

SERFF Tracking Number: NWLC-126115021 State: Arkansas
 Filing Company: Nationwide Life Insurance Company State Tracking Number: 42098
 Company Tracking Number: NSHMM 2000 (SK)
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: Group Mini-Medical
 Project Name/Number: NSHMM 2000/NSHMM 2000

Filing at a Glance

Company: Nationwide Life Insurance Company

Product Name: Group Mini-Medical

SERFF Tr Num: NWLC-126115021 State: ArkansasLH

TOI: H15G Group Health -

SERFF Status: Closed

State Tr Num: 42098

Hospital/Surgical/Medical Expense

Sub-TOI: H15G.002 Large Group Only

Co Tr Num: NSHMM 2000 (SK)

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Susan Coulter, Jonna Shields

Disposition Date: 05/11/2009

Date Submitted: 04/16/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: NSHMM 2000

Status of Filing in Domicile: Pending

Project Number: NSHMM 2000

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 05/11/2009

Explanation for Other Group Market Type:

State Status Changed: 05/11/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Nationwide Life Insurance Company

NAIC # 66869 FEIN # 31-4156830

This is a [Limited Medical Benefit Plan][Limited Comprehensive Plan] that will be offered to large employer (51 +)

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groups. The benefits include inpatient, outpatient, outpatient diagnostic, surgical, doctor's office visits, and emergency room, wellness, childbirth, and supplemental accident benefits. Other benefits include dental, vision, life insurance, disability and accidental death and dismemberment.

There are five riders being submitted that will give the option of selecting a prescription benefit, felonious assault, mental health and substance abuse, critical illness and conversion benefit. When applicable an amendment is being submitted to include state specific language.

The application that will be used has been submitted with another company filing under SERFF tracking number #NWLC-126115288.

The forms are new and do not replace any forms previously approved by your department.

The forms listed below are submitted for your review and approval.

Form Number Form Name

NSHMM 2000 Master Policy
NSHMM 2500 Certificate of Coverage
NSHMM2500-SCHED Schedule of Benefits
NSHMM 2400-RX RX Rider
NSHMM 2400-FA Felonious Assault Rider
NSHMM 2400-MH/SA Mental Health/Substance Abuse Rider
NSHMM 2400-CI Critical Illness Rider
NSHMM 2400-Conversion Conversion Rider
NSHMM 2700-AR Amendment

Company and Contact

Filing Contact Information

Susan Coulter,

susan@coulter-and-associates.com

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379 Princeton-Hightstown Road (609) 443-7940 [Phone]
Cranbury, NJ 08512

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

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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Nationwide Life Insurance Company	\$50.00	04/16/2009	27208725

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/11/2009	05/11/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Schedule of Benefits	Form	Susan Coulter	04/27/2009	04/27/2009
Wellness Rider	Form	Susan Coulter	04/24/2009	04/24/2009
Wellness Rider	Form	Susan Coulter	04/20/2009	04/20/2009

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Form	Group Policy	Approved-Closed	Yes
Form	Certificate of Coverage	Approved-Closed	Yes
Form (revised)	Schedule of Benefits	Approved-Closed	Yes
Form	Schedule of Benefits	Replaced	Yes
Form	Prescription Drug Expense Benefit Rider	Approved-Closed	Yes
Form	Felonius Assault Benefit Rider	Approved-Closed	Yes
Form	Mental Health[/Substance Abuse]	Approved-Closed	Yes
	Covered Services Benefit Rider		
Form	Conversion Benefit Rider	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form (revised)	Wellness Rider	Approved-Closed	Yes
Form	Wellness Rider	Replaced	Yes

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Amendment Letter

Amendment Date:
 Submitted Date: 04/27/2009

Comments:

Sent corrected Schedule of Benefits, the Inpatient Plan Year Max should be \$150,000 instead of \$50,000.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
NSHMM 2500-SCHED	Schedule Pages	Schedule of Benefits	Initial				62	NSHMM 2500-SCHED.pdf

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 Project Name/Number: NSHMM 2000/NSHMM 2000

Amendment Letter

Amendment Date:
 Submitted Date: 04/24/2009

Comments:
 form number revision

Changed Items:
Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
NSHSAS 2400 - Wellness	Policy/Contract/Fraternal Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Wellness	Initial					NSHMM 2400-Wellness.pdf

SERFF Tracking Number: NWLC-126115021 State: Arkansas
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Amendment Letter

Amendment Date:
 Submitted Date: 04/20/2009

Comments:

Additional rider submitted.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
NSHSAS 2400 - Wellness	Policy/Contract/Fraternal Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Wellness	Initial					NSHSAS 2400 - Wellness.pdf

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Form Schedule

Lead Form Number: NSHMM 2000

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	NSHMM 2000	Policy/Cont ract/Fratern al Certificate	Group Policy	Initial		66	NSHMM 2000.pdf
Approved-Closed	NSHMM 2500	Certificate	Certificate of Coverage	Initial		62	NSHMM 2500.pdf
Approved-Closed	NSHMM 2500-SCHED	Schedule Pages	Schedule of Benefits	Initial		62	NSHMM 2500-SCHED.pdf
Approved-Closed	NSHMM 2400-RX	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Prescription Drug Expense Benefit Rider	Initial		68	NSHMM 2400-RX.pdf
Approved-Closed	NSHMM 2400-FA	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Felonius Assault Benefit Rider	Initial		60	NSHMM 2400-FA.pdf
Approved-Closed	NSHMM 2400-MHSA	Policy/Cont ract/Fratern al Certificate: Services Benefit	Mental Health[/Substance Abuse] Covered	Initial		50	NSHMM 2400-MHSA.pdf

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Amendmen Rider

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 Page,
 Endorseme
 nt or Rider

Approved- Closed	NSHMM 2400- Conversion	Policy/Cont Conversion Benefit ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	65	NSHMM 2400- Conversion.p df
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Approved- Closed	NSHMM 2700-AR	Policy/Cont Amendment ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		Amendment - Arkansas.pdf
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Approved- Closed	NSHSAS 2400 - Wellness	Policy/Cont Wellness Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		NSHMM 2400- Wellness.pdf
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Nationwide Life Insurance Company

Home Office: One Nationwide Plaza, Columbus, Ohio 43216
(Hereafter called We, Us or Our in this Policy)

GROUP [HOSPITAL-MEDICAL EXPENSE BENEFITS][LIFE][DENTAL][VISION CARE][NON-OCCUPATIONAL WEEKLY DISABILITY INCOME BENEFITS] [ACCIDENTAL DEATH AND DISMEMBERMENT] POLICY

Policyholder: [JOHN DOE CO.]

Policyholder Effective Date: [January 1, 2009]

Policy Number: [000000]

[Policyholder Address: [Address]]

[First Policy Anniversary: [July 1, 2005]]

[Subsequent Policy Anniversaries: Each [July 1]]

State or Other Jurisdiction of Issue: [Any State]

[Eligible Classes: [As defined by the Policyholder – insert eligibility requirements here]]

We agree to insure the Eligible Persons described in the Eligible Classes section [shown above][shown in the Schedule of Benefits]. We will do this while this Policy stays in force. We agree to pay the benefits of this Policy to the persons insured. Details of the benefits are shown in the certificates attached to this Policy. These certificates form a part of this Policy.

Premiums

The Policyholder has applied for this Policy and understands that the required premium must be paid to get the insurance and keep it in force.

When This Policy Will Take Effect

This Policy will take effect at 12:01 A.M. standard time at the Policyholder's address on the Effective Date above, its date of issue.

We witness that this Policy is executed on its date of issue at Columbus, Ohio.

Signed for Nationwide Life Insurance Company

Secretary

President

Countersigned at _____ Date _____

(where required) _____
Resident Licensed Agent

Non-Participating Insurance which can be terminated by Us as described in the Policy.

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS

Agency

The Policyholder and any administrator appointed by the Policyholder shall not be considered Our agents for any purpose. We are not liable for any of their acts or omissions.

Entire Contract

The entire contract consists of:

1. this Policy;
2. the Certificate;
3. any Riders, Endorsements and Amendments, if any, adding or changing the provisions of the Policy or Certificate;
4. the Application of the Policyholder

A copy of the Policyholder's Application is attached to this Policy on the date it is signed. All statements made in the Application and Enrollment Form, in the absence of fraud, are representations and not warranties. No statement made by an Insured Person under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured Person.

ERISA

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

Individual Certificate

We will make a certificate available to each Insured Person under this Policy. Certificates will state the insurance protection to which a Covered Person is entitled and to whom the benefits are payable.

Conformity With State Laws

The insurance laws of some states require that certain Policy provisions comply with the law of the state for all permanent residents of the state. Any Policy provision herein which does not conform with such law is hereby modified to the minimum extent necessary to satisfy legal requirements.

Misstatements

If any relevant fact as to a Covered Person to whom this insurance relates is found to have been misstated, the true facts will be used to determine whether His insurance is in force under the Policy and in what amount. If the error has an effect on the Premium, an adjustment of the Premium due will be made.

Non-Participating

This Policy is non-participating. This means that it does not share in Our surplus earnings.

Assignment

No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us.

Incontestability

[Except for material fraudulent misstatements,] this Policy will be incontestable, except for non-payment of premium, after it has been in force for two years.

Clerical Error

Any clerical error by Us in keeping relevant records, or a delay in making any entry, will not void any insurance otherwise validly in force or continue insurance otherwise validly terminated. When a clerical error or delay is found, Premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

Changes In Policy

The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by Our Executive Vice President or Our Corporate Secretary. Any changes will be made without the consent of, or notice to, any Insured Person. No agent has authority to contract directly with Us for this Policy or to change, alter or amend any of its terms or provisions in any way.

Policyholder Required Information

Certain facts are needed to administer the Policy. We have the right to decide which facts We need. The Policyholder is required to comply with any reasonable request for information which We deem necessary to administer the Policy. We have the right to inspect any records of the Policyholder that have a bearing on the insurance or Premium under the Policy.

Incorporation Provision

The provisions of the attached Certificate of Insurance, any Rider(s), and any Endorsement(s), including any Rider or Endorsement added after the Group [Hospital-Medical Expense Benefits][Life][Dental][Vision Care][Non-Occupational Weekly Disability Income Benefits] [Accidental Death and Dismemberment] Policy. The Certificate(s) and Rider(s) attached to this Policy will control each Covered Person's coverage eligibility, effective date, termination date, benefits, limitations and exclusions.

New Entrants

New persons to the groups or classes eligible for insurance must be added to the groups or classes for which they are eligible.

[Workers' Compensation Not Affected

This Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.]

PREMIUM PROVISIONS

[Payment of Premiums

The Premiums due under this Policy are payable in advance directly to Us. The first Premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the cover page of this Policy. The payment of any Premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under the Grace Period provision.]

[Premium Calculation

The total Premium owed to Us under this Policy is obtained by multiplying the number of Covered Persons [in each tier category] by the applicable Premium rates in effect for all Covered Persons covered under this Policy and then summing the results. All payments made to Us will be made in United States dollars.]

Premium Adjustments

When additional or increased insurance begins or ends and the change is due to a change in the terms of this Policy, any adjustment in the Premium will be made as of the date the change is effective. Otherwise, any adjustment in Premium will be made on the Premium Due Date which occurs on or next follows the date of change (or the first day of the calendar month which occurs on or next follows the date of change if Premiums are payable other than monthly).

Changes in Premium Rates

We have the right to change the Premium rates on any Premium Due Date after the Initial Term. After the Initial Term, We will not increase the Premium rates more than once in any [1, 3, 6, 12] month period. We will notify the Policyholder in writing at least [31, 45, 60] days in advance of any increase.

[Premium Rate Guarantees

Any Premium rate guarantees are subject to the following provisions:

1. The benefits outlined in the Certificate as well as the eligibility remain unchanged;
2. There are no additions or deletions of subsidiaries or affiliates;
3. The census or geographic distribution does not change by more than [10-50%, in 5% increments];
4. The employer contribution, if applicable, to the Premium is not reduced.]

[Policyholder Grace Period - Policyholder

A Grace Period of [31 45, 60] days (without interest charge) is granted for the payment of any Premium Due Date after the first. This Policy will continue in effect during this period unless the Policyholder has given written notice to Us that the insurance under this Policy is to be ended on the first day before the Grace Period would otherwise start. If the Premium

is not paid by the end of the Grace Period all insurance under this Policy will end on the last day of the Grace Period, and the Policyholder will owe Us all Premiums then due and unpaid including the Premium for the Grace Period.

If the Policyholder gives Us written notice that insurance under this Policy is to be ended during the Grace Period, all insurance will end on the date We receive the written notice or the date specified, if later. The Policyholder will owe Us the pro-rata Premium for the time the insurance was in effect during the Grace Period.]

TERMINATION OF INSURANCE

The Policy will continue for as long as Premiums are paid or until it is terminated or cancelled. Notice to cancel or terminate the Policy may come from either the Policyholder or from Us. The Policyholder may cancel any or all of the insurance by giving Us written notice. It will terminate on the later of:

1. The date requested in the cancellation notice; or
2. The date We receive the notice.

We may terminate insurance as of a Premium due date with a [31, 45, 60 day] advance notice in writing to the Policyholder. However, prior to the first Policy anniversary, We may only do this:

1. If the Policyholder does not perform its duties under the Policy to Our satisfaction; or
2. Less than [10%-75%, in 5% increments] of those eligible are enrolled for insurance; [or
3. [If the Policyholder ceases to sponsor coverage under the Policy, or sponsors the same or similar coverage through another arrangement without Our written agreement.

In either event, Premium is due and payable through the date on which coverage under the Policy terminates. If the Premium is not paid, the Policy will terminate as of the last day for which Premium was paid.

Insurance will end as provided above without the consent of, or notice to, any Covered Person, unless otherwise required by state law.



On Your Side®

Nationwide Life Insurance Company

CERTIFICATE OF COVERAGE
GROUP [HOSPITAL-MEDICAL EXPENSE BENEFITS][LIFE][DENTAL][VISION CARE][NON-OCCUPATIONAL WEEKLY DISABILITY INCOME BENEFITS] [ACCIDENTAL DEATH AND DISMEMBERMENT]

INSURING AGREEMENT

The Nationwide Life Insurance Company has issued a Policy covering certain Eligible Classes of the Policyholder.

The Benefits of the Policy are described in this Certificate and Your Schedule of Benefits.

Final interpretation is governed by the Policy. You may review the Policy at the Policyholder's address during normal business hours. This Certificate replaces any and all Certificates previously issued for the eligible classes under the Policy. This Certificate describes the Policy in detail.

NOTICE CONCERNING YOUR CERTIFICATE

The Benefits and provisions of the Policy are described in this Certificate.

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

IMPORTANT NOTICE: Benefits are payable only for losses incurred while a Covered Person's insurance is in force and after any applicable Benefit Waiting Periods have been served. The applicable Benefit Waiting Period is shown in the Schedule of Benefits.

The Policy under which the Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person who Claims rights or Benefits under the Policy.

Signed for Nationwide Life Insurance Company

Secretary

President

**[LIMITED BENEFIT HEALTH COVERAGE
BENEFITS PROVIDED
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES]**

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GENERAL DEFINITIONS

[Accident or Accidental or Accidental Injury or Injury: A specific unforeseen event, that is:

1. sudden, unexpected, and unintended, over which a Covered Person has no control and which happens while the Covered Person is covered under the Policy;
2. which directly, and from no other cause, results in an Injury; and
3. is independent from sickness, disease, bodily infirmity, or Illness.]

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

[Accredited: The school, college or university has been evaluated and awarded accreditation by an accrediting agency that is recognized by the U.S. Department of Education or the Council on Higher Education Accreditation (CHEA) in Washington, DC.]

[Actively at Work: You are performing the normal duties of Your regular occupation and working Your normal hours. [You must be working at least the number of hours per week as defined by the Policyholder on a [permanent] [Full-Time][Part-Time] basis and must be paid regular earnings.]

Your work site must be:

1. at the Policyholder's usual place of business; or
2. at a location to which the Policyholder's business requires You to travel.

You are not considered Actively at Work when You are off work or lose time due to Illness, injury, leave of absence, strike or lay-off. Paid days off will count as Actively at Work if You were fully capable of performing the normal duties of Your regular occupation during the paid days off, provided that You were Actively at Work on the last working day prior to [the paid days off.]]

Age: Age at last birthday.

Ambulatory Surgical Center: A Health Care Facility that is mainly engaged in performing Outpatient Surgical Procedures.

Amendment: A document that modifies the Policy and becomes part of the Policy.

[Basic Weekly Earnings: Your average weekly earnings, excluding commissions, bonuses, incentive pay, unscheduled overtime or other compensation earned from the Policyholder in the prior calendar year or during the period worked, whichever is less. This amount will be updated on the Policy Anniversary date each year thereafter.]

[Beneficiary: The one who will receive Benefits payable upon a Covered Person's death. You may designate or change the Beneficiary at any time by filing written notice on a form We provide and sending it back to the [Policyholder] [Our Agent or Us.]

Benefit: The dollar amount payable by Us to a claimant or assignee under the Policy.

[Benefit Waiting Period: The period of time starting on a Covered Person's Effective Date before Benefits for certain Services become payable. The Benefit Waiting Period is shown in the Schedule of Covered Procedures in the Schedule of Benefits.]

[Calendar Year: For the first year the period of time that begins on the Effective Date and ends on December 31st. For subsequent years, the period of time that begins on January 1st and ends December 31st. The Effective Date is shown in Your Schedule of Benefits.]

Certificate: This document which provides a description of the Coverage available under the Policy.

[Chartered Aircraft: An aircraft the Policyholder does not own but hires for an occasional specific trip. The time the Policyholder has it may not exceed the number of consecutive days shown in the Schedule or more than the number of days shown in the Schedule in any one 12-month period. One or more aircraft hired on a regular or frequent basis are not considered Chartered Aircrafts.]

[Child or Children: See definition of Eligible Dependent.

Claim: A request for payment of covered Benefits.

Claimant: A person who has filed a claim for Benefits under the Policy, as a Covered Person or as the Beneficiary of a Covered Person.

[Complication of Pregnancy: A condition which:

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

Complications of Pregnancy will not include: (1) false labor; (2) occasional spotting; (3) Doctor prescribed rest during the period of pregnancy; or, (4) morning sickness.]

[Coinsurance: The fixed percentage amounts a Covered Person and the Policy must pay for certain Covered Services. The Schedule of Benefits shows the amount of Coinsurance that the Policy will pay. Your Coinsurance percentage is the difference between the amount shown in the Schedule of Benefits and 100%. You must pay Your Coinsurance Amount to Your Provider.]

[Confinement/Confined: an uninterrupted stay following admission to a Health Care Facility due to an Illness or Injury. The re-admission to a Health Care Facility for the same or related Illness or Accidental Injury, within a 72-hour period, will be considered a continuation of the same Illness or Accidental Injury. Confinement/Confined does **not** include observation, which is the review or assessment, of 23 hours or less, of a person's Illness or Injury that does not result in the admission to a Health Care Facility.]

[Contributory: You pay all or a portion of the premium for Coverage.]

[Copayment: the amount a Covered Person must pay per visit when receiving certain Covered Services. This amount, if any, is shown in the Schedule of Benefits and must be paid to the Provider at the time the services are provided, if the Provider requests payment at that time. If the Provider does not request the Copayment at the time services are provided, the Provider will bill the Covered person at a later date. The Provider, of its sole discretion, will determine when the Copayment is due and payable.]

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

Covered Person: You and Your Eligible Dependents whom You have enrolled for insurance and paid any Premium due under the Policy.

[Custodial Care: A level of routine maintenance and supportive care that is primarily for the purpose of attending to the activities of daily living and for which the services of a skilled professional are not Medically Necessary. Custodial care includes, but is not limited to, assistance in walking, getting in or out of bed, bathing, dressing or grooming, feeding, taking medicine, exercise, or entertainment.]

[Deductible: The amount of Covered Expense that must be paid in full by You each Plan Year for each Covered Person (or to the maximum per family limit, when applicable) before any Benefits are payable by Us. The Deductible does not include Copayment amounts, if any. The Deductible is shown on the Schedule of Benefits.]

[Dentist: A dental practitioner who is duly licensed and qualified under the law of the jurisdiction in which treatment is administered and who is acting within the scope of that license.]

[Dependent or Covered Dependent: Your Eligible Dependent who is insured under the Policy.]

[Disabled: That You are unable to perform the Material and Substantial duties of [Your occupation][any occupation for which you are or may become reasonably qualified by education, training or experience.]

[Doctor: A person who is:

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

[Domestic Partner: An individual in a relationship with You that satisfies the following criteria:

- [1. For at least [six] consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, [have had a declaration of domestic partnership on file with a state or local government Domestic Partner Registry] [are and have been each other's sole Domestic Partner and have maintained the same principal place of residence]; and]
- [2. Your Domestic Partner is at least 18 years of age; and]
- [3. You and Your Domestic Partner are not married or related by blood; and]
- [4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and]
- [5. [You and Your Domestic Partner have filed a Domestic Partner affidavit [with Us; and]
- [6. You and Your Domestic Partner are not legally married to anyone else.]]

Effective Date: The date on which insurance Coverage begins under the Policy.

[Eligibility Waiting Period: The continuous length of time a Covered Person must serve in an Eligible Class to reach his or her eligibility date and begin his or her Coverage [and Your Eligible Dependent Coverage.] [The Eligibility Waiting Period is shown in the Schedule of Benefits.]]

Eligible Class: Is a group of people who are eligible for Coverage under the Policy. [See the Schedule of Benefits for a list of Eligible Classes.] Each person of the Eligible Class will qualify for insurance on the date he or she completes the required Eligibility Waiting Period.

[Eligible Dependent: Includes:

1. Your Spouse (if not legally separated or divorced from You);
2. unwed Child from the moment of birth, until the Child attains age [19]; and
3. [unwed Child who is a student may be covered until attaining age [25] provided such Child is a Full-Time Student and more than 50% dependent on You for support and maintenance and proof of the Child's enrollment as a Full-Time Student must be submitted to Us.

Children include natural children, stepchildren, adopted children, [grandchildren] children Placed for Adoption, children appointed to Your custody by a court order, or foster children who are dependent upon You for support. Adopted children include a child where an Eligible Person has the assumption and retention of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Such child is no longer considered an Eligible Dependent upon the termination of that legal obligation.

[The term Eligible Dependent does not include any person who:

1. [Is in full-time active duty in the armed forces of any country or international authority; or]]
2. [Lives outside of the United States [or Canada][Mexico]]; or
3. [Is an Insured Person under the Policy.]]

[Eligible Person: A person who belongs to an Eligible Class as described in the Schedule of Benefits.]

Emergency Services: Includes:

1. A medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition;
2. Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

[Emergency Medical Condition: The sudden onset of a medical condition manifested by symptoms of such severity that the failure to immediately provide Medically Necessary treatment could reasonably be expected to result in:

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

Enrollment Form: The document completed by You in electing Coverage under the Policyholder's Policy. The document may be written or electronic on a form that is furnished or approved by Us.

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

[Experimental or Investigational: The service, supply, care or treatment has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication and has not been approved or accepted as essential to the treatment of Injury or Illness by any of the following:

- The American Medical Association
- The United States Surgeon General
- The United States Department of Public Health
- The National Institutes of Health Medicare

For further explanation, see definition of Medically Necessary.]

[Eye Doctor: An ophthalmologist, optometrist or a person licensed to provide covered Vision Care within the scope of their license.]

[Full-time: A regular workweek as defined by the Policyholder. We have the right to verify the hours worked by reviewing payroll records and/or income tax statements.]

[Full-time Student: A student who is enrolled in an Accredited educational institution or licensed trade school and considered full time according to the institution or school that he or she is attending.] A person ceases to be a Full-Time Student at the end of the calendar month during which the person graduates or ceases to be enrolled and in attendance on a full-time basis. A person continues to be a Full-Time Student during periods of vacation established by the school, college, or university if he or she was a Full-Time Student on the day before the start of the vacation period. We may require proof of Full-Time Student status.]

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

[Health Care Facility: a Hospital, Skilled Nursing, Sub-Acute, hospice, or other duly licensed, certified, and approved health care institution that provides care and treatment for sick or injured persons.]

[Hospital: An institution that:

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

Unless otherwise provided in the Policy, Hospital does not include any of the following:

1. A rest or nursing home, home for the aged or convalescent home; or
2. A Skilled Nursing Facility; an extended care facility; or
3. A hospice or a place for custodial care, birthing center.]

[Illness: Includes:

1. a sickness, disease or condition that impairs a Covered Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident;[and
2. the pregnancy, Complications of Pregnancy, childbirth and related medical conditions of a Covered Person.]]

[Inpatient: Confinement of 24 hours or greater.]

Insured Person: A person who is an Eligible Person, who has qualified for insurance by completing any Eligibility Waiting Period, paying any premium due, and for whom insurance under the Policy has become effective.

[Leave of Absence: An arrangement where You and the Policyholder agree that You will not be Actively at Work for a specified period of time and You are expected to be Actively at Work at the end of that period. Refer to When Your Insurance Ends to determine how long Your Coverage can be continued during a Leave of Absence.]

[Maximum Lifetime Benefit: The maximum amount payable for each Covered Person under this Policy during his or her lifetime. This maximum is shown in the Schedule of Benefits.]

[Maximum Allowable Charge: As it pertains to the Dental and Vision Provisions of the Policy, the amount determined by Us to be the appropriate fee.]

[Medically Appropriate: A Covered Service is rendered in the most cost effective manner and type of setting appropriate for the care and treatment of the Illness or Injury.]

[Medically Necessary: Any services or supplies provided for the diagnosis and treatment of a specific Illness, Injury, or condition which are:

[1. As it pertains to Hospital-Medical Benefits: services or supplies that meet all of the following:

- (a) Ordered or recommended by a Doctor; and
- (b) Required for the treatment or management of a medical condition or symptom; and
- (c) The most appropriate supply or level of service which can safely be provided to a person; and
- (d) Provided in accordance with approved and generally accepted medical or surgical practice; and
- (e) Furnished in the least intensive type of medical care setting required by the Covered Person's condition.
- (f) Not provided solely for educational purposes or the convenience of the Covered Person, the Covered Person's family, Doctor or Hospital; and
- (g) Not for services or supplies which are Experimental or Investigational; and
- (h) Not provided for treatment with or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA). If the prescribed drug is recognized as safe and effective for the treatment of an Illness or Injury by one or more of the Standard Medical Reference Compendia or in the Medical Literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Illness or Injury, Coverage will be provided, subject to the Exclusions and limitations of the Policy.

[2. As it pertains to Dental Benefits, Dental Care that is:

- (a) Required to maintain generally acceptable dental health; and
- (b) Recommended by a Dentist; and
- (c) Commonly recognized in the dental profession as acceptable treatment for the condition.]]

[Material and Substantial Duties: Job duties that:

1. Are normally required for the performance of Your own or any occupation; and
2. Cannot be reasonably omitted or modified.]

[Medicare: The benefits provided under Part A and Part B of Title XVIII of the Federal Social Security Act.]

[Normal Daily Activities: Activities normally performed by a person of like age and sex including but not limited to: (a) mobility; (b) dressing; (c) bathing; (d) toileting; (e) transferring; (f) eating; that are used to assess degree of impairment and determine eligibility for Benefits.]

[Non-Contributory: You pay no portion of the premium for Coverage.]

[Non-Occupational: An Illness, Accident or Injury that does not occur out of or as a result of any employment for wage or profit.]

[Non-Skilled: Persons without any special occupational skills and experience.]

[Occurrence: For Injuries due to an Accident, Occurrence means all Injuries related to a single Accident.

[Outpatient: An individual who received health care services where he or she is not admitted to a Hospital or other Health Care Facility.]

[Outpatient Surgical Facility: A Surgical Center is a licensed health care facility that specializes in providing surgery services in an outpatient setting.]

[Part-Time: A schedule of work defined as part-time by the Policyholder. We have the right to verify the hours worked by reviewing payroll records and/or income tax records.]

[Percentage of Covered Expenses: The percent of Eligible Dental Charges or Covered Vision Expenses payable under the Policy and shown in the Schedule of Benefits.]

[Placement for Adoption; Placed for Adoption; Placement: A Child is placed in Your physical custody for the purpose of adoption.]

[Plan Year: The period of time shown in the Schedule of Benefits as Calendar Year or Policy Year.]

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

Policy Anniversary: The month and day as shown [on the Schedule of Benefits][in the Policy] as the Policy Anniversary.

[Policy Year: For the first year is the period of time that begins on the Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary. The Policy Year is shown in Your Schedule of Benefits.]

[Policyholder: The organization [named in the Schedule of Benefits] who has contracted with Us to provide Benefits to You.]

[Premium: The periodic fee required to maintain Coverage for each Eligible Person and Dependent in accordance with the terms of the Policy.]

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

[Proof: Evidence satisfactory to Us that the terms and provisions of the Policy have been met. Proof may include but is not limited to: questionnaires, physical exams, or Written documentation and records as required by Us. Proof must be received by Us at Our [Home Office][Administrative Office]. All Proof must be given at Your expense (or that of Your representative or Beneficiary), unless otherwise specifically provided by the terms of the Policy. If any additional Proof is reasonably required by Us, [a Covered Person] may be required to give Us authorization to obtain such additional Proof.

The following is a specific type of Proof referenced under the Policy:

Proof of Loss: Evidence satisfactory to Us that a person has satisfied the conditions and requirements for a Benefit. Proof of Claim must establish:

1. the nature and extent of the loss or condition;
2. Our obligation to pay the claim under the Policy; and
3. the Claimant's right to receive payment.

[Proof of Insurability: Evidence satisfactory to Us of a person's health and other information related to insurability which enables Us to determine whether the person can become insured, or is eligible for an increase in Coverage.]]

[Provider: Any Doctor, health professional, Hospital, Health Care Facility, Skilled Nursing/Sub-Acute Facility, home health agency or other person or recognized entity licensed to provide Hospital or medical services to Covered Persons.]

[Regular Care:

1. You are under the continuing care of and personally visit a Doctor as frequently as is medically required according to standard medical practice, to effectively diagnose, manage and treat Your disabling condition(s); and
2. You are receiving appropriate treatment and care of Your disabling condition(s) which conforms with standard medical practice by a Provider whose specialty and clinical experience is appropriate for Your disabling condition(s) according to standard medical practice.]

Reinstatement: The resumption of Coverage which has lapsed under the Policy.

[Reservist: A member of a reserve component of the Armed Forces of the United States. "Reservist" also includes a member of the Army National Guard or the Air National Guard.]

Schedule of Benefits: Shows the amount of Benefits provided under this Policy.

[Sign or Signed: The use by a person of a symbol or method with the present intention to authenticate a record. [Such authentication may be executed and/or transmitted by paper or electronic media, provided it is acceptable to Us and consistent with the applicable law.]]

[Skilled Nursing/Sub-Acute Facility: A free-standing facility or part of a Hospital that is certified by Medicare to accept patients in need of rehabilitative and skilled care.]

[Sound Natural Tooth: A tooth which can withstand normal chewing forces, and has:

1. Normal, healthy periodontium; and
2. Adequate healthy dentin; and
3. Adequate enamel.

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

[Spouse: Your lawful Spouse who is an Eligible Dependent. [The term also includes [a registered] [Domestic Partner][civil union] who is an Eligible Dependent, where allowed by law].

[Surgical Expense means charges:

1. by a Doctor for a Surgical Procedure;
2. for the necessary preoperative treatment during a Hospital stay in connection with such procedure or while at an Outpatient Surgical Center or Ambulatory Surgical Center;
3. services of an anesthetist; and
4. the usual post-operative treatment.]

[Surgical Procedure includes but is not limited to:

1. a cutting procedure;
2. suturing of a wound;
3. treatment of a fracture;
4. reduction of a dislocation;
5. radiotherapy;
6. electrocauterization;
7. diagnostic and therapeutic endoscopic procedures;
8. mastectomy;
9. injection treatment for hemorrhoids and varicose veins;
10. an operation by means of a laser beam
11. surgically implanted contraceptives (Norplant);
12. sterilizations including vasectomy and tubal ligation.]

[Temporomandibular Joint (T.M.J.) Syndrome: The symptoms associated with, or exhibited as a malfunction of, the temporomandibular joint. These are frequently caused by, but not exclusive to:

1. Improper or incorrect space between the maxilla and mandible;

2. Improper dental occlusion; and
3. Muscular spasm in the T.M.J. area.]

[Totally Disabled/Total Disability: Your Disability:

1. Is a result of Illness or Accidental Bodily Injury; and
2. Which causes You to be wholly and continuously prevented from performing the Material and Substantial duties of [Your own work or occupation][any occupation for which You are or may become reasonably qualified by education, training, or experience] for pay or profit.]]

[Disability of a Dependent:

1. Is the result of Illness or Accidental Bodily Injury; and
2. Which prevents the Dependent from performing the normal activities of a person of the same Age and sex.]]

[Treatment Plan: The Dentist's report of recommended treatment on a form satisfactory to Us which:

1. itemizes the medical services or treatment; and,
2. lists the charges for each itemized service; and
3. is accompanied by supporting pre-operative X-rays and other appropriate diagnostic materials or medical records required by Us.]

[Urgent Care: Short-term medical care for non-life threatening Illness or Injury that can be mitigated or require care within 48 hours of onset.]

We, Us, and Our: The insurer, Nationwide Life Insurance Company.

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

You and Your: An Insured Person.

Other terms are defined elsewhere under the Certificate

[COVERED PERSONS PREMIUMS

When are Your Premiums due?

The first Premium for each Covered Person is due on the date he or she becomes covered under this Policy.][he or she enrolls for insurance under the Group Policy.] Each Premium after the initial Premium is due at the end of the period for which his or her preceding Premium was paid. [See the Schedule of Benefits for the Frequency of Premium payment.]

What happens if You are late with a Premium payment?

A Grace Period of [30-90] days from the Your Premium due date is allowed for each Covered Person for payment of each Premium due after the initial Premium. The Covered Person's insurance will be continued during the Grace Period. If the Covered Person incurs a covered loss during the Grace Period, You will be liable to Us for payment of any Premium accruing during the period We continued his or her Coverage and covered for his or her covered Dependents in force under this provision.

The Grace Period will not continue Coverage beyond a date as described in the “**When will Coverage end?**” provision.]

WHEN COVERAGE BEGINS AND ENDS

Who is eligible?

Eligible Person: [An individual is eligible for Coverage if he or she is in an Eligible Class as [described in the Schedule of Benefits][defined by the Policyholder][and if he or she satisfies any Eligibility Waiting Period].]

[Eligible Dependent: Your Eligible Dependents are also eligible for Coverage, provided that You are insured under the Policy and that Dependent Coverage is provided under the Policy.]

[Dual Eligibility Status: If both an Eligible Person and his or her Spouse are in an Eligible Class of the Policyholder, [each may enroll individually or as a Dependent of the other, but not as both. Any Eligible Dependent Child may also only be enrolled by one parent/guardian. If the Spouse carrying dependent Coverage ceases to be eligible, please notify Us immediately. Dependent Coverage then becomes effective under the other Spouse's Coverage].

Do You have to satisfy an Eligibility Waiting Period for [Life and][Hospital-Medical Expense Benefit] [Dental] [Vision] [Non-Occupational Disability] [Accidental Death and Dismemberment] Insurance?

If You are [an Eligible Person] on the Effective Date of the Policy, You are eligible for [Life][Hospital-Medical Expense Benefit] [Dental][Vision][Non-occupational Weekly Disability Income] insurance [on that date] [provided You [have completed the number of days shown in the Schedule of Benefits of [continuous] employment with the Policyholder. [Otherwise, You become eligible on [the first day of the calendar month coinciding with or next following] the date You become [an Eligible Person] and complete Your Eligibility Waiting Period.] The Eligibility Waiting Period is shown in the Schedule of Benefits.

[If Your employment with the Policyholder ends and You are rehired within the period of time shown in the Schedule of Benefits, Your previous work while [an Eligible Employee] will be applied toward the number of days shown in the Schedule of Benefits for continuous employment period described above.]

When do You enroll?

Enrollment is when an Eligible Person completes an Enrollment Form giving the information We require. [As the Eligible Person, if You are required to pay all or part of the Premium for Coverage, You must acknowledge Your permission to the Policyholder to withhold such Premium from Your Pay.] The enrollment for Coverage may be written or electronic on an Enrollment Form furnished or approved by Us.

Eligible Person: An Eligible Person who has met all eligibility requirements of the Group prior to the effective date of the Policy may request enrollment during the enrollment period that precedes the Effective Date of the Policy. After the Effective Date of the Policy, a [new, newly hired] Eligible Person must request enrollment [during the Eligibility Waiting Period][no later than the number of days shown in the Schedule of Benefits after [the date of hire][the end of the Eligibility Waiting Period][the date he or she becomes eligible]. An Eligible Person who does not enroll as indicated in the enrollment period as described above [will be considered a late enrollee][and][may not enroll until the next annual enrollment period unless there is a Change in Family Status, as described below] [Additional Benefit Waiting Periods may apply].

If You enroll [after the Eligibility Waiting Period][after the numbers of days shown in the Schedule of Benefits as the enrollment period after [the date of hire][the end of the Eligibility Waiting Period][the date he or she becomes eligible], You will be required to provide Proof of Insurability, at Your cost for You and any Eligible Dependents that You want covered, if:

1. You apply for Coverage after the enrollment period shown in the Schedule of Benefits after You become eligible; or
2. You become covered for the [Life], [Accidental Death and Dismemberment][, and, if applicable, Non-Occupational Weekly Disability Income Benefits] when You become eligible, but apply for other Benefits more than [30-90] days after You become eligible; or
3. You apply for Reinstatement of Coverage that was cancelled at Your request; or
4. [Your amount of Life Insurance is in excess of the guarantee issue limit as determined by Us.]

{or}

[An Eligible Person who has met all eligibility requirements of the Policyholder may enroll at any time throughout the Plan Year. The Enrollment Form must be completed and Signed on or before the desired Effective Date of Coverage.]

[Eligible Dependent: If the Policy provides for Dependent Coverage, an Eligible Person may request enrollment of his or her Dependents at the time he or she requests enrollment for himself per the above. As an Insured Person, You may request enrollment when You acquire a new Dependent. [If Eligible Dependents are not enrolled at this time, the Dependent will be considered a late enrollee.] [The Dependent may not enroll [until the next annual enrollment period] unless there is a *Change in Family Status*, as described below.] Proof of the Dependent relationship may be required by Us.]

Change in Family Status: Eligible Persons may enroll or change their Coverage if a change in family status occurs, provided an Enrollment Form is received within [30-90] days of the event. A change in family status means any of the following:

1. Marriage [or lawful domestic partnership][civil union]; and,
2. Divorce or legal separation; and,
3. Birth, adoption, or Placement for Adoption of a Child; and,
4. Death of a Spouse or Child; and
5. A court or administrative order requiring the Eligible Person to provide Coverage for his or her Child; and
6. Other changes as permitted by the Policyholder and Us.]

[Annual Enrollment: Eligible Persons may enroll themselves and their Eligible Dependents during an annual enrollment period, as specified by the Policyholder and Us.]

[If Proof of Insurability is required what do You have to do?

If an Eligible Person is required to give Proof of Insurability for all or a portion of his or her insurance, We will provide forms for providing such Proof and instructions for their completion.]

[When will Your Coverage begin?

[If the Policyholder requires You to contribute toward the cost of all or part of the insurance, no such Contributory insurance will become effective for You before You agree to make the required contributions and the first premium is paid. The form may be obtained from the Policyholder.]

Subject to [the Eligibility Waiting Period] [and] Your enrollment and payment of any Contributory portion of the premium due], insurance is effective on the later of 12:01 AM at the main office of the Policyholder on:

1. The Policy Effective Date, if You are eligible prior to the Policy Effective Date, You enroll and You pay the Contributory portion for the entire amount requested; or
2. The date an Eligible Person enrolls and pays the premium due for the entire amount requested, if an Eligible Person enrolls for Coverage after the Policy Effective Date.

[Notwithstanding the above, if You are not Actively at Work on the date Your insurance Coverage would begin, Your insurance will begin on the date You come back to Active Work.]

[If enroll for insurance more than [30-90] days after You became eligible, Your insurance will be deferred until the date We approve Your Written Proof of Insurability.]

When will Coverage begin for Your Dependents?

Subject to the enrollment procedure described above, payment of the Premium due, and satisfactory Proof of Insurability, Your Dependents will become insured on the same date and at the same time as You. If You acquire additional Dependents after Your Effective Date of Coverage and have Dependent Coverage, and provided You enroll Your Eligible Dependents as indicated above, the Effective Date of the newly acquired Dependents will be [the date We accept the new enrollment], subject to timely payment of any Premium due. Such Dependents may be added without Proof of Insurability. However, We require You to notify Us of additional Dependents to assure accurate claims handling.

If You acquire additional Dependents after Your Effective Date of Coverage and do not have Dependent Coverage, and provided You enroll Your newly Eligible Dependents as indicated above, the Effective Date will be:

1. [for Your Spouse, the first of the month following the event causing eligibility];

2. [for all other Eligible Dependents other than newborns and children Placed for Adoption, the date You enroll such Dependent];
subject to payment of any Premium due. If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such child shall take effect on the [date of enrollment][date of the order, if We are notified in accordance with our enrollment guidelines] once the required Premium, if any, has been paid.

With regard to newborns and a child Placed for Adoption, the Enrollment Form must be completed prior to the expected birth of a child or Placement. If You did not elect Dependent's Coverage before the birth or Placement of a child, Coverage on that child will not be denied, with respect to [Life][Hospital-Medical Expense Benefit] [Dental][Vision], if You notify Us in writing of the birth of such child and [authorize the Policyholder to make the required payroll deductions][make any premium payment due] toward the cost of Dependents Coverage, within [30-90] days of the date of birth. If You already have Dependent Coverage for one Dependent, more Dependents later acquired will be added without Proof of Insurability. However, We require You to notify Us of additional Dependents to assure accurate claims handling.

[The Policyholder may require employees to contribute toward the cost of all or part of their Dependent insurance. If so, the only Eligible Dependent who may become insured before You agree to those contributions is Your newborn Child. The form for this agreement may be obtained from the Policyholder. [If You [Sign the form] more than [30-90] days after You became eligible for Dependent insurance, the insurance for each Eligible Dependent will be deferred until the date We approve Proof of Insurability for each Eligible Dependent as described below in the **How is the Effective Date affected if Proof of Insurability is required for Your Dependent's Insurance?** provision.]

[If You do not enroll for Dependent Coverage within the [31-90, in 1 day increments] day period after You became eligible for Dependent insurance, You [can only] [may] enroll during the group's annual enrollment period as specified in the Schedule of Benefits. Coverage will take effect on the [January 1st] [1st of the month] that next follows the Plan Sponsor's annual enrollment period during which you enrolled [once the required premium, if any, has been paid].]

[How is the Effective Date affected if Proof of Insurability is required for Your Dependent's Insurance?

[No insurance shall become effective prior to Our approval of Proof of Insurability. After We approve such Proof, a Dependent's insurance will be effective:

1. On a date set by Us if You apply more than [30-90] days after he or she becomes eligible; or
2. On a date set by Us if You apply for Reinstatement of Coverage that was cancelled at Your request.]

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

[Are there situations when Your Dependents' Effective Date may be deferred?

If any Eligible Dependent, other than a newborn child, is confined due to Injury or Illness at home or in a hospital or other medical facility [on the date insurance would otherwise begin] [during the [2-10] days prior to the date that they would otherwise be eligible to become covered], Coverage will become effective on the first day after a period of [2-10] [consecutive days during which all of the following requirements are met:

1. The Dependent has not been so confined.
2. The Dependent has received no medical care or services.
3. The Dependent has engaged in their Normal Daily Activities.]

[Your newborn Child is the only Eligible Dependent whose insurance may begin on a day that he or she is a hospital inpatient. Insurance so deferred for any other Eligible Dependent will become effective on the day he or she is discharged from the hospital.]

[In no event will coverage for an Eligible Dependent start:

1. Before the Eligible Person's Coverage starts; and
2. For a newborn child, before the child reaches any minimum age stated in the ["when will Coverage begin for Your Dependent's" section] [Schedule of Benefits].]]

When will Benefits [and/or rates] change?

Change in Eligible Class [,Age] [,Location]: Your [and Your Eligible Dependents] [rates and/or] Benefit amount may change if You become insured under a different Eligible Class[,or change Location][,or if You [and/or Your Dependent Spouse] have a change in age].

[The change][If the change would increase the amount of insurance [and/or rates], the increase] takes effect on the [next Policy Anniversary] [first day of the Policy month [You are Actively at Work]] following the latest of the date:

1. The change occurred; or
2. [The Policyholder tells Us [in Writing] about a change in Class; or]
3. [The Premium is paid based on the change.]

[If You are not Actively at Work, such change will be effective on the first day on which You return to work. If You or Your Policyholder do not make the required payment within [30-90] days of the change, any increased Benefits will not be effective until You give Proof of Insurability satisfactory to Us. Such increased Benefits will be effective on a date set by Us.]

[If the change would *decrease* Your amount of insurance [and/or rates], the decrease takes effect [on the next Policy Anniversary] [the first of the month following the date of the change][on the date of the change.]]

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

[Changes in Benefits due to an Amendment to the Policy: The amount of Your Benefit [and/or Benefits for Your Covered Dependents] may change due to Amendment to the Policy as follows:

For You:

On the Amendment date, if You are Actively at Work performing all the normal duties of Your job for a full work day:

1. While physically present at Your normal place of employment; or
2. At some other place of business that the Policyholder requires You to go; or
3. On the day You return to work, if You are not actively at work on the Amendment date.

For Your Dependent (if applicable):

1. On the Amendment date, if the Dependent is not confined to a Hospital; or
2. On the day after the Dependent is released from a Hospital, if Hospital confined on the Amendment date.]

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

Any reduction in the amount of Benefits due to Your reaching an Age specified in the Schedule of Benefits will be made if You are Actively at Work or not.

[With respect to Dental Benefits only, if the required payment is not made within [30-90] days of any change, any increased Dental Benefits due to a change in Your Eligible Class or due to an Amendment to the Policy will not be effective until [1-36] month(s) have elapsed.]

[Changes in Hour Bank Requirements

The amount of hours of work credit that must be credited in Your reserve account before You are eligible for coverage, shall remain in effect until the Policyholder notifies Us of its desire to amend such requirement. Such notification shall be given to Our agent or Us, postmarked at least two calendar months prior to the desired effective date of the change.

Upon receipt of the notice, We shall then have [30-90] days in which to approve the desired change. In the event that We notify the Policyholder of Our refusal to approve the change within the [30-90] day period mentioned above, the hour bank requirements shall remain unchanged.]

When will Your Coverage end?

All of Your insurance under the Policy will terminate at 12:01 a.m. at the main office of the Policyholder on the earliest of the following dates:

1. [The [date] [last day of the month in] which Your employment terminates. For the purposes of insurance coverage Your employment will terminate when You are no longer Actively at Work. [However, if You are not

Actively at Work due to Illness or Injury, Your insurance will be continued in force under the Policy until the earlier of:

- a. the date on which We receive Written notice from the Policyholder that Your insurance is terminated.
 - b. the end of the [[1-36] month period following the date on which You were last Actively at Work]]
2. The date the Policy terminates;
 3. [[The date] Your [employer, company] ceases to be an Affiliated [employer, company] with the Policyholder;]
 4. The [date][last day of the month] in which You cease to be an Eligible Person[,except due to a Leave of Absence];
 5. The date specified by Us in written notice to You that Your Coverage ends due to fraud or misrepresentation;
 6. The [date][last day of the month in which] We receive written notice from You or Policyholder telling Us to terminate Coverage of a Covered Person or the date requested in that notice, whichever is later;
 7. The last day of the period for which premium was paid, if a premium is not paid when due;
 8. The [date] [last day of the month] in which] the Policy is changed to end the insurance for Your Eligible Class;
 9. [The [date][last day of the month in which] You retire unless Your insurance is continued in a retired Eligible Class [as defined by the Policyholder][as shown in the Schedule of Benefits];]
 10. [For retirees, the date Your status as a retiree ends in accordance with the Policyholder's retirement plan];
 11. [The [date][last day of the month in which] You enter full-time active duty in the armed forces of any country or international authority];
 12. [The [last day of the month following][date of] Your [50th – 99th] birthday;]
 13. The date of Your death.

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

Your Dependent's insurance under the Policy will terminate at 12:01 a.m. at the main office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates;
2. [The [date][last day of the month] the Dependent ceases to be an Eligible Dependent] or [if the Dependent ceases to be an Eligible Dependent, the earliest of:
 - a. the [date][last day of the month] the Dependent reaches his or her maximum age under the Policy; or
 - b. the [last day of the month] following a [1,2,3] year period of time from the date the Dependent lost eligibility];
3. The [date][last day of the month] in which You cease to be insured under the Policy, [unless Benefits are extended under the **"Will Benefits be extended beyond the termination date for any reason?"** provision noted below];
4. The [date][last day of the month in which] You cease to be in an Eligible Class for Dependent Coverage;
5. The last day of the period for which premium was paid, if a premium is not paid when due;
6. The [date][last day of the month] We receive written notice from You or the Policyholder telling Us to terminate Coverage on any Dependent or the date requested in that notice, whichever is later;
7. The [date] the Policy is changed to end the insurance for Your Eligible Class;
8. [The [date] that the Dependent enters full-time active duty in the armed forces of any country or international authority];
9. [For Your Dependent Spouse [the [last day of the month following][date of][Your][his or her] [50th – 99th] birthday];
10. [The [date][last day of the month in which] You retire;]
11. The date of Your death.

[Handicapped Dependent Children: Insurance will continue for a handicapped child who has attained either limiting Age shown in the Schedule of Benefits, if such child is unwed and mentally or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered on the day immediately prior to attaining the limiting Age. Proof of incapacity must be furnished to Us within the number of days shown in the Schedule of Benefits of attainment of the limiting Age.

Notice Required When Your Coverage Terminates: [The Policyholder][You] must be inform our agent or Us within the [30-90] days of the date Your Coverage terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above. In the event Premiums have been paid to Us on Your behalf after Your Coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up [1-12] Policy month(s) shown in the Schedule [or to the last Policy Anniversary, whichever is less]. If We are not notified that Your Coverage is terminated and We pay any Benefits for Your Covered

Expenses incurred after the date Your Coverage terminated, [the full amount of those Benefits will be considered an overpayment which must be repaid to Us][or You will be responsible for payment of all Premiums due through the Policy month in which Benefits were paid].

May Benefits be extended due to Total Disability after Coverage terminates per the above Termination Provisions?

Yes, Benefits may be extended if a Covered Person is Totally Disabled as described in the following provisions:

[Non-Occupational Weekly Disability Income Benefit

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

1. The date You cease to be Totally Disabled; or
2. The date You have reached the maximum Benefit period under the Benefit.]

[Hospital-Medical Expense Benefit

The Hospital-Medical Expense Benefit, if applicable, will continue to be payable under the Policy when Coverage terminates, if the Covered Person:

1. Is Totally Disabled;
2. Is confined to a Hospital or a Skilled Nursing/Sub-Acute Care Facility for the disabling Illness or Injury; and
3. Such confinement began before the date Coverage would otherwise terminate.

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

1. [30-90] days from the date Coverage would have otherwise terminated; or
2. The date on which the disabled Covered Person has reached the applicable maximum Benefit period for Hospital or Skilled Nursing/Sub-Acute Care Facility Confinement as shown in the Schedule.

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

What happens if You return to [Active Work][eligible status]?

After release from active duty: If Your insurance or Your Eligible Dependent's insurance ends due to Your being called or ordered to full-time active duty in the armed forces of any country or international authority, such insurance will be reinstated without any Eligibility Waiting Period when You return to Active Work.

[After [termination of employment][or][loss of eligibility]]: If You [return to Active Work] [or] [meet the definition of Eligible Person] [within the same Plan Year][but no more than][within][the number of days shown in the Schedule of Benefits as the reinstatement period of the date Your Coverage terminated][within the same Plan Year], You may [become an Insured Person][re-enroll for insurance under this Policy]. We will waive the Eligibility Waiting Period and give You and Your Covered Dependents credit for any portion of the [Deductible][and][Benefit Waiting Period] satisfied prior to termination.

If You have ceased to be eligible for Coverage, You may qualify for Reinstatement within [30-90] days from the date You were last eligible. You will be reinstated and eligible for Coverage on the first day of the calendar month following a month in which You are working the minimum required hours as elected by the Policyholder shown in the Schedule of Benefits.

If You do not qualify for Reinstatement within [30-90] days from the date You were last eligible, You shall be treated as a new hire.

BENEFITS

[HOSPITAL-MEDICAL EXPENSE

What Benefits are provided to Covered Persons?

Benefits are provided only to the extent that they are shown in the Schedule of Benefits and described below. Subject to the terms, conditions, limitations and exclusions of the Policy, payment will be considered for Expenses Incurred for the Covered Services described below. All benefits are per Plan Year, unless otherwise indicated. [Except for well baby care and child care and well adult care,] all Covered Services must be Medically Necessary and Medically

Appropriate. For details on Benefit limits, Deductible, Copayment, and Coinsurance amounts, please refer to the Schedule of Benefits.

[What Wellness Services are Covered Services?

Well baby care and Child Care for ages [15-24] and under include:

1. Routine examinations and medical history, including development assessment and anticipatory guidance;
2. Routine immunizations;
3. One hearing screening from birth to age one; and
4. One vision screening per Plan Year to determine if there are underlying medical conditions or if a refractive examination needs to be performed. Vision screening does not include refractive examinations.

Well Adult Care for ages [16-25] and over include:

1. One routine physical examination per Plan Year;
2. Routine gynecological care, including cytologic screening;
3. One prostate specific antigen test and one rectal examination per Plan Year for men age 50 and older;
4. Chest X-ray and routine laboratory services;
5. One Screening Mammography per Plan Year per Covered Person age 35 and older, subject to the benefit limits shown in the Schedule of Benefits; [and;]
6. [Routine adult immunizations including but not limited to influenza, tetanus, and pneumonia.]

What Outpatient Medical Services are Covered Services?

Medical treatment, services, and supplies rendered on an Outpatient basis during Urgent Care or Office visits related to treatment or diagnosis of Injury or Illness of a Covered Person. Expenses Incurred for the Doctor's charges are paid under the Doctor Office Visits benefit and not this Benefit. Expenses incurred for Outpatient diagnostic services are paid under the Diagnostic Services Benefit and not this Benefit.

What Inpatient Services are Covered Services?

1. Hospital Services including semi-private room and board, intensive care units, meals and prescribed diets, x-ray and laboratory services which are diagnostic or therapeutic and Doctor services, therapeutic services and supplies, general nursing services, and pharmaceuticals administered while an Inpatient.
2. Skilled Nursing/Sub-Acute Facility, subject to the maximum number of days shown in the Schedule of Benefits, including semi-private room and board, meals and prescribed diets, x-ray and laboratory services which are diagnostic or therapeutic and Doctor services, therapeutic services and supplies, and general nursing services.
3. Doctor services including visits during Confinement in a Hospital or Skilled Nursing/Sub-Acute Facility and related services including radiology and laboratory services ordered by or provided by a Doctor while Confined.

[What Maternity Services are Covered Services?

[A.] Childbirth Services: Coverage for maternity care starts on the date the Covered Person's Coverage becomes effective under the Policy and ends when the Covered Person's Coverage terminates, unless the Covered Person is Confined in a Hospital of Skilled Nursing/Sub-Acute Facility on that date. If a Covered Person is Confined in a Hospital of Skilled Nursing/Sub-Acute Facility on that date, Coverage will terminate when the Covered Person has been discharged.

The following are Covered Services for childbirth:

48 hours of Inpatient care following a normal delivery and 96 hours of Inpatient care following a cesarean delivery, Pre-natal and post-natal visits to a Doctor including:

1. Delivery Charges;
2. In-Hospital Doctor visits;
3. In-Hospital care for a newborn child, subject to any enrollment and premium payment requirements described in the provision entitled **When will Coverage begin for Your Dependents?**; and
4. Rooming in for maternity care.

For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor. For a mother and newborn child who have a shorter Hospital stay after conferring with the Doctor or a certified nurse-midwife who consults with the Doctor, We will pay for post-discharge care to the mother and her newborn. Post-discharge care will consist of two visits by a Doctor or a registered professional nurse with experience in maternal and child health nursing. The location and schedule of the

visits will be determined by the Doctor. One visit must be in the Insured Person's home. Services may be provided in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or other nationally recognized medical organization.

[B. Services for abortion when the mother's life is in endangered as a result of pregnancy, or if the pregnancy was the result of rape or incest.]

The Policy will not pay for pre-natal visits that occur prior to the date Coverage takes effect. Pre-natal visits that occur after Coverage takes effect are covered under the Doctor Office Visits and Outpatient Diagnostic Services Benefits to the extent that they are not due to a Pre-existing Condition and for which a separate charge is made independent of the Benefits payable under this Childbirth Services Benefit.]

What Emergency Services are Covered Services?

Emergency Services may be obtained at any time of the day or night. If due to an Emergency Medical Condition, a Covered Person receives Medically Necessary and Medically Appropriate:

1. Ambulance transportation to the emergency room of a Hospital;
2. Emergency Services in the emergency room of a Hospital for stabilization or the initiation of treatment for an Emergency Medical Condition; or
3. Urgent Care at the emergency room of a Hospital (when the emergency room is the only facility available and accessible).

Benefits payable and limits for each visit are shown in the Schedule of Benefits.

The [Copayment amount and] Emergency Room Deductible, if any, [is,are] waived if a Covered Person is admitted to the Hospital for the same Illness or Injury within 48 hours of the visit.

What Doctor Office Visit Services are Covered Services?

Diagnosis, medical advice, care or treatment of an Illness (other than for mental illness/substance abuse), or Injury. The visit must be made to the Doctor's office or clinic. The Benefit is not payable for a surgeon's visit in a Hospital following surgery. This benefit includes the first Doctor's Office Visit for the diagnosis of a pregnancy. Benefits that are covered for pregnancy under the Childbirth Services Benefit will be paid under that Benefit and not this Benefit.

What Outpatient Diagnostic Services are Covered Services?

Subject to the Deductible, Coinsurance, and maximum limits shown in the Schedule of Benefits, Medically Necessary and Medically Appropriate Outpatient diagnostic services to diagnose an Illness, or Injury. The services must be provided by the Covered Person's Doctor or by another Doctor or a laboratory if the Covered Person's Doctor refers the Covered Person to one. Covered Services include:

- Diagnostic X-rays
- Diagnostic Radiology including radium, radon, cobalt therapy, ultra-sound testing, radioisotopes, computerized axial tomography (CAT) scans, magnetic resonance imaging (MRI) scans and positron emission tomography (PET) scans.
- Diagnostic Services including tests such as thyroid function, electrocardiogram (EKG), electroencephalogram (EEG), pulmonary function studies, nerve conduction, and electromyogram (EMG)
- Diagnostic Laboratory and Pathology Services

What Surgical Services are Covered Services?

We will pay the Surgical Expense, in connection with any one Surgical Procedure as shown in the Schedule of Benefits if Medically Necessary and Medically Appropriate for treatment of Illness or Injury. If multiple Surgical Procedures are required for the treatment of the Illness or Injury, We will pay for only one Surgical Procedure. We will pay for the Surgical Procedure with the highest associated cost. Expenses Incurred for anesthesia are included in this Benefit. We will pay for reconstructive surgery, other than resulting from complications of cosmetic surgery, when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect. We will also provide benefits in connection with a mastectomy requiring breast reconstruction in connection with such mastectomy including:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the nondiseased breast to restore and achieve symmetry;

3. Prosthetic Devices and treatment of physical complications for all stages of a Mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes); and
4. Hospitalization, for a length of stay as determined by the attending Doctor and surgeon in consultation with the Insured Person, and consistent with sound clinical principles and processes

[Are there Supplemental Benefits for Accidents?

Yes, if a Covered Person is Injured in an Accident, We will pay the medical Expenses Incurred for treatment of the Injury up to the limits shown in the Schedule of Benefits.]

Are any losses excluded under the Policy for Hospital-Medical Expense Benefit?

Yes, Benefits will not be paid if excluded from Coverage under the Policy. We will not pay Benefits for any loss excluded by the **EXCLUSIONS** Section. In addition, the following exclusions apply to any and all Hospital-Medical Benefits:

1. [Charges which are not Medically Necessary or Medically Appropriate (as defined) for treatment of Illness or Injury;]
2. [Charges for services which are not related to and consistent with the treatment of any Injury or Illness of the Covered Person;]
3. [Charges for medical care, services, or supplies which are not furnished or prescribed by a Doctor (as defined);]
4. [Charges in excess of the average semi-private room rate for the Hospital where Confined unless a private hospital room is Medically Necessary and prescribed by a Doctor and personal comfort or convenience items while Confined, such as television, telephone charges, or guest meals;]
5. [Habilitative treatment or therapy, physical, occupational, and speech therapy, developmental language and articulation disorders or developmental delay including, but not limited to, slurred speech, stuttering and aphasia;]
6. [Nutrition counseling services;]
7. [Childbirth classes;]
8. [Prescription drugs, oral contraceptives, non-prescription contraceptive supplies, investigational or experimental drugs, contraceptive jellies, ointment or foams, drugs for cosmetic purposes (including Retin A if You are over age 25 and topical applications of Rogaine), drugs provided through Workers' Compensation, over-the-counter drugs, over-the-counter smoking cessation products and over-the-counter products to treat nicotine addiction, drugs for weight control or eating disorders, drugs which are not dispensed by a licensed pharmacist or Doctor, drugs (except insulin) that can be legally obtained without a prescription, drugs which may be received without charge under local, state or federal programs, and prescription drugs for smoking cessation and weight loss;]
9. [Charges for Mental Illness or Substance Abuse;]
10. [Massage therapy or aquatic therapy (unless part of a formal physical therapy program or spinal manipulation services) unless specifically covered as a Covered Service;
11. [Consumable or disposable medical items including, but not limited to, replacement batteries, benzoin, diapers, and "chux;]
12. [Personal convenience items while Confined or not Confined including, but not limited to, breast pumps, overbed tables and remote control devices;]
13. [Organ or tissue transplants;]
14. [Surgery for psychological reasons, including treatment of psychogenic impotence, gender reassignment surgery and treatment for sexual dysfunction;
15. [Physical examinations, tests or care required to obtain or continue employment, or for insurance, marriage, business or leisure travel, adoption or relating to legal orders or for medical research, or to obtain or maintain any type of license;
16. [Treatment of military service-related disabilities when the Covered Person is legally entitled to other coverage and for which Health Care Facilities are reasonably available to the Covered Person;
17. [Services which are due to or related to complications arising from treatment or services otherwise excluded under the Policy;]
18. [Services rendered by a Provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including Spouse, brother, sister, parent or child;]
19. [Expenses, services or supplies for the following immunizations/vaccinations and others as detailed in Our guidelines: Routine adult immunizations including but not limited to influenza, tetanus, and pneumonia; Adenovirus; Anthrax; Bacillus Calmette vaccine; Cholera Vaccine; Hepatitis A vaccine; Hepatitis B vaccine for adults only; typhoid vaccine; Yellow Fever vaccine; Plague vaccine; and Japanese encephalitis vaccine;]
20. [Services of an assistant surgeon provided solely to satisfy a hospital by-law requirement or hospital room custom. Services of an assistant surgeon are covered if the services are deemed Medically Necessary because of the complexity of the procedure or the severity of the circumstances under which the procedure is taken;]

21. [Cosmetic surgery and complications resulting from cosmetic surgery, unless specifically covered under the Policy;]
22. [Expenses, services or supplies which, through Our investigation, are found to have been: a) rendered or provided under fraudulent circumstances; or b) made a part of fraudulent medical records or c) not substantiated in the patient's medical record;]
23. [Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an Injury or Illness by any of the following:
 - The American Medical Association
 - The U.S. Surgeon General
 - The U.S. Department of Public Health
 - The National Institutes of Health;]
24. [Unless specifically provided in the Policy:
 - [Charges for dental treatment]
 - [Charges for oral surgery]
 - [Charges for routine physicals or general health exams]
 - [Charges for refractions, eyeglasses or hearing aids or their fitting]
 - [Charges in connection with [treatment of anorexia and bulimia,] obesity, weight reduction, or dietetic control, including general fitness, exercise programs and health club memberships [but not including disease etiology or bariatric surgery for morbid obesity including gastric bypass, gastric banding, sleeve gastrectomy, and biliopancreatic diversion with duodenal switch];]
 - [Prescription medication recommended or dispensed by; a physician, surgeon, nurse or other Doctor;]
25. [Charges for reversal procedures in connection with previous male or female sterilization;]
26. [Charges for services in the nature of educational or vocational testing or training;]
27. [Any charges for elective abortions;]
28. [Any charges for outpatient food, food supplements or vitamins;]
29. [Radial keratotomies;]
30. [Charges for treatment of male or female infertility; in vitro and in vivo fertilization of an ovum; or artificial insemination including but not limited to:
 - Drugs and medicines;
 - Diagnostic and surgical procedures including but not limited to:
 - Aspiration of ovarian cysts
 - Harvesting or obtaining eggs
 - Other surgical treatment of infertility
 - Diagnostic laboratory and pathology procedures
 - Diagnostic radiology, nuclear medicine and ultra sound procedures.]
31. [Charges for stand-by Doctors to include but not limited to surgeons, pediatricians, anesthesiologists, anesthesiologists, or other Doctor as defined by the Policy; or stand-by supplies, equipment, rooms, or any other service, supply or treatment not actually used in the care or treatment of an Illness or Injury;]
32. [Charges for Custodial Care;]
33. [Charges for durable medical equipment;]
34. [Charges related to smoking cessation;]
35. [Charges for general therapy and counseling and alternative therapies including but not limited to hydrotherapy, biofeedback, and acupuncture, unless specifically covered as a Covered Service.]

[DENTAL BENEFIT PROVISIONS

What Dental Benefits are Provided?

Dental Benefits are payable only if You or Your Dependent incur eligible dental expense charges for dental care while covered under the Policy. Before We determine Benefits, the Covered Person must satisfy any Benefit Waiting Periods and the Deductible, if applicable. We then pay the Percentage of Covered Expense, subject to the Plan Year Benefit Maximum, for Dental Benefits. The Dental Benefits must be for:

1. Necessary dental treatments to a Covered Person while his or her Coverage under the Policy is in force; and
2. Treatment, which in Our opinion has a reasonably favorable prognosis for the patient.

The procedure must be performed by a Dentist.

Benefits will be equal to the Percentage of Covered Expenses, shown in the Schedule of Benefits, times the excess of eligible Dental expense charges that are over and above the Deductible amount for Dental Benefits.

The maximum Dental Benefit, Benefit Waiting Period, Deductible amount and Percentage of Covered Expenses under the Policy are shown in the Schedule of Benefits.

[Eligible dental expense charges incurred and applied to the Deductible amount for Dental Benefits during the last 3 months of a Plan Year will be used to reduce the next Plan Year Deductible for Dental Benefits.]

[Orthodontic Treatment: Eligible dental expense charges for any one course of treatment will be paid at [50%-100%] as follows:

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

The Benefits will not be subject to the Plan Year maximum. The Deductible amount does not apply to Orthodontic Treatment.

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

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

[TYPE I

- Oral Exams - routine oral examination including diagnosis, but not more than [1-3] examinations for each Covered Person during any Plan Year
- Prophylaxis - including cleaning, scaling and polishing, but not more than [1-3] times in any Plan Year for each Covered Person
- Fluoride Treatment - limited to children [10-16] years of Age or younger
- Space Maintainers
- Palliative Emergency Treatment
- X-rays:
 - [a. Full mouth X-rays not to exceed one series in any [2-5] consecutive Plan Year periods;]
 - [b. Bitewing X-rays not more than [once, twice] per Plan Year.]

[TYPE II

- Laboratory Tests and other diagnostic examinations.
- Sealants:
 - a. Limited to children Age [10-16] or younger;
 - b. Only for a tooth or teeth posterior to cuspids; and
 - c. Not more than one application in a Plan Year per tooth
- Simple (routine) Extractions
- Surgical Extractions
- Oral Surgery
- Alveolectomy
- Anesthesia
- Therapeutic Injections
- Restorations - fillings of amalgam or synthetic process
- Denture Repair and Bridge Repair
- Full mouth X-rays not to exceed one series in any [2-5] consecutive Plan Year periods]
- Endodontics - a charge will be deemed incurred on the date the tooth was opened for root canal therapy
- Periodontics.

- (a) The total amount of Benefits payable per Covered Person for any diagnosis, surgery or related services for periodontal disease will in no event exceed the periodontal maximum shown in the Schedule of Benefits; and
- (b) The total amount of Benefits will also be subject to the Plan Year maximum.]

[TYPE III

- Inlays
- Onlays
- Crowns
- Prosthetics, including bridges and dentures as follows:
 1. The initial installation, or addition to full or partial dentures or fixed or removable bridgework will be eligible, provided:
 - (a) The installation or addition was required as a result of an extraction of injured or diseased natural tooth or teeth while the Covered Person is covered;
 - (b) The installation or addition includes the replacement of an extracted tooth or teeth; and
 - (c) The denture or bridgework was completed within [1-36] month(s) following the date of extraction.
 2. Dentures and bridgework are considered initially installed if they do not replace any existing dentures or bridgework.
 3. The replacement or alteration of full or partial dentures, fixed or removable bridgework will be considered for payment when:
 - (a) Medically Necessary;
 - (b) Incurred while the Covered Person was covered; and
 - (c) Completed within [1-36] month(s) after one of the following:
 - An Accidental Bodily Injury which requires surgical treatment; or
 - Oral surgical treatment which involves the repositioning of muscle attachments, or the removal of a tumor, cyst, torus, or redundant tissue; or

The replacement of a full or partial denture or fixed bridgework when required because of structural change in the mouth or removable bridgework that was no longer serviceable provided the replacement:

- (a) Is made [2-10] years or more after the installation date of the denture or bridgework; and
- (b) In no event less than [2-10] years after the Covered Person's Effective Date.

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

[TYPE IV

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

Are any losses excluded under the Policy?

Exclusions that apply are in **EXCLUSIONS** Section. In addition, no Benefits are payable under the Policy for the services listed below. In addition, the services listed below will not be recognized toward the satisfaction of any Deductible:

1. [For services received from the dental or medical department of any employer, union, employee benefit association, trustee, or similar organization, or for services of a dentist or clinic contracted for or by any of these organization;]
2. [For replacement of a tooth or teeth extracted prior to the Covered Person's Effective Date unless the replacement satisfies one of the conditions listed under Type I-IV of Dental Care;]
3. [For any services which are not included in this Certificate.]
4. [For any service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least [1-5] (s), as determined by Us;]
5. [Crowns, inlays, onlays, cast restorations, or other laboratory prepared restorations on teeth, which may be satisfactorily restored with an amalgam or composite resin filling;]
6. [Any treatment which is elective or primarily cosmetic in nature and not recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations unless such procedure is included in this Certificate;]
7. Appliances, Services or procedures relating to:
 - a. the change or maintenance of vertical dimension;

- b. restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards);
 - c. splinting;
 - d. correction of attrition, abrasion, erosion or abfraction;
 - e. bite registration; or
 - f. bite analysis;
8. [For denture or bridgework adjustments within [1-36] month(s) of the placement of a denture or bridgework;]
 9. [Charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments unless such procedures are listed as Covered Procedures in the Schedule of Covered Procedures;]
 10. [Athletic mouth guards; myofunctional therapy; [treatment for malignancies, cysts and neoplasms;] failure to keep scheduled appointment; charges for completion of Claim forms, [infection control]; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; [treatment of jaw fractures]; orthognathic surgery; exams required by a third party other than Us, personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
 11. [Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;]
 12. [Any charge for a service for which benefits are available under Worker's Compensation or an Occupational Disease Act or Law, even if You did not purchase the coverage that is available to You;]
 13. [For porcelain veneered crowns or pontics on or replacing a tooth or teeth posterior to the second bicuspid, which exceeds the maximum allowable charge payable for acrylic veneered crowns or pontics;]
 14. [For a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the dental expense charge for the permanent denture or bridge;]
 15. [For tooth re-implantology not resulting from an Accidental Bodily Injury.]
 16. [For drugs, other than injectable antibiotics administered by a dentist as a result of dental treatment;]
 17. [For treatment initiated while not covered under the Policy, except for orthodontic treatment.]
 18. [For treatment or services not included in Type I-IV of eligible dental care']
 19. [For any Treatment Plan which involves full-mouth reconstruction by the removal and reestablishment of occlusal contacts of 10 or more teeth with restorations, crowns, onlays, inlays, fixed partial dentures, dentures, or any combination of these Services;]
 20. [Services with respect to congenital (hereditary) or developmental (before birth) malformations, except during the [15,31,45,60] day period immediately following the birth of Your Child, including but not limited to; cleft palate, maxillary and mandibular (upper and lower) malformations, enamel hypoplasia (lack of development), fluorosis, and anodontia;]
 21. [Dental services performed in a hospital and related hospital fees;]
 22. [Services covered under an existing medical plan.]

GENERAL DENTAL PROVISIONS

[The replacement of a tooth or teeth extracted but not replaced prior to the Effective Date of the Policy will be covered provided:

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

The replacement of full or partial dentures, fixed or removable bridgework within [2-10] years of a Covered Person's Effective Date under the Policy will be covered provided:

- Other replacement rules listed under the Type of Dental Care section of the Policy were met; and
- The Covered Person's Coverage was continuous for a combined period of at least [2-10] years with the prior Policy.]

Are alternative Benefits acceptable or required?

There is often more than one Service that can be used to treat a dental problem or disease. In determining the Benefits payable on a Claim, different materials and methods of treatment will be considered. The amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. The Covered Person and his or her Dentist may decide on a more costly procedure or material than We have determined to be satisfactory for the treatment of the condition. We will pay a Benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefit shown in the Schedule of Benefits for the least costly Service. We will not pay the excess amount.

May the Company examine a Covered Person while a claim is pending?

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

When does a Covered Person have to obtain a pre-estimate for the cost of a procedure?

Whenever the charge for any treatment is expected to exceed the amount shown in the Schedule of Benefits, We suggest that the Treatment Plan be submitted to Us by the Dentist for review before treatment begins. The Treatment Plan should be accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials that We or Our dental consultants request.

We will notify the Covered Person's attending Dentist of the estimated Benefits payable based upon the Treatment Plan. In determining the amount of Benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. We will pay a Benefit toward the cost of the more expensive procedure or material, but payment will be limited to the Benefits payable for Covered Expenses for the least costly Service. We will not pay the excess amount.]

]

[VISION CARE BENEFIT PROVISIONS

What Vision Benefits are Provided?

You or Your Covered Dependent will be entitled to Benefits if covered vision expenses are incurred while covered under the Policy.

Benefits will be equal to the Percentage of Covered Expenses shown in the Schedule of Benefits. The maximum amount of vision care Benefits payable under the Policy is shown in the Schedule of Benefits.

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

1. Eligible expenses by an Eye Doctor for one routine eye exam within [2-36] consecutive months.
2. Eligible expenses for one pair of eyeglass lenses and frames or one pair of contact lenses including disposable contacts within [2-36] consecutive months. The eyeglasses or contact lenses must be prescribed by an eye Doctor.

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

Are any losses excluded under the Policy?

Yes, Benefits are not provided for:

1. [Any medical or surgical treatment of the eye;]
2. [Sunglasses, plain or prescription; or safety lenses or goggles;]
3. [Orthoptics, vision training or aniseikonia;]
4. [Scratch coating, tinting, and eye glass insurance.]

In addition, We will not pay Benefits for any loss excluded by the **EXCLUSIONS** Section.]

[NON-OCCUPATIONAL WEEKLY DISABILITY INCOME BENEFITS FOR YOU

Are Disability Income Benefits payable for Total Disability due to a Non-Occupational Accident or Illness?

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

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

1. The day You are no longer Disabled; or
2. The last day of the Maximum Period of Disability shown on the Schedule of Benefits.

These Benefits may not be assigned.

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

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

1. The day You are no longer disabled; or
2. The end of the Maximum Period of Disability as shown in the Schedule of Benefits.

Are any losses excluded under the Policy?

Yes, We will not pay Benefits for any loss excluded by the **EXCLUSIONS** Section.]

[LIFE INSURANCE

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

What Benefits are provided to Covered Persons?

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

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

[The Benefit will be paid in one sum.][The Benefit will be paid in one sum unless, prior to payment, You or the Beneficiary elect that payment be made in installments. This is called a settlement option. If no settlement option is in effect upon Your death, Your Beneficiary may then elect such an option. Any settlement option requires a Written agreement with Us. Contact the Policyholder for instructions.]

[If the amount of Benefit paid is at least the amount shown in the Schedule of Benefits, We will make available to Your Beneficiary a retained asset account. Payment for the life Claim may be accessed by writing a check in a single sum or retained in the account by the Beneficiary to write checks in smaller sums.]

[Dependent Life Insurance shall be payable to You, if living, otherwise to Your estate, on receipt by Us at Our [Home Office][Administrative Office] of due Proof of the death of the Covered Person. You will be considered the Beneficiary for Dependent Life Insurance. [Payment will be made in one sum.] [In the event the Dependent commits suicide, Life Insurance Benefits will be limited as described in the Suicide provision below.]]

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

What happens when death is due to suicide?

No payment will be made with respect to the amount of Life insurance under the Policy when a Covered Person commits suicide [whether while sane or insane] and death occurs within [two years] after the date on which the deceased became insured for or elected an increased amount of insurance. [Our liability with respect to such Life Insurance Benefits of such a person will be limited to an amount equal to the premiums paid thereon.]

How do I designate a Beneficiary?

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

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

Do Benefits reduce due to attainment of certain ages?

Yes. Benefits reduce based on Your age [and Your Spouse's age] as shown in the Schedule of Benefits.

[CONVERSION OF YOUR LIFE INSURANCE BENEFITS

Who May Convert?

You will have the right to convert to an individual life insurance policy without submitting Proof of Insurability if [all or part of] Your insurance under the Policy terminates for any of the following reasons:

- [1. Your employment terminates while the Policy is in force;]
- [2. Your membership in an Eligible Class terminates while the Policy is in force;]
- [3. The Policy terminates. You must have been insured under the Policy for at least [1-10] year(s);]
- [4. The Policy is amended to cancel the insurance on the Eligible Class under which You were insured [as shown in the Schedule of Benefits]. You must have been insured under the Policy for at least [1-10] year(s).]

The policy will only be issued to You if You make a Written application to Us and the first premium due for the policy is received at Our [Administrative Office] [Agent] within [30-90] days of such termination [or Benefit reduction]. This [30-90] day period is the conversion period. The policy will not take effect until the end of the conversion period.

If You should die during the [30-90] day conversion period, and prior to becoming insured under the conversion policy, an amount of insurance equal to the maximum amount for which You were entitled to convert will be paid as a death Benefit.

The premium for the individual policy will be determined by the policy type, the risk classification to which You belong, Our published rates in effect and Your age [(nearest birthday)] at the time of conversion.

What type of life insurance policy is available upon conversion?

The policy may be on any plan, [other than term insurance], with level premiums and level death Benefit, which We are then issuing. [However, You may elect single premium term insurance for the policy's [first year] in force.] [It may [not] include any provision for [Accidental Death and Dismemberment] or other Benefit.]

Are there limits on the amount of individual life insurance that may be obtained?

The amount of insurance You may select under the Conversion policy is subject to the following limits:

1. It may not be less than the minimum amount for which We then issue such a policy;
2. If You ceased to be insured because of reason [1 or 2] shown in the Who May Convert section of this provision, it may not be more than the amount of insurance that has been terminated, reduced by any amount of life insurance for which You may be or may become entitled under this or any group insurance policy within the conversion period;
3. [It may not exceed the amount of insurance that has been terminated less any applicable age reductions under the Policy;]
4. If You ceased to be insured because of reason [3 or 4] shown in the **Who May Convert** section of this provision, it may not be more than the smaller of the following amounts:
 - a. the amount of insurance that applied to You at the time it terminated, reduced by any amount of life insurance for which You may be or may become entitled to under any group insurance policy within the conversion period; or
 - b. [\$100 - \$100,000 in [\$1], [\$5],[25][50] [\$100], [\$500] [\$1,000] increments;
5. It may not, in any event, exceed the maximum amount of insurance You are eligible to convert as stated in clause [2] or [4] above reduced by any amount of life insurance currently in force and previously converted under the Policy.

Will You receive a notice of conversion?

The Policyholder is required to give You Written notice of Your right to convert without submitting Proof of Insurability. [If You are not given notice of the existence of the right at least [15-90] days prior to the expiration date of the [30-90] day conversion period, then You have [15-90] days after the notice is given by the Policyholder to exercise the right to convert. The additional period shall not extend beyond [1-90] day(s) after the expiration date of the [30-90] day conversion period.] Written notice presented to You or mailed by the Policyholder to Your last known address constitutes notice for the purpose of this paragraph. In any event, all life insurance terminates at the end of the [30-90] day conversion period, unless properly converted within said time.

[CONVERSION OF DEPENDENT LIFE INSURANCE

Who May Convert?

If Your Covered Dependent ceases to be insured under the Dependent's Insurance provision of the Policy, [he] will have the right to buy an individual life insurance policy without submitting Proof of Insurability if [all or part of]his or her insurance terminates for any of the following reasons:

- [1. Your employment terminates;]
- [2. Your membership in an Eligible Class terminates while the Policy is in force;]
- [3. The Policy terminates. You must have been insured under the Policy for at least [1-10] year(s);]
- [4. The Policy is amended to cancel the insurance on the Eligible Class [as shown in the Schedule of Benefits] under which You were insured. You must have been insured under the Policy for at least [1-10 year(s);]
- [5. Your death;]
- [6. Your Covered Dependent ceases to be a Covered Dependent as defined under Eligible Dependents;]
- [7. You become subject to the terms of the Waiver of Premium provision.]

The policy will be issued to Your Covered Dependent only if a Written application and first premium due for the policy are received by Us at Our [Administrative Office] [Agent] within [30-90] days of such termination[or Benefit reduction].

The [30-90] day period is the conversion period. The individual policy will not take effect until the end of this conversion period.

If Your Covered Dependent should die during the [30-90] day conversion period, and prior to becoming insured under a policy again, the amount of insurance for which the Covered Dependent was entitled to convert will be paid as a death Benefit.

The premium for the individual policy will be determined by the policy type and amount, Covered Dependent's] risk classification, Our published rates in effect and the Covered Dependent's] age [(nearest birthday)] at the time of conversion.

What type of life insurance policy is available upon conversion?

The policy may be on any plan, [other than term insurance], with level premiums and level death Benefit, which We are then issuing. [However, single premium term insurance may be elected for the policy's [first year] in force.] [It may [not] include any provision for [Accidental Death and Dismemberment] or other Benefit.]

Are there limits on the amount of individual life insurance that may be obtained?

The amount of insurance that the [Covered Person] may select under the Conversion policy is subject to the following limits.

1. It may not be less than the minimum amount for which We then issue such a policy;
2. If the Covered Dependent ceased to be insured because of reason [1, 2, 5, 6 or 7] shown in the **Who May Convert** section, it may not be more than the amount of insurance that has been terminated;
3. If the Covered Dependent ceased to be insured because of reason [3 or 4] shown in the **Who May Convert** section, it may not be more than the smaller of the following amounts:
 - a. the amount of insurance that applied to the Covered Dependent] at the time it terminated, reduced by any amount of life insurance for which the Covered Dependent may be or may become entitled under this or any group insurance policy within the conversion period; or
 - b. [\$100 - \$100,000 in [\$1], [\$5],[25][\$50] [\$100], [\$500] [\$1,000] increments;
4. It may not, in any event, exceed the maximum amount of insurance the Covered Dependent is eligible to convert as stated in reason [2 or 3] above reduced by any amount of life insurance currently in force and previously converted under [the Policy.]

Will You receive a notice of conversion?

The Policyholder is required to give [a Covered Person] written notice of the right to convert without submitting Proof of Insurability. [If [a Covered Person] is not given notice of the existence of the right at least [1-90] day(s) prior to the expiration date of the [30-90] day conversion period, then [the Insured] has [15-90] days after the notice is given by the Policyholder to exercise the right to convert. The additional period shall not extend beyond [1-90] day(s) after the expiration date of the [30-90] day conversion period.] Written notice presented to [the Insured] mailed by the Policyholder to the last known address constitutes notice for the purpose of this paragraph. In any event, all life insurance terminates at the end of the [30-90] day conversion period, unless properly converted within said time.]

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When are Accidental Death and Dismemberment Benefits Paid?

Payment for any Accidental Death and Dismemberment Insurance Benefit will be subject to all of the following conditions:

- 1. The Loss is caused solely by an Accident.
2. The Loss is not excluded by the terms of the Exclusions section of this provision.
3. The Accident must occur while a Covered Person is insured under this provision.
4. [The Loss must occur within number of days shown in the Schedule of Benefits after the date on which the Accident occurred [unless otherwise specified].]
5. The maximum amount payable will be subject to the terms of the Limitations section of this provision.

[We may, at Our expense, require a Covered Person to undergo an Independent Medical Exam so that We may determine that a Covered Person is eligible for Benefits under the Policy.]

Definitions for Accidental Death and Dismemberment Insurance

The following definitions apply to the Accidental Death and Dismemberment Policy provisions and Benefits:

Loss: A Benefit from the Schedule of Losses for Accidental Death and Dismemberment which is payable under [the Policy's] terms and conditions. [To be considered for Accidental Death and Dismemberment Benefits, a Loss must occur within number of days shown in the Schedule of Benefits of the Accident [, unless otherwise specified].]

Definitions Related to this Benefit:

Loss: With regard to:

- 1. [An arm, leg, hand or foot, [the total and irrecoverable loss of its use, provided the loss is continuous for [1-36] [consecutive] month(s) and such loss of use is determined to be permanent at the end of such time.][complete severance at or above the wrist or at or above the ankle]]
2. [A thumb and [index] finger or all four fingers of one hand, complete severance at or above the metacarpophalangeal joints.]
3. [All five toes (one foot), complete severance at or above the metatarsophalangeal joints.]
4. [An eye, the total and irrecoverable loss of sight.]
5. [Speech, the complete and irrecoverable loss of speech.]
6. [Hearing, the complete and irrecoverable loss of hearing.]
7. [Quadriplegia, the total paralysis of both upper and lower limbs provided the loss is continuous for [1-36] [consecutive] month(s) from the date of the loss.]
8. [Paraplegia, the total paralysis of both lower limbs provided the loss is continuous for [1-36] [consecutive] month(s) from the date of the loss.]
9. [Hemiplegia, the total paralysis of upper and lower limbs on one side of the body provided the loss is continuous for [1-36] [consecutive] month(s) from the date of the loss.]
10. [Uniplegia, the total paralysis of one limb provided the loss is for [1-36] [consecutive] month(s) from the date of the loss.]

Principal Sum: The amount which applies to a Covered Person under the applicable Amount of Insurance provision at the time of the Accident.

What Benefits are Payable?

We will pay the amount described in the Schedule of Losses if You suffer a covered Loss due to an Accidental Injury, subject to all of the terms and limitations of the Policy:

[Your Schedule of Losses for Accidental Death and Dismemberment

Table with 2 columns: Nature of Loss, Amount Payable. Rows include Life, The sight of both eyes, Either both hands or both feet, One hand and one foot, The sight of one eye and either one hand or one foot.

[Speech <u>and</u> loss of hearing in both ears	[The Principal Sum]]
[Either one arm <u>or</u> one leg.....	[Three-quarters of the Principal Sum]]
[Either one hand <u>or</u> one foot.....	[One-half of the Principal Sum]]
[The sight of one eye or one ear.....	[One-half of the Principal Sum]]
[Speech <u>or</u> hearing in both ears.....	[One-half of the Principal Sum]]
[Both the thumb <u>and</u> [index] finger of one hand.....	[One-quarter of the Principal Sum]]
[Both thumbs of both hands.....	[One-quarter of the Principal Sum]]
[All four fingers of one hand.....	[One-quarter of the Principal Sum]]
[All of the toes of one foot.....	[One-eighth of the Principal Sum]]
[Quadriplegia.....	[The Principal Sum]]
[Paraplegia.....	[One-half of the Principal Sum]]
[Hemiplegia.....	[One-half of the Principal Sum]]
[Uniplegia.....	[One-quarter of the Principal Sum]]

Covered Dependents: We will pay the amount described in the Schedule of Losses if Your Covered Dependent suffers a covered Loss due to an Accident Injury, subject to all of the terms and limitations of the Policy:

[Covered Dependent Schedule of Losses for Accidental Death and Dismemberment]

<u>Nature of Loss</u>	<u>Amount Payable</u>
[Life	[The Principal Sum]
[The sight of both eyes	[The Principal Sum]]
[Either both hands <u>or</u> both feet	[The Principal Sum]]
[One hand <u>and</u> one foot.....	[The Principal Sum]]
[The sight of one eye <u>and</u> either one hand <u>or</u> one foot.....	[The Principal Sum]]
[Speech <u>and</u> loss of hearing in both ears	[The Principal Sum]]
[Either one arm <u>or</u> one leg.....	[Three-quarters of the Principal Sum]]
[Either one hand <u>or</u> one foot.....	[One-half of the Principal Sum]]
[The sight of one eye or one ear.....	[One-half of the Principal Sum]]
[Speech <u>or</u> hearing in both ears.....	[One-half of the Principal Sum]]
[Both the thumb <u>and</u> [index] finger of one hand.....	[One-quarter of the Principal Sum]]
[Both thumbs of both hands.....	[One-quarter of the Principal Sum]]
[All four fingers of one hand.....	[One-quarter of the Principal Sum]]
[All of the toes of one foot.....	[One-eighth of the Principal Sum]]
[Quadriplegia	[The Principal Sum]]
[Paraplegia.....	[One-half of the Principal Sum]]
[Hemiplegia.....	[One-half of the Principal Sum]]
[Uniplegia.....	[One-quarter of the Principal Sum]]

Any amount payable for Accidental Death and Dismemberment Benefits will be paid to You, except in the case of Your Loss of life, in which case, payment will be made to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.

The Benefit will be payable when We receive due Proof of a Loss. A Covered Person’s Principal Sum for Accidental Death and Dismemberment insurance is shown in the Schedule of Benefits. [The Benefit to be paid is the amount from the Schedule of Losses for Accidental Death and Dismemberment, subject to any conditions or reductions of the Policy.] If, as the result of any one Accident, a Covered Person suffers more than one of the Losses shown in the Schedule of Losses with respect to any one limb, payment will be made only for the Loss for which the largest amount is payable. The total maximum amount payable for all Losses will not exceed the Covered Person’s Principal Sum.

May You convert Accidental Death and Dismemberment Benefits upon Termination of Insurance?

No, if Your Covered Dependents’ Accidental Death and Dismemberment Insurance ceases or is reduced, You can not convert that group insurance to an individual policy.

[Are there additional benefits available under the Accidental Death and Dismemberment Benefit? Yes

[Additional Benefit for Child Education

If a Benefit due to Your Accidental Loss of life becomes payable under the Policy, We will reimburse the reasonable and necessary expenses actually incurred according to the Additional Benefit stated below for each Covered Dependent Child who is enrolled as a Full-Time Student and is under the age of [25-32] on the date of Your death:

The Child must be:

1. In an Accredited Institution for Higher Learning above the secondary school level; or
2. At the secondary school level but who will enroll as full-time student(s) in an Accredited Institution for higher learning within [1-365] day(s) after the date of Your death.

The maximum Additional Benefit for Child Education will be the [lowest of the following amounts]:

1. [[1%-10% in 5% increments] of [Your] Principal Sum per year for each Dependent Child;]
2. [[[\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] per year for each Dependent Child;]
3. [[[\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] for all Dependent Children and all years;]
4. [the amount of expense actually incurred.]

[In addition, the Additional Benefit will not exceed a maximum of [1-8] year(s), which must run consecutively from [Your] date of death, with respect to any one Dependent Child.]

The Additional Benefit will be reimbursed [quarterly, semi-annually, annually,] upon receipt of satisfactory Proof that the Dependent Child is attending an Accredited Institution for higher learning as a full-time student, but reimbursement will not be made for expenses incurred prior to Your death, or for room, board or other ordinary living, traveling or clothing expenses.

In the event the Dependent Child satisfies the requirements indicated above and has reached the age of legal majority, such Child will be deemed the Beneficiary with respect to Benefits payable under this Additional Benefit. If the Dependent Child satisfies the requirements indicated above, and has not yet reached the age of legal majority, the Benefit will be payable [annually] to the legal guardian of the estate of the Dependent Child, until such Child reaches the age of legal majority.]

[Additional Benefit for Seat Belt[and Air Bag] [Vehicle Safety Device]

If a Benefit due to Your [Your Covered Spouse's][Your Covered Dependent's] [a Covered Person's] Accidental Loss of life becomes payable under the terms of the Policy, We will pay an Additional Benefit, called the Seat Belt [and Air Bag Benefit], if You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] were/was wearing a Seat Belt [and the Automobile was equipped with Air Bag(s)] at the time of the Accident, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. [The [Seat Belt] Benefit equals the lesser of (i) [\$100-\$500,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] or (ii) [1%-100%, 1% increments] of the amount of the Accidental Death [and Dismemberment] Insurance Benefit paid because of [Your] Accidental death in accordance with the Schedule of Losses.]
2. [The Air Bag Benefit equals the lesser of (i) [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments] or (ii) [1%-100%, 1% increments] of the amount of the Accidental Death [and Dismemberment] Insurance Benefit paid because of [Your] Accidental death in accordance with the Schedule of Losses.]
3. Satisfactory Proof that Your [Your Covered Spouse's][Your Covered Dependent's] [a Covered Person's] death resulted from an Automobile Accident independent of all other causes, and that You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] [were][was] wearing a seat belt at the time of the Accident must be received at the time of Claim. [Proof that the Automobile was equipped with Air Bags may also be required.]
4. [No payment will be made for an Air Bag Benefit if at the time of the Accident You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] [were][was] not in a seat for which the Automobile provided an Air Bag, and wearing a Seat Belt.]
5. A copy of the police accident report must be submitted with the Claim. [The report must certify the position of the Seat Belt.]

6. No payment will be made for the Seat Belt [or Air Bag] Benefit for any Covered Person who is driving or riding as a passenger if:
 - (a) The blood alcohol of the driver or operator of the Automobile is in excess of [1-100 in increments of 1 milligrams of alcohol per 100 milliliters of blood]; or
 - (b) The use of any intoxicant or drug by the driver or operator or any passenger of the Automobile is determined to be a contributing cause of the Accident, whether or not the intoxicant or drug was prescribed by a Provider.

The Additional Benefit for Seat Belt [and Air Bag] will be payable to You, or in the case of [Your death, to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.]

Definitions for this Seat Belt[and Air Bag] [Vehicle Safety Device] Benefit

[Seat Belt: A properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.]

Automobile: A motor vehicle licensed for use on public highways which is a self-propelled passenger vehicle that has four wheels and an internal combustion engine. It may include electric passenger vehicles and certain hybrids. It excludes all other motorized vehicles. [The automobile must be a personally owned vehicle.]

[Air Bag: An inflatable supplemental passive restraint system installed by the manufacturer of the Automobile that inflates upon collision to protect an individual from Injury and death.]]

[Additional Benefit for Repatriation

If You [Your Covered Spouse][Your Covered Dependent] [a Covered Person] sustain Accidental Loss of life more than [1-1,000 [mile][miles] from Your [a Covered Person] normal place of residence and indemnity for such Loss becomes payable under the terms of the Policy, We will reimburse expenses incurred for the transportation of the body of the deceased person, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. Reimbursement for all expenses under this Additional Benefit will not exceed [\$100-\$250,000, in [\$1],[5],[25],[50],[100],[500],[1,000], [\$5,000], [\$10,000], or [\$25,000] increments]]; and
2. Eligible expenses will include transportation of the body, and charges directly related to the preparation of the body for such transportation; and
3. Transportation of the body will be to the first resting place (including, but not limited to, a funeral home or the place of interment) in proximity to the normal place of residence of the deceased; and
4. Satisfactory Proof of the actual expenses will be required at the time of Claim.

The Additional Benefit will be paid to You, or if You are deceased, to Your Beneficiary, as determined in accordance with the Beneficiary Provision[s] under the Policy.]

[Do Accidental Death and Dismemberment Benefits terminate upon attainment of a certain age?

Yes, Benefits under the Accidental Death and Dismemberment Benefit terminate upon Your [or Your Covered Dependent's] attainment of the age shown in the Schedule of Benefits.]

Is any Accidental Death and Dismemberment Loss excluded?

Yes, We will not pay Benefits for any loss excluded by the **EXCLUSIONS** Section. In addition, no benefit will be paid for any Accidental Death and Dismemberment Benefit for any death or Loss resulting in whole or in part from, or contributed to, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury:

1. [Illness, sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these;]
2. [The medical or surgical treatment, diagnostic or preventative care of an Illness, sickness, or disease or bodily infirmity, whether the loss results directly or indirectly from the treatment, including but not limited to cosmetic surgery and gastric bypass surgery;]
3. [Infections of any kind regardless of how contracted including as the result of surgery, except bacterial infection that is the direct result of an accident cut or wound independent and in the absence of any underlying sickness, Illness, disease or condition including but not limited to diabetes;]

4. [Travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a civil aircraft having a valid and current airworthiness certificate and operated by a duly licensed or certified pilot while such aircraft is being used for the sole purpose of transportation only, unless such travel is beyond the earth's atmosphere. Operating, riding in, or descending from any aircraft, if the Covered Person:
 - a. is a pilot, officer, or member of the crew of such aircraft
 - b. is giving or receiving any kind of training or instruction,
 - c. has any duties aboard or requiring descent from such aircraft, except when descent by parachute is for self-preservation.]
5. [Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.]]

]

Do Benefits reduce due to attainment of certain ages?

Yes. Benefits reduce based on Your age [and Your Spouse's age] as shown in the Schedule of Benefits.

[EXCLUSIONS AND LIMITATIONS FOR ALL BENEFITS

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

1. [Committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;]
2. [An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;]
3. [Any period while [a Covered Person] is confined to a penal or correctional institution;]
4. [Participation in any riot or violent disorder;]
5. [An Injury or Illness which arises out of or in the course of [Your] [a Covered Person's] employment;]
6. [Any Injury or Illness covered by any Workers' Compensation Act, Occupational Disease law or similar law;]
7. [Charges for which:
 - there is no legal obligation to pay, or
 - no charge is made, or
 - in the absence of Coverage, no charge would be made;]
8. [Charges incurred before the Effective Date or after the Termination Date, except in those instances noted in this Certificate;]
9. [Suicide or any attempt at suicide while sane [or insane] [and only if it can be shown that the Covered Person intended suicide at the time of purchase of this [Policy][Certificate][Coverage];]
10. [Intentionally self-inflicted Injury while sane [or insane], including any form of auto-eroticism;]
11. [Voluntary poisoning in any form, including, but not limited to, ingestion or inhalation of gas, fumes, chemicals, drugs, alcohol or any combination thereof;]
12. [Being under the influence of any drug, narcotic, intoxicant or chemical, unless administered by or taken according to the advice of a Provider;]
13. [Participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;]
14. [Riding, driving, or testing a Motorized Vehicle used in a race or speed contest, sport, exhibition work or test driving. A Motorized Vehicle for the purpose of this provision means any self-propelled vehicle or conveyance, including [but not limited to] automobiles, trucks, motorcycles, ATV's, snow mobiles, tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. Motorized Vehicle does not include a medically necessary motorized wheelchair;]
15. [Participating in any activity or event, including the operation of a vehicle, while being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Provider and taken according to the Provider's instructions) [as defined by the law of the jurisdiction in which the accident occurred]. [Conviction is not necessary for determination of being "under the influence";]]
16. [For any procedure We determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsement or is Experimental or Investigational in nature;]
17. [Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;]
18. [Services paid for, required, or provided by or under the laws of a national, state, local or provincial government, or treatment furnished within a hospital or other facility owned or operated by a national or state government unless the Insured Person has a legal obligation to pay;]
19. [Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law;]
20. [Charges related to cosmetic surgery or dental care done to beautify a person without medical or dental indication of Injury or Illness;]
21. [All dental services and related anesthesia, dental appliances including, but not limited to, mouth guards, orthotics, orthodontics, and bite plates.]

[PRE-EXISTING CONDITIONS LIMITATION

Are there limitations on Injuries or Illnesses for which a Covered Person was treated prior to the Effective Date of his or her Coverage?

Yes. There may be limits on Pre-existing Conditions.

What is a Pre-existing Condition and how does it affect the Benefits?

A Pre-existing Condition is any condition [(a) that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the [3,6,12] months immediately prior to a Covered Person's Effective Date (look back period);][(b) for which medical advice, diagnosis, care or treatment was recommended or received within [3,6,12] months immediately prior to a Covered Person's Effective Date (look back period);][(c) a pregnancy existing on the Covered Person's Effective Date.] The [3,6,12] month period is called a look back period.

Benefits are not provided for Covered Services rendered for a Pre-existing Condition under the Policy.

A condition will no longer be considered a Pre-existing Condition for any Covered Person who is not a late enrollee per the "When do You enroll" provision after such person has been covered for [6, 12, 24] consecutive months from his or her Effective Date. A condition will no longer be considered a Pre-existing Condition for any Covered Person who has been covered for [6,12,24] consecutive months from his or her Effective Date.

[The Pre-existing Condition look back period will not apply to:

1. [Pregnancy, even if the woman had no prior coverage before enrolling in her current employer's plan.]
2. Conditions present in a newborn or a child under 18 who is adopted or placed for adoption (even if the adoption is not yet final), as long as the child is enrolled in health coverage within 30 days of birth, adoption, or placement for adoption. In addition, the child must not have a subsequent, significant break in coverage (defined as 63 days).]

Is a Pre-existing Condition Limitation affected if a Covered Person had prior health insurance?

Yes, the Pre-existing Condition look back period will be reduced by the aggregate period of Creditable Coverage of the Covered Person, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the coverage.

Creditable Coverage: Health benefits or coverage provided to a person pursuant to:

1. A group health plan;
2. A health benefit plan;
3. Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395c et seq., also known as Medicare;
4. Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq., also known as Medicaid, other than coverage consisting solely of benefits under Sec. 1928 of that Title, 42 U.S.C. Sec. 1396s;
5. The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. Sec. 1071 et seq.;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefit risk pool;
8. A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. Sec. 8901 et seq.;
9. A public health plan as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Health Service Act, 42 U.S.C. Sec. 300gg(c)(1)(I);
10. A health benefit plan under Sec. 5(e) of the Peace Corps Act, 22 U.S.C. Sec. 2504(e).

[CONTINUATION OF COVERAGE

[COBRA (Consolidated Omnibus Budget Reconciliation Act)

Continuation Coverage under COBRA: Continuation applies only to employers which are subject to the provisions of COBRA. You should contact the Policyholder's plan administrator to determine if You are eligible to continue Coverage under COBRA or under the "State Law Continuation" provision. We are not obligated to provide continuation Coverage to a Covered Person if the Policyholder or its designated plan administrator fails to perform its duties under federal law. These duties include but are not limited to:

1. notifying the Covered Person in a timely manner of the right to elect continuation Coverage; and
2. notifying Us in a timely manner of the Covered Person's election of continuation Coverage.

We are not the Policyholder's designated plan administrator and do not assume any duties of a plan administrator pursuant to federal law.

If You chose continuation coverage under a Takeover Benefit plan which was replaced by this Policy, Your continued coverage shall terminate on the first to occur of:

1. the date scheduled under the Prior Plan; or

2. in accordance with the terminating events stated below.

Qualifying Events for COBRA Continuation Coverage: If Your Coverage terminates due to one of the following qualifying events, You are entitled to continue [Medical] [and] [Dental] Coverage. You may elect the same [Medical] [and] [Dental] Coverage that You had at the time of the qualifying event. Qualifying Events are:

1. Your termination of employment with the Policyholder or reduction of hours, for any reason other than gross misconduct; or
2. Your death; or
3. a Covered Person's divorce or legal separation; or
4. a Dependent Child's loss of eligibility; or
5. entitlement of the Eligible Person to Medicare benefits; or
6. for You, if retired, and Your Covered Dependents, the filing of Chapter 11 bankruptcy by the Policyholder; or
7. full-time active duty in the armed forces of any country or international authority.

COBRA notification requirements and election period: The Covered Person must notify the Policyholder's designated plan administrator within sixty (60) days of his or her divorce, legal separation or loss of eligibility as a Dependent. Continuation must be elected by the later of:

1. 60 days after the qualifying event occurs; or
2. 60 days after You receive notice of the continuation right from the Policyholder's designated plan administrator.

You must pay the initial Premium due to the Policyholder's designated plan administrator within forty-five (45) days after electing continuation. Your monthly Premium under COBRA may exceed the premium rate for the [Medical] [and] [Dental] plan under the Policy.

Terminating events for COBRA continuation coverage: COBRA continuation under the Policy will end on the earliest of the following dates:

1. 18 months from the date continuation began, if Your Coverage ended because employment was terminated or hours were reduced as described above. If You are disabled at any time during the first 60 days of COBRA coverage, beginning on the day after termination of employment or reduction in hours, continuation Coverage may be extended to a maximum of twenty-nine (29) months. You must give notice of Your disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend Coverage beyond 18 months. If You provide such notice, Your Coverage may be extended up to a maximum of 29 months from the date of such qualifying event or until the first month that begins more than 30 days after the date of any final decision that You are no longer disabled. If You are disabled but have non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29 month disability extension. You must provide notice of any final determination that he or she is no longer disabled within 30 days of such determination;
2. 36 months from the date continuation began for a Dependent whose Coverage ended because of Your death, divorce or legal separation from You, loss of eligibility by a Dependent Child or entitlement of the Eligible Person to Medicare benefits, in accordance with Qualifying Events described in items 2-6 above;
3. The date Coverage terminates under the Policy for failure to make timely payment of the Premium;
4. The date coverage is obtained under any other Group health plan. If such coverage has a limitation or exclusion with respect to a Covered Person's pre-existing condition, continuation will end on the date such limitation or exclusion ends. The other Group health coverage shall be primary for all health care except health care which is subject to the pre-existing condition limitation or exclusion. If the other Group health plan's pre-existing condition limitations or exclusions cannot be applied because of the restrictions under the Health Insurance Portability and Accountability Act of 1996, then COBRA continuation will end on the date You became covered under the other Group health plan;
5. The date a Covered Person becomes entitled to Medicare, except that this will not apply if the Coverage was terminated because the Policyholder filed for bankruptcy, in accordance with Qualifying Event in item 6 above;
6. The date the Policy terminates; or
7. The date Coverage would otherwise terminate under the Policy.

If Your Coverage ended because employment was terminated or hours reduced as described in item 1 of Qualifying Events and during the 18 month continuation period a second Qualifying Event occurs, Your Coverage may be extended up to a maximum of 36 months. The 36 month period starts from the date Coverage ended due to the first Qualifying Event. If You are entitled to continuation because the Policyholder filed for bankruptcy, as described in

item 6 of the Qualifying Events and You, if retired, dies during the continuation period, the Dependents are entitled to continue Coverage for 36 months from the date of death. Terminating events 2-7 above shall apply during any extended continuation period.

A Dependent whose continuation Coverage terminates because the Eligible Person becomes entitled to Medicare should contact the Policyholder's designated plan administrator for information regarding an extension of continuation Coverage for an additional period of time.]

[State Law Continuation

Eligibility for state continuation coverage: If Your Coverage under the Policy would otherwise terminate due to involuntary termination of employment, You and Your Covered Dependents are entitled to continue Coverage if all the following criteria apply:

1. You were continuously covered under the Policy (or under the Policy and any similar Group plan which was replaced by this Policy) for the entire 3 month period before the termination of employment; and
2. You are entitled to unemployment compensation benefits at the time of the termination of employment; and
3. You are not and do not become covered by or eligible for coverage by Medicare; and
4. You are not and do not become covered under any other Group health plan.

Notification requirements and election period under state law: The Policyholder must notify You of the right to continue Coverage at the time the Policyholder notifies You of the termination of employment.

You must file a written election of continuation with the Policyholder and pay the first month's Premium for continued Coverage no later than:

1. [10] days after the date Your Coverage would otherwise terminate, if the Policyholder notified You of the right of continuation prior to such date; or
2. [10] days after the Policyholder notifies You of the right of continuation, if the notice is given after the date on which Your Coverage would otherwise terminate; or
3. [31] days after the date his or her Coverage would otherwise terminate, if the Policyholder fails to tell You of the right of continuation.

Terminating events for state continuation coverage: Continuation Coverage under the Policy will end on the earliest of the following dates:

1. The date You cease to be eligible for continuation as described in this provision;
2. 6 months from the date continuation began;
3. The date Coverage terminates under the Policy for Your failure to make timely payment of a required Premium;
4. The date the Policy terminates; or
5. the date Coverage would otherwise terminate under the Policy.]]

CLAIMS PROVISIONS

Submitting Claims and Receiving Reimbursement

How to submit a Claim: [Written notice of Claim and request for Claim forms must be given to Us within [20,30,60,90] days after the loss or as soon after as is reasonably possible. Upon receipt by Us of such request, We will send Claim forms for providing Proof of Loss within [10-90 days] to the Claimant, Beneficiary, or You and instructions as to how they should be completed and where they should be sent. Claimants should be sure to fully complete the forms. Incomplete forms may delay the processing of the Claim.] For a Claim for loss of life, a certified copy of the death certificate must be provided to Us.

When to submit Proof of Loss: Written Proof of Loss must be provided within [30-180] days from the date of loss. We will not deny or reduce any Claim filed after [30-180] days from the date of loss if:

1. it was not reasonably possible to file the Claim within that [30-180]-day period.
2. the Claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us [in a reasonable time.] [within [1-3] year(s) after it is due, unless You are legally incapable of doing so.]

What If additional information is required? When We receive Notice of Claim that does not contain all necessary information or is not on an appropriate Claim Form, forms for filing Proof of Loss will be sent to the Claimant along with a request for the missing information.

When and to whom will the Claim be paid? [Except for loss of life or Accidental Dismemberment Benefits,] after receiving written Proof of Loss and Premium payment, We will pay all Benefits then due for Claims directly to [You][Your Doctor]. We will pay all Claims or any portion of any Claims within [30-180] days, or as required by Your state, after receipt of the Claim. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within [30-180] days after receipt of the Claim by us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within [30-180] days. We shall not pay or deny any Claim later than [30-180] days after receiving the Claim. [We will, upon request, provide to You an estimate of the amount We will pay for a particular dental Service.]

[Benefits payable under the Policy for any Accidental Dismemberment loss will be paid as they accrue immediately upon receipt of due Written Proof of Loss. Covered Benefits for any Accidental Dismemberment will be paid to You.]

[Benefits payable under the Policy for Your loss of life will be paid immediately upon receipt of due Written Proof of Loss to the Beneficiary. The Beneficiary is the person or persons You designate to receive any Benefit payable because of Your death. The designation must be made in a Written statement on a form approved by Us. [The Written statement must be placed on file with the [Policyholder] [Our Agent or Us]. Benefits for loss of life for a Covered Person other than You will be paid to You, if alive. Otherwise Benefits will be paid to Your estate.]

You may change Beneficiaries at any time, subject to applicable law. To do so, You must provide a Written statement on a new form. The form changing the Beneficiary must be given to the Policyholder.

Any designation or change of Beneficiary will be effective on the date of its execution; regardless of whether or not You are living at the time it is given to the Policyholder. In the event You die before any designation or change is recorded, any death Benefit We may have already paid will be deducted from the amount payable to a newly named Beneficiary. [A Beneficiary may not be changed by a Power of Attorney.]

If You designate more than one person to share any death Benefit, You should specify on the form how the Benefit is to be divided among them. Otherwise, they will share the Benefit equally. All rights of any Beneficiary cease if he or she dies before You do.

If for all or part of Your insurance, no Beneficiary has been properly designated in accordance with the Policy provisions and applicable law, the amount of Your insurance for which there is no Beneficiary will be payable [to Your estate.] [in equal shares to the first of the following categories of surviving Beneficiaries:

1. legal Spouse;
2. natural, legally adopted children or placed for adoption;
3. mother and father;

4. brother and sister;
5. estate.]

If You and the Beneficiary die from the same accident, and the order of deaths cannot be determined, We will pay the Benefit as though You survived the Beneficiary.]

All payments made to or by Us will be made in United States dollars.

[May We release for payment any life proceeds to persons incurring expenses related to a Covered Person's fatal condition or burial? We may pay up to [\$1,000.00-\$100,000, in [\$1], [\$25], [\$100], [\$500], [\$1,000] increments] for the Life Benefit to the person We feel is entitled to payment because that person incurred expenses in connection with Your last illness, death or burial. This payment will be considered a part of the Your total life insurance Benefit.]

May We conduct physical examinations and autopsy? We shall have the right and opportunity to have any Covered Person whose Injury or Illness is the basis of a Claim undergo an Independent Medical Exam. This may be done when and as often as We may reasonably require. If the person has died, We may require an autopsy, unless it is prohibited by law. Such examination or autopsy will be at Our expense.

Do We have discretionary authority for Benefit determination? Yes, We will make the final decision on Claims for Benefits under the Policy. When making a Benefit determination, We will have discretionary authority to interpret the terms and provisions of the Policy. This discretionary authority should not be construed to limit the legal action that may be taken by a Covered Person or Beneficiary in accordance with the Legal Actions provision of the Policy, and any applicable state or federal law.]]

What if there is an overpayment of Benefits? We reserve the right to deduct from any Benefits properly payable under this Policy the amount of any payment that has been made:

1. in error; or
2. pursuant to a misstatement contained in a Proof of Loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such Coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a Claim for which Benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such Benefits are recovered.

Such deduction may be against any future Claim for Benefits under the Policy made by an Insured Person if Claim payments previously were made with respect to an Insured Person.

What if the Doctor does not accept the copayment described in the Schedule of Benefits?

If the Doctor does not accept a copayment, the Covered Person will be billed for the entire charge. Notify Us of the claim following the instructions above in the **Submitting Claims and Receiving Reimbursement** provision. We will reimburse the claimant for Covered Services at the Benefit level shown in the Schedule of Benefits minus of the copayment that would otherwise have been paid to the Doctor.

COMPLAINT AND APPEAL PROCEDURES

What if I have a complaint about a claim?

Administrative Complaints:

Complaints due to the denial of services or payment of a claim must be reported no later than [twelve (12), eighteen (18)] months from the date of service. Most complaints can be resolved by calling, or writing to, Our Customer Service Department. The telephone number and address are on Your Identification Card.

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

How do I appeal an unfavorable decision regarding claims or inquiries?

Quality of Care or Service Complaint

Quality of care complaints will be forwarded to the unit responsible for such investigations immediately upon receipt by Customer Service. We will send You a written acknowledgment within [three (3), five (5), ten (10), fifteen (15)] working days of receipt of the complaint. All quality of care complaints will be investigated and corrective action taken where problems and/or deficiencies are verified.

1. If We cannot provide You with a satisfactory solution to Your complaint, You may file a standard or urgent (if applicable) appeal for internal review by contacting Us at the address or phone number on the back of your ID card or write to or call the Department of Insurance, whose information is located in the Important Notice section of this Policy.
2. If We deny a claim as “not Medically Necessary” and cannot provide You with a satisfactory solution to Your complaint, You may request an Independent Medical Review (IMR) by writing to or calling Us [or the Department of Insurance, whose information is located in the Important Notice section of this Policy].

Internal Appeal Review

1. Standard Appeals

You, an authorized person, or a Provider, with Your consent, may submit a written appeal to Us if Coverage is denied, reduced or terminated. The appeal must be requested no later than [sixty (60), ninety (90), one hundred eighty (180), or three hundred sixty (360)] calendar days from the date of receipt of the denial letter.

The appeals staff will review all of the information. A decision will be made within [forty (40), sixty (60)] calendar days of receipt for a Post-Service Claim Appeal. This time period may be extended for up to an additional sixty (60) calendar days if additional information is needed. You will be notified in writing of the Appeals Department’s decision. If the appeal involves a medical necessity determination, an independent peer reviewer, who is in the same or a similar specialty, as the Provider who will perform or performed the service will review the file.

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

2. Urgent Appeals

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

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

External Appeal Process

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

1. Department of Insurance Review - Coverage Decision Denials

If We deny Benefits because the service is not a Covered Service, a review of the Coverage Decision may be requested by contacting the:

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

2. [Independent Medical Review –Medical Necessity Denials

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

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

Eligibility:

The Department of Insurance will review Your application for IMR if it is filed within [one (1), two (2), three (3), four (4), five (5), six (6)] months of any of the following qualifying periods or events. All of the following Conditions must be met:

- a. Your Provider has recommended a health care service as Medically Necessary; or
- b. You have received Urgent Care or Emergency services that a Provider determined was Medically Necessary; or
- c. In the absence of (a) or (b) You have been seen by a Participating Provider for the diagnosis or treatment of the medical Condition for which You seek independent review; and
 - The claim has been denied, modified, or delayed by Us based in whole or in part on a decision that the health care service is not Medically Necessary; and
 - You have filed an appeal with Us and the disputed decision is upheld or the appeal remains unresolved after [30, 40, 60] days. If Your appeal requires expedited review You may bring it immediately to the Department of Insurance's attention. The Department of Insurance may waive the requirement that You follow the appeal process in unusual cases.

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

For non-urgent cases, the IMR organization, independent of the Company, and/or designated by the Department of Insurance must provide its' determination within [30, 40, 60] days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential Loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

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

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

Eligibility:

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

- a. You have a Life Threatening or Seriously Debilitating Condition, as certified by Your Doctor.
 - (i) "Life Threatening" means either or both of the following:
 - Diseases or Conditions where the likelihood of death is high unless the course of the disease is interrupted;
 - Diseases or Conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
 - (ii) "Seriously Debilitating Condition" means diseases or Conditions that cause major irreversible morbidity.
- b. Your Doctor certifies that one of the following situations applies:
 - standard therapies have not been effective in improving the Condition;
 - standard therapies are not Medically Necessary for You;
 - there is no standard therapy covered under the Policy that will benefit You more than the requested therapy;
- c. Your Doctor has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to benefit You more than standard therapies; or You or Your Doctor have requested a therapy that based on two (2) documents from the Medical and Scientific Evidence as defined below, is likely to be more beneficial for You than any available standard therapy.
- d. The Doctor's certification includes a statement of the evidence relied upon when certifying the recommendation. We will not pay for services of a Non-Participating Provider that are not otherwise covered.
- e. You have been denied Benefits/Covered Services for services requested in (2) above, unless Coverage for the specific therapy is excluded by this Policy;
- f. The drug, device, procedure or other therapy would be covered under the Policy if it were not considered to be Experimental or Investigational.

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

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

How do I request an Independent Review?

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

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

GENERAL PROVISIONS

[Assignment

You may wish to assign ownership of any Life Benefits to someone else. No assignment of rights, title, interests and incidents of ownership will be binding on Us unless and until the original of the form documenting the assignment, or a true copy of it is received and acknowledged by Us at [Our Administrative office.]

We will have no responsibility:

1. for the validity or effect of any assignment; or
2. to provide any assignee with notices which We may be obligated to provide to You.]

Changes to Policy

The Policy may be amended at any time by written agreement between the Policyholder and Us, without the consent of or notice to any other individual. Any amendment to the Policy must be [in Writing] and be attached to it. The amendment must bear the signature or a reproduction of the signature of Our President, a Vice President, or Secretary.

[If an employee who is otherwise eligible for insurance is not Actively at Work on the Effective Date of the amendment, the effective date with respect to that employee will be on the date that he or she is again Actively at Work. However, if the amendment reduces the amount of insurance to which the employee is entitled, the effective date will be the effective date of the amendment.]

[Contestability of Coverage][Incontestability]

We will not use misrepresentations made by You in a written application to contest the validity of the insurance with respect to which such statement was made, after such insurance has been in force prior to the contest for a period of two years during the Your lifetime, unless the misrepresentations are fraudulent. This section does not prevent Us from using at any time a defense based on:

1. non-payment of Premium; *or*
2. any other provision of the Policy; *or*
3. any other defense that is allowed by law.

If You apply to add additional Covered Persons, the incontestable period with respect to newly added Covered Persons is for two years from such Covered Person's effective date. If You apply for increased Benefits under the Policy, We will not use misrepresentations made by You in a written application for such increase to contest the validity of the increased insurance with respect to which such statement was made, after such increase has been in force prior to the contest for a period of two years from the effective date of the increase.

Errors

You must be properly insured under the Policy. An error or omission by the Policyholder or by Us will not cause You to become Insured. An error or omission by the Policyholder or by Us will not cancel insurance that should continue nor continue insurance that should end. The requirements of the Policy must be properly met for any change in the amount of Your insurance to take effect. We have the right to full recovery of any overpayments made. Such reimbursement will be required regardless of whether the overpayment occurred due to an error by Us, or by You, or Your representative or beneficiary, or the Policyholder.

Legal Actions

No legal action may be brought against Us to recover Policy Benefits until at least [60-365] days after the required written Notice of Loss is submitted to Us. No such action may be brought more than [2-6] years after the time written Proof of Loss is required by the Policy to be given or as required by law.

Misrepresentation

Any statement You make in an application to become insured is a representation and not a warranty. No representation made by You in an application to become insured will be used to reduce or deny Your Claim or contest the validity of Your insurance unless:

1. Your insurance would not have been approved except for Your misrepresentation; *and*
2. Your misrepresentation is contained in a written instrument [Signed] by You; *and*
3. We give You or Your representative a copy of the written instrument that contains Your misrepresentation.

Misstatement of Age or Fact

If a Covered Person's age or any other fact was misstated, We will use the correct facts to determine whether he or she is

insured and if so, for what amount and duration. We will adjust Premium rates to the Covered Person's correct age. We may make this change back to the date Coverage became effective based on the misstated information.

Notice to Policyholder

Written notice given by Us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of the Policy, including termination of the Policy and termination of individual Coverage under the Policy.

Workers' Compensation Not Affected

The Policy does not replace or change any requirement for coverage under workers' compensation insurance.

SCHEDULE OF BENEFITS

This Certificate Schedule of Benefits shows highlights of the coverage available under the Group Policy. Final interpretation of all provisions and coverages will be governed by the Group Policy on file with Nationwide Life Insurance Company at its administrative office and with the Policyholder.]

[Policyholder: [Group Name]]

[Policy Effective Date: [January 1, 2008]]

[Policy Number: [111]]

[Policyholder Address: [Address]]

[Associated Companies [Company name(s)]

[Insured Person: [name]]

[Certificate Effective Date: [January 1, 2007]]

[Covered Dependents [named Spouse, children, Domestic Partner]]

[Covered Dependents Effective Date: [January 1, 2007]]

[Initial Term: [1-24 Months in one month increments]]

[Eligible Classes: [As defined by the Policyholder – insert eligibility requirements here]]

[Eligibility Waiting Period: [[0, 30,60, 90, 180 days][0-3 months] from the first day of being Actively at Work] [during an open enrollment period agreed to by the Policyholder and Us]]

[Rehire Time Period: [1-365] days, weeks, months, years

[Actively At Work Hours [1-40] Hours per week

[Contributory][Non-Contributory]

[Enrollment Period: [10-90] days]

[Frequency of Premium Payment: [Weekly, Bi-weekly, Monthly, Quarterly, Semi-annually, Annually, or coincident with the payroll cycle]]

[Method of Premium Payment: [Remitted by Policyholder to Us or Our Agent] [and/or] [Remitted by Insured Person to Us or Our Agent]]

[Premium Due Date: [1st thru 31st]]

[Plan Year [Policy Year][Calendar Year]]

Pre-Existing Condition Look Back Period: [3-6-12] months prior to Effective Date

We will provide the benefits shown. Any change in amount is subject to the **Change in Amounts of Benefits “When will Benefits Change”** provision in the Certificate.

[HOSPITAL/MEDICAL BENEFITS FOR YOU AND YOUR DEPENDENTS

[Maximum Lifetime Benefit for all Benefits combined: [\$1,000-\$250,000, in \$500 increments]]

[Combined Plan Year Inpatient and Outpatient Deductible: [Per Individual [\$0-\$500, in \$25 increments]]
[Per Family [\$0-\$1,500, 2X or 3x Individual]]]

Inpatient Hospital and Medical Expense Covered Services

[Plan Year Inpatient Deductible for [Surgical,] Hospital and Medical Covered Services combined
Per Individual [\$0-\$500, in \$25 increments]
Per Family [\$0-\$1,500, 2x or 3x Individual]]

Plan Year Maximum per Covered Person: [\$1,000 - \$150,000, in \$500 increments]
Coinsurance per Covered Person: [50% - 100%, in 5% increments][,after Deductible is satisfied]

Outpatient Expenses

[Plan Year Outpatient Deductible for [Surgical,] Medical and Diagnostic Covered Services combined
Per Individual [\$0-\$500, in \$25 increments]
Per Family [\$0-\$1,500, 2x or 3x Individual]]

Coinsurance per Covered Person [50% - 100%] [,after Deductible is satisfied]

Outpatient Medical Expenses

Plan Year Maximum per Covered Person: [\$250 - \$50,000, in \$50 increments]

Outpatient Diagnostic Services

Plan Year Maximum per Covered Person: [\$100 - \$25,000, in \$50 increments]

Inpatient and Outpatient Surgical Services

Combined Inpatient/Outpatient Plan Year Maximum per Covered Person: [\$100 - \$25,000, in \$50 increments] [, subject to Inpatient and Outpatient Plan Year Maximums]

Coinsurance per Covered Person for Inpatient or Outpatient Surgical Services [50% - 100%, in 5% increments] [after Deductible is satisfied]

Doctor Office Visits (Doctor Charge only)

Plan Year Maximum per Covered Person: [Subject to Outpatient Medical Plan Year maximum
Per Covered Person primary care and specialty care office visit Copayment* [\$10-\$100, in \$5 increments]

Balance of Doctors Charges [50%-100%, in 5% increments] [, after Copayment]

Coinsurance for balance of charges for all other expenses in office [50% - 100%, in 5% increments] [, after Deductible is satisfied]

Emergency Services - Emergency Room Visits - Outpatient

Emergency Room Plan Year Maximum per Covered Person: [\$100 - \$5,000, in \$50 increments] [, subject to Outpatient Plan Year Maximum]

Emergency Room Plan Year Deductible per Covered Person [\$0-\$100, in \$25 increments] [, per visit]

Emergency Room Coinsurance per Covered Person [50% - 100%, in 5% increments] [,after Deductible is satisfied]

[Wellness Benefit

Plan Year Maximum per Covered Person: [\$100- \$500, in \$50 increments] [, subject to Outpatient Plan Year Maximum]
 Per Covered Person Copayment* [\$0-\$100, in \$5 increments]
 Coinsurance per Covered Person [50% - 100%, in 5% increments] [, after Copayment]]

[Maternity Services

Plan Year Maximum per Covered Person: [\$1,000 - \$20,000, in \$500 increments] [, subject to Inpatient and Outpatient Plan Year Maximums]
 Plan Year Deductible per Covered Person: [\$0- \$500, in \$25 increments]
 Coinsurance per Covered Person [50% - 100%, in 5% increments] [,after Deductible is satisfied]]

[Supplemental Accident Benefit – Inpatient and Outpatient

Per Accident/Occurrence Maximum per Covered Person [\$300 - \$15,000, in \$50 increments] [, subject to Inpatient and Outpatient Plan Year Maximums]
 [Deductible per Covered Person per Occurrence [\$0 - \$250, in \$25 increments]]
 Coinsurance per Covered Person [50% - 100%, in 5% increments] [, after Deductible is satisfied]
 Plan Year Maximum [1-5] Accident(s)/Occurrence(s)]

*See the Claims section in the Certificate for a description of how claims are paid when a Doctor or other Provider does not accept a Copayment.

[DENTAL BENEFIT

[Benefit Waiting Period:

Procedure Type	Waiting Period
[I Preventive/Diagnostic]	[0, 3, 6, 12, 18, 24, 36] Months
II Basic]	[0, 3, 6, 12, 18, 24, 36] Months
[III Major]	[0, 3, 6, 12, 18, 24, 36] Months
[IV Orthodontia]	[0, 3, 6, 12, 18, 24, 36] Months

Deductible Amount for Type I, II, or III Services Per Covered Person Per Plan Year	Type I, II, or III Services (Non-Orthodontic) Per Covered Person Plan Year Maximum	Type IV Services (Orthodontic) Per Covered Person Lifetime Maximum
[\$50 (Non-Orthodontic only)	\$250	\$125]
[\$50 (Non-Orthodontic only)	\$500	\$250]
[\$50 (Non-Orthodontic only)	\$1,000	\$500]
[\$100 (Non-Orthodontic only)	\$1,000	\$500]
[\$50 (Non-Orthodontic only)	\$1,500	\$750]
[\$100 (Non-Orthodontic only)	\$1,500	\$750]

Dental Benefit Type I Services Only

[Covered charges for exams and cleanings are limited as follows:

[[[\$25, \$50] per visit with a maximum of [\$50, \$100] per Covered Person per Plan Year.] or
 [[[\$25, \$50] per visit but not more than [1-3] examinations for each Covered Person during any Plan Year.

Percentage of Covered Expenses:

- Type I and Type II: [80% - 100% in 5% increments]

- Type III and Type IV: [50% - 100% in 5% increments]

Submission of a pre-estimate of the cost of procedures is recommended for Dental claims exceeding [\$200 - \$500 in \$50 increments].]

[VISION CARE BENEFIT

Percentage of Covered Expenses: [50% - 100% in 5% increments]

Maximum Amount of Vision Expense Benefits per Covered Person per Plan Year: [\$100-\$300 in \$25 increments]]

[NON-OCCUPATIONAL WEEKLY DISABILITY INCOME BENEFITS FOR YOU.

Maximum Amount of Insurance [50%, 66%] of the Basic Weekly Earnings to a Maximum Amount of [\$150 -\$750 in \$50 increments] per week rounded to the next [\$1, \$10].

Waiting Period for Accident [0, 7, 14] days. Benefits begin on the [1st, 8th, 15th day]] [Waiting period for Illness [7, 14] days. Benefits begin on the [8th ,15th day]]

Maximum Period of Disability [13, 26 weeks.]]

LIFE INSURANCE BENEFITS FOR YOU

Amount of Life Insurance [\$5,000-\$50,000 in \$5,000 increments]

[Benefits terminate at age: [80-110]

[The following age reduction rules apply to Your [and Your Spouse’s] Life Insurance Benefit

[Please review the Life Insurance Amount Reduction Schedule. Your amount of insurance [, and the amount of insurance for Your Dependent Spouse] shall reduce as follows [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows][Your][Your Covered Spouse’s] attainment of age [50-99, in 1 year increments]. [[The][Each] reduction shall be based upon [the Benefit prior to age [50-99, in 1 year increments] [the reduced Benefit amount].] [Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the Schedule of Benefits.] [Such person’s amount of insurance will be reduced to the amount shown.]

Life Insurance Amount Reduction Schedule

[Age	{or} % of Coverage Reduction	{or} Benefit %	{or} Benefit Amount
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[After [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]

[Reduced amounts of Life Insurance will be rounded to the next higher multiple of [\$1, \$100, \$500, \$1,000], if not already such a multiple.]]

[Covered Person insurance benefits reduce to [0%-100%, in 1% increments] at age [50-99, in 1 year increments], further reducing to [0%-100%, in 1% increments] of the original amount of insurance at age [50-99, in 1 year increments]. Insurance then reduces by an additional [0%-100%, in 1% increments] of the original amount each subsequent year until it equals [0%-100%, in 1% increments] of the original amount of insurance.]

[Reductions in Your Spouse's Coverage is based upon [Your][Your Spouse's] age. [Coverage for Your Spouse will terminate [on the date] [the last day of the month] when [You] attain[Your Spouse attains] age [50-99, in 1 year increments].]

[Minimum Amount for retained asset account: [\$1,000-\$50,000 in \$1,000 increments]

[LIFE INSURANCE BENEFITS FOR YOUR DEPENDENTS

Maximum Amounts of Dependent Life Insurance are:

<u>Spouse</u>	<u>Child from [10 days] to [6 months]</u>	<u>Child from [6] months to [19] years (to [26] years if a Full Time Student)</u>
[\$2,500	\$200	\$1,250
\$5,000	\$400	\$2,500
\$7,500	\$600	\$3,750
\$10,000	\$800	\$5,000
\$12,500	\$1,000	\$6,250
\$15,000	\$1,200	\$7,500
\$17,500	\$1,400	\$8,750
\$20,000	\$1,600	\$10,000
\$22,500	\$1,800	\$11,250
\$25,000]	\$2,000	\$12,500]

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR YOU

Principal Sum- Same as amount of Life Insurance.

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

Maximum Time Period between Accident and Loss: [90, 180, 365]

[The following age reduction rules apply to Your [and Your Spouse's] Accidental Death and Dismemberment

[Your amount of insurance [, and the amount of insurance for Your Dependent Spouse] shall reduce as follows [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows][Your][Your Covered Spouse's] attainment of age [50-99, in 1 year increment]. [[The][Each] reduction shall be based upon [the Benefit prior to age [50-99, in 1 year increment]][the reduced Benefit amount].] [Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the Schedule of Benefits.] [Such person's amount of insurance will be reduced to the amount shown.]

Accidental Death and Dismemberment Reduction Schedule

[Age	{% of Coverage Reduction (or)	Benefit %	Benefit Amount
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[After [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]

[Reduced amounts of Accidental Death and Dismemberment Insurance will be rounded to the next higher multiple of [\$1, \$100, \$500, \$1,000], if not already such a multiple.]

[Covered Person insurance benefits reduce to [1%-100%, in 1% increments] at age [50-99, in 1 year increments], further reducing to [1%-100%, in 1% increments] of the original amount of insurance at age [50-99, in 1 year increments]. Insurance then reduces by an additional [1%-100%, in 1% increments] of the original amount each subsequent year until it equals [1%-100%, in 1% increments] of the original amount of insurance.]

[Reductions in Your Spouse's Coverage is based upon [Your][Your Spouse's] age. [Coverage for Your Spouse will terminate [on the date] [the last day of the month] when [You] attain][Your Spouse attains] age [50-99, 1 year increments].]

[ADDITIONAL BENEFITS

[Additional Benefit for Child Education]

[Additional Benefit for Repatriation]

[Additional Benefit for Seat Belt[and Air Bag] [Vehicle Safety Device]]

PRESCRIPTION DRUG EXPENSE BENEFIT RIDER

**NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio**

Issues this rider to

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

[The effective date of this rider is the effective date of the policy to which this rider is attached.]
[Effective Date: _____]

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

Subject to the Benefits and Limitations in the Policy, this Rider provides prescription drug benefit.

Schedule of Benefits

[Prescription Drugs

[Plan Year Maximum Benefit per Covered Person [\$50 - \$3,000, in \$25 increments]]
[Maximum Benefit per Covered Person per month [\$25 - \$500, in \$5 increments]]
[Co-pay per prescription – Generic Drugs [\$5 - \$50, \$5 increments]]
[Co-pay per prescription – Brand Name Drugs [\$5 - \$100, \$5 increments]]

[Rx Sample Calculation:

Rx Sample Plan Design:

Co-pay Generic Drug	\$10.00
Co-pay Brand Name Drug	\$25.00
Monthly Maximum	\$50.00

Rx Cost for Brand Name Drug (billed amount):	\$100.00
Insured Person Co-pay	<u>-\$25.00</u>
Balance	\$ 75.00
Monthly Maximum (amount We pay)	<u>\$ -50.00</u>
Insured Person Balance Due	\$ 25.00

Total amount owed by Insured person: \$50.00 (\$25.00 Co-pay + \$25.00 Balance Due)]

Prescription Drug Benefit

Subject to the terms, conditions, limitations and exclusions of the Policy, payment will be considered for Expenses Incurred for the Covered Services described below. All benefits are per Plan Year, unless otherwise indicated.

If by reason of Injury or Sickness, an Insured Person requires drugs, We will pay the Expenses Incurred by the Insured Person for such drugs and the Medically Necessary and Medically Appropriate services associated with the administration of such drugs, subject to the Copayment shown in the Plan of Insurance.

The drugs must be prescribed by a Doctor. We only cover drugs, which are approved for the treatment of the Insured Person's Injury or Illness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia:

1. the American Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information;
3. the United States Pharmacopoeia Drug Information; or
4. it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

[Also covered are prescription drugs or devices approved by the Federal Food and Drug Administration for use as a contraceptive.]

In addition to the exclusions that are in **GENERAL EXCLUSIONS AND LIMITATIONS**, the Company will not pay for the following:

1. [Contraceptive medications and devices, regardless of the reason they were prescribed];
2. [Therapeutic devices or appliances including, but not limited to, hypodermic or disposable needles and syringes when not dispensed with a covered injectable drug, insulin or self-administered chemotherapeutic drugs;]
3. [Drugs prescribed for cosmetic purposes, including but not limited to the removal of wrinkles or other natural skin blemishes due to ageing or physical maturation or treatment of acne; treatment of alopecia (hair loss) or hirsutism (hair removal); anabolic steroids used for body building;]
4. [Drugs containing nicotine or other smoking deterrent medication;]
5. [Drugs for the treatment or purpose of weight control;]
6. [Drugs for the treatment of infertility;]
7. [Treatment of nail (toe or finger) fungus;]
8. [The charge for any prescription refill in excess of the number specified by the prescriber or any refill dispensed one year after the prescriber's prescription order;]
9. [Any vaccine given solely to resist infectious diseases;]
10. [Administration of covered drugs (e.g., injections);]
11. [More than a 34-day supply of a covered drug. We may make exceptions for certain maintenance drugs or for drugs whose minimal package size prevents a 34-day supply from being dispensed (e.g., inhalers);]
12. [More than 12 doses of an impotence drug in a 34-day period;]
13. [Experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed;]
14. [Any covered drug provided for which no charge is made to the Insured Person;]
15. [Anything other than covered drugs and services;]
16. [Diagnostic agents;]
17. [Any drug or device prescribed for uses or in dosages other than those specifically approved by the Federal Food and Drug Administration. This is often referred to as the off-label use of a drug or device, except as specifically described above;]
18. [Drugs that are not labeled "Rx only" including obtainable over the counter drugs, except for state-controlled drugs and insulin;]
19. [Vaccinations, immunizations or care required to obtain or continue employment, or for insurance, marriage, business or leisure travel, adoption or relating to legal orders or for medical research, or to obtain or maintain any type of license;]
20. [Drugs or services obtained before the effective date of this certificate, or after the certificate ends;]
21. [Support garments or other nonmedical items.]

Definitions

[Brand Name Drugs: Drugs for which the drug manufacturer's trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.]

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

There are no other changes to the policy or certificate to which it is attached.



President

FELONIOUS ASSAULT BENEFIT

**NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio**

Issues this rider to

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

[The effective date of this rider is the effective date of the policy to which this rider is attached.]
[Effective Date: _____]

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

The Policy and Certificate to which this rider is attached is amended as follows:

The Accidental Death and Dismemberment Benefit is amended by the addition of the following benefit:

If an Accidental Injury which results in a Loss payable under the terms of the Policy is the result of a Felonious Assault inflicted upon You, We will pay an additional [20%] of the Principal Sum, subject to all of the terms and limitations of the Policy and all of the following conditions:

1. [The Felonious Assault must be inflicted by someone other than a Fellow Employee or Family Member and while You are performing Your normal work duties for the Policyholder or on Employer Premises; and]
2. A report of the criminal activity is required to have been filed with the appropriate law enforcement authority within [48] hours of the incident. A certified copy of this report must accompany the Claim for Benefits. The criminal and civil codes where the Felonious Assault or attempt was perpetrated shall be the basis for interpretation of the terms used in this paragraph.

Definitions for the Victim of Felonious Assault Benefit

[Employer Premises: A building, structure or property maintained by the Policyholder [or Associated Employer] for conducting its business operations.]

[Fellow Employee: Another employee of the Policyholder [or Associated Employer], whether or not insured under the Policy, and includes a former employee whose employment has terminated within [120 days] of the Felonious Assault.]

[Felonious Assault: A physical attack by another person resulting in bodily harm. A physical attack is any willful or unlawful use of force or violence with the intent to cause bodily injury. The physical attack must be considered a felony or misdemeanor in the jurisdiction in which it occurs. The Felonious Assault must not be either a moving violation as defined under the applicable state motor vehicle laws or an act of a Family Member.]



President

MENTAL HEALTH [/SUBSTANCE ABUSE] COVERED SERVICES RIDER

**NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio**

Issues this rider to

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

[The effective date of this rider is the effective date of the policy to which this rider is attached.]
[Effective Date: _____]

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

The Policy and Certificate to which this rider is attached is amended to include the following benefits for treatment of [Biologically Based] Mental Illness and Substance Abuse:

We cover such charges the same way We treat Covered Services for any other Illness, including limitations, coinsurance, deductibles, and co-payments for up to the following limits per Covered Person in a Calendar Year:

Definitions:

[Biologically Based] Mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. bipolar disorders (hypomanic, manic, depressive, and mixed);
2. depression in childhood and adolescence;
3. major depressive disorders (single episode or recurrent);
4. obsessive-compulsive disorders;
5. paranoid and other psychotic disorders;
6. schizo-affective disorders (bipolar or depressive);
7. schizophrenia;
8. [Substance Abuse;]
9. Autism spectrum disorder including autism, Asperger's syndrome, or Pervasive Developmental Disorder—Not Otherwise Specified; and
10. a neurobiological disorder which is an Illness of the nervous system caused by genetic, metabolic, or other biological factors.

[Substance Abuse: The psychological or physical dependence on, or addiction to alcohol, drugs and other controlled substances.]

CONVERSION BENEFIT RIDER

NATIONWIDE LIFE INSURANCE COMPANY Columbus, Ohio

Issues this rider to

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

[The effective date of this rider is the effective date of the policy to which this rider is attached.]
[Effective Date: _____]

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

CONVERSION OF HOSPITAL-MEDICAL EXPENSE BENEFITS

Who may convert?

We have contracted with another licensed insurer (hereinafter called Conversion Carrier) to issue and administer the conversion coverage described in this section. You may contact Us, the Conversion Carrier, or Your Employer to begin the application process.

You may be eligible for the hospital-medical conversion coverage described below if Your Coverage under the Policy ends because:

1. An Eligible Person's employment terminates;
2. An Eligible Person died;
3. Your Dependent status changed;
4. Your COBRA continuation coverage has been exhausted per the section entitled **CONTINUATION OF COVERAGE**; or
5. Your state continuation coverage has been exhausted per the provision entitled State Law Continuation.

You must have been insured under the Policy or any policy that it replaced for at least [90] days before You may apply for conversion.

Will the Benefits under the conversion policy be the same as the Benefits under the Policy?

No, benefits and premiums under the conversion policy may differ from the Benefits and premium under the Policy. Read the conversion policy carefully.

When will the conversion policy become effective for me?

No lapse in Coverage is permitted. The effective date of the conversion policy will be the day following the date Coverage under the Policy terminated, if within the 31 day conversion period, You submit a completed application and pay the required premium to the Conversion Carrier. If extended benefits are payable under the Policy, the amount payable under the conversion plan will be reduced. The total amount paid will not exceed the amount that would have been payable under the Policy.

Will I be notified of my conversion right at termination of Coverage?

Yes. You will receive written notice from Us of the Conversion Carrier about the conversion option. This notice will be mailed to Your address listed in the Policyholder's records. The Policyholder must notify Us or the Conversion Carrier of the event giving rise to the conversion option. You have 31 days from the date of the event to apply for conversion coverage and pay the initial premium.

If you do not receive written notice of the conversion option at least 15 days prior to the end of the 31 day conversion period, the conversion period will be extended. The extension period ends 15 days after notice is sent. The maximum extension period is 91 days after the date of the event giving rise to the conversion option. Your completed application and required premium must be received during the applicable extension period before Your conversion coverage will take effect.

Are there circumstances when conversion is not available?

Yes, it is not available to anyone where any of the following situations apply:

1. The Covered Person is eligible for similar benefits from any other source including any other group benefit plan or Medicare;
2. Coverage was ended by Us for cause. Cause may include, but is not limited to:
 - a) non-compliance with Our terms and conditions as determined by Us;
 - b) non-payment of premium;
 - c) fraud;
3. Coverage under the Policy terminates because the entire Policy is terminated;
4. A Covered Person has reached the maximum Benefits under the Policy; or
5. Total benefits provided by conversion coverage and any other health coverage would result in overinsurance.

The conversion coverage may be cancelled if certain events occur as described in the conversion policy.



President

Nationwide Life Insurance Company
Columbus, Ohio

AMENDMENT NUMBER [1]

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

State Mandated Benefits:

Benefits are subject to policy deductible, coinsurance and/or copays and limitations found in the schedule of benefits.

Contraceptives

If the plan provides coverage for prescription medications then all FDA-approved contraceptives are covered.

In-Vitro Fertilization

Coverage required under this section includes services performed at a medical facility licensed or certified by the Department of Health, those performed at a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics, or those performed at a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilization.

The patient is the insured or the spouse of the insured and a covered dependent under that policy or certificate, and

B. The patient's oocytes are fertilized with the sperm of the patient's spouse, and

C.(1) The patient and the patient's spouse have a history of unexplained infertility of at least two (2) years' duration; or

(2) The infertility is associated with one or more of the following medical conditions:

- Endometriosis;
- Exposure in utero to Diethylstilbestrol, commonly known as DES;
- Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
- Abnormal male factors contributing to the infertility, and

D. The in vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.

E. The patient has been unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the policy.

The benefits for in vitro fertilization shall be the same as the benefits provided under maternity benefit provisions and may be subject to the same deductibles, co-insurance and out-of-pocket limitations provided in the policy or certificate that apply to maternity benefits. Any preexisting condition limitation shall not exceed a period of twelve (12) months. The policy or certificate may include a lifetime maximum benefit of not less than Fifteen Thousand Dollars (\$15,000.00).

Breast Reconstruction Mastectomy

Policies that cover mastectomy are subject to the following:

(1) For medical and surgical benefits for any hospital stay in connection with a mastectomy for not less than forty-eight (48) hours unless the decision to discharge the patient before the expiration of the

minimum length of stay is made by an attending physician in consultation with the enrollee or insured;

(2) The following medical and surgical benefits with respect to mastectomy coverage if You receive benefits in connection with a mastectomy and elect breast reconstruction:

- (A) Surgery and reconstruction of the breast on which the mastectomy has been performed;
- (B) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (C) Prostheses and coverage for physical complications at all stages of a mastectomy, including lymphedemas

Children's Preventative Health Care

Plans providing benefits for children's preventative health care services on a periodic basis include at a minimum twenty (20) visits at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years. Services are covered to the extent that these services are provided by or under the supervision of a single physician during the course of one (1) visit.

Benefits for recommended vaccine and immunization services are exempt from any co-payment, coinsurance, and deductible or dollar limit provisions; all other children's preventative health care services are to be subject to co-payment, coinsurance, deductible, or dollar limit provisions in the policy or contract.

Children's preventative health care services " means physician-delivered or physician-supervised services for eligible dependents from birth through eighteen (18) years of age, with periodic preventative care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section; and

"Periodic preventative care visits "means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

Colorectal Cancer Screening

Benefits provided include colorectal cancer examinations and laboratory tests within the policy's coverage.

The coverage includes colorectal cancer examinations and laboratory tests for:

- (1) Covered persons who are fifty (50) years of age or older;
- (2) Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines ; and
- (3) Covered persons experiencing the following symptoms of colorectal cancer as determined by a physician licensed under the Arkansas Medical Practices Act:

- (A) Bleeding from the rectum or blood in the stool; or

- (B) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than five (5) days.

The colorectal screening involves an examination of the entire colon, including:

(A) The following examinations or laboratory tests, or both:

- (i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

- (ii) A double-contrast barium enema every five (5) years; or

- (iii) A colonoscopy every ten (10) years; and

(B) Any additional medically recognized screening tests for colorectal cancer required by the Director of

the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

Determination of the choice of screening strategies is to be made in consultation with a health care provider.

Colorectal screening examinations are subject to the choices and frequency provided by this subsection:

Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

(1) If the initial colonoscopy is normal, follow-up is recommended in ten (10) years;

(2) For individuals with one (1) or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;

(3) If single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and

(4) For patients with large sessile adenomas greater than three centimeters (3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

" Persons at high risk for colorectal cancer " means:

(A) Individuals over fifty (50) years of age or who face a high risk for colorectal cancer because of:

(i) The presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy;

(ii) A family history of colorectal cancer in close relatives of parents, brothers, sisters, or children;

(iii) Genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

(iv) A personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or

(v) The presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and

(B) Any additional or expanded definition of "persons at high risk for colorectal cancer" as recognized by medical science and determined by the Director of the Division of Health of the Department of Health and Human Services in consultation with the University of Arkansas for Medical Sciences.

Dental Anesthesia

Coverage provided for payment of anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if:

(1) The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and

(2) The patient is:

(A) A child under seven (7) years of age who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act, § 17-82-101 et seq., to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;

(B) A person with a diagnosed serious mental or physical condition; or

(C) A person with a significant behavioral problem as determined by the covered person's physician as licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq.

May require prior authorization for hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered medical conditions.

If You are covered under both a health benefit plan that provides dental benefits and a health benefit plan that provides medical benefits, the health benefit plan that includes dental benefits is the primary payer and the health benefit plan that provides medical benefits is the secondary payer.

This section does not apply to treatment rendered for temporomandibular joint disorders.

Diabetic Supplies/Education

Includes medical coverage for medically necessary equipment, supplies and services for the treatment of Type I, Type II, and gestational diabetes, when prescribed by a physician.

Coverage for one (1) per lifetime training program per insured for diabetes self-management training when medically necessary as determined by a physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training.

"Diabetes self-management training " means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association;

Provide coverage for the equipment, supplies and services listed in this section prescribed by an insured's physician, which are medically necessary for the treatment of diabetes mellitus, including and not limited to Type 1, Type 2, and gestational diabetes.

- (1) Blood glucose monitors, which include all commercially available blood glucose monitors designed for patient use and for persons who have been diagnosed with diabetes;
- (2) Blood glucose monitors for the legally blind, which include all commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes;
- (3) Test strips for glucose monitors, which include all test strips approved by the Federal Food and Drug Administration, glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
- (4) Visual reading and urine testing strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones. Urine test strips for glucose only are not acceptable as the sole method of monitoring;
- (5) Insulin, which includes all commercially available insulin preparations including insulin analog preparations available in either vial or cartridge;
- (6) Injection aids, which include devices used to assist with insulin injection;
- (7) Syringes, which include insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin injection devices;
- (8) Insulin pumps as prescribed by the physician and appurtenances thereto, which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
- (9) Oral agents for controlling the blood sugar level, which are prescription drugs;
- (10) Podiatric appliances for prevention of complications associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment; and
- (11) Glucagon Emergency Kits and injectable glucagon.

Newborn Infant Coverage

Coverage for tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.

Coverage to pay for routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

Formula for PKU/Medical Foods & Low Protein Modified Food Products

Provide coverage for amino acid modified preparations, low protein modified food products, and any other special dietary products and formulas prescribed under the direction of a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

"Inherited metabolic disease " means a disease caused by an inherited abnormality of body chemistry;

" Low protein modified food product " means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease;

"Medical food " means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

Loss or Impairment of Speech or Hearing

Provide coverage for the necessary care and treatment of loss or impairment of speech or hearing, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as other covered services in the policies or contracts.

The audiology and speech pathology coverage requirements will not apply to disability income, specified disease, hospital indemnity, or accident-only policies.

Mental Health Parity

Provide benefits for diagnosis and mental health treatment of mental illnesses and developmental disorders under the same terms and conditions as provided for covered benefits offered under the health benefit plan for the treatment of other medical illnesses or conditions.

Off-Label Drug Use

Exclusion of FDA approved cancer drugs prohibited. No insurance policy that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided:

(1) The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more such compendia:

- (A) The American Hospital Formulary Service drug information;
- (B) The United States Pharmacopoeia dispensing information; or

(2) The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

(c) Coverage of a drug includes medically necessary services associated with the administration of the drug, provided that such services are covered by the insurance policy.

Is not to be construed to do any of the following:

- (1) Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed;
- (2) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration; or
- (3) Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

[Hospice

Provides coverage for hospice facilities and hospice programs.]

[Mental Disorders

Payable as any other illness]

[Mammogram

§23-79-140

Coverage provided for the following mammogram screening of occult breast cancer:

- (1) A baseline mammogram for a woman covered by such a policy who is thirty-five (35) to forty (40) years of age;
- (2) A mammogram for a woman covered by such a policy who is forty (40) to forty-nine (49) years of age, inclusive every one (1) to two (2) years based on the recommendation of the woman's physician;
- (3) A mammogram each year for a woman covered by such a policy who is at least fifty (50) years of age; or
- (4) Upon recommendation of a woman's physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer.]

Prostate Cancer Screening

Coverage provided for prostate cancer screening to men forty (40) years of age or older is required to provide coverage for screening for the early detection of prostate cancer in men forty (40) years of age or older.

Coverage includes at least one (1) screening per year for any man forty (40) years of age or older according to the National Comprehensive Cancer Network guidelines.

The coverage for the prostate cancer screening is not subject to the deductibles and will not exceed the actual cost of the prostate screening up to the maximum allowable cost per screening.

If a medical practitioner recommends that the insured undergo a prostate specific antigen blood test, coverage will not be denied on the ground that the insured has already had a digital rectal examination and the examination result was negative.

[Psychological Examiners

Coverage for the payment of services rendered by psychological examiners for mental health coverage.]

[TMJ (Musculoskeletal Disorders of Face, Neck or Head)

Coverage provided for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment includes both surgical and nonsurgical procedures.

This coverage is provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

This coverage shall be the same as that provided for any other musculoskeletal disorder in the body and is provided whether prescribed or administered by a physician or dentist.]

This amendment is hereby accepted and deemed valid on the effective date of [].

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

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

Signed for the Company at Columbus, Ohio



Vice President
Nationwide Life Insurance Company

NATIONWIDE LIFE INSURANCE COMPANY
One Nationwide Plaza
Columbus, Ohio 43215-2220

Wellness and/or Health Care Services Endorsement

General Information Regarding this Endorsement

This Insured's Wellness and/or Health Care Services Endorsement ("Endorsement") revises the terms and conditions of the policy to which it is attached. To the extent the terms of the policy and this Endorsement are inconsistent, the terms of this Endorsement shall control. Non-defined terms shall have the meaning given to them in the policy.

There is no additional charge or required Premium for programs or services offered pursuant to this Endorsement.

Purpose

The purpose of this Endorsement is to inform the Policy Owner that, from time to time, we may offer the Insured access to certain health and/or wellness programs and services.

Programs and Services

The programs and services may include, but are not limited to, access to service provider referral networks, benefit consultation services and/or wellness programs. Such programs and/or services will be offered on all eligible policies on a uniform and not unfairly discriminatory basis.

We may arrange for third party service providers to administer such program or service.

All terms and conditions regarding the program or service, if any, are determined by the third party service provider. We are not liable for negligent acts or omissions of such third party service providers. Participation in such program or service is voluntary.

Availability

Programs and services provided under this Endorsement are subject to availability and may be modified, suspended, or terminated providing you with written notice.


President



SERFF Tracking Number: NWLC-126115021 State: Arkansas
Filing Company: Nationwide Life Insurance Company State Tracking Number: 42098
Company Tracking Number: NSHMM 2000 (SK)
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: Group Mini-Medical
Project Name/Number: NSHMM 2000/NSHMM 2000

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 05/11/2009
Comments:
Attachment:
Readability Cert.pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 05/11/2009
Bypass Reason: The application that will be used has been submitted under another filing and is awaiting review.
The SERFF number for the filing is NWLC-126115288.
Comments:

Satisfied -Name: Authorization **Review Status:** Approved-Closed 05/11/2009
Comments:
Attachment:
Authorization letter.pdf

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

<u>Form Number(s)</u>	<u>Policy/Certificate:</u>	<u>Flesch Score:</u>
NSHMM 2000	Policy	65.83
NSHMM 2500	Certificate of Coverage	62.47
NSHMM 2500-Sched	Schedule of Benefits	61.87
NSHMM 2400-RX	Rider	67.51
NSHMM 2400-FA	Rider	59.88
NSHMM 2400-MHSA	Rider	50.37
NSHMM 2400-Conversion	Rider	65.23

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 .



Tom DeNoma
Associate Vice President

Date: **April 13, 2009**



Jonna L. Shields, Compliance Specialist
5525 Parkcenter Circle CO-01-30
Dublin, Ohio 43017
PH: 614-854-3049 FAX: 614-854-3469
shieldj@nationwide.com

Office of Chief Legal Officer

April 7, 2009

To Whom It May Concern:

Coulter & Associates is hereby authorized to submit rate, rule, and form filings on behalf of **Nationwide Life Insurance Company, NAIC # 66869, FEIN – 31-4156830**

This authorization includes providing additional information and responding to questions regarding the filings on our behalf as necessary. This authorization is deemed to be in effect until rescinded in writing.

Please direct all correspondences and inquiries related to this filing to Coulter & Associates at the following address:

State Filings Department
Coulter & Associates
379 Princeton Hightstown Rd
Cranbury, NJ 08512
Phone: 609-443-1811
Fax: 609-443-4103

Please contact me if you have any questions regarding this authorization.

Very truly yours,

A handwritten signature in black ink that reads "Jonna Shields". The signature is written in a cursive, flowing style.

Jonna Shields
Compliance Specialist
614.854.3049
614.854.3469
shieldj@nationwide.com

SERFF Tracking Number: NWLC-126115021 State: Arkansas
 Filing Company: Nationwide Life Insurance Company State Tracking Number: 42098
 Company Tracking Number: NSHMM 2000 (SK)
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: Group Mini-Medical
 Project Name/Number: NSHMM 2000/NSHMM 2000

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	Schedule of Benefits	04/16/2009	NSHMM 2500-SCHED.pdf
No original date	Form	Wellness Rider	04/20/2009	NSHSAS 2400 - Wellness.pdf

SCHEDULE OF BENEFITS

This Certificate Schedule of Benefits shows highlights of the coverage available under the Group Policy. Final interpretation of all provisions and coverages will be governed by the Group Policy on file with Nationwide Life Insurance Company at its administrative office and with the Policyholder.]

[Policyholder:	[Group Name]]
[Policy Effective Date:	[January 1, 2008]]
[Policy Number:	[111]]
[Policyholder Address:	[Address]]
[Associated Companies	[Company name(s)]
[Insured Person:	[name]]
[Certificate Effective Date:	[January 1, 2007]]
[Covered Dependents	[named Spouse, children, Domestic Partner]]
[Covered Dependents Effective Date:	[January 1, 2007]]
[Initial Term:	[1-24 Months in one month increments]]
[Eligible Classes:	[As defined by the Policyholder – insert eligibility requirements here]]
[Eligibility Waiting Period:	[[0, 30,60, 90, 180 days][0-3 months] from the first day of being Actively at Work] [during an open enrollment period agreed to by the Policyholder and Us]]
[Rehire Time Period:	[1-365] days, weeks, months, years
[Actively At Work Hours	[1-40] Hours per week
[Contributory][Non-Contributory]	
[Enrollment Period:	[10-90] days]
[Frequency of Premium Payment:	[Weekly, Bi-weekly, Monthly, Quarterly, Semi-annually, Annually, or coincident with the payroll cycle]]
[Method of Premium Payment:	[Remitted by Policyholder to Us or Our Agent] [and/or] [Remitted by Insured Person to Us or Our Agent]]
[Premium Due Date:	[1 st thru 31 st]]
[Plan Year	[Policy Year][Calendar Year]]
Pre-Existing Condition Look Back Period:	[3-6-12] months prior to Effective Date

We will provide the benefits shown. Any change in amount is subject to the **Change in Amounts of Benefits “When will Benefits Change”** provision in the Certificate.

[HOSPITAL/MEDICAL BENEFITS FOR YOU AND YOUR DEPENDENTS

[Maximum Lifetime Benefit for all Benefits combined: [\$1,000-\$250,000, in \$500 increments]]

[Combined Plan Year Inpatient and Outpatient Deductible: [Per Individual [\$0-\$500, in \$25 increments]]
[Per Family [\$0-\$1,500, 2X or 3x Individual]]]

Inpatient Hospital and Medical Expense Covered Services

[Plan Year Inpatient Deductible for [Surgical,] Hospital and Medical Covered Services combined Per Individual [\$0-\$500, in \$25 increments]
Per Family [\$0-\$1,500, 2x or 3x Individual]]
Plan Year Maximum per Covered Person: [\$1,000 - \$50,000, in \$500 increments]
Coinsurance per Covered Person: [50% - 100%, in 5% increments][,after Deductible is satisfied]

Outpatient Expenses

[Plan Year Outpatient Deductible for [Surgical,] Medical and Diagnostic Covered Services combined Per Individual [\$0-\$500, in \$25 increments]
Per Family [\$0-\$1,500, 2x or 3x Individual]]
Coinsurance per Covered Person [50% - 100%] [,after Deductible is satisfied]

Outpatient Medical Expenses

Plan Year Maximum per Covered Person: [\$250 - \$50,000, in \$50 increments]

Outpatient Diagnostic Services

Plan Year Maximum per Covered Person: [\$100 - \$25,000, in \$50 increments]

Inpatient and Outpatient Surgical Services

Combined Inpatient/Outpatient Plan Year Maximum per Covered Person: [\$100 - \$25,000, in \$50 increments] [, subject to Inpatient and Outpatient Plan Year Maximums]
Coinsurance per Covered Person for Inpatient or Outpatient Surgical Services [50% - 100%, in 5% increments] [after Deductible is satisfied]

Doctor Office Visits (Doctor Charge only)

Plan Year Maximum per Covered Person: [Subject to Outpatient Medical Plan Year maximum
Per Covered Person primary care and specialty care office visit Copayment* [\$10-\$100, in \$5 increments]
Balance of Doctors Charges [50%-100%, in 5% increments] [, after Copayment]
Coinsurance for balance of charges for all other expenses in office [50% - 100%, in 5% increments] [, after Deductible is satisfied]

Emergency Services - Emergency Room Visits - Outpatient

Emergency Room Plan Year Maximum per Covered Person: [\$100 - \$5,000, in \$50 increments] [, subject to Outpatient Plan Year Maximum]
Emergency Room Plan Year Deductible per Covered Person [\$0-\$100, in \$25 increments] [, per visit]
Emergency Room Coinsurance per Covered Person [50% - 100%, in 5% increments] [,after Deductible is satisfied]

[Wellness Benefit

Plan Year Maximum per Covered Person: [\$100- \$500, in \$50 increments] [, subject to Outpatient Plan Year Maximum]
 Per Covered Person Copayment* [\$0-\$100, in \$5 increments]
 Coinsurance per Covered Person [50% - 100%, in 5% increments] [, after Copayment]]

[Maternity Services

Plan Year Maximum per Covered Person: [\$1,000 - \$20,000, in \$500 increments] [, subject to Inpatient and Outpatient Plan Year Maximums]
 Plan Year Deductible per Covered Person: [\$0- \$500, in \$25 increments]
 Coinsurance per Covered Person [50% - 100%, in 5% increments] [,after Deductible is satisfied]]

[Supplemental Accident Benefit – Inpatient and Outpatient

Per Accident/Occurrence Maximum per Covered Person [\$300 - \$15,000, in \$50 increments] [, subject to Inpatient and Outpatient Plan Year Maximums]
 [Deductible per Covered Person per Occurrence [\$0 - \$250, in \$25 increments]]
 Coinsurance per Covered Person [50% - 100%, in 5% increments] [, after Deductible is satisfied]
 Plan Year Maximum [1-5] Accident(s)/Occurrence(s)]

*See the Claims section in the Certificate for a description of how claims are paid when a Doctor or other Provider does not accept a Copayment.

[DENTAL BENEFIT

[Benefit Waiting Period:

Procedure Type	Waiting Period
[I Preventive/Diagnostic]	[0, 3, 6, 12, 18, 24, 36] Months
[II Basic]	[0, 3, 6, 12, 18, 24, 36] Months
[III Major]	[0, 3, 6, 12, 18, 24, 36] Months
[IV Orthodontia]	[0, 3, 6, 12, 18, 24, 36] Months

Deductible Amount for Type I, II, or III Services Per Covered Person Per Plan Year	Type I, II, or III Services (Non-Orthodontic) Per Covered Person Plan Year Maximum	Type IV Services (Orthodontic) Per Covered Person Lifetime Maximum
[\$50 (Non-Orthodontic only)	\$250	\$125]
[\$50 (Non-Orthodontic only)	\$500	\$250]
[\$50 (Non-Orthodontic only)	\$1,000	\$500]
[\$100 (Non-Orthodontic only)	\$1,000	\$500]
[\$50 (Non-Orthodontic only)	\$1,500	\$750]
[\$100 (Non-Orthodontic only)	\$1,500	\$750]

Dental Benefit Type I Services Only

[Covered charges for exams and cleanings are limited as follows:

[[[\$25, \$50] per visit with a maximum of [\$50, \$100] per Covered Person per Plan Year.] or
 [[[\$25, \$50] per visit but not more than [1-3] examinations for each Covered Person during any Plan Year.

Percentage of Covered Expenses:

- Type I and Type II: [80% - 100% in 5% increments]

- Type III and Type IV: [50% - 100% in 5% increments]

Submission of a pre-estimate of the cost of procedures is recommended for Dental claims exceeding [\$200 - \$500 in \$50 increments].]

[VISION CARE BENEFIT

Percentage of Covered Expenses: [50% - 100% in 5% increments]

Maximum Amount of Vision Expense Benefits per Covered Person per Plan Year: [\$100-\$300 in \$25 increments]]

[NON-OCCUPATIONAL WEEKLY DISABILITY INCOME BENEFITS FOR YOU.

Maximum Amount of Insurance [50%, 66%] of the Basic Weekly Earnings to a Maximum Amount of [\$150 -\$750 in \$50 increments] per week rounded to the next [\$1, \$10].

Waiting Period for Accident [0, 7, 14] days. Benefits begin on the [1st, 8th, 15th day]] [Waiting period for Illness [7, 14] days. Benefits begin on the [8th ,15th day]]

Maximum Period of Disability [13, 26 weeks.]]

LIFE INSURANCE BENEFITS FOR YOU

Amount of Life Insurance [\$5,000-\$50,000 in \$5,000 increments]

[Benefits terminate at age: [80-110]

[The following age reduction rules apply to Your [and Your Spouse’s] Life Insurance Benefit

[Please review the Life Insurance Amount Reduction Schedule. Your amount of insurance [, and the amount of insurance for Your Dependent Spouse] shall reduce as follows [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows][Your][Your Covered Spouse’s] attainment of age [50-99, in 1 year increments]. [[The][Each] reduction shall be based upon [the Benefit prior to age [50-99, in 1 year increments] [the reduced Benefit amount].] [Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the Schedule of Benefits.] [Such person’s amount of insurance will be reduced to the amount shown.]

Life Insurance Amount Reduction Schedule

[Age	{or} % of Coverage Reduction {or}	Benefit %	{or} Benefit Amount
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[After [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]

[Reduced amounts of Life Insurance will be rounded to the next higher multiple of [\$1, \$100, \$500, \$1,000], if not already such a multiple.]]

[Covered Person insurance benefits reduce to [0%-100%, in 1% increments] at age [50-99, in 1 year increments], further reducing to [0%-100%, in 1% increments] of the original amount of insurance at age [50-99, in 1 year increments]. Insurance then reduces by an additional [0%-100%, in 1% increments] of the original amount each subsequent year until it equals [0%-100%, in 1% increments] of the original amount of insurance.]

[Reductions in Your Spouse's Coverage is based upon [Your][Your Spouse's] age. [Coverage for Your Spouse will terminate [on the date] [the last day of the month] when [You] attain[Your Spouse attains] age [50-99, in 1 year increments].]

[Minimum Amount for retained asset account: [\$1,000-\$50,000 in \$1,000 increments]

[LIFE INSURANCE BENEFITS FOR YOUR DEPENDENTS

Maximum Amounts of Dependent Life Insurance are:

<u>Spouse</u>	<u>Child from [10 days] to [6 months]</u>	<u>Child from [6] months to [19] years (to [26] years if a Full Time Student)</u>
[\$2,500	\$200	\$1,250
\$5,000	\$400	\$2,500
\$7,500	\$600	\$3,750
\$10,000	\$800	\$5,000
\$12,500	\$1,000	\$6,250
\$15,000	\$1,200	\$7,500
\$17,500	\$1,400	\$8,750
\$20,000	\$1,600	\$10,000
\$22,500	\$1,800	\$11,250
\$25,000]	\$2,000	\$12,500]

[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR YOU

Principal Sum- Same as amount of Life Insurance.

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

Maximum Time Period between Accident and Loss: [90, 180, 365]

[The following age reduction rules apply to Your [and Your Spouse's] Accidental Death and Dismemberment

[Your amount of insurance [, and the amount of insurance for Your Dependent Spouse] shall reduce as follows [immediately upon][on the first of the month following][on the Policy Anniversary which occurs on or next follows][Your][Your Covered Spouse's] attainment of age [50-99, in 1 year increment]. [[The][Each] reduction shall be based upon [the Benefit prior to age [50-99, in 1 year increment]][the reduced Benefit amount].] [Benefits will be reduced to a percentage of the amount of insurance calculated in accordance with the Schedule of Benefits.] [Such person's amount of insurance will be reduced to the amount shown.]

Accidental Death and Dismemberment Reduction Schedule

[Age	{ % of Coverage Reduction (or)	{ Benefit %	{ Benefit Amount
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[Age [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]
[After [50-99, in 1 year increments]	[0%-100%, in 1% increments]]	[0%-100%, in 1% increments]]	[\$1,000- \$50,000 in \$500 increments]

[Reduced amounts of Accidental Death and Dismemberment Insurance will be rounded to the next higher multiple of [\$1, \$100, \$500, \$1,000], if not already such a multiple.]

[Covered Person insurance benefits reduce to [1%-100%, in 1% increments] at age [50-99, in 1 year increments], further reducing to [1%-100%, in 1% increments] of the original amount of insurance at age [50-99, in 1 year increments]. Insurance then reduces by an additional [1%-100%, in 1% increments] of the original amount each subsequent year until it equals [1%-100%, in 1% increments] of the original amount of insurance.]

[Reductions in Your Spouse's Coverage is based upon [Your][Your Spouse's] age. [Coverage for Your Spouse will terminate [on the date] [the last day of the month] when [You] attain][Your Spouse attains] age [50-99, 1 year increments].]

[ADDITIONAL BENEFITS

[Additional Benefit for Child Education]

[Additional Benefit for Repatriation]

[Additional Benefit for Seat Belt[and Air Bag] [Vehicle Safety Device]]

NATIONWIDE LIFE INSURANCE COMPANY
One Nationwide Plaza
Columbus, Ohio 43215-2220

Wellness and/or Health Care Services Endorsement

General Information Regarding this Endorsement

This Insured's Wellness and/or Health Care Services Endorsement ("Endorsement") revises the terms and conditions of the policy to which it is attached. To the extent the terms of the policy and this Endorsement are inconsistent, the terms of this Endorsement shall control. Non-defined terms shall have the meaning given to them in the policy.

There is no additional charge or required Premium for programs or services offered pursuant to this Endorsement.

Purpose

The purpose of this Endorsement is to inform the Policy Owner that, from time to time, we may offer the Insured access to certain health and/or wellness programs and services.

Programs and Services

The programs and services may include, but are not limited to, access to service provider referral networks, benefit consultation services and/or wellness programs. Such programs and/or services will be offered on all eligible policies on a uniform and not unfairly discriminatory basis.

We may arrange for third party service providers to administer such program or service.

All terms and conditions regarding the program or service, if any, are determined by the third party service provider. We are not liable for negligent acts or omissions of such third party service providers. Participation in such program or service is voluntary.

Availability

Programs and services provided under this Endorsement are subject to availability and may be modified, suspended, or terminated providing you with written notice.


President

