable by Us to a claimant or assignee under this Policy.

CALENDAR YEAR.
The period from January 1 through December 31 of the same year.

CERTIFICATE.
The Certificate of Coverage given to the Covered Person. It describes the Coverage for the Covered Person and Dependents, if any. It lists any limitations on Coverage. It tells the Covered Person how to make a Claim against the Policy.

CLAIM.
A request for payment of benefits

CLAIMANT.
A person making a Claim under this Policy.

COVERAGE.
The right of the Covered Person to receive benefits subject to the terms, conditions, limitations, and exclusions of the Group Policy.

COVERED PERSON.
An Eligible Person or a Dependent of the Eligible Person, who has enrolled for Coverage and for whom Premium has been paid to Us, so long as Coverage of such person under the Group Policy is in effect.

CUSTODIAL CARE.
Services (including room and board) or supplies which are provided:
- Primarily to help the person perform the activities of daily living; and
- Can safely be provided by Non-Skilled Persons; and
- Are not Medically Necessary to reduce the disability.

It does not matter where these services or supplies are provided or who recommends them. If a physically or mentally disabled person is not receiving care specifically designed so that the person can live outside the Hospital or Skilled Nursing Facility in accordance with a Treatment Plan, it is considered Custodial Care.

DENTIST.
A person who is:
- Licensed to practice dentistry and acting within the scope of that license; or
- Any other Doctor furnishing any dental services the Doctor is licensed to perform.

Dental prophylaxis performed by a hygienist employed and directly supervised by a Dentist, will be considered the same as if performed by a Dentist.

DEPENDENT.
A person who is designated by You may become covered or is entitled to benefits under the Policy and must be verified by the Program Manager if they are one of the following:

For Life Insurance.
Your:
- spouse (if not legally separated or divorced from You).
- unwed child from 10 days until the child attains Age 19.

Children include stepchildren, adopted children or foster children who are dependent upon You for support and maintenance.

For the Limited Medical Benefits.
Your:
- Spouse (if not legally separated or divorced from You).
- Unwed child from the moment of birth, until the child attains Age 19.
- Unwed child who is a student may be covered until Age 26 provided such child is:
  a. A Full-Time Student; and
  b. More than 50% dependent on You for support and maintenance.
  c. Proof of the child's enrollment as a Full-Time Student must be submitted to Us.
- Handicapped child who has attained either limiting Age shown above, if such child is:
  - Unwed; and
  - Mentally retarded or physically incapable of earning their own living; and
  - Dependent on You for support and maintenance; and
  - Was covered on the day immediately prior to attaining the limiting Age.

Proof of incapacity must be furnished to Us within 31 days of attainment of the limiting Age.
Children include stepchildren, adopted children or foster children who are dependent upon You for support.

FULL-TIME STUDENT.
A person who is enrolled in and attending, on a full-time basis, a recognized course of study or training at: (1) An Accredited high school or vocational school; (2) An Accredited college or university; (3) A licensed technical or trade or similar training school, which offers general education classes.
Full-Time Student status is determined by the standards set forth by the school, college or university. A person ceases to be a Full-Time Student at the end of the calendar month during which the person graduates or ceases to be enrolled and in attendance on a full-time basis. A person continues to be a Full-Time Student during periods of vacation established by the school, college, or university if he or she was a Full-Time Student on the day before the start of the vacation period.
Accredited means the school, college or university has been evaluated and awarded accreditation by an accrediting agency that is recognized by the U.S. Department of Education or the Council on Higher Education Accreditation (CHEA) in Washington, DC.
We may require proof of Full-Time Student status.

DISABLED.
That you are unable to perform the substantial and material duties of your occupation.

DOCTOR.
A person who is:
- Licensed as a provider of medical services by the state in which the provider practices.
- Acting within the scope of their license.
- Not one of the following:
  - A person who ordinarily resides in Your household.
  - A member of Your immediate family.
  - The Policyholder.

EFFECTIVE DATE.
The date under which this Policy goes into effect for a Covered Person and any eligible Dependents.

ELIGIBLE CLASS.
An hourly-paid staff, salaried staff or contract staff of Policyholder meeting all eligibility requirements in Policy.

ELIGIBLE PERSON.
An Eligible Employee or a person whose employment or whose status with the Policyholder is the basis for eligibility for Coverage under the Group Policy and who meets the enrollment rules. An Eligible Person cannot also be enrolled as a Dependent under the Group Policy.

EMERGENCY.
The sudden onset of a medical condition manifested by symptoms of such severity that the failure to immediately provide Medially Necessary treatment could reasonably be expected to result in:
- Placing the Covered Person's health in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

EMPLOYEE.
A person who is employed by and paid by Employer.

EMPLOYER.
The entity on the Schedule of Benefits and Application who had applied for Coverage under this Policy.

ENROLLMENT FORM.
The document completed by You in electing Coverage under the Policyholder's Policy.

EXPERIMENTAL/INVESTIGATIONAL
Care, treatment, services or supplies not approved or accepted as essential to the treatment of Injury or Illness by any of the following:
- The American Medical Association.
- The United States Surgeon General.
- The United States Department of Public Health.
- The National Institutes of Health.
- Medicare.

EYE DOCTOR.
An ophthalmologist, optometrist or a person licensed to provide covered Vision Care within the scope of their license.

GROUP.
The Policyholder or entity who has entered into a contract with Us to provide Coverage under the Group Policy.

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

HOME OFFICE.
The Headquarters of Nationwide Life Insurance Company located at : Nationwide Insurance, One Nationwide Plaza, 04-06-101, Columbus, OH 43215; Telephone: 800-525-8669; E-Mail: SpecRsks@Nationwide.com; FAX: 614-677-3763.

HOSPICE.
A health care facility, other than a Hospital, providing medical care and support services for terminally ill persons.

HOSPITAL
An institution that:
- Operates pursuant to law; and
- Has 24 hour nursing services by registered nurses; and
- Has a staff of one or more Doctors; and
- Provides inpatient therapeutic and diagnostic services for Injury or Illness; and
- Provides facilities for major surgery or has a formal arrangement with another institution for surgical facilities; and
- Is approved by the Joint Commission on the Accreditation of Health Care Facilities as a Hospital (JCAHO); or
- Is approved by the American Hospital Association (AHA); or
- Is approved by the American Osteopathic Healthcare Association (AOHA); or
- Is approved by the American Osteopathic Association accreditation (AOA); or
- Is approved by the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation.

Unless otherwise provided in the Policy, Hospital does not include any of the following:
- A rest or nursing home, home for the aged or convalescent home; or
- A Skilled Nursing Facility; an extended care facility; or
- A hospice or a place for custodial care, birthing center.

ILLNESS.
- A disorder or disease of the mind or body; or
- A pregnancy.

INJURY.
Accidental Bodily Injury sustained by a Covered Person while he is covered under the Policy, which results in Loss. It must be independent of sickness, disease, bodily infirmity or other causes.

INSURED.
A person who is eligible for Coverage under this Policy as an [Employee] or as a Dependent, is enrolled, and for whom Premium is paid.

LIFETIME MAXIMUM.
Dollar limitation of all benefits which will be paid for any one Covered Person during their lifetime, while covered under the Policy.

MAXIMUM ALLOWABLE CHARGE.
As it pertains to the Dental and Vision Provisions of this Policy, the amount determined by Us to be the appropriate fee.

MEDICALLY NECESSARY.
Any services or supplies provided for the diagnosis and treatment of a specific Illness, Injury, or condition which are:
1. As it pertains to Limited Medical Benefits
- Ordered or recommended by a Doctor; and
- Required for the treatment or management of a medical condition or symptom; and
- The most appropriate supply or level of service which can safely be provided to person; and
- Provided in accordance with approved and generally accepted medical or surgical practice; and
- Not for the convenience of the Insured person or Doctor; and

- Not for services or supplies which are Experimental or Investigational; and
- Furnished in the least intensive type of medical care setting required by the Insured person's condition.

Services and supplies will not automatically be considered Medically Necessary because they were ordered by a Doctor.

2. As it pertains to Dental Benefits

Dental Care that is:

- Required to maintain generally acceptable dental health; and
- Recommended by a dentist; and
- Commonly recognized in the dental profession as acceptable treatment for the condition.

MEDICARE.
The benefits provided under Part A and Part B of Title XVIII of the Federal Social Security Act.

MENTAL ILLNESS DISORDER.
A pathological state of mind producing clinically significant psychological or physiological symptoms together with impairment in one (1) or more major areas of functioning wherein improvement in the ability to perform the normal tasks of daily living can reasonably be anticipated with therapy.

NORMAL DAILY ACTIVITIES.
Means activities normally including: (a) mobility; (b) dressing; (c) bathing; (d) toileting; (e) transferring; (f) eating; that are used to assess degree of impairment and determine eligibility for Benefits.

NON-SKILLED.
Persons without any special occupational skills and experience.

OUTPATIENT.
An individual who received health care services where he or she is not admitted to a Hospital or other health care facility.

PERCENTAGE PAYABLE.
The percent of Eligible Dental Charges or Covered Vision Expenses payable under the Policy and shown in the Schedule of Benefits.

PLAN SUPERVISOR.
Nationwide Life Insurance Company.

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

POLICY ANNIVERSARY.
The date twelve months after the date of the Effective Date of Coverage under this Policy, or as indicated on the Schedule of Benefits.

POLICYHOLDER.
The Employer or Group who has entered into a contract with Us to provide Coverage under the Group Policy.

PREMIUM.
The dollar amount paid by the Policyholder or Covered Person to keep this Policy in force.

PRINCIPAL SUM.
The maximum paid for all Losses as the result of any one Accidental Bodily Injury is the Principal Sum.

PROGRAM MANAGER.
The entity named as the Program Manager, if any, in the Schedule of Benefits.

PROOF OF GOOD HEALTH.
Whatever information we may require to determine whether an individual may be Insured. This may include information from a Doctor or a Hospital, or physical examination by a Doctor, or other information regarding the person applying for Coverage.

PROOF OF LOSS.
A statement that must be furnished by You to Us before any Benefit may be paid under this Policy.

PROVIDER.
Any Doctor, health professional, Hospital, Nursing Facility, home health agency or other person or recognized entity licensed to provide Hospital or medical services to Insureds covered under this Policy.

REINSTATEMENT.
The resumption of Coverage which has lapsed under this Policy.

SCHEDULE OF BENEFITS.
Shows the amount of benefits provided under this Policy.

SKILLED NURSING FACILITY.
A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of rehabilitative and skilled care.

SOUND NATURAL TOOTH.
A tooth which can withstand normal chewing forces, and has:
- Normal, healthy periodontium; and
- Adequate healthy dentin; and
- Adequate enamel.

A Sound Natural Tooth includes a natural tooth that has been restored by amalgam (or similar process), crown, inlay or onlay.

SPOUSE.
The legal husband or wife of the Eligible Person as recognized by state law.

SUBSTANCE ABUSE DISORDER.
The psychological or physical dependance on, or addiction to alcohol, drugs and other controlled substances.

TEMPORMANDIBULAR JOINT (T.M.J.) SYNDROME.
The symptoms associated with, or exhibited as a malfunction of, the temporomandibular joint. These are frequently caused by, but not exclusive to:
- Improper or incorrect space between the maxilla and mandible;
- Improper dental occlusion; and
- Muscular spasm in the T.M.J. area.

TOTALLY DISABLED/TOTAL DISABILITY.
Your Disability:
- Is a result of Illness or Accidental Bodily Injury; and
- Which causes You to be wholly and continuously prevented from performing the substantial and material duties of Your own work or occupation for pay or profit.

Disability of a Dependent:
- Is the result of Illness or Accidental Bodily Injury; and
- Which prevents the Dependent from performing the normal duties of a person of the same Age and sex.

TREATMENT PLAN.
A written statement on a form satisfactory to Us in which the Doctor lists:
- The findings from an examination of the person;
- The suggested plan of treatment; and
- The approximate cost and duration of such treatment.

WAITING PERIOD.
The time period set forth in the Schedule of Benefits.

WELL CHILD CARE.
The periodic review of a child's physical and emotional statues and includes the following in keeping with prevailing medical standards: (a) a medical history; (b) complete physical examination; (c) developmental assessment; (d) anticipatory guidance; (e) appropriate immunizations; (f) laboratory tests; or (g) hearing and vision screening.

WE/US/OUR/COMPANY.
Refers to Nationwide Life Insurance Company.

WORKERS' COMPENSATION.
Insurance against liability imposed on certain employers to pay insurance benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

YOU/YOUR.
A person in the Eligible Classes who is covered under the Policy.

LIFE INSURANCE BENEFITS FOR YOU

This benefit provision only applies if it is shown in the Schedule of Benefits.

Your amount of Life Insurance will be paid upon proof of Your death. Your beneficiary is the person or persons who will receive your Life Benefit if you die.

The proceeds will be paid to your designated Beneficiary, if there is a Beneficiary designated. Any amount of insurance for which there is no Beneficiary designated, or if there is no Beneficiary surviving at Your death, will be payable to Your survivors in order of precedence: (1) your spouse, (2) children born to or legally adopted by you, share and share alike, (3) parents, or (4) your estate.

Any benefits payable to a minor will be paid to the minor's legally appointed guardian.

BENEFICIARY.
The one who will receive benefits payable upon Your death. You may designate or change your Beneficiary at any time by filing written notice on a form We provide and sending it back to the Policyholder.

LIFE INSURANCE FOR YOUR DEPENDENTS

This benefit provision only applies if it is shown in the Schedule of Benefits.

We will pay the amount of life insurance for Dependents shown in the Schedule of Benefits. We will pay this amount upon receipt of proof of the Dependent's death.

The insurance will be paid to You, if living at the time of death of the Dependent. If You are not living, payment will be made to Your estate.

DESIGNATION OF BENEFICIARY

You may designate or change Your Beneficiary at any time by filing written notice on a form satisfactory to Us. This designation or change must be made on forms we provide and must be received by the Policyholder. Any change will be effective on the date You sign Our forms. We will not be responsible for a change received after Your Claim has been paid. When You change Your Beneficiary, any previous choice of Beneficiary will be null and void.

You may name more than one Beneficiary. We will pay the amount You specify to each person. If You do not specify amounts, we will divide the benefit equally. If one of Your Beneficiaries dies before You die, we will divide Your Benefit equally among the others, unless You specify otherwise.

LIFE INSURANCE CONVERSION RIGHTS FOR YOU

A. If You lose all or part of your life insurance because:
- Your employment terminates; or
- Your membership in an Eligible Class terminates; or
- You retire; or
- You reach the reduction Age shown on the Schedule of Benefits;

  You will be entitled to convert to an individual life insurance policy. You may convert all or part of the amount of life insurance you lost.

B. If Your life insurance ends because the Policy terminates or Your insurance class terminates, You may convert to an individual life insurance policy. You will be entitled to convert only if:
- Our Policy was in force at least 5 years; and
- You were continuously insured by Our Policy at least 3 years.

The amount You can convert is the amount for which You were insured less any group life insurance for which You become eligible during the conversion period. The maximum amount You can convert is $2,000.

This converted insurance will be an individual life insurance policy. It will be issued to You without Proof of Good Health. Written application and the first premium payment must be made to Us within 31 days from the date of termination. The Premium for Your policy will be based on Our rates that apply to Your individual policy on the effective date of that policy. This policy will be on the forms We normally use. We will not issue a policy of term insurance or a policy that contains disability or other supplementary benefits. This policy will go into effect at the end of the 31-day conversion period.

Your insurance will continue during the 31-day conversion period. This is true regardless of whether or not You have applied for conversion. If You die during this period, we will pay as a death Benefit under the group insurance policy the maximum amount You were eligible to convert.

LIFE INSURANCE CONVERSION RIGHTS FOR DEPENDENT SPOUSE

A. If Your dependent spouse loses all or part of his or her life insurance because:

- Your employment terminates; or
- Your membership in an Eligible Class terminates; or
- You retire; or
- You reach the reduction Age shown on the Schedule of Benefits**;**

Your spouse will be entitled to convert to an individual life insurance policy. He or she may convert all or part of the amount of life insurance lost.

B. If Your dependent spouse's life insurance ends because the Policy terminates or Your insurance class terminates, he or she may convert to an individual life insurance policy. He or she will be entitled to convert only if:

- this Policy was in force at least 5 years; and
- he or she was continuously insured by this Policy at least 3 years.

The amount Your dependent spouse can convert is the amount for which he or she was insured less any group life insurance for which he or she becomes eligible during the conversion period. The maximum amount that can be converted is $2,000.

This converted insurance will be an individual life insurance policy. It will be issued to Your dependent spouse without Proof of Good Health. Written application and the first premium payment must be made to us within 31 days from the date of termination. The premium for Your dependent spouse's policy will be based on Our rates that apply to his or her individual policy on the effective date of that policy. This policy will be on the forms We normally use. We will not issue a policy of term insurance or a policy that contains disability or other supplementary benefits. This policy will go into effect at the end of the 31-day conversion period.

Your dependent's spouse's insurance will continue during the 31-day conversion period. This is true whether or not he or she has applied for conversion. If he or she dies during this period, We will pay as a death benefit under the group insurance policy the maximum amount he or she was eligible to convert.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR YOU

This benefit provision only applies if it is shown in the Schedule of Benefits.

We will pay the Benefit shown for any loss listed for Accidental Bodily Injury incurred while covered.

Loss must be the direct result of an Accidental Bodily Injury independent of all other causes. There must be a visible wound on the body (except in the case of drowning or internal injuries revealed by autopsy). Loss must occur within 90 days of the Accident.

Only one amount will be paid for all Losses resulting from one Accident. We will pay the largest Benefit amount to which You are entitled. Payment will be made to You, or in the event of Your death, to the named Beneficiary.

TABLE OF BENEFITS

The Principal Sum will be shown in the Schedule of Benefits.

In the event of Loss of:	The Benefit Will Be:
Life	The Principal Sum
Both Hands or Both Feet	The Principal Sum
Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand	One Half The Principal Sum
One Foot	One Half The Principal Sum
Sight of One Eye	One Half The Principal Sum

Loss means:

(1) the actual, total, permanent and irrecoverable loss of a natural:
   (a) arm or leg completely severed at or above the elbow or knee joint;
   (b) hand or foot completely severed at or above the wrist or ankle joint;
   (c) thumb and index finger of the same hand completely severed at or above the joints that attach them to the hand;
   (d) thumb completely severed at or above the joint that attaches it to the hand;
   (e) joint of a thumb, finger, or toe completely severed at or above the joint; or

(2) the actual, total, uncorrectable, permanent and irrecoverable loss (without reasonable medical hope of recovery) of the entire:
   (a) sight of a natural eye
   (b) natural speech; or
   (c) hearing of a natural ear.

Accidental Death and Dismemberment Exclusions and Limitations

Benefits are not provided for Loss, Injury or Illness which results directly or indirectly, wholly or partly from:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. Disease or disorder of the body or mind.
3. Medical or surgical treatment or diagnosis thereof.
4. Injury occurring after termination of coverage.
5. Ptomaines or bacterial infections, except pyogenic infections at the same time and as a result of a visible wound.
6. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
7. Travel or flight in any vehicle for aerial navigation, including boarding or alighting therefrom:
   a. While being used for any test or experimental purpose; or
   b. While You are operating, learning to operate or serving as a member of the crew thereof; or
   c. Any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by You or any member of Your household; or
8. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Doctor.
9. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.

NON-OCCUPATIONAL WEEKLY DISABILITY INCOME BENEFITS FOR YOU

This benefit provision only applies if it is shown in the Schedule of Benefits.

We will pay Non-Occpational Weekly Disability Income Benefits if You become Totally Disabled as defined due to an Accident or Illness. You must be under the regular care of a Doctor for this Benefit to be payable.

Your benefits are payable every two weeks. Benefits are based on a week of seven days. If Your benefits are due for a partial week, they will accumulate on a daily basis at a rate of one-seventh of your weekly rate. The benefit amount and day of disability on which it begins are shown on the Schedule of Benefits. Benefits will end on the earlier of:

- the day You are no longer disabled; or
- the last day of the Maximum Period of Disability shown on the Schedule of Benefits.

These benefits may not be assigned.

If You return to active work and are disabled again within two weeks, the disabilities will be treated as one period of disability. The exception to this would be if the most recent disability was due to a cause totally unrelated to the previous one. In this case, the two will be treated as different disabilities provided they were separated by at least one day of active work.

If Your Policy terminates while You are disabled, We will continue to pay benefits until the earlier of:

- the day you are no longer disabled; or
- the end of the Maximum Period of Disability as shown in the Schedule of Benefits.

We will not pay benefits for any loss excluded by the **GENERAL EXCLUSIONS AND LIMITATIONS.**

HOSPITAL ADMISSION BENEFIT

This benefit provision only applies if it is shown in the Schedule of Benefits.

Subject to the terms and conditions of the Policy, benefits will be paid for You or a Dependent who is admitted to a Hospital as a result of a non-occupational Injury or Illness while covered under the Policy.

We will pay the one time lump sum Benefit specified in the Schedule of Benefits for such Hospital admission resulting in a confinement of 24 hours or more.

A Hospital Admission Benefit will be paid only if:

- You or a Dependent is confined in a Hospital; and
- The confinement is Medically Necessary; and
- A charge is made for room and board; and
- The Hospital confinement is recommended and approved by a Doctor, and
- Covered Person is not admitted as a newborn child; and
- The confinement is not excluded from Coverage.

Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

DAILY IN-HOSPITAL AND SKILLED NURSING FACILITY INDEMNITY BENEFIT

This benefit provision only applies if it is shown in the Schedule of Benefits.

Subject to the terms and conditions of the Policy, benefits will be paid for You or a Dependent who becomes confined in a Hospital or a Skilled Nursing Facility as a result of a non-occupational Injury or Illness while covered under the Policy. We will pay the daily Benefit specified in the Schedule of Benefits for each day of such Hospital and Skilled Nursing Facility confinement. However, such benefits will not exceed the applicable maximum number of days shown in the Schedule of Benefits.
Daily In-Hospital and Skilled Nursing Facility Indemnity Benefits will be paid only if:

- You or a Dependent is confined in a Hospital or Skilled Nursing Facility; and
- The confinement is Medically Necessary; and
- A charge is made for room and board; and
- The entire duration of such Hospital or Skilled Nursing Facility confinement is recommended and approved by a Doctor, and
- The confinement is not excluded from Coverage.

Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

EMERGENCY ROOM VISIT INDEMNITY BENEFIT (ILLNESS ONLY)

This benefit provision only applies if it is shown in the Schedule of Benefits.

Subject to the terms and conditions of the Policy, a Benefit will be paid for You or a Dependent who has an Emergency Room Visit as a result of a non-occupational Illness while covered under the Policy for services Medically Necessary and provided on an Emergency basis that do not result in Hospital confinement.

The maximum amount per visit and for all visits in a Calendar Year is shown in the Schedule of Benefits.

The Emergency Room Visit must occur within the time limit for visit shown in the Schedule of Benefits from the time the Illness first manifested itself.

Emergency is defined as the sudden onset of a medical condition manifested by symptoms of such severity that the failure to immediately provide Medially Necessary treatment could reasonably be expected to result in:

- Placing the Covered Person's health in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Illness is defined as a disorder or disease of the mind or body, or a pregnancy.

Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

DOCTOR'S OFFICE VISITS INDEMNITY BENEFIT

This benefit provision only applies if it is shown in the Schedule of Benefits.

Subject to the terms and conditions of the Policy, benefits will be paid for You or a Dependent. We will pay the benefit specified in the Schedule of Benefits for each Doctor's Office Visit. However, such benefits will not exceed the applicable maximum shown in the Schedule of Benefits.

Benefits will not be paid if such benefits are excluded from Coverage.

Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

PREVENTIVE CARE INDEMNITY BENEFIT

This benefit provision only applies if it is shown in the Schedule of Benefits.

Subject to the terms of the Policy, a Benefit will be paid for You or a Dependent for the following charges:

1 Well baby and Child Care ages 18 and under:
   - Routine examinations and medical history, including development assessment and anticipatory guidance;
   - Routine immunizations;
   - One hearing screening from birth to Age one;
   - One Vision Screening per Calendar Year;

2 Well Adult Care ages 19 and over:
   - One routine physical examination per Calendar Year;
   - Routine gynecological care, including cytologic screening;
   - One prostate specific antigen test and one rectal exam per Calendar Year, for men Age 50 and older;
   - Chest x-ray and routine laboratory services;
   - One screening mammography per Calendar Year for a Covered Person Age 35 or older, subject to the Benefit limits shown on the Schedule of Benefits.

Well Child Care is the periodic review of a child's physical and emotional status. This periodic review will only be covered to the extent that the services are provided by, or under the supervision of, a single Doctor during the course of one visit. Keeping with prevailing medical standards a review shall include:

- A history;
- Complete physical examination;
- Developmental assessment;
- Anticipatory guidance;
- Appropriate immunizations;
- Laboratory tests; and
- Hearing and Vision Screening.

Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

OUTPATIENT DIAGNOSTIC X-RAY AND LAB INDEMNITY BENEFIT

This benefit provision only applies if it is shown in the Schedule of Benefits.

Subject to the terms and conditions of the Policy, benefits will be paid for You or a Dependent. We will pay the Benefit specified in the Schedule of Benefits for each Outpatient Diagnostic X-Ray and Lab Test. However, such benefits will not exceed the applicable maximum shown in the Schedule of Benefits.
Benefits will be paid only if:

- You or a Dependent is not confined in a Hospital; and
- Diagnostic X-Ray and Lab tests are ordered or performed by a Doctor; and
- Benefits are not excluded from Coverage.

Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

ACCIDENT EXPENSE BENEFITS FOR YOU AND YOUR DEPENDENTS

This benefit provision only applies if it is shown in the Schedule of Benefits.
Charges must be incurred within 90 days of the date of the Accidental Bodily Injury. Payment will be made for the following:

- Medical, dental or surgical treatment or supplies; and
- Confinement in a Hospital; and
- X-ray and lab exams; and
- Registered nurses; and
- Prescription drugs.

Benefits will be paid only if they are not excluded from Coverage.

Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

DENTAL BENEFIT PROVISIONS

This benefit provision only applies if it is shown in the Schedule of Benefits.

Dental benefits are payable only if You or Your Dependent incur eligible dental expense charges for dental care while covered under the Policy.
Benefits will be equal to the Percentage Payable, shown in the Schedule of Benefits, times the excess of eligible Dental expense charges that are over and above the deductible amount for dental benefits.
The maximum dental benefit, deductible amount and Percentage Payable under the Policy are shown in the Schedule of Benefits.
Eligible dental expense charges incurred and applied to the deductible amount for dental benefits during the last 3 months of a Calendar Year will be used to reduce the next Calendar Year deductible for dental benefits.

Orthodontic Treatment.
Eligible dental expense charges for any one course of treatment will be paid at 50% as follows:

1. An initial amount equal to one-fourth (1/4) of the eligible dental expenses for the course of Orthodontic Treatment. This initial amount covers the fee incurred for:
   - Diagnosis;
   - Evaluation;
   - Pre-orthodontic treatment; and
   - The insertion of orthodontic appliances, not to exceed the dentist's actual charge, if less; and
2. A monthly amount equal to the eligible dental expense charges for the course of Orthodontic Treatment minus the initial payment, divided by the number of months in the projected period of treatment.
   Covered charges will be paid each month for the number of months in the projected period of treatment.

The benefits will not be subject to the Calendar Year maximum. The deductible amount does not apply to Orthodontic Treatment.

Consideration will be given for orthodontic eligible dental expenses incurred after the Covered Person's Effective Date of Coverage. Benefits will be based on the dentist's original Treatment Plan and the procedures listed above.
Only monthly benefits remaining in the projected period of treatment will be considered.

Types of Eligible Dental Care
The following are eligible dental expense charges and are incurred as of the date the procedure, service or supply was furnished.

TYPE I

- Oral Exams - routine oral examination including diagnosis, but not more than 2 examinations for each Covered Person during any Calendar Year.
- Prophylaxis - including cleaning, scaling and polishing, but not more than 2 times in any Calendar Year for each Covered Person.
- Fluoride Treatment - limited to children 14 years of Age or younger.
- Space Maintainers.
- Palliative Emergency Treatment.
- X-rays:
  a. Full mouth X-rays not to exceed one series in any 3 consecutive Calendar Year periods,
  b. Bitewing X-rays not more than twice per Calendar Year.

TYPE II

- Laboratory Tests and other diagnostic examinations.
- Sealants:
  a. Limited to children Age 14 or younger;
  b. Only for a tooth or teeth posterior to cuspids; and
  c. Not more than one application in a Calendar Year per tooth.
- Simple (routine) Extractions.
- Surgical Extractions.
- Oral Surgery.
- Alveolectomy.
- Anesthesia.
- Therapeutic Injections.
- Restorations - fillings of amalgam or synthetic process.
- Denture Repair and Bridge Repair.
- Endodontics - a charge will be deemed incurred on the date the tooth was opened for root canal therapy.
- Periodontics.
  a. The total amount of benefits payable per Covered Person for any diagnosis, surgery or related services for periodontal disease will in no event exceed the periodontal maximum shown in the Schedule of Benefits; and
  b. The total amount of benefits will also be subject to the Calendar Year maximum.

TYPE III

- Inlays.
- Onlays.
- Crowns.
- Prosthetics, including bridges and dentures as follows:
  1. The initial installation, or addition to full or partial dentures or fixed or removable bridgework will be eligible, provided:
     a. The installation or addition was required as a result of an extraction of injured or diseased natural tooth or teeth while the Covered Person is covered;
     b. The installation or addition includes the replacement of an extracted tooth or teeth; and
     c. The denture or bridgework was completed within 12 months following the date of extraction.
  2. Dentures and bridgework are considered initially installed if they do not replace any existing dentures or bridgework.
  3. The replacement or alteration of full or partial dentures, fixed or removable bridgework will be considered for payment when:
     a. Medically Necessary;
     b. Incurred while the Covered Person was covered; and
     c. Completed within 12 months after one of the following:
        - An Accidental Bodily Injury which requires surgical treatment; or
        - Oral surgical treatment which involves the repositioning of muscle attachments, or the removal of a tumor, cyst, torus, or redundant tissue; or

     The replacement of a full or partial denture or fixed bridgework when required because of structural change in the mouth or removable bridgework that was no longer serviceable provided the replacement:
     a. Is made 5 years or more after the installation date of the denture or bridgework; and
     b. In no event less than 2 years after the Covered Person's Effective Date.

  Eligible dental expense charges for fixed partial dentures, crowns, inlays or onlays will be considered incurred on the date of preparation of the tooth or teeth involved, and for removable partial or complete dentures, on the date the first impression was taken.

TYPE IV

- Orthodontic appliances - furnishing and attachment of any necessary orthodontic appliance.
- Orthodontic treatment - based on the dentist's original Treatment Plan.
- A separate orthodontic maximum will apply for each Covered Person.

Dental Exclusions and Limitations

Benefits are not provided for any charges:

1. for services received from the dental or medical department of any employer, union, employee benefit association, trustee, or similar organization, or for services of a dentist or clinic contracted for or by any of these organization.
2. for replacement of a tooth or teeth extracted prior to the Covered Person's Effective Date unless the replacement satisfies one of the conditions listed under Type I-IV of Dental Care.
3. for dentures, crowns, inlays, onlays, bridgework or appliances or services for increasing vertical dimensions.
4. for denture or bridgework adjustments within 6 months of the placement of a denture or bridgework.
5. for replacement of a lost or stolen prosthesis or for a duplicate prosthesis.
6. for oral hygiene, dietary or plaque control instructions and programs.
7. for athletic mouth guards.
8. for porcelain veneered crowns or pontics on or replacing a tooth or teeth posterior to the second bicuspid, which exceeds the maximum allowable charge payable for acrylic veneered crowns or pontics.
9. for a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the dental expense charge for the permanent denture or bridge.
10. made by a dentist for failure to appear as scheduled for an appointment.
11. for tooth re-implantology not resulting from an Accidental Bodily Injury.
12. for drugs, other than injectable antibiotics administered by a dentist as a result of dental treatment.
13. for procedures, services, or supplies which do not meet accepted standards of dental practice.
14. for treatment initiated while not covered under the Policy, except for orthodontic treatment.
15. not included in Type I-IV of eligible dental care.

Other Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

GENERAL DENTAL PROVISIONS

Replacement of Policy: In addition to the Policy's Replacement of Policy provision, the following will apply to Dental Benefits. The replacement of a tooth or teeth extracted but not replaced prior to the Effective Date of the Policy will be covered provided:

- The tooth or teeth were extracted and eligible for replacement under the prior Policy; and
- The replacement was completed within the first year of the Policy.

The replacement of full or partial dentures, fixed or removable bridgework within 2 years of a Covered Person's Effective Date under the Policy will be covered provided:

- Other replacement rules listed under the Type of Dental Care section of the Policy were met; and
- The Covered Person's Coverage was continuous for a combined period of at least 2 years with the prior Policy.

Dental Administration: Alternative Course of Treatment: If alternative services may be employed to treat a dental condition, Eligible Dental Expense Charges will be limited to those services:

- Which are customarily employed in the treatment of the condition; and
- Which are recognized in the dental profession to be appropriate according to broadly accepted national standards of dental practice.

Dental Examination: We will have the right to have a Covered Person examined at Our expense as often as may be reasonably required while a claim is pending.

Treatment Plan: If the treatment can be expected to involve covered Eligible Dental Expense Charges in excess of $250.00, a Treatment Plan should be submitted to Us before treatment begins.

VISION CARE BENEFIT PROVISIONS

This benefit provision only applies if it is shown in the Schedule of Benefits.

You or Your Dependent will be entitled to benefits if covered vision expenses are incurred while covered under the Policy. Benefits will be equal to the Percentage Payable shown in the Schedule of Benefits. The maximum amount of vision care benefits payable under the Policy is shown in the Schedule of Benefits.

Covered Vision Expenses are Maximum Allowable Charges for the Vision Care Benefit set forth below.
Such charges will be covered if they are incurred while covered under the Policy's Vision Care Benefit.

- Eligible expenses by an Eye Doctor for one routine eye exam within 12 consecutive months.
- Eligible expenses for one pair of eyeglass lenses and frames or one pair of contact lenses including disposable contacts within 24 consecutive months. The eyeglasses or contact lenses must be prescribed by an eye Doctor.

With regard to disposable contact lenses, "one pair of contact lenses" shall mean multiple pairs of contact lenses the cost of which do not exceed the cost of a single pair or permanent contact lenses.

Vision Exclusions and Limitations
Benefits are not provided for:

- Any medical or surgical treatment of the eye.
- Sunglasses, plain or prescription; or safety lenses or goggles.
- Orthoptics, vision training or aniseikonia.
- Scratch coating, tinting, and eye glass insurance

Other Exclusions that apply are in **GENERAL EXCLUSIONS AND LIMITATIONS.**

GENERAL EXCLUSIONS AND LIMITATIONS

Benefits are not provided for Loss, Injury or Illness which results directly or indirectly, wholly or partly from:

1. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression,
2. Declared or undeclared war or acts thereof.
3. Accidental Bodily Injury occurring while serving on full-time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by Us pro-rata for any period of active-full time duty).
4. Any Injury or Illness arising out of or in the course of work for wage or profit.
5. Any Injury or Illness covered by any Workers' Compensation Act, Occupational Disease law or similar law.
6. Except in regard to Limited Medical Benefits, Accidental Bodily Injuries received while the Covered Person was operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
7. Charges for which:
   - there is no legal obligation to pay, or
   - no charge is made, or
   - in the absence of Coverage, no charge would be made.
8. Charges incurred after Termination of Coverage, except as provided under the Extension Due to Total Disability provision.
9. Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law.
10. Charges which are not Medically Necessary (as defined) for treatment of Illness or Injury.
11. Charges for services which are not related to and consistent with the treatment of any Injury or Illness of the Covered Person.
12. Charges for medical care, services, or supplies which are not furnished or prescribed by a Doctor (as defined).
13. Charges for Experimental or Investigational treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices.
14. Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an Injury or Illness by any of the following:
    - The American Medical Association;
    - The U.S. Surgeon General;
    - The U.S. Department of Public Health;
    - The National Institutes of Health; or
15. Charges related to cosmetic surgery or dental care done to beautify a person without medical or dental indication of Injury or Illness.
16. <u>Unless specifically provided in the Policy</u>:
    - charges for dental treatment.
    - charges for oral surgery.
    - charges for treatment of Mental Illness Disorders.
    - charges for treatment of Substance Abuse Disorders.
    - charges for routine physicals or general health exams, unless they are necessary for the diagnosis and treatment of an Illness.
    - charges for refractions, eyeglasses or hearing aids or their fitting.
    - charges in connection with obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology.
    - charges for treatment or services for temporomandibular joint dysfunction or TMJ pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope.
    - charges for routine immunizations and vaccinations, including but not limited to polio, mumps, measles, small pox, DPT, Influenza or tine tests.
    - Birth control medication in any form.
    - Prescription medication recommended or dispensed by; a physician, surgeon, nurse or other Doctor.

GENERAL EXCLUSIONS AND LIMITATIONS continued

17. Charges for reversal procedures in connection with previous male or female sterilization.
18. Charges for services in the nature of educational or vocational testing or training.
19. Any charges for elective abortions.
20. Any charges for outpatient food, food supplements or vitamins.
21. Radial keratotomies.
22. Charges for treatment of male or female infertility; in vitro and in vivo fertilization of an ovum; or artificial insemination including but not limited to:
    - Drugs and medicines;
    - Diagnostic and surgical procedures including but not limited to:
        - Aspiration of ovarian cysts;
        - Harvesting or obtaining eggs;
        - Other surgical treatment of infertility;
        - Diagnostic laboratory and pathology procedures; and
        - Diagnostic radiology, nuclear medicine and ultra sound procedures.
23. Charges for stand-by Doctors to include but not limited to surgeons, pediatricians, anesthesiologists, anesthetists, or other Doctor as defined by the Policy; or stand-by supplies, equipment, rooms, or any other service, supply or treatment not actually used in the care or treatment of an Illness or Injury.
24. Charges for Custodial Care.
25. Charges for durable medical equipment.
26. Charges related to smoking cessation.
27. Charges for the treatment of the following:
    - Codependency;
    - Social, occupational, or religious maladjustments;
    - Compulsive gambling;
    - Chronic marital or family problems when not related to the primary focus of treatment which must be a diagnosable Mental Illness Disorder.

TERMINATION OF COVERAGE

Your Coverage will cease on the earliest of the following dates:

- The date Your membership in an Eligible Class ceases; or
- The date You or the Policyholder cease Premium payments for Your Coverage; or
- The date You are pensioned or retired; or
- The date the Policy ceases; or
- The date specified by Us in written notice to You that Your Coverage ends due to fraud or misrepresentation; or
- The date We receive written notice from the Eligible Person or Policyholder telling Us to terminate Coverage of a Covered Person or the date requested in such notice, whichever is later.

In addition, Coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder in the Schedule of Benefits.

Dependent Coverage, if applicable, will cease on the earliest of the following dates:

1. The date You are no longer in a Eligible Class for Dependent Coverage; or
2. The date You or the Policyholder cease premium payments for Dependent Coverage; or
3. The date We cancel all Dependent Coverage under the Policy; or
4. The date Your Coverage ceases.

In addition, Dependent's Coverage will be terminated on the first day of the calendar month following any month in which the number of hours worked falls below the minimum required hours as elected by the Policyholder in the Schedule of Benefits.

See "Continuation of Coverage", "Life Insurance Conversion Rights for You", and "Extension Due to Total Disability" for exceptions to above.

EXTENSION DUE TO TOTAL DISABILITY

Accidental Death and Dismemberment Benefit
Coverage will continue for 90 days from the date of Loss even if Coverage terminates.

Non-Occupational Weekly Disability Income Benefit
The Non-Occupational Weekly Disability Income Benefits, if applicable, will continue to be payable under the Policy, after Coverage terminates, until the earlier of:

- The date You cease to be Totally Disabled; or
- The date You have reached the maximum benefit period under the benefit.

Limited Medical Benefits
The Limited Medical Benefits, if applicable, will continue to be payable under the Policy when Coverage terminates, if the Covered Person:

- Is Totally Disabled; and
- Is confined to a Hospital or a Skilled Nursing Facility for the disabling Illness or Injury before the date Coverage would otherwise terminate.

Benefits paid under this extension will be paid until the earliest of:

- The date which is 90 days from the date Coverage would have otherwise terminated; or
- The date on which the disabled Covered Person's Daily In-Hospital and Skilled Nursing Facility Indemnity Benefit has reached the applicable maximum benefit period under this Benefit.

This extension of Coverage applies only to the disabled Covered Person and no Premium is due.

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS

Misstatements
We consider any statement made by You or the Policyholder, in the absence of fraud, to be a representation and not a warranty. No statement will be used to avoid the insurance, reduce benefits, or deny a claim unless:
- the statement is in writing; and
- a copy of that statement is given to You or Your beneficiary.

The Policy may be changed at any time by a written agreement between the Policyholder and Us. Only Our executive officers can change this Policy.

ERISA
If the Group Policy is being purchased by the Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. Section 1001 et seq., We are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Physical Examination And Autopsy
We may require that a claimant have a physical examination, at our expense, as often as is necessary to settle a claim. In the case of death an autopsy may be required, unless forbidden by law.

GENERAL PROVISIONS APPLICABLE TO LIFE INSURANCE BENEFITS ONLY

Incontestability
The validity of the Policy will not be contested, except for nonpayment of Premiums, after it has been in force for two years from its Effective Date.

The validity of a Covered Person's life insurance will not be contested after that Covered Person's life insurance has been in force for two years during the Covered Person's lifetime. No statement You make relating to Your or Your Dependent's insurability will be used in any contest unless:
- it is contained in a written application signed by You; and
- a copy of the Application has been furnished to You or to Your beneficiary.

Misstatement Of Age
If You have misstated Your Age or the Age of a Dependent, the true Age will be used to determine:
- the Effective Date or termination date of insurance; and
- the amount of insurance; and
- any other rights or Benefits.

Premiums will be adjusted if too much or too little was paid due to the misstatement.

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS EXCEPT LIFE INSURANCE

Incontestability
The validity of the Policy will not be contested, except for nonpayment of Premium, after it has been in force for two years from its Effective Date. The validity of a Covered Person's insurance will not be contested after that Covered Person's insurance has been in force for two years during the Covered Person's lifetime.

Notice Of Claim
If You or Your insured Dependent have an Injury or Illness that may result in a claim for benefits under this Policy, written notice must be given to Us at our Home Office or to one of Our authorized agents. This must be done within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as is reasonably possible. The notice must contain enough information to identify the claimant.

Claims Forms
When We or the Program Manager receive written or verbal notice of a claim for Life, Accidental Death and Dismemberment or Disability, claim forms will be sent with which to file Proof of Loss. If these forms are not given to the claimant within 15 days, the claimant will be excused from filing the forms as long as the person sends us Proof of Loss as described below.

Proof Of Loss
Proof of Loss includes, but is not limited to, information about the extent, time, place, and events surrounding a loss. Written Proof of Loss must reach Us:

- for a disability claim, within 90 days of the beginning of the period for which benefits are payable; and
- for a stay in a Hospital, Skilled Nursing Facility or other health care facility, within 90 days of the end of the stay for which benefits are payable.

Written proof for all other losses must reach Us within 90 days of the loss. These time periods may be extended up to an additional year so long as You cannot reasonably furnish written Proof of Loss. This time limit does not apply so long as You do not have legal capacity.

Time Of Payment Of Claims
Benefits for loss of time will be paid as shown in the Policy for that benefit section. Any amount unpaid at the end of the period for which claim is made will be paid as soon as We receive written Proof of Loss. Benefits for all other types of losses will be paid as soon as they accrue so long as We receive written Proof of Loss.

Payment Of Claims
Benefits payable under this Policy will be directly to: (a) You; (b) Your legally appointed guardian if You are not legally able to accept such benefits; or (c) a provider of medical treatment or services if a written assignment is made.

In the event You die and on the date You die there is: (a) no named Beneficiary or (b) no living named Beneficiary, We may at Our option, pay any benefits due under this Policy to the following survivors in order of precedence: (1) Your spouse, (2) children born to or legally adopted by You, share and share alike, (3) parents, or (4) Your estate.

Any payment made in good faith fully discharges Us to the extent of that payment. Failure to honor an assignment to a provider or Doctor due to inadvertent error will not subject Us to double payment.

Free Choice Of Doctor
You and Your insured Dependents have free choice of a Doctor. The Doctor-patient relationship will be maintained.

Legal Actions
No action at law or in equity may begin prior to 60 days after We receive a valid written Proof of Loss. No such action may begin after three years from the day written Proof of Loss was required.

Workers' Compensation Not Affected
This policy does not replace or change any requirement for Coverage under Workers' Compensation insurance.

CONTINUATION OF COVERAGE

THIS PROVISION IS SUBJECT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) AND ALL SUBSEQUENT LAWS EFFECTING THIS ACT.

This provision applies to an Employer with twenty (20) or more Employees on a typical business day during the preceding Calendar Year if group health Coverage was provided to Employees. Due to COBRA's complexity, this provision only includes information that would allow a qualified beneficiary to make a general determination of his rights under the law.

This provision is not a detailed account of the law and does not contain the full text of the law or regulations. Therefore, it is imperative that legal counsel or other appropriate counsel be sought for additional needed information.

Generally, all group health plans with over twenty (20) Employees are directly affected under COBRA or, under a federal law that COBRA may have amended. The only plans that may be exempt are church plans, state and local government group health plans and plans maintained by the Government of the District of Columbia or any territory or possession of the United States. Your Employer or plan administrator may be contacted for the plan's exempt or nonexempt status.

An individual may be eligible for Coverage if on the day before a qualifying event he was covered under his Employer's group health plan. If Coverage was lost due to a qualifying event, continuation of Coverage may be available for a certain period of time. Non-resident aliens who do not receive any United States income are not qualified ~~B~~ beneficiaries and cannot continue under COBRA.

The term "qualified beneficiary" means, with respect to a covered Employee any other individual who, on the day before the qualifying event for that Employee, is a beneficiary under the plan as:
a. The spouse of the covered Employee;
b. The Dependent child of the covered Employee;
c. The surviving Spouse of the covered Employee; or
d. A child born to or adopted by a covered Employee during a period of COBRA Coverage.

The term "qualifying event" means, with respect to any covered Employee, any of the following events which would result in the loss of Coverage of a qualified beneficiary.

QUALIFYING EVENTS AND MAXIMUM CONTINUATION PERIODS:

1. 18 Months:
   - Termination of covered Employee's employment (except for gross misconduct)
   - The covered Employee's reduction of work hours.
2. 36 Months:
   - The death of the covered Employee.
   - The covered Employee's legal separation or divorce from the Employee's spouse.
   - The covered Employee's entitlement to Medicare.
   - The Dependent child ceasing to be a Dependent child under the terms of the Plan.
3. 29 Months:
   - Only applies if the qualifying event was a termination of employment (except for gross misconduct) or a reduction in work hours that allowed an eighteen (18) month period of continuation.

In order to qualify for the additional eleven (11) months of coverage, the Social Security Administration must make a determination that the qualified beneficiary was disabled at the time of a termination or reduction in hours of employment or that covered Employee or qualified beneficiary became disabled at any time during the first sixty (60) days of COBRA continuation coverage. If the covered Employee or qualified beneficiary entitled to the additional eleven (11) months of coverage has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the additional eleven (11) months of coverage. If the covered Employee or qualified beneficiary is determined to be disabled, the covered Employee or qualified beneficiary must give notice to the plan administrator within sixty (60) days of the Social Security determination and before the end of the original eighteen (18) month continuation period. The plan administrator may charge an additional amount for this Coverage.

CONTINUATION OF COVERAGE

Coverage will terminate if a covered Employee or qualified beneficiary recovers from the disability during the eleven (11) month period. The covered Employee or qualified beneficiary is responsible for notifying the plan administrator within thirty (30) days of the date the Social Security Administration no longer finds the disability to exist. Coverage can terminate in the month that begins more than thirty (30) days after the determination date of the Social Security Administration.

4. Certain Bankruptcy Proceeding Under Title 11, United States Code: Under this special proceeding, loss of Coverage means a substantial elimination of Coverage within one (1) year before or after the Employer has entered into a bankruptcy proceeding.

For the purpose of this special proceeding, a qualified beneficiary may be a covered Employee who retired on or before the date of the loss of coverage and any other individual who on the date before the event was:
a. The Spouse of the covered Employee;
b. The Dependent child of the covered Employee;
c. The surviving Spouse of the covered Employee; or
d. A child born to or adopted by a covered Employee during a period of COBRA coverage.

It appears that Coverage may continue until the death of the covered Employee or qualified beneficiary, or up to thirty-six (36) months for the surviving Spouse or Dependent child(ren) of the covered Employee after the date of the death of the covered Employee.

As Bankruptcy Laws and COBRA are two (2) very distinct and unique laws, legal counsel should be consulted before determinations and actions commence under this qualifying event. For notification and election termination, reduction of hours, death, bankruptcy, the Plan Participant must notify the plan administrator within thirty (30) days of the qualifying event. The plan administrator will then provide written notice to the covered Employee or qualified beneficiary within fourteen (14) days. The covered Employee or qualified beneficiary must then elect COBRA coverage within sixty (60) days.

The election period will end sixty (60) days after the date of the qualifying event or sixty (60) days after the date the written notice was received, whichever is later. In addition, the required Premium must be paid within forty (45) days of the date of election.

For divorce, legal separation or ineligibility of a Dependent under the plan each covered Employee or qualified beneficiary must notify the Employer or plan administrator within sixty (60) days of the event. If the notice is not sent to the Employer or plan administrator within sixty (60) days, the group health plan does not have to offer the qualified beneficiary an opportunity to elect continuation Coverage.

Once the plan administrator is notified of the event, the plan administrator will provide written notice to the qualified beneficiary. The qualified beneficiary must then elect COBRA coverage within sixty (60) days. The election period will end sixty (60) days after the date of the qualifying event or sixty (60) days after the date the written notice was received, whichever is later. In addition, the required Premium must be paid within forty-five (45) days of the date of election. Notification to an individual who is qualified as the Spouse of the covered Employee, will be treated as notification to all other qualified beneficiaries residing with the Spouse at the time of the notification.

Each qualified beneficiary has the opportunity to make an independent election. However, if a qualified beneficiary who is the Spouse of a covered Employee makes an election to provide any other qualified beneficiary with COBRA coverage, the election will be binding on that qualified beneficiary.

CONTINUATION OF COVERAGE

Waiver:
If a covered Employee or qualified beneficiary waives the right to continue under COBRA and later revokes the waiver, he must do so within the election period. Coverage will not be provided during the period of time when coverage was waived. Waivers and revocations are considered made on the date they are sent to the Employer or plan administrator.

Other Reasons Why Cobra Coverage May Terminate:
COBRA continuation coverage can end prior to the maximum continuation period due to any of the following events:
A. The first day on which timely Premium payment is not made.
B. The date upon which the Employer ceases to maintain any group health plan.
C. The date upon which the covered Employee or qualified beneficiary is covered under any other group health plan whether or not such new plan contains limitation periods with respect to any pre-existing condition as long as the limitation period does not apply to the covered Employee or qualified beneficiary.
D. The date the covered Employee or qualified beneficiary is entitled to Medicare. However, this event by itself may not end coverage for a covered Employee or qualified beneficiary who has End Stage Renal Disease. “Entitled” means - having made application and qualified for Medicare.
E. The date on which Coverage would terminate for similarly situated active Employees to whom a qualifying event had not occurred.

Any alternative continuation coverage will not extend the maximum COBRA coverage period and will run concurrent with COBRA continuation.

When a covered Employee or qualified beneficiary’s coverage ends under COBRA, and if the policy provides the right to convert to a health plan, the covered Employee or qualified beneficiary will be entitled to the conversion privilege.
The plan administrator may be contacted for additional information on COBRA. If further information is needed the U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, N.W. - Room N-5658, Washington, DC 20210 may be contacted.

CONTINUANCE OF COVERAGE
Benefits for the Plan Participant and his Dependents may continue past the day they would otherwise cease as provided under Termination of Coverage upon payment of the required premium.
The Plan Participant’s coverage will continue:
A. For up to two (2) months after he ceases full-time work due to temporary layoff or leave of absence; or
B. For up to six (6) months after he ceases full-time work due to Illness or Injury; or
C. Until the first day of the Plan month following any month in which the number of hours worked falls below the required minimum. Dependent coverage will continue if A. or B. above apply to the Plan Participant.

This coverage will not continue if the Plan Participant begins work for pay or profit with another employer.

The Plan Sponsor must follow a plan which prevents individual selection. If benefits are to be continued under this provision, written notice must be provided to Us by the Plan Sponsor if a Plan Participant is pensioned, retired or absent from work for any other reason. State law may provide a special continuance of coverage when You terminate. See your Plan Sponsor for details.

COMPLAINT AND APPEAL PROCEDURES

COMPLAINT RESOLUTION

Administrative Complaints

Complaints due to the denial of services, payment of a claim or handling of inquiries must be reported no later than one year 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.

INTERNAL REVIEW

(1) Standard Appeals

You, an authorized person, or a Doctor, 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 180 calendar days from the date of receipt of the denial letter.

A Clinical Reviewer will review the file. A Clinical Reviewer is a Doctor or any other provider who is in the same or a similar specialty, as the Doctor or provider who will perform the service. The Appeals Department will review all of the information. A decision will be made within 30 calendar days of receipt for a Pre-Service Claim Appeal and within 60 calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to 45 calendar days if additional information is needed. You will be notified in writing of the Appeals Department's decision.

A Pre-Service Claims Appeal is an appeal of any claim for benefits under the terms of the Policy, which must be approved (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 that is not a Pre-Service Claims Appeal.

(2) Urgent Appeals

You, an authorized person or a Doctor, with Your consent, may request an Urgent Appeal. This request may be verbal or written. A decision will be made within 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 INDEPENDENT REVIEW

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

Denial of Benefits/Covered Services

If We deny Benefits because the service is not a covered service, a review may be requested by contacting the insurance department shown on the Schedule of Benefits.

NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") applies to Nationwide[1] and describes the legal obligations of Nationwide, and your legal rights regarding your protected health information held by Nationwide under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your Protected Health Information ("PHI" as that term is defined below) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law.

Nationwide is required by HIPAA and certain state laws to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice so long as it remains in effect. Nationwide reserves the right to change the terms of this Notice and to make the new Notice effective for all PHI maintained by us, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of the revised Notice by mail to your last-known address on file.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by Nationwide and that relates to: (1) your past, present, or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present, or future payment for the provision of health care to you. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Certain uses and disclosures of PHI require your authorization. For example, most uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require a written authorization. Except as outlined below, we will not use or disclose your PHI without your written authorization. If you have given us an authorization, you may revoke it in writing at any time, unless we have already acted on the authorization. Once we receive your written revocation, it will only be effective for future uses and disclosures.

Disclosures for Treatment, Payment or Health Care Operations. We may use or disclose your PHI as permitted by law for your treatment, payment, or health care operations. For instance, for your treatment, a doctor or health facility involved in your care may request information we hold in order to make decisions about your care. For payment, we may disclose your PHI to our pharmacy benefit manager for administration of your prescription drug benefit. For health care operations, we may use and disclose your PHI for our health care operations, which include responding to customer inquiries regarding benefits and claims.

[1] Nationwide Life Insurance Company®, National Casualty Company and the area within Nationwide Mutual Insurance Company® that performs healthcare functions.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care.

If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. For example, we may disclose your PHI to a business associate to administer claims or to provide support services. In all cases, we require these business associates by contract to appropriately safeguard the privacy of your information.

Other Health-Related Products or Services. We may, from time to time, use your PHI to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products, or services which may be available to you as a member of the health plan. For example, we may use your PHI to identify whether you have a particular illness, and advise you that a disease management program to help you manage your illness better is available to you. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Plan Administration. We may release your PHI to your plan sponsor for administrative purposes, provided we have received certification that the information will be maintained in a confidential manner and not used in any other manner not permitted by law.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. We may release your PHI for any purpose required by law. This may include releasing your PHI to law enforcement agencies; public health agencies; government oversight agencies; workers compensation; for government audits, investigations, or civil or criminal proceedings; for approved research programs; when ordered by a court or administrative agency; to the armed forces if you are a member of the military; and other similar disclosures we are required by law to make.

OTHER PRIVACY LAWS AND REGULATIONS

Certain other state and federal privacy laws and regulations may further restrict access to and uses and disclosures of your personal health information or provide you with additional rights to manage such information. If you have questions regarding these rights, please send a written request to your designated contact as explained in the "Contact Information" section, below.

RIGHTS THAT YOU HAVE

Access to Your PHI. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your personal representative. We may charge you a fee if you request a copy of the information. The amount of the fee will be indicated on the request form. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Amendments to Your PHI. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. A request form can be obtained by writing to your designated contact at the address provided in the "Contact Information" section.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your PHI. Requests must be made in writing and signed by you or your personal representative. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on some of our uses and disclosures of your PHI. We will consider, but are not required to agree to, your restriction request. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Request for Confidential Communications. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI information from us by alternative means or at alternative locations. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Right to be Notified of a Breach. You have the right to be notified in the event we discover a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you have requested such copy by e-mail or other electronic means.

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the "Contact Information" section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-855-495-1190, or mail your request to:

Fringe Benefit Group, Inc.
Attn: Carol Adams, Privacy Officer
11910 Anderson Mill Road
Austin, TX 78726

EFFECTIVE DATE

This Notice is effective 9/15/2015

Nationwide and the Nationwide N and Eagle are service marks of Nationwide Mutual Insurance Company.

NH-0524-1E-09152015

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Nationwide Life Insurance Company, d/b/a Nationwide Health Plans (hereinafter "Nationwide"), and Fringe Benefit Group, Inc. (hereinafter "Fringe") are required by law to maintain the privacy of our Insureds' health information. Fringe, a business associate of Nationwide, performs certain claims and/or administrative functions for Nationwide. Unless you have signed a form authorizing the use or disclosure, Fringe and/or Nationwide will not use or disclose your health information for any purpose other than its role in treatment, payment or for health care operations. **With your written approval, we may disclose your health information to others, including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s).** A copy of this form is as valid as the original.

ONE FORM MUST BE COMPLETED FOR EACH FAMILY MEMBER AGE 18 AND OVER. Additional forms are available from Fringe or Nationwide or this form can be reproduced.

I, _____, hereby authorize the use or disclosure of health information about me (print insured's or minor dependent's name) as described below.

As the parent, I authorize the use or disclosure of health information about my minor dependent(s), age 17 and under as described below.

_____,_____,
_____,_____
(print minor dependent'(s) full name)

1. Person(s) or group of persons authorized to disclose the information:
   - NHP
   - Fringe (Fringe Insurance Benefits, Inc. and/or Plan Benefit Service, Inc.)

2. Person(s) or group of persons authorized to receive and use the information from Nationwide and/or Fringe.
   - Family and friends: check all that apply if you wish a family member or friend to be able to discuss your coverage and claims with Nationwide and/or Fringe, and to receive health information which Fringe and/or Nationwide maintains about you:

☐ Spouse: write in name and address _____

☐ Family member: write in name and address _____
Explain relationship if family member _____

☐ Friend(s) or other(s): write in name and address _____
Explain relationship if friend or "other" _____

3. Description of the information that may be used or disclosed:
   - All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition and any other Policy related information.

4. I understand that if the person or entity that receives the information described herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

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3. If the person completing this authorization is the personal representative of the insured or the dependent, describe your authority to act on this person's behalf, e.g., Power of Attorney.

   _____

4. I understand that I am not required to sign this authorization form and that Nationwide and/or Fringe will not condition initial enrollment or continued enrollment in the group health plan or the provision of payment to me on the signing of this authorization.

5. As described in the Notice of Privacy Practices, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Nationwide or Fringe in reliance on this authorization, by sending a written signed and dated revocation to Fringe or NHP. The Notice of Privacy Practices is available from Fringe or from NHP's web site at www.nationwidehealthplans.com.

6. I understand that either I or my personal representative, may receive a copy of this authorization upon request and that I may inspect or copy the information to be used or disclosed.

7. This authorization will expire 30 months from the date of signature if I am/have been declined for coverage or upon termination of my coverage under the Policy if I am/have been approved for coverage.

Insured's Signature: _____
Date: _____

Dependent's Signature, if applicable: _____
Date: _____

Personal Representative Name, if applicable: _____
(as described above in #5)

Personal Representative Signature _____
Date_____

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NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE MUTUAL INSURANCE COMPANY
Home Office: Columbus, Ohio

CHANGE OF BENEFICIARY FORM

This form only applies if you have purchased life insurance benefits.

Complete this form only if you desire to change the beneficiary provision contained in your enrollment form and certificate of coverage or you desire to cancel and replace a previous beneficiary designation.

Please type (or print with a ballpoint pen), except for signatures

Insured _____
(First) (Middle) (Last)

Plan Sponsor or Employer _____ Certificate Number (if applicable) _____
(Group Name)

I request that the following change(s) be made under Policy Number _____

	Name	Address	Telephone Number (XXX)XXX-XXXX	Relationship	Social Security Number XXX-XX-XXXX	Date of Birth XX-XX-XX
Change Beneficiary to:						

I understand that if a beneficiary change is shown above, it will take effect when I sign my name below - whether or not the insured is living when it is received by Nationwide. Such change is without prejudice to Nationwide for payment it may make or action it may take before it receives this form. Also, I reserve the right to change a beneficiary designated above unless I have indicated that it is "irrevocable".

I understand that if two or more beneficiaries are designated, any payment to them will be in equal shares to the survivor(s) - unless stated otherwise.

* If a trust is named as the beneficiary, the trustee's name and address must also be provided in the section. If the trustee changes, you must inform us and provide us with the updated information.

THIS BENEFICIARY DESIGNATION CANCELS AND SUPERSEDES ALL PREVIOUS REVOCABLE ONES.

Dated at _____ (City) (State) this _____ day of _____ year_____

_____
Witness (signature of a person other than a beneficiary)

_____
Signature of Certificateholder

_____
Street Address

_____
City State Zip

Mail completed forms to: **Fringe Benefit Group, Inc.**
11910 Anderson Mill Rd
Austin, TX 78726
Fax: 512-349-4770

WHEN THIS FORM IS RETURNED, PLEASE ATTACH IT TO THE INSURANCE CERTIFICATE (POLICY).

FOR NATIONWIDE ADMINISTRATOR'S USE ONLY
The recording of the change(s) requested above is acknowledged.
Plan Benefit Services, Inc.
Date _____By_____

State Fraud Notices

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

(Alaska) A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

(Arizona) Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

(Arkansas) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Colorado) It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

(Delaware) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

(District of Columbia) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Idaho) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Indiana) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Kentucky) Application Any person who knowingly and with intent to defraud any insurance company or other
person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

(Kentucky) Claim Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

(**Louisiana**) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Maine) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Minnesota) A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

(New Hampshire) Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

(New Jersey) Claim Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

(New Jersey) Application Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

(New Mexico) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

(Ohio) Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

(Oklahoma) WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Tennessee) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(Texas) Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Virginia) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(Washington) It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(West Virginia) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Nationwide Life Insurance Company
Columbus, Ohio

AMENDMENT NUMBER 2

WAIVER OF PREMIUMS

This form only applies if you have purchased the disability insurance benefit.

If an Insured becomes Totally Disabled as a result of a covered Injury or Illness, We will waive the payment of any future premiums for his and all dependent coverage associated with the plan. Premiums will be waived during the continuance of the disability until the first Premium Due Date following the earlier of:

A. The end of the Maximum Disability Benefit Period; or
B. The date the Insured is no longer Totally Disabled.

Thereafter, the coverage will continue only if:

A. The proper premium is paid; and
B. The Insured is otherwise eligible for coverage.

An Insured will be deemed to be no longer disabled 31 days after:

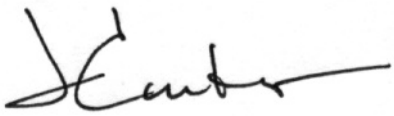
A. His or her refusal to be examined by a Physician of Our choice at Our expense; or
B. His or her refusal to provide the required proof of continuing Total Disability.

This Amendment is hereby accepted and deemed valid on the effective date of December 1, 2005.

Payment of premium on or after the effective date of the Amendment shall constitute acceptance by the Policyholder of the Policy modifications contained herein.

No other Policy provision or condition is changed in any way by this Amendment, except as described above.

Signed for the Company at Columbus, Ohio



John Carter
President
Nationwide Life Insurance Company

Nationwide Life Insurance Company

Columbus, Ohio

AMENDMENT NUMBER 1

This amendment forms a part of the Plan to which it is attached and amends such Plan in the manner indicated for GEORGIA residents only. Anything specifically stated in this amendment overrides anything to the contrary in the Plan, and will be subject to all other parts of the Plan.

1. The definition of "Dependent" for the Limited Medical Benefits is amended by the addition of the following Children" includes any child who is related to You without regard to the fact that:
   a. the child was born out of wedlock.
   b. the child is claimed as a dependent on Your federal tax return.

   Any requirement that a child must live with You to be considered an eligible Dependent does not apply. A child dependent on the other parent is considered an eligible Dependent. The proportion of the child's support that You provide does not affect the child's eligibility.

   If You are required by a court or administrative order to provide health coverage for Your children; You will be able to enroll such children.

2. The "How Will A Dependent Become a Covered?" provision is amended as follows:
   Any reference to"
   a. "newborn child" shall be deemed to include a "child placed for adoption".
   b. "birth" shall be deemed to include "placement".

3. The "When Will A Dependent Become a Covered?" provision is amended as follows:
   Any reference to"
   a. "newborn child" shall be deemed to include a "child placed for adoption".
   b. "birth" shall be deemed to include "placement".

4. The "Claims Forms" provision is amended as follows:
   The time period We have to give You a claim form is changed to 10 days.

5. The "Time Of Payment Of Claims" provision is amended by the addition of the following:
   We may fail to respond to a claim. Within 15 working days of receipt of proof of loss, We must mail the You a letter or notice explaining why the claim or any part has not been paid. The letter also has to include a list of any information needed to process the claim.

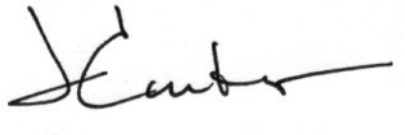
   When We have received this additional information, We have 15 working days to either pay or deny the claim. We must explain Our decision.

   If We do not meet all of the above conditions, We must pay You 18% interest per year. This applies only to benefits due under the Policy for which the above procedure has not been followed.

This amendment is hereby accepted and deemed valid on the effective date of September 1, 2004.

Payment of premium on or after the effective date of the Amendment shall constitute acceptance by the Policyholder of the Plan modifications contained herein.

No other Plan provision or condition is changed in any way by this amendment, except as described above.
Signed for the Company at Columbus, Ohio



John Carter
President
Nationwide Life Insurance Company

WOMEN'S HEALTH AND CANCER RIGHTS ACT

IMPORTANT NOTICE REGARDING HEALTH POLICIES PROVIDING COVERAGE FOR THE TREATMENT OF BREAST CANCER

Your health policy provides coverage for medically necessary mastectomies. If an insured person is receiving benefits under the plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications all stages of mastectomy, including lymphedemas.

Covered charges are subject to the plan benefit maximums. Call your plan administrator at (855) 495-1190 for more information.

Your current coverage may already provide the benefits for the treatment described above. This notice is provided to you in compliance with the federal Women's Health and Cancer Rights Act, which became effective on October 21, 1998. Nationwide will also comply with any laws in your state that apply to coverage of breast cancer treatment