

SERFF Tracking Number:	NWLC-125924217	State:	Arkansas
Filing Company:	Nationwide Life Insurance Company	State Tracking Number:	40985
Company Tracking Number:	K-12 FILING		
TOI:	H04 Health - Blanket Accident/Sickness	Sub-TOI:	H04.000 Health - Blanket Accident/Sickness
Product Name:	K-12 Filing		
Project Name/Number:	/		

Filing at a Glance

Company: Nationwide Life Insurance Company

Product Name: K-12 Filing

SERFF Tr Num: NWLC-125924217 State: ArkansasLH

TOI: H04 Health - Blanket Accident/Sickness

SERFF Status: Closed

State Tr Num: 40985

Sub-TOI: H04.000 Health - Blanket

Co Tr Num: K-12 FILING

State Status: Withdrawn

Accident/Sickness

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Bobby Handley, Jonna

Disposition Date: 12/04/2008

Shields

Date Submitted: 12/02/2008

Disposition Status: Withdrawn

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Blanket

Filing Status Changed: 12/04/2008

State Status Changed: 12/04/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This is an blanket accident only form that will provide coverage to students attending K-12 schools. It provides coverage while students are on school premises or participating in covered activities. There is also a voluntary 24-hour benefit available.

Company and Contact

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Product Name: K-12 Filing
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Filing Contact Information

Bobby Handley, Assistant General Counsel handleb2@nationwide.com
5525 Parkcenter Circle (614) 854-3375 [Phone]
Dublin, OH 43017 (614) 854-3469[FAX]

Filing Company Information

Nationwide Life Insurance Company CoCode: 66869 State of Domicile: Ohio
5525 Parkcenter Circle Group Code: 140 Company Type:
Dublin, OH 43017 Group Name: State ID Number:
(800) 525-8669 ext. 43508[Phone] FEIN Number: 31-4156830

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: Ohio charges \$50 per filing.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	\$50.00	12/02/2008	24256478

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Rosalind Minor	12/04/2008	12/04/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Rosalind Minor	12/03/2008	12/03/2008	Bobby Handley	12/04/2008	12/04/2008
Industry Response						

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Please withdraw this Filing	Note To Reviewer	Bobby Handley	12/04/2008	12/04/2008

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Project Name/Number: */*

Disposition

Disposition Date: 12/04/2008

Implementation Date:

Status: Withdrawn

Comment: The filing is being withdrawn as requested.

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Withdrawn	Yes
Supporting Document	Application	Withdrawn	Yes
Form (revised)	Student Accident Policy	Withdrawn	Yes
Form	Student Accident Policy	Withdrawn	Yes
Form	Application	Withdrawn	Yes

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Product Name: K-12 Filing
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 12/03/2008

Submitted Date 12/03/2008

Respond By Date

Dear Bobby Handley,

This will acknowledge receipt of the captioned filing.

Objection 1

- Student Accident Policy (Form)

Comment:

Under the "Notice" on Page 17, the address and phone number is incorrect for the Arkansas Insurance Department. Please change to read: 1200 West Third Street, Little Rock, AR 72201-1904.
Phone: (501) 371-2640.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 12/04/2008

Submitted Date 12/04/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Address and phone number have been changed.

Thank you, Bobby

Related Objection 1

SERFF Tracking Number: NWLC-125924217 State: Arkansas
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 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: K-12 Filing
 Project Name/Number: /

Applies To:
 - Student Accident Policy (Form)
 Comment:

Under the "Notice" on Page 17, the address and phone number is incorrect for the Arkansas Insurance Department. Please change to read: 1200 West Third Street, Little Rock, AR 72201-1904.
 Phone: (501) 371-2640.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Student Accident Policy	SRK12 2000 AR		Policy/Contract/Fraternal Certificate	Initial		50	SRK12 2000 AR.pdf
Previous Version							
Student Accident Policy	SRK12 2000 AR		Policy/Contract/Fraternal Certificate	Initial		50	SRK12 2000 AR.pdf

No Rate/Rule Schedule items changed.

Sincerely,
 Bobby Handley, Jonna Shields

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Product Name: *K-12 Filing*
Project Name/Number: /

Note To Reviewer

Created By:

Bobby Handley on 12/04/2008 02:12 PM

Subject:

Please withdraw this Filing

Comments:

Thank you,

Bobby

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Form Schedule

Lead Form Number: SRK12 2000 AR

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Withdrawn	SRK12 2000 AR	Policy/Cont Student Accident ract/Fratern Policy al Certificate	Initial		50	SRK12 2000 AR.pdf
Withdrawn	SRK12 2300	Application/ Application Enrollment Form	Initial		0	SRK12 2300 .pdf



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

BLANKET STUDENT ACCIDENT POLICY

On Your Side®

Policy Number: [00123456]

Policyholder: [ABC School]

Blanket Coverage Effective Date: [1/1/2007]

Expiration Date: [12/31/2007]

Voluntary Coverage Effective Date: [1/1/2007]

Expiration Date: [12/31/2007]

<u>Premium Type</u>	<u>Policy Type</u>	<u>Premium Rate</u>
Voluntary Extended Dental	Dental	[\$ 8.00]
Voluntary School Time	Plan 1	[\$ 65.00]
Voluntary 24 Hour	Plan 1	[\$135.00]
Voluntary School Time	Plan 2	[\$ 45.00]
Voluntary 24 Hour	Plan 2	[\$ 99.00]
Voluntary School Time	Plan 3	[\$ 30.00]
Voluntary 24 Hour	Plan 3	[\$ 75.00]

[Interscholastic Sports and Activities]

[Plan]

This Policy is issued to the Policyholder by Nationwide Life Insurance Company on the Effective Date at 12:01 a.m. standard time at Policyholder's address. The Policyholder and Effective Date are shown on the Schedule of Benefits.

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

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

Nationwide Life Insurance Company

President

READ YOUR POLICY CAREFULLY.

**ONE YEAR NON-RENEWABLE TERM
BLANKET POLICY PROVIDING
ACCIDENT INJURY COVERAGE**

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ELIGIBILITY AND TERMINATION PROVISIONS

VOLUNTARY SCHOOL TIME COVERAGE

Each Covered Person for whom the premium for Voluntary School Time Coverage has been paid will be covered for Injury which occurs:

1. On or after the later of the following dates:
 - a. The effective date of the Policy for all students that remit the enrollment form and correct premium to the Company before September 1;
 - b. The date the enrollment form and correct premium are received by the Company for those students who remit the enrollment form and premium after September 1.
2. On or before the last day of the regular school term, including summer school. (Must be school sponsored and supervised.)
3. During the regular school term while the Covered Person is:
 - a. On the school premises during the hours when school is in session; or during the hours when school is not in session if he is participating in or attending any School-Sponsored and Supervised Activity;
 - b. Away from the premises if he is participating in or attending any School-Sponsored and Supervised Activity;
 - c. Traveling directly and uninterruptedly to or from his Residence and the school Premises on days when he has regularly scheduled classes or work; if travel is by any mode of transportation other than the school bus, travel time will be limited to one hour before his first class or the beginning of his work period (school employees only) and one hour after he is dismissed or his work period ends; or
 - d. Traveling directly, uninterruptedly and under the direct supervision of a qualified adult school authority to or from a School-Sponsored and Supervised Activity in a vehicle furnished by the school.

VOLUNTARY 24-HOUR COVERAGE

Each Covered Person for whom the Premium for Voluntary 24-Hour Coverage has been paid will be covered for Injury which occurs:

1. On or after the later of the following dates:
 - a. The effective date of the Policy for all students that remit the enrollment form and correct premium to the Company on or before September 1;
 - b. The date the enrollment form and correct premium are received by the Company for those students who remit the enrollment form and premium after September 1.
2. On or before one year after the date the school year began.

JV/VARSITY VOLUNTARY FOOTBALL COVERAGE

Each Covered Person for whom the Premium for Voluntary Football Coverage has been paid will be covered for Injury while practicing for or operating in regularly scheduled high school football which occurs:

1. For voluntary or waiver coverage, on or after the first day of practice as defined by the state governing body, provided a list of football players to be insured is postmarked by the Post Office within 15 days of the first practice. Otherwise, coverage will be effective the date the list of football players and correct premium are postmarked by the Post Office.
2. For mandatory, voluntary or waiver coverage, on or before the last day of the regularly scheduled football season including play-off games and Spring Training (with contact).

Spring Football: For those Covered Persons who participate in Spring Training, the term of coverage for "Football Coverage" expiring December 31, is hereby amended as to the expiration date to be May 31. For those new players who participate in Spring Training and who are not already insured under the School's blanket coverage, the additional premium charged will be 40% of the regular premium charged for Football Coverage.

The insured School District warrants that Spring Training shall be restricted and limited to the rules promulgated by the State High School Athletic Association, and in lieu of reporting the actual dates in advance, the school authority shall maintain a register of actual days practiced which shall be available for inspection by the Company, on demand, at all reasonable times.

EXTENDED DENTAL COVERAGE

Each Covered Person enrolled in "School Time", "24-Hour", "Football", or "Interscholastic" coverage is eligible to purchase this benefit. By adding an additional premium to the base plan rates, dental benefits may be extended under the overall maximum benefit to provide payment of covered expenses to a maximum of \$5,000.00. The additional benefit provides payment for the usual and customary expenses incurred within 1 year from the date of Covered accident for treatment, repair or replacement of each injured, natural tooth, including examination, diagnosis, X-rays, restorative treatment, endodontics, and oral surgery, plus for the replacement of caps, crowns, dentures and orthodontic appliances. Coverage is in effect 24 hours a day even when selected with School Time coverage. If there is more than one way to treat a dental problem, the Company will pay benefits for the least expensive procedure provided that it meets acceptable dental standards.

BLANKET INTERSCHOLASTIC COVERAGE

Note: If specified as Blanket Interscholastic Coverage, all premium will be paid by the Policyholder.

Each Covered Person for whom the premium for Blanket Interscholastic Coverage has been paid by the Insured will be covered under the specified Schedule of Benefits for Injures as outlined under the "Coverage Options" listed below.

Blanket Interscholastic Coverage does not cover normal classroom activities, intramural activities or Physical Education classes and is restricted to interscholastic athletics and activities as defined and sanctioned by the state interscholastic governing body. Spring Training, off-season workouts and play-off games as defined by the state interscholastic governing body are included under the Blanket Interscholastic Coverage Options.

Coverage becomes effective on the date specified by the state interscholastic governing body as the first official day of practice for each interscholastic sport and/or associated activity.

All coverage options expire the last day of the spring term with the exception of the state interscholastic governing body sanctioned competitions that extend beyond the last day of the regular school term, including summer school.

Blanket Coverage Options may include one of the following options, extending to applicable grade levels:

1. JV/Varsity Football Only - Benefits will be paid for Injuries sustained by a Covered Person while:

- a) Actually engaged, as an official representative of the Policyholder, in the play or practice of Football under the supervision of a regularly employed coach or trainer of the Policyholder, including managers and trainers; and
- b) Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the scheduled play or practice of Football.

2. Interscholastic Sports Only - Benefits will be paid for Injuries sustained by a Covered Person while:

- a) Actually engaged, as an official representative of the Policyholder, in the play or practice of Interscholastic Athletics under the supervision of a regularly employed coach or trainer of the Policyholder. Interscholastic Athletics must be School sponsored and supervised.
- b) Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the Interscholastic Athletic competitions.

3. Interscholastic Sports and Activities - Benefits will be paid for Injuries sustained by a Covered Person:

- a) Actually engaged, as an official representative of the Policyholder, in the play or practice of Interscholastic Sports and Activities under the supervision of a qualified adult school authority. Interscholastic Sports and Activities must be School sponsored and supervised.
- b) Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the designated interscholastic sport or activity; travel time will be limited to one hour before the interscholastic activity begins and one hour after the activity ends.

4. All School Plan – Benefits will be paid for injuries sustained by a covered person while school is in session:

- a) While attending or participating in a school sponsored and supervised activity on or off the school premises.
- b) Participation in interscholastic sports and football (where applicable).
- c) Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the designated interscholastic sport or activity; travel time will be limited to one hour before the interscholastic activity begins and one hour after the activity ends.

GENERAL PROVISIONS

Entire Contract, Changes: This policy including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. All statements made by the Policyholder or by a covered person shall, in absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under this policy, unless it is contained in a written application and a copy of the application has been furnished to the Policyholder.

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

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

Notice of Claim: Written notice of claim must be given to the Company within [30 minimum; 90 maximum] days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Covered Person or the beneficiary to the Company at [P.O. Box 702348, Dallas, Texas 75370-2348], or to any authorized agent of the Company, with information sufficient to identify the Covered Person shall be deemed notice to the Company.

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

Proof of Loss: Written proof of loss must be furnished to the Company, GM – Southwest, [P.O. Box 702348, Dallas, Texas 75370-2348], in case of claim for loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims: Indemnities payable under this Policy for any loss will be paid upon receipt of due written proof of such loss.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation, if any. If no such designation is effective, such indemnity shall be payable to the estate of the insured.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1000, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

All or a portion of any indemnities provided by this Policy may, at the Company's option, and unless the Covered Person requests otherwise in writing not later than the time of filing proofs of such loss, be paid

directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Covered Person or the Estate of the Covered Person.

Physical Examination: The company at its own expense shall have the right and opportunity to examine the person of any Covered Person when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the Covered Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Illegal Occupation: The Company shall not be liable for any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person's being engaged in an illegal occupation.

Narcotics: The Company shall not be liable for any loss sustained or contracted in consequence of the Covered Person's being under the influence of any narcotic unless administered on the advice of a Physician.

Subrogation: The Company shall be subrogated to all rights of recovery which any Covered Person has against any person, firm or corporation to the extent of payments for Benefits made by the Company to or for benefit of a Covered Person. The Covered Person shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

Policy Termination: We may terminate coverage any time after the First Policy Term provided at least 31 days written notice is given.

The Policyholder may terminate its coverage any time after the First Policy Term provided at least 31 days prior written notice is given. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

Termination will not affect a claim for covered loss due to an Accident which occurred while coverage was in effect.

Notice: If you wish to contact the Arkansas Department of Insurance, you may do so at 1200 W. Third Street, Little Rock, Arkansas 72201-1904. The phone numbers are 1-800-852-5494 or 501-371-2640.

PREMIUM PROVISIONS

Grace Period:

A grace period of not less than 31 days is granted for each premium due after the first. Coverage will stay in force during this period unless notice has been sent, in accordance with the Policy Termination provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the grace period.

Reporting Requirements:

The Policyholder or its authorized agent must report to Us, by the premium due date:

- (1) the names of all persons insured on the Policy Effective Date;
- (2) the names of all persons who are insured after the Policy Effective Date;
- (3) the names of those persons whose insurance has terminated; and
- (4) additional information required as agreed to by Us and the Policyholder.

This information may be waived, if agreed to by the Policyholder and Us.

DEFINITIONS

Covered Medical Expenses means reasonable charges which are: 1) not in excess of Usual and Customary charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are Medically Necessary; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Person is any registered student or employee of the Policyholder for whom the appropriate premium has been paid.

Insurance coverage for a Covered Person is non-cancelable. A Covered Person insured under the 24-Hour Coverage provision remains protected under the Policy even though his schooling or employment may be discontinued with the Policyholder. A Covered Person insured under the School Time coverage provision may transfer to any school in the United States and Canada and still be covered, but in either case, subject to the Policy provisions and limitations herein applicable to all Covered Persons under this Policy.

Deductible means if an amount is stated in the Schedule of Benefits or any endorsement to this Policy as a deductible, it shall mean an amount to be subtracted from the amount(s) otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury) as specified in the Schedule of Benefits.

Dentist means a Doctor of Medical Dentistry (D.M.D.) or a Doctor of Dental Surgery (D.D.S.) (other than a member of the Covered Person's family or any person employed or retained by the Policyholder.)

Diagnostic Imaging – means those forms of radiographs that are not plain film radiography (x-rays). It includes but is not limited to: computerized axial tomography (CAT); magnetic resonance imaging (MRI); radionuclid imaging (nuclear medicine) and ultrasound (US). These examinations may be performed with or without contrast materials.

Durable Medical Equipment – means equipment which can be rented, leased or purchased and which is designed to provide treatment and/or support for an extended period of time. It includes but is not limited to: CPM machines, drug pumps; and H2O pumps.

Excess Provision – means no benefits are payable under this coverage for any expense incurred for Injury which is paid or payable by: 1) other valid and collectible insurance; or 2) under an automobile insurance policy. (This limitation will not be applied to the first \$150 of medical expenses incurred). Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Covered Person failing to comply with policy provisions or requirements.

Hospital means an institution operated pursuant to law for the care and treatment of sick or injured persons, with organized facilities for diagnosis and surgery within the confines of the institution and

having 24 hour nursing service. Hospital does not include (1) a convalescent unit within or affiliated with the hospital, (2) a clinic, (3) a nursing, rest or convalescent home or (4) an institution operated primarily for care of the aged or treatment of mental disease, drug addiction or alcoholism.

Hospital Confined/Hospital Confinement means confined in a Hospital for at least 18 hours by reason of an Injury for which benefits are payable.

Injury – means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional or structural disorder; 3) a source of loss; and sustained while the Covered Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury.

The term Injury also means a re-injury sustained while the Insured is covered under this Policy for which the Insured has remained treatment free for a period of 180 days prior to the Policy Effective Date. If benefits have been paid under this Policy for any Injury, a re-injury will be considered new if:

- a) the re-injury occurs while the Insured is covered under this Policy; and
- b) the Insured remains treatment free for a period of 180 days between the date of the last treatment for the original Injury and the date of the new Injury.

A re-injury that is incurred within 180 days of the original Injury will be considered a continuation of the original Injury.

Medically Necessary means those services or supplies provided or prescribed by a Hospital or Physician, which are: 1) Essential for the symptoms and diagnosis or treatment of the injury; and 2) Provided for the diagnosis, or the direct care and treatment of the injury.

Nurse means a registered graduated professional nurse (R.N.), (other than a member of the Covered Person's family or any person employed or retained by the Policyholder).

Physician shall mean only a legally qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or Doctor of Podiatry (D.P.) or Doctor of Chiropractic (D.C.) or Doctor of Optometry (O.D.) other than a relative of the Covered Person by blood or marriage who is duly licensed as such by the proper state authorities and who is acting within the scope of such license.

Physical Therapy means physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form, manipulation or massage administered by a Physician or physiotherapist acting within the scope of their license.

Prescription Drug means a drug which has been determined to be safe and effective by the Food and Drug Administration and which can, under federal or state law, only be dispensed when ordered by a Physician who is duly licensed to prescribe such medication.

Residence means the premises on which the dwelling place of the Covered Person is located.

School-Sponsored Activity means any school function which is scheduled by the school and which is under the direct supervision of a qualified adult school authority.

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

Usual and Customary means the fee(s) for medical services or supplies which is (are): (1) the usual fee(s) charged by the provider for the service or supply given, (2) the average fee charged for the service or supply in the locality in which the service or supply is received, and (3) reasonable in relationship to the service or supply given and the severity of the condition. No payment will be made under this policy for any expenses incurred which in the judgement of the Company are in excess of usual and customary.

COVERED LOSS – TIME LIMITS

Covered Medical Expenses will be paid under the Schedule of Benefits for loss due to Injury to a Covered Person provided treatment by a Physician: a) begins within 90 days after the date of Injury; and b) is received within 52 weeks after the date of Injury.

MEDICAL EXPENSE BENEFITS – ACCIDENT ONLY

Benefits are payable for Covered Medical Expenses (see “Definitions”) less any Deductible incurred by or for a Covered Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) if any, the coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the “Definitions” section and the “Exclusions and Limitations” section carefully. No benefits will be paid for services designated as “No Benefits” in the Schedule of Benefits or for any matter described in “Exclusions and Limitations”. If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged for by the Hospital.
2. **Hospital Miscellaneous Expenses:** 1) while Hospital confined; or 2) as a precondition for being Hospital confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. If a specific benefit is designated in the Schedule of Benefits for any of these miscellaneous services, no benefits will be paid in excess of the maximum specified therein. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
3. **Surgery:** Physician’s fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this inpatient surgery benefit; or under the outpatient surgery benefit, but not both. If two or more procedures are performed through the same incision at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.
4. **Assistant Surgeon’s fees:**
5. **Anesthetist Services:** in connection with inpatient surgery. Benefits will be paid for the Physician who performs the actual administration of the anesthesia. No benefits will be paid for supervision of an anesthetist.
6. **Registered Nurse’s Services:** 1) private duty nursing care only; 2) while Hospital confined; and 3) ordered by a licensed Physician. General nursing care provided by the Hospital is not covered under this benefit.
7. **Physician’s Visits:** when hospital confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.

8. **Surgery (Outpatient); Physician's fees for outpatient surgery.** Payment will be made based upon the surgical the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this outpatient surgery benefit; or under the inpatient surgery benefit, but not both. If two or more procedures are performed through the same incision at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.
9. **Day Surgery Miscellaneous (Outpatient);** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; x-ray examinations; anesthesia; drugs or medicines; therapeutic services and supplies.
10. **Anesthetist (Outpatient):** in connection with outpatient surgery. Benefits will be paid for the Physician who performs the actual administration of anesthesia. No benefits will be paid for supervision of an anesthetist.
11. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physical Therapy.
12. **Physical Therapy (Outpatient):** benefits are limited to one visit per day.
13. **Emergency Room (Outpatient):** use of the room, supplies, and all other charges with the exception to MRI, X-rays/Diagnostic Testing, and Lab for which an additional benefit is provided. Treatment must be rendered within 72 hours.
14. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.
15. **Orthopedic Braces and Appliances:** 1) when prescribed by a Physician; and 2) a written Prescription accompanies the claim when submitted. Replacement orthopedic braces and appliances are not covered. Orthopedic braces and appliances include durable, medical equipment which is equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of purchase price.
16. **Dental Treatment:** 1) performed by a Physician practicing within the scope of his license; and 2) made necessary by Injury to sound, natural teeth.
17. **Consultant Physician Fees:** when requested and approved by the attending Physician.
18. **Re-injury** will be covered if the insured has been treatment free for a period of 180 days (6 months) prior to the effective date of the policy.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If such injury shall independently of all other causes and within 365 days from the date of accident solely result in any one of the following specific losses, THIS BENEFIT IS PAID IN ADDITION TO THE MEDICAL EXPENSE BENEFITS. **For loss of:**

Life	[\$5,000]
Both hands or both feet or the sight of both eyes	[\$5,000]
One hand and one foot	[\$5,000]

One hand and the sight of one eye	[\$5,000]
One foot and the sight of one eye	[\$5,000]
One hand or one foot or the sight of one eye	[\$5,000]

Loss means with regard to hands and feet, actual severance through or above the wrist or ankle joint; with reference to the eye, the irrecoverable loss of its entire sight. If more than one loss results from any one accident, only one amount, the largest, will be paid.

Severance means the complete separation and dismemberment of the part from the body. If more than one loss results from any one accident, only one amount, the largest, will be paid.

HOME HEALTH CARE BENEFIT

We will pay the Eligible Expenses incurred for the services and supplies shown below which are furnished to a Covered Person at home by the Home Health Care Agency for care in keeping with a Home Health Care Plan. Benefits will be limited to the Maximum Benefit Amount as shown on the Schedule of Benefits under the Accident Medical Expense Benefit.

Eligible Expenses include:

- 1) skilled nursing by a registered Nurse or licensed vocational Nurse under the supervision of at least one registered nurse and at least one Doctor;
- 2) physical, occupational, speech or respiratory therapy;
- 3) the service of a Home Health Aide under the supervision of a registered Nurse; and;
- 4) the furnishing of medical equipment and medial supplies other than drugs and medicines.

Coverage is provided for a maximum of 10 Home Health Care visits per policy period.

Each visit by a Home Health Care Agency employee constitutes a Home Health Care visit and each four hours of Home Health Aide services constitutes a Home Health Care visit. If service extends beyond four hours, each four hours or portion of that period is considered as one Home Health Care visit.

Benefits are subject to the Deductible Amount and Coinsurance Percentage, if any.

Home Health Care Expenses will not include:

- 1) Charges for services by a person who usually resides in the Covered Person's home or is a member of the Covered Person's family.
- 2) Charges incurred while the Covered Person is not under the care of a Doctor.
- 3) Charges in excess of the Usual and Customary charges or charges for unnecessary care or treatment. Also, no payment will be made for expenses incurred for or in connection with custodial care.
- 4) Charges for services or supplies not specified in the Home Health Care Plan.

Definitions

- 1) "Home Health Service" means the provision of a health service for payment or other consideration in a patient's residence under a plan of care established, approved in writing, and reviewed at least once every two months by the attending physician and certified by the attending Doctor as necessary for medical purposes.
- 2) "Home Health Aide" means a person who provides care of a medical or therapeutic nature and who reports to, and is under the direct supervision of a Home Health Care Agency.
- 3) "Home Health Care Agency" means a business that provides Home Health Services and is licensed by the appropriate state licensing authority.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1. Services or treatment rendered by a physician, nurse or any other person who is: 1) employed or retained by you; or 2) who is the insured or a member of his/her immediate family.
2. Charges which: 1) the insured would not have to pay if he/she did not have insurance; or 2) are in excess of Usual and Customary expenses.
3. Any injury that is: 1) intentionally self-inflicted, suicide or attempt thereat; or 2) caused by war or any act of war; or 3) is caused while the insured is serving full-time active duty (more than 31 days) in any Armed Forces; or 4) caused by taking part in a riot or insurrection.
4. Any injury that is caused by air travel except while as a fare-paying passenger on a regularly scheduled commercial air carrier; travel in or upon, sitting in or upon, alighting to or from, or working on or around any motorcycle, recreational vehicle or any motorized or engine driven vehicle not designed primarily for use on public streets and highways including but not limited to: two-or-three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; or snowmobile.
5. Any accident where the insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
6. An injury for which the insured is covered under state or federal worker's compensation or employer's liability or occupational disease laws or any other party liability coverage.
7. That part of medical expenses payable by any automobile insurance policy without regard to fault (does not apply in any state that prohibits such limitation).
8. An injury that is: 1) the result of the insured being intoxicated (Intoxicated shall be determined according to the laws of the jurisdiction in which the injury occurred.); 2) caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a physician; or 3) insured's taking part in committing or attempting to commit a felony.
9. A sickness or disease or diagnostic test or treatment, (except infection which occurs directly from an accidental cut or wound, or ingestion of contaminated food), aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physical infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics, injuries involving bone cysts or dental implants.
10. Play or practice of junior varsity or varsity interscholastic high school football (in which 10th, 11th or 12th grade students participate) or college football; except where a specific additional premium is paid.
11. No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations section of this policy.

SCHEDULE OF BENEFITS -VOLUNTARY ONLY

Maximum Benefit \$25,000 (For each injury)
52 Week Benefit Period, Primary Excess \$150

Plan 1

The Benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

In-Patient

[Room & Board:]	[90% of Usual & Customary up to \$500 per day]
[Hospital Miscellaneous:]	[90% of Usual & Customary to a \$3,500 maximum]
[X-Rays:]	[\$500 maximum]
[Physical Therapy:]	[\$35 per visit /\$350 maximum]
[Surgery:]	[90% of Usual & Customary to a \$3,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Physician's Visits:]	[\$45 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	

Outpatient

[Surgery:]	[90% of Usual & Customary to a \$3,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Day Surgery Miscellaneous:]	[\$1,250 maximum]
[(Facility Charge)]	
[Physician's Visits:]	[\$45 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	
[Physical Therapy:]	[\$35 per visit /\$350 maximum]
[Emergency Room:]	[90% of Usual & Customary to a \$300 maximum]
[(Use of Room and Supplies:)] [Treatment must be rendered within 72 hours from time of injury)]	
[X-rays, Diagnostic Testing:]	[\$500 maximum]
[Lab:]	[100% of Usual & Customary]

Other

[Ambulance:]	[90% of Usual & Customary to a \$800 maximum]
[Orthopedic Braces & Appliances:]	[90% of Usual & Customary to a \$500 maximum]
[Dental:]	[\$500 per tooth]
[Neurological Consultant:]	[\$150 per visit]
[Anesthetist:]	[90% of Usual & Customary to a \$600 maximum]
[Assistant Surgeon:]	[90% of Usual & Customary to a \$600 maximum]
[MRI/CT Scan:]	[90% of Usual & Customary to a \$1,000 maximum]
[Eyeglasses, Contact Lens, and Hearing Aids:]	[\$500 maximum]
[Prescriptions:]	[\$200 maximum]
[Home Health Care:]	[10 visits /\$50 per visit]
[Injections:]	[\$15 per visit /\$75 maximum]

No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations portion of the policy.

SCHEDULE OF BENEFITS - VOLUNTARY ONLY

**Maximum Benefit \$25,000 (For each injury)
52 Week Benefit Period, Primary Excess \$150**

Plan 2

The Benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

In-Patient

[Room & Board:]	[80% of Usual & Customary up to \$250 per day]
[Hospital Miscellaneous:]	[80% of Usual & Customary to a \$2,500 maximum]
[X-rays:]	[\$300 maximum]
[Physical Therapy:]	[\$35 per visit /\$350 maximum]
[Surgery:]	[80% of Usual & Customary to a \$2,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Physician's Visits:]	[\$35 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	

Outpatient

[Surgery:]	[80% of Usual & Customary to a \$2,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Day Surgery Miscellaneous:]	[\$1,000 maximum]
<i>(Facility Charge)</i>	
[Physician's Visits:]	[\$35 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	
[Physical Therapy:]	[\$35 per visit /\$350 maximum]
[Emergency Room:]	[\$200 maximum]
[(Use of Room and Supplies: Treatment must be rendered within 72 hours from time of injury)]	
[X-rays, Diagnostic Testing:]	[\$300 maximum]
[Lab:]	[90% of Usual & Customary]

Other

[Ambulance:]	[80% of Usual & Customary to a \$600 maximum]
[Orthopedic Braces & Appliances:]	[80% of Usual & Customary to a \$300 maximum]
[Dental:]	[\$350 per tooth]
[Neurological Consultant:]	[\$100 maximum]
[Anesthetist:]	[80% of Usual & Customary to a \$500 maximum]
[Assistant Surgeon:]	[80% of Usual & Customary to a \$500 maximum]
[MRI/Cat Scan:]	[80% of Usual & Customary to a \$600 maximum]
[Eyeglasses, Contact Lens and Hearing Aids:]	[\$300 maximum]
[Prescriptions:]	[\$100 maximum]
[Home Health Care:]	[10 visits /\$50 per visit]
[Injections:]	[\$15 per visit /\$75 maximum]

No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations portion of the policy.

SCHEDULE OF BENEFITS - VOLUNTARY ONLY

Maximum Benefit \$25,000 (For each injury)
52 Week Benefit Period, Primary Excess \$150

Plan 3

The Benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

In-Patient

[Room & Board:]	[\$150 per day]
[Hospital Miscellaneous:]	[\$1,500 maximum]
[X-rays:]	[\$150 maximum]
[Physical Therapy:]	[\$150 maximum]
[Surgery:]	[\$1,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Physician's Visits:]	[\$25 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	

Outpatient

[Surgery:]	[\$1,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Day Surgery Miscellaneous:]	[\$750 maximum]
[(<i>Facility Charge</i>)]	
[Physician's Visits:]	[\$25 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	
[Physical Therapy:]	[\$25 per visit to a \$150 maximum]
[Emergency Room:]	[\$100 maximum]
[(Use of Room and Supplies: Treatment must be rendered within 72 hours from time of injury)]	
[X-rays, Diagnostic Testing:]	[\$150 maximum]
[Lab:]	[80% of Usual & Customary]

Other

[Ambulance:]	[\$350 maximum]
[Orthopedic Braces & Appliances:]	[\$200 maximum]
[Dental:]	[\$200 per tooth]
[Neurological Consultant:]	[\$50 maximum]
[Anesthetist:]	[\$300 maximum]
[Assistant Surgeon:]	[\$300 maximum]
[MRI/Cat Scan:]	[\$350 maximum]
[Eyeglasses, Contact Lens, and Hearing Aids:]	[\$200 maximum]
[Prescriptions:]	[\$75 maximum]
[Home Health Care:]	[10 visits /\$50 per visit]
[Injections:]	[\$15 per visit /\$75 maximum]

No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations portion of the policy.

Notice

You may contact Us at the following:

Nationwide Life Insurance Company
[5525 Parkcenter Circle,
Dublin, Ohio 43017]

[1-800-xxx-xxxx]

If we fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
[1200 West Third Street, Little Rock, AR 72201-1904.
Phone: (501) 371-2640.]

Application For Student Accident Insurance Policy

Underwritten By:

Nationwide Life Insurance Company (NW)

Policy Number _____

School or District _____ District UIL Class _____

Mailing Address _____ City _____ State _____ Zip _____

Contact Person _____ Title _____

Phone # _____ Fax # _____ E-Mail _____

Date of First Scheduled Sport/Activity _____ Date School begins _____

Plan Selected _____ Deductible \$ _____

OPTION 1: Blanket Athletic/Activities Coverage (premium paid by School)

A. JV / Varsity Football Only: \$ _____

B. Interscholastic Sports Only: \$ _____ Grades _____

C. Interscholastic Sports and Activities \$ _____ Grades _____

OPTION 2: All School Plan (premium paid by School)

\$ _____ # of students _____

OPTION 3: JV/Varsity Football

\$ _____ per player

Voluntary Accident Medical Coverage (premium paid by parent/guardian)

	Plan 1	Plan 2	Plan 3	Dental (optional)
24 – Hour	[\$125.00]	[\$85.00]	[\$60.00]	[\$8.00]
School Time	[\$ 65.00]	[\$45.00]	[\$30.00]	[\$8.00]
24 – Hour (Upgrade)	[\$ 75.00]	[\$55.00]	[\$35.00]	[\$8.00]

Date supplies needed _____ (Attach instructions if requesting shipment to more than one address/location)

Shipping Address _____ City _____ State _____ Zip _____

We hereby apply to Nationwide Life Insurance Company for a Student Accident Policy. We understand that insurance will be in force if this Application is accepted by the Company, and the required premium is received by the Company when due. **Make check payable to Nationwide.**

Signature of School Official _____ Date Signed _____

Print Name and Title _____ Phone _____

Agent Signature _____

PLAN ADMINISTRATOR

GM-Southwest

P.O. Box 803422

Dallas, TX 75380-3422

Fax – (972) 404-0722 (800) 381-4517

www.gmsouthwest.com

(Office Use Only) Date Master Policy Issued _____

SERFF Tracking Number: NWLC-125924217 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 40985
Company Tracking Number: K-12 FILING
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
Product Name: K-12 Filing
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: NWLC-125924217 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 40985
Company Tracking Number: K-12 FILING
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
Product Name: K-12 Filing
Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status:

Withdrawn

12/04/2008

Comments:

Attachments:

Read Cert.pdf

Certification of Compliance.PDF

Satisfied -Name: Application

Review Status:

Withdrawn

12/04/2008

Comments:

Application is included under the Form Schedule.

CERTIFICATION OF COMPLIANCE WITH
INSURANCE POLICY SIMPLIFICATION REQUIREMENTS

Name and Address of Insurer:

Nationwide Life Insurance Company
5525 Parkcenter Circle
Dublin, OH. 43017-3584
Mail Code: CO-01-30

Policy/Certificate Form Number(s):

SRK12 2000	Policy
SRK12 2300	Application

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with the Flesch reading ease score and the other requirements set forth in the Insurance Policy Language Simplification Act of the State of Arkansas.



Tom DeNoma
Associate Vice President

Date: December 2, 2008

CERTIFICATION OF COMPLIANCE

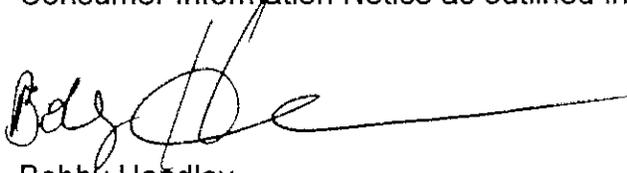
Name and Address of Insurer:

Nationwide Life Insurance Company
5525 Parkcenter Circle
Dublin, OH. 43017-3584
Mail Code: CO-01-30

Policy/Certificate Form Number(s):

SRK12 2000 *AR*
SRK12 2300

I certify that, to the best of my knowledge and belief, the policy/certificate forms are in compliance with Arkansas Rule/Regulation 19, Arkansas Rule/Regulation 49 and the Consumer Information Notice as outlined in ACA 23-79-138.

A handwritten signature in black ink, appearing to read "Bobby Handley", with a long horizontal line extending to the right.

Bobby Handley
Assistant General Counsel

Date: December 2, 2008

SERFF Tracking Number: NWLC-125924217 State: Arkansas
 Filing Company: Nationwide Life Insurance Company State Tracking Number: 40985
 Company Tracking Number: K-12 FILING
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: K-12 Filing
 Project Name/Number: /

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Student Accident Policy	12/01/2008	SRK12 2000 AR.pdf



Nationwide Life Insurance Company

Home Office: Columbus, Ohio

BLANKET STUDENT ACCIDENT POLICY

On Your Side®

Policy Number: [00123456]

Policyholder: [ABC School]

Blanket Coverage Effective Date: [1/1/2007]

Expiration Date: [12/31/2007]

Voluntary Coverage Effective Date: [1/1/2007]

Expiration Date: [12/31/2007]

<u>Premium Type</u>	<u>Policy Type</u>	<u>Premium Rate</u>
Voluntary Extended Dental	Dental	[\$ 8.00]
Voluntary School Time	Plan 1	[\$ 65.00]
Voluntary 24 Hour	Plan 1	[\$135.00]
Voluntary School Time	Plan 2	[\$ 45.00]
Voluntary 24 Hour	Plan 2	[\$ 99.00]
Voluntary School Time	Plan 3	[\$ 30.00]
Voluntary 24 Hour	Plan 3	[\$ 75.00]

[Interscholastic Sports and Activities]

[Plan]

This Policy is issued to the Policyholder by Nationwide Life Insurance Company on the Effective Date at 12:01 a.m. standard time at Policyholder's address. The Policyholder and Effective Date are shown on the Schedule of Benefits.

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

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

Nationwide Life Insurance Company

President

READ YOUR POLICY CAREFULLY.

**ONE YEAR NON-RENEWABLE TERM
BLANKET POLICY PROVIDING
ACCIDENT INJURY COVERAGE**

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ELIGIBILITY AND TERMINATION PROVISIONS

VOLUNTARY SCHOOL TIME COVERAGE

Each Covered Person for whom the premium for Voluntary School Time Coverage has been paid will be covered for Injury which occurs:

1. On or after the later of the following dates:
 - a. The effective date of the Policy for all students that remit the enrollment form and correct premium to the Company before September 1;
 - b. The date the enrollment form and correct premium are received by the Company for those students who remit the enrollment form and premium after September 1.
2. On or before the last day of the regular school term, including summer school. (Must be school sponsored and supervised.)
3. During the regular school term while the Covered Person is:
 - a. On the school premises during the hours when school is in session; or during the hours when school is not in session if he is participating in or attending any School-Sponsored and Supervised Activity;
 - b. Away from the premises if he is participating in or attending any School-Sponsored and Supervised Activity;
 - c. Traveling directly and uninterruptedly to or from his Residence and the school Premises on days when he has regularly scheduled classes or work; if travel is by any mode of transportation other than the school bus, travel time will be limited to one hour before his first class or the beginning of his work period (school employees only) and one hour after he is dismissed or his work period ends; or
 - d. Traveling directly, uninterruptedly and under the direct supervision of a qualified adult school authority to or from a School-Sponsored and Supervised Activity in a vehicle furnished by the school.

VOLUNTARY 24-HOUR COVERAGE

Each Covered Person for whom the Premium for Voluntary 24-Hour Coverage has been paid will be covered for Injury which occurs:

1. On or after the later of the following dates:
 - a. The effective date of the Policy for all students that remit the enrollment form and correct premium to the Company on or before September 1;
 - b. The date the enrollment form and correct premium are received by the Company for those students who remit the enrollment form and premium after September 1.
2. On or before one year after the date the school year began.

JV/VARSITY VOLUNTARY FOOTBALL COVERAGE

Each Covered Person for whom the Premium for Voluntary Football Coverage has been paid will be covered for Injury while practicing for or operating in regularly scheduled high school football which occurs:

1. For voluntary or waiver coverage, on or after the first day of practice as defined by the state governing body, provided a list of football players to be insured is postmarked by the Post Office within 15 days of the first practice. Otherwise, coverage will be effective the date the list of football players and correct premium are postmarked by the Post Office.
2. For mandatory, voluntary or waiver coverage, on or before the last day of the regularly scheduled football season including play-off games and Spring Training (with contact).

Spring Football: For those Covered Persons who participate in Spring Training, the term of coverage for “Football Coverage” expiring December 31, is hereby amended as to the expiration date to be May 31. For those new players who participate in Spring Training and who are not already insured under the School’s blanket coverage, the additional premium charged will be 40% of the regular premium charged for Football Coverage.

The insured School District warrants that Spring Training shall be restricted and limited to the rules promulgated by the State High School Athletic Association, and in lieu of reporting the actual dates in advance, the school authority shall maintain a register of actual days practiced which shall be available for inspection by the Company, on demand, at all reasonable times.

EXTENDED DENTAL COVERAGE

Each Covered Person enrolled in “School Time”, “24-Hour”, “Football”, or “Interscholastic” coverage is eligible to purchase this benefit. By adding an additional premium to the base plan rates, dental benefits may be extended under the overall maximum benefit to provide payment of covered expenses to a maximum of \$5,000.00. The additional benefit provides payment for the usual and customary expenses incurred within 1 year from the date of Covered accident for treatment, repair or replacement of each injured, natural tooth, including examination, diagnosis, X-rays, restorative treatment, endodontics, and oral surgery, plus for the replacement of caps, crowns, dentures and orthodontic appliances. Coverage is in effect 24 hours a day even when selected with School Time coverage. If there is more than one way to treat a dental problem, the Company will pay benefits for the least expensive procedure provided that it meets acceptable dental standards.

BLANKET INTERSCHOLASTIC COVERAGE

Note: If specified as Blanket Interscholastic Coverage, all premium will be paid by the Policyholder.

Each Covered Person for whom the premium for Blanket Interscholastic Coverage has been paid by the Insured will be covered under the specified Schedule of Benefits for Injures as outlined under the “Coverage Options” listed below.

Blanket Interscholastic Coverage does not cover normal classroom activities, intramural activities or Physical Education classes and is restricted to interscholastic athletics and activities as defined and sanctioned by the state interscholastic governing body. Spring Training, off-season workouts and play-off games as defined by the state interscholastic governing body are included under the Blanket Interscholastic Coverage Options.

Coverage becomes effective on the date specified by the state interscholastic governing body as the first official day of practice for each interscholastic sport and/or associated activity.

All coverage options expire the last day of the spring term with the exception of the state interscholastic governing body sanctioned competitions that extend beyond the last day of the regular school term, including summer school.

Blanket Coverage Options may include one of the following options, extending to applicable grade levels:

1. JV/Varsity Football Only - Benefits will be paid for Injuries sustained by a Covered Person while:

- a) Actually engaged, as an official representative of the Policyholder, in the play or practice of Football under the supervision of a regularly employed coach or trainer of the Policyholder, including managers and trainers; and
- b) Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the scheduled play or practice of Football.

2. Interscholastic Sports Only - Benefits will be paid for Injuries sustained by a Covered Person while:

- a) Actually engaged, as an official representative of the Policyholder, in the play or practice of Interscholastic Athletics under the supervision of a regularly employed coach or trainer of the Policyholder. Interscholastic Athletics must be School sponsored and supervised.
- b) Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the Interscholastic Athletic competitions.

3. Interscholastic Sports and Activities - Benefits will be paid for Injuries sustained by a Covered Person:

- a) Actually engaged, as an official representative of the Policyholder, in the play or practice of Interscholastic Sports and Activities under the supervision of a qualified adult school authority. Interscholastic Sports and Activities must be School sponsored and supervised.
- b) Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the designated interscholastic sport or activity; travel time will be limited to one hour before the interscholastic activity begins and one hour after the activity ends.

4. All School Plan – Benefits will be paid for injuries sustained by a covered person while school is in session:

- a) While attending or participating in a school sponsored and supervised activity on or off the school premises.
- b) Participation in interscholastic sports and football (where applicable).
- c) Actually being transported in a school furnished vehicle as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the designated interscholastic sport or activity; travel time will be limited to one hour before the interscholastic activity begins and one hour after the activity ends.

GENERAL PROVISIONS

Entire Contract, Changes: This policy including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. All statements made by the Policyholder or by a covered person shall, in absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under this policy, unless it is contained in a written application and a copy of the application has been furnished to the Policyholder.

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

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

Notice of Claim: Written notice of claim must be given to the Company within [30 minimum; 90 maximum] days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Covered Person or the beneficiary to the Company at [P.O. Box 702348, Dallas, Texas 75370-2348], or to any authorized agent of the Company, with information sufficient to identify the Covered Person shall be deemed notice to the Company.

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

Proof of Loss: Written proof of loss must be furnished to the Company, GM – Southwest, [P.O. Box 702348, Dallas, Texas 75370-2348], in case of claim for loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims: Indemnities payable under this Policy for any loss will be paid upon receipt of due written proof of such loss.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation, if any. If no such designation is effective, such indemnity shall be payable to the estate of the insured.

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1000, to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

All or a portion of any indemnities provided by this Policy may, at the Company's option, and unless the Covered Person requests otherwise in writing not later than the time of filing proofs of such loss, be paid

directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Covered Person or the Estate of the Covered Person.

Physical Examination: The company at its own expense shall have the right and opportunity to examine the person of any Covered Person when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the Covered Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Illegal Occupation: The Company shall not be liable for any loss to which a contributing cause was the Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person's being engaged in an illegal occupation.

Narcotics: The Company shall not be liable for any loss sustained or contracted in consequence of the Covered Person's being under the influence of any narcotic unless administered on the advice of a Physician.

Subrogation: The Company shall be subrogated to all rights of recovery which any Covered Person has against any person, firm or corporation to the extent of payments for Benefits made by the Company to or for benefit of a Covered Person. The Covered Person shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

Policy Termination: We may terminate coverage any time after the First Policy Term provided at least 31 days written notice is given.

The Policyholder may terminate its coverage any time after the First Policy Term provided at least 31 days prior written notice is given. Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

Termination will not affect a claim for covered loss due to an Accident which occurred while coverage was in effect.

Notice: If you wish to contact the Arkansas Department of Insurance, you may do so at 1200 W. Third Street, Little Rock, Arkansas 72201-1904. The phone numbers are 1-800-852-5494 or 501-371-2640.

PREMIUM PROVISIONS

Grace Period:

A grace period of not less than 31 days is granted for each premium due after the first. Coverage will stay in force during this period unless notice has been sent, in accordance with the Policy Termination provision, of the intent to terminate coverage under the Policy. Coverage will end if the premium is not paid by the end of the grace period.

Reporting Requirements:

The Policyholder or its authorized agent must report to Us, by the premium due date:

- (1) the names of all persons insured on the Policy Effective Date;
- (2) the names of all persons who are insured after the Policy Effective Date;
- (3) the names of those persons whose insurance has terminated; and
- (4) additional information required as agreed to by Us and the Policyholder.

This information may be waived, if agreed to by the Policyholder and Us.

DEFINITIONS

Covered Medical Expenses means reasonable charges which are: 1) not in excess of Usual and Customary charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are Medically Necessary; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Person is any registered student or employee of the Policyholder for whom the appropriate premium has been paid.

Insurance coverage for a Covered Person is non-cancelable. A Covered Person insured under the 24-Hour Coverage provision remains protected under the Policy even though his schooling or employment may be discontinued with the Policyholder. A Covered Person insured under the School Time coverage provision may transfer to any school in the United States and Canada and still be covered, but in either case, subject to the Policy provisions and limitations herein applicable to all Covered Persons under this Policy.

Deductible means if an amount is stated in the Schedule of Benefits or any endorsement to this Policy as a deductible, it shall mean an amount to be subtracted from the amount(s) otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury) as specified in the Schedule of Benefits.

Dentist means a Doctor of Medical Dentistry (D.M.D.) or a Doctor of Dental Surgery (D.D.S.) (other than a member of the Covered Person's family or any person employed or retained by the Policyholder.)

Diagnostic Imaging – means those forms of radiographs that are not plain film radiography (x-rays). It includes but is not limited to: computerized axial tomography (CAT); magnetic resonance imaging (MRI); radionuclid imaging (nuclear medicine) and ultrasound (US). These examinations may be performed with or without contrast materials.

Durable Medical Equipment – means equipment which can be rented, leased or purchased and which is designed to provide treatment and/or support for an extended period of time. It includes but is not limited to: CPM machines, drug pumps; and H2O pumps.

Excess Provision – means no benefits are payable under this coverage for any expense incurred for Injury which is paid or payable by: 1) other valid and collectible insurance; or 2) under an automobile insurance policy. (This limitation will not be applied to the first \$150 of medical expenses incurred). Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Covered Person failing to comply with policy provisions or requirements.

Hospital means an institution operated pursuant to law for the care and treatment of sick or injured persons, with organized facilities for diagnosis and surgery within the confines of the institution and

having 24 hour nursing service. Hospital does not include (1) a convalescent unit within or affiliated with the hospital, (2) a clinic, (3) a nursing, rest or convalescent home or (4) an institution operated primarily for care of the aged or treatment of mental disease, drug addiction or alcoholism.

Hospital Confined/Hospital Confinement means confined in a Hospital for at least 18 hours by reason of an Injury for which benefits are payable.

Injury – means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional or structural disorder; 3) a source of loss; and sustained while the Covered Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury.

The term Injury also means a re-injury sustained while the Insured is covered under this Policy for which the Insured has remained treatment free for a period of 180 days prior to the Policy Effective Date. If benefits have been paid under this Policy for any Injury, a re-injury will be considered new if:

- a) the re-injury occurs while the Insured is covered under this Policy; and
- b) the Insured remains treatment free for a period of 180 days between the date of the last treatment for the original Injury and the date of the new Injury.

A re-injury that is incurred within 180 days of the original Injury will be considered a continuation of the original Injury.

Medically Necessary means those services or supplies provided or prescribed by a Hospital or Physician, which are: 1) Essential for the symptoms and diagnosis or treatment of the injury; and 2) Provided for the diagnosis, or the direct care and treatment of the injury.

Nurse means a registered graduated professional nurse (R.N.), (other than a member of the Covered Person's family or any person employed or retained by the Policyholder).

Physician shall mean only a legally qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or Doctor of Podiatry (D.P.) or Doctor of Chiropractic (D.C.) or Doctor of Optometry (O.D.) other than a relative of the Covered Person by blood or marriage who is duly licensed as such by the proper state authorities and who is acting within the scope of such license.

Physical Therapy means physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form, manipulation or massage administered by a Physician or physiotherapist acting within the scope of their license.

Prescription Drug means a drug which has been determined to be safe and effective by the Food and Drug Administration and which can, under federal or state law, only be dispensed when ordered by a Physician who is duly licensed to prescribe such medication.

Residence means the premises on which the dwelling place of the Covered Person is located.

School-Sponsored Activity means any school function which is scheduled by the school and which is under the direct supervision of a qualified adult school authority.

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

Usual and Customary means the fee(s) for medical services or supplies which is (are): (1) the usual fee(s) charged by the provider for the service or supply given, (2) the average fee charged for the service or supply in the locality in which the service or supply is received, and (3) reasonable in relationship to the service or supply given and the severity of the condition. No payment will be made under this policy for any expenses incurred which in the judgement of the Company are in excess of usual and customary.

COVERED LOSS – TIME LIMITS

Covered Medical Expenses will be paid under the Schedule of Benefits for loss due to Injury to a Covered Person provided treatment by a Physician: a) begins within 90 days after the date of Injury; and b) is received within 52 weeks after the date of Injury.

MEDICAL EXPENSE BENEFITS – ACCIDENT ONLY

Benefits are payable for Covered Medical Expenses (see “Definitions”) less any Deductible incurred by or for a Covered Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) if any, the coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the “Definitions” section and the “Exclusions and Limitations” section carefully. No benefits will be paid for services designated as “No Benefits” in the Schedule of Benefits or for any matter described in “Exclusions and Limitations”. If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged for by the Hospital.
2. **Hospital Miscellaneous Expenses:** 1) while Hospital confined; or 2) as a precondition for being Hospital confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. If a specific benefit is designated in the Schedule of Benefits for any of these miscellaneous services, no benefits will be paid in excess of the maximum specified therein. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
3. **Surgery:** Physician’s fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this inpatient surgery benefit; or under the outpatient surgery benefit, but not both. If two or more procedures are performed through the same incision at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.
4. **Assistant Surgeon’s fees:**
5. **Anesthetist Services:** in connection with inpatient surgery. Benefits will be paid for the Physician who performs the actual administration of the anesthesia. No benefits will be paid for supervision of an anesthetist.
6. **Registered Nurse’s Services:** 1) private duty nursing care only; 2) while Hospital confined; and 3) ordered by a licensed Physician. General nursing care provided by the Hospital is not covered under this benefit.
7. **Physician’s Visits:** when hospital confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.

8. **Surgery (Outpatient); Physician's fees for outpatient surgery.** Payment will be made based upon the surgical the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this outpatient surgery benefit; or under the inpatient surgery benefit, but not both. If two or more procedures are performed through the same incision at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable.
9. **Day Surgery Miscellaneous (Outpatient);** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; x-ray examinations; anesthesia; drugs or medicines; therapeutic services and supplies.
10. **Anesthetist (Outpatient):** in connection with outpatient surgery. Benefits will be paid for the Physician who performs the actual administration of anesthesia. No benefits will be paid for supervision of an anesthetist.
11. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physical Therapy.
12. **Physical Therapy (Outpatient):** benefits are limited to one visit per day.
13. **Emergency Room (Outpatient):** use of the room, supplies, and all other charges with the exception to MRI, X-rays/Diagnostic Testing, and Lab for which an additional benefit is provided. Treatment must be rendered within 72 hours.
14. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.
15. **Orthopedic Braces and Appliances:** 1) when prescribed by a Physician; and 2) a written Prescription accompanies the claim when submitted. Replacement orthopedic braces and appliances are not covered. Orthopedic braces and appliances include durable, medical equipment which is equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of purchase price.
16. **Dental Treatment:** 1) performed by a Physician practicing within the scope of his license; and 2) made necessary by Injury to sound, natural teeth.
17. **Consultant Physician Fees:** when requested and approved by the attending Physician.
18. **Re-injury** will be covered if the insured has been treatment free for a period of 180 days (6 months) prior to the effective date of the policy.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If such injury shall independently of all other causes and within 365 days from the date of accident solely result in any one of the following specific losses, THIS BENEFIT IS PAID IN ADDITION TO THE MEDICAL EXPENSE BENEFITS. **For loss of:**

Life	[\$5,000]
Both hands or both feet or the sight of both eyes	[\$5,000]
One hand and one foot	[\$5,000]

One hand and the sight of one eye	[\$5,000]
One foot and the sight of one eye	[\$5,000]
One hand or one foot or the sight of one eye	[\$5,000]

Loss means with regard to hands and feet, actual severance through or above the wrist or ankle joint; with reference to the eye, the irrecoverable loss of its entire sight. If more than one loss results from any one accident, only one amount, the largest, will be paid.

Severance means the complete separation and dismemberment of the part from the body. If more than one loss results from any one accident, only one amount, the largest, will be paid.

HOME HEALTH CARE BENEFIT

We will pay the Eligible Expenses incurred for the services and supplies shown below which are furnished to a Covered Person at home by the Home Health Care Agency for care in keeping with a Home Health Care Plan. Benefits will be limited to the Maximum Benefit Amount as shown on the Schedule of Benefits under the Accident Medical Expense Benefit.

Eligible Expenses include:

- 1) skilled nursing by a registered Nurse or licensed vocational Nurse under the supervision of at least one registered nurse and at least one Doctor;
- 2) physical, occupational, speech or respiratory therapy;
- 3) the service of a Home Health Aide under the supervision of a registered Nurse; and;
- 4) the furnishing of medical equipment and medial supplies other than drugs and medicines.

Coverage is provided for a maximum of 10 Home Health Care visits per policy period.

Each visit by a Home Health Care Agency employee constitutes a Home Health Care visit and each four hours of Home Health Aide services constitutes a Home Health Care visit. If service extends beyond four hours, each four hours or portion of that period is considered as one Home Health Care visit.

Benefits are subject to the Deductible Amount and Coinsurance Percentage, if any.

Home Health Care Expenses will not include:

- 1) Charges for services by a person who usually resides in the Covered Person's home or is a member of the Covered Person's family.
- 2) Charges incurred while the Covered Person is not under the care of a Doctor.
- 3) Charges in excess of the Usual and Customary charges or charges for unnecessary care or treatment. Also, no payment will be made for expenses incurred for or in connection with custodial care.
- 4) Charges for services or supplies not specified in the Home Health Care Plan.

Definitions

- 1) "Home Health Service" means the provision of a health service for payment or other consideration in a patient's residence under a plan of care established, approved in writing, and reviewed at least once every two months by the attending physician and certified by the attending Doctor as necessary for medical purposes.
- 2) "Home Health Aide" means a person who provides care of a medical or therapeutic nature and who reports to, and is under the direct supervision of a Home Health Care Agency.
- 3) "Home Health Care Agency" means a business that provides Home Health Services and is licensed by the appropriate state licensing authority.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1. Services or treatment rendered by a physician, nurse or any other person who is: 1) employed or retained by you; or 2) who is the insured or a member of his/her immediate family.
2. Charges which: 1) the insured would not have to pay if he/she did not have insurance; or 2) are in excess of Usual and Customary expenses.
3. Any injury that is: 1) intentionally self-inflicted, suicide or attempt thereat; or 2) caused by war or any act of war; or 3) is caused while the insured is serving full-time active duty (more than 31 days) in any Armed Forces; or 4) caused by taking part in a riot or insurrection.
4. Any injury that is caused by air travel except while as a fare-paying passenger on a regularly scheduled commercial air carrier; travel in or upon, sitting in or upon, alighting to or from, or working on or around any motorcycle, recreational vehicle or any motorized or engine driven vehicle not designed primarily for use on public streets and highways including but not limited to: two-or-three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; or snowmobile.
5. Any accident where the insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
6. An injury for which the insured is covered under state or federal worker's compensation or employer's liability or occupational disease laws or any other party liability coverage.
7. That part of medical expenses payable by any automobile insurance policy without regard to fault (does not apply in any state that prohibits such limitation).
8. An injury that is: 1) the result of the insured being intoxicated (Intoxicated shall be determined according to the laws of the jurisdiction in which the injury occurred.); 2) caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a physician; or 3) insured's taking part in committing or attempting to commit a felony.
9. A sickness or disease or diagnostic test or treatment, (except infection which occurs directly from an accidental cut or wound, or ingestion of contaminated food), aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physical infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics, injuries involving bone cysts or dental implants.
10. Play or practice of junior varsity or varsity interscholastic high school football (in which 10th, 11th or 12th grade students participate) or college football; except where a specific additional premium is paid.
11. No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations section of this policy.

SCHEDULE OF BENEFITS -VOLUNTARY ONLY

Maximum Benefit \$25,000 (For each injury)
52 Week Benefit Period, Primary Excess \$150

Plan 1

The Benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

In-Patient

[Room & Board:]	[90% of Usual & Customary up to \$500 per day]
[Hospital Miscellaneous:]	[90% of Usual & Customary to a \$3,500 maximum]
[X-Rays:]	[\$500 maximum]
[Physical Therapy:]	[\$35 per visit /\$350 maximum]
[Surgery:]	[90% of Usual & Customary to a \$3,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Physician's Visits:]	[\$45 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	

Outpatient

[Surgery:]	[90% of Usual & Customary to a \$3,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Day Surgery Miscellaneous:]	[\$1,250 maximum]
[(Facility Charge)]	
[Physician's Visits:]	[\$45 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	
[Physical Therapy:]	[\$35 per visit /\$350 maximum]
[Emergency Room:]	[90% of Usual & Customary to a \$300 maximum]
[(Use of Room and Supplies:)] [Treatment must be rendered within 72 hours from time of injury)]	
[X-rays, Diagnostic Testing:]	[\$500 maximum]
[Lab:]	[100% of Usual & Customary]

Other

[Ambulance:]	[90% of Usual & Customary to a \$800 maximum]
[Orthopedic Braces & Appliances:]	[90% of Usual & Customary to a \$500 maximum]
[Dental:]	[\$500 per tooth]
[Neurological Consultant:]	[\$150 per visit]
[Anesthetist:]	[90% of Usual & Customary to a \$600 maximum]
[Assistant Surgeon:]	[90% of Usual & Customary to a \$600 maximum]
[MRI/CT Scan:]	[90% of Usual & Customary to a \$1,000 maximum]
[Eyeglasses, Contact Lens, and Hearing Aids:]	[\$500 maximum]
[Prescriptions:]	[\$200 maximum]
[Home Health Care:]	[10 visits /\$50 per visit]
[Injections:]	[\$15 per visit /\$75 maximum]

No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations portion of the policy.

SCHEDULE OF BENEFITS - VOLUNTARY ONLY

**Maximum Benefit \$25,000 (For each injury)
52 Week Benefit Period, Primary Excess \$150**

Plan 2

The Benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

In-Patient

[Room & Board:]	[80% of Usual & Customary up to \$250 per day]
[Hospital Miscellaneous:]	[80% of Usual & Customary to a \$2,500 maximum]
[X-rays:]	[\$300 maximum]
[Physical Therapy:]	[\$35 per visit /\$350 maximum]
[Surgery:]	[80% of Usual & Customary to a \$2,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Physician's Visits:]	[\$35 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	

Outpatient

[Surgery:]	[80% of Usual & Customary to a \$2,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Day Surgery Miscellaneous:]	[\$1,000 maximum]
<i>(Facility Charge)</i>	
[Physician's Visits:]	[\$35 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	
[Physical Therapy:]	[\$35 per visit /\$350 maximum]
[Emergency Room:]	[\$200 maximum]
[(Use of Room and Supplies: Treatment must be rendered within 72 hours from time of injury)]	
[X-rays, Diagnostic Testing:]	[\$300 maximum]
[Lab:]	[90% of Usual & Customary]

Other

[Ambulance:]	[80% of Usual & Customary to a \$600 maximum]
[Orthopedic Braces & Appliances:]	[80% of Usual & Customary to a \$300 maximum]
[Dental:]	[\$350 per tooth]
[Neurological Consultant:]	[\$100 maximum]
[Anesthetist:]	[80% of Usual & Customary to a \$500 maximum]
[Assistant Surgeon:]	[80% of Usual & Customary to a \$500 maximum]
[MRI/Cat Scan:]	[80% of Usual & Customary to a \$600 maximum]
[Eyeglasses, Contact Lens and Hearing Aids:]	[\$300 maximum]
[Prescriptions:]	[\$100 maximum]
[Home Health Care:]	[10 visits /\$50 per visit]
[Injections:]	[\$15 per visit /\$75 maximum]

No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations portion of the policy.

SCHEDULE OF BENEFITS - VOLUNTARY ONLY

Maximum Benefit \$25,000 (For each injury)
52 Week Benefit Period, Primary Excess \$150

Plan 3

The Benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

In-Patient

[Room & Board:]	[\$150 per day]
[Hospital Miscellaneous:]	[\$1,500 maximum]
[X-rays:]	[\$150 maximum]
[Physical Therapy:]	[\$150 maximum]
[Surgery:]	[\$1,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Physician's Visits:]	[\$25 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	

Outpatient

[Surgery:]	[\$1,500 maximum]
[(No more than one procedure through the same incision will be paid)]	
[Day Surgery Miscellaneous:]	[\$750 maximum]
[(<i>Facility Charge</i>)]	
[Physician's Visits:]	[\$25 per visit]
[(Benefits are limited to one visit per day and do not apply when related to surgery or Physical Therapy)]	
[Physical Therapy:]	[\$25 per visit to a \$150 maximum]
[Emergency Room:]	[\$100 maximum]
[(Use of Room and Supplies: Treatment must be rendered within 72 hours from time of injury)]	
[X-rays, Diagnostic Testing:]	[\$150 maximum]
[Lab:]	[80% of Usual & Customary]

Other

[Ambulance:]	[\$350 maximum]
[Orthopedic Braces & Appliances:]	[\$200 maximum]
[Dental:]	[\$200 per tooth]
[Neurological Consultant:]	[\$50 maximum]
[Anesthetist:]	[\$300 maximum]
[Assistant Surgeon:]	[\$300 maximum]
[MRI/Cat Scan:]	[\$350 maximum]
[Eyeglasses, Contact Lens, and Hearing Aids:]	[\$200 maximum]
[Prescriptions:]	[\$75 maximum]
[Home Health Care:]	[10 visits /\$50 per visit]
[Injections:]	[\$15 per visit /\$75 maximum]

No benefits will be paid for services not listed in the Schedule of Benefits, or for any service described in the Exclusions and Limitations portion of the policy.

Notice

You may contact Us at the following:

Nationwide Life Insurance Company
[5525 Parkcenter Circle,
Dublin, Ohio 43017]

[1-800-xxx-xxxx]

If we fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
[400 University Tower Building
Little Rock, AR 72204]
[(501) 371-1811]