Nationwide Life Insurance Company

Home Office: Columbus, Ohio

Blanket Accident Insurance
Policyholder Application

(Print or type only)

1. Policyholder Information

Policyholder Name LIVINGSTON COUNTY SCHOOLS				Policy Number JXS0000028331700
Location Address 127 E. ADAIR ST. P.O. BOX 219 SMITHLAND, KY 42081				
Mailing Address (if different from above)	City	State	Zip	County
Phone ( )	Administrative Contact			
Fax ( )	Title			
Effective Date (MM/DD/YYYY) 08/01/17	Email Address			

2. Premium Payment

It is understood and agreed that premiums are due and payable as agreed upon by the Policyholder and the Company.

3. General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. All necessary administrative information concerning all Insured Persons shall be subject to the provisions of the Policy and shall be maintained by the Policyholder.
2. This Application is subject to the approval of Nationwide Life Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.
3. All benefits will be in accordance with the benefits proposed and agreed upon between Nationwide Life Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.

It is understood that all of the answers We have provided are representations and not warranties.

State Fraud Notice

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

Please Sign & Date

By signing below, you agree that you have read all of the General Conditions provided with this application.	
Agent's Signature	Signature of Applicant
Agent's Printed Name and Number K&K INSURANCE GROUP INC 13-0090572	Printed Name of Applicant and Title
Agent's Phone Number	Applicant's Phone Number
Agent's E-mail Address	Applicant's E-mail Address

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

Blanket Accident Insurance
Policyholder Application

(Print or type only)

1. Policyholder Information

Policyholder Name LIVINGSTON COUNTY SCHOOLS				Policy Number JXS0000028331700
Location Address 127 E. ADAIR ST. P.O. BOX 219 SMITHLAND, KY 42081				
Mailing Address (if different from above)	City	State	Zip	County
Phone ( )	Administrative Contact			
Fax ( )	Title			
Effective Date (MM/DD/YYYY) 08/01/17	Email Address			

2. Premium Payment

It is understood and agreed that premiums are due and payable as agreed upon by the Policyholder and the Company.

3. General Conditions

In applying for the Benefits set forth herein, the undersigned understands and agrees that:

1. All necessary administrative information concerning all Insured Persons shall be subject to the provisions of the Policy and shall be maintained by the Policyholder.
2. This Application is subject to the approval of Nationwide Life Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this Application has been so approved.
3. All benefits will be in accordance with the benefits proposed and agreed upon between Nationwide Life Insurance Company and the Policyholder as set forth in the Policy, subject to the Policyholder's approval.

It is understood that all of the answers We have provided are representations and not warranties.

State Fraud Notice

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

Please Sign & Date

By signing below, you agree that you have read all of the General Conditions provided with this application.	
Agent's Signature	Signature of Applicant
Agent's Printed Name and Number K&K INSURANCE GROUP INC 13-0090572	Printed Name of Applicant and Title
Agent's Phone Number	Applicant's Phone Number
Agent's E-mail Address	Applicant's E-mail Address

SCHEDULE OF BENEFITS

This Schedule of Benefits shows highlights of the coverage available under the Policy. Final interpretation of all provisions and coverages will be governed by the Policy on file with Nationwide Life Insurance Company.

Policyholder: LIVINGSTON COUNTY SCHOOLS

Policy Number: JXS0000028331700

Policy Effective Date: 08/01/17

Policy Termination Date: 08/31/18

Policy Term: 08/01/17 - 08/31/18

Eligible Class(es):

Class	Number of Eligible Persons	Description of Eligible Persons	Effective Date	Termination Date
1	999	Students and employees on whose behalf the required premium contribution is made for Low Option 24-Hour coverage.	08/01/17	Twelve months from the Effective Date
2	999	Students and employees on whose behalf the required premium contribution is made for High Option 24-Hour coverage.	08/01/17	Twelve months from the Effective Date
3	999	Students on whose behalf the required premium contribution is made for Low Option Summer Only coverage.	08/01/17	08/31/18
4	999	Students on whose behalf the required premium contribution is made for High Option Summer Only coverage.	08/01/17	08/31/18
5	999	Students and employees on whose behalf the required premium contribution is made for Low Option At-School coverage.	08/01/17	Twelve months from the Effective Date
6	999	Students and employees on whose behalf the required premium contribution is made for High Option At-School coverage.	08/01/17	Twelve months from the Effective Date
7	100	Student members of the High School Football team on whose behalf the required premium contribution is made for full football season Low Option coverage.	08/01/17	Twelve months from the Effective Date
8	100	Student members of the High School Football team on whose behalf the required premium contribution is made for full football season High Option coverage.	08/01/17	Twelve months from the Effective Date

9	100	Student members of the High School Football team on whose behalf the required premium contribution is made for Spring football Low Option coverage.	08/01/17	Twelve months from the Effective Date
10	100	Student members of the High School Football team on whose behalf the required premium contribution is made for Spring football High Option coverage.	08/01/17	Twelve months from the Effective Date

Covered Activities:

Class	Description of Activities
1 & 2	All activities, excluding high school football
3 & 4	All activities between the last day of the school year commencing during the policy period and the first day of the following school year.
5 & 6	Participating in or attending any Policyholder sponsored activity, excluding high school football; or while traveling to or from the Insured Person's residence and the Policyholder's premises on days when the Insured Person has regularly scheduled classes or work and within one hour of the scheduled start of or dismissal from the scheduled class or work or at any other time if traveling by transportation furnished or approved by the Policyholder.
7, 8, 9 & 10	Practice or play of football in accordance with the rules of the state high school athletics authority. Group or team travel supervised by the Policyholder to or from a practice or play is covered if in a vehicle furnished or approved by the Policyholder.

Note: The maximum amounts below are used to determine amounts payable under each Benefit. Actual amounts payable will not exceed the maximums, and may be less than the maximums under circumstances specified in the Policy.

ACCIDENT MEDICAL EXPENSE BENEFIT	**Class 1, 3, 5, 7 & 9**
Maximum Benefit Amount:	$25,000 per Insured per Injury
Deductible:	$0 per Insured per Injury
Benefit Percentage:	100% of R&C
Loss Period:	60 days
Benefit Period:	1 year
Note: This Benefit is subject to the Exclusions and other provisions of the Policy. In addition, the following limitations apply. Benefits for Covered Expenses shown below are subject to the Maximum Benefit Amount, Deductible, Benefit Percentage, Loss Period, and Benefit Period shown above, unless otherwise specified. Benefits sub-limits shown below are per Insured Person per Injury, unless otherwise specified.	
Covered Expenses:	**Benefit Sub-Limits:**
Inpatient Hospital Services	
Room & Board – Semi-Private or Private	Maximum $150 per day
Hospital Miscellaneous Expense (including general nursing care and pre-admission testing performed within 3 working days prior to admission)	Maximum $600 per day
Registered Nurse Services (private duty nursing care when ordered by a licensed Physician)	75% of R&C
Emergency Room Services (including use of the emergency room and supplies)	Maximum $150 if rendered within 72 hours of Injury

Physician Services	
Physician Non-Surgical Services	Maximum $40 for the first visit, and $30 for each subsequent visit, limited to one visit per day.
Physician Surgical Services, Inpatient or Outpatient	Maximum $1,000 (limited to primary procedure per injury)
Consultant Physician, when requested and approved by the attending Physician	Maximum $200
Assistant Surgeon	20% of Physician Surgical Maximum
Anesthetist Services (not including supervision of an anesthetist)	20% of Physician Surgical Maximum
Day Surgery Miscellaneous (including supplies, drugs and services in connection with scheduled outpatient day surgery)	Maximum $1,000
X-Ray Services	Maximum $200 for Outpatient
Diagnostic Imaging Services	Maximum $300 for Outpatient
Laboratory Services	Maximum $50 for Outpatient
Combined Ground and Air Ambulance Services	Maximum $300
Orthopedic Braces and Appliances	Maximum $75
Dental Services	Maximum $10,000 per policy term
Outpatient Physical Therapy	Maximum $30 for the first visit, and $20 for each subsequent visit for a maximum of 5 visits, limited to one visit per day
Prescription Drugs	Maximum $75
Expenses for the following are not covered:	Injections, Prosthetic Devices, Mental and Nervous Disorders, Home Health Care

R&C = Reasonable Charges

ACCIDENT MEDICAL EXPENSE BENEFIT	**Class 2, 4, 6, 8 & 10**
Maximum Benefit Amount:	$25,000 per Insured per Injury
Deductible:	$0 per Insured per Injury
Benefit Percentage:	100% of R&C
Loss Period:	60 days
Benefit Period:	1 year
Note: This Benefit is subject to the Exclusions and other provisions of the Policy. In addition, the following limitations apply. Benefits for Covered Expenses shown below are subject to the Maximum Benefit Amount, Deductible, Benefit Percentage, Loss Period, and Benefit Period shown above, unless otherwise specified. Benefits sub-limits shown below are per Insured Person per Injury, unless otherwise specified.	
Covered Expenses:	**Benefit Sub-Limits:**
Inpatient Hospital Services	
Room & Board – Semi-Private or Private	80% of R&C
Hospital Miscellaneous Expense (including general nursing care and pre-admission testing performed within 3 working days prior to admission)	Maximum $1,200 per day
Registered Nurse Services (private duty nursing care when ordered by a licensed Physician)	100% of R&C
Emergency Room Services (including use of the emergency room and supplies)	Maximum $300 if rendered within 72 hours of Injury
Physician Services	
Physician Non-Surgical Services	Maximum $60 for the first visit, and $40 for each subsequent visit, limited to one visit per day

Physician Surgical Services, Inpatient or Outpatient	Maximum $1,200 (limited to primary procedure per injury)
Consultant Physician, when requested and approved by the attending Physician	Maximum $400
Assistant Surgeon	25% of Physician Surgical Maximum
Anesthetist Services (not including supervision of an anesthetist)	25% of Physician Surgical Maximum
Day Surgery Miscellaneous (including supplies, drugs and services in connection with scheduled outpatient day surgery)	Maximum $1,200
X-Ray Services	Maximum $600 for Outpatient
Diagnostic Imaging Services	Maximum $600 for Outpatient
Laboratory Services	Maximum $300 for Outpatient
Combined Ground and Air Ambulance Services	Maximum $800
Orthopedic Braces and Appliances	Maximum $140
Dental Services	Maximum $10,000 per policy term
Outpatient Physical Therapy	Maximum $60 for the first visit, and $40 for each subsequent visit for a maximum of 5 visits, limited to one visit per day
Prescription Drugs	Maximum $200
Expenses for the following are not covered:	Injections, Prosthetic Devices, Mental and Nervous Disorders, Home Health Care

R&C = Reasonable Charges

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT	**Class ALL**
Aggregate Limit of Liability:	$500,000
Accidental Death Principal Sum:	$10,000
Specific Loss Principal Sum:	$10,000
See the Specific Loss Benefit Provision in the Policy for any applicable benefit reduction in the Principal Sum.	

RIDERS ATTACHED AT ISSUANCE:	**Form Number:**	**Applicable to Class:**
Riders attached to this Policy will provide the coverage described in the Rider at the benefit levels shown in the Rider.		
EXCESS BENEFITS RIDER	NSHBA 2400 EXC A	All Classes

Nationwide Life Insurance Company
Home Office: One Nationwide Plaza, Columbus, Ohio

BLANKET ACCIDENT POLICY

INSURING AGREEMENT

This Policy is issued in consideration of the Application made by the Policyholder. We promise to pay, subject to the Policy Terms, the Benefits stated herein. We make this promise and issue this Policy to You in exchange for the Premium shown in the Schedule of Benefits. The Policy insures only those persons referred to in the Schedule of Benefits for whom proper Premium has been paid. This Policy is a legal contract between You and Us.

POLICY TERM

The Policy Term starts at 12:01 a.m. standard time at Your address on the effective date shown in the Schedule of Benefits. This Policy is a non-renewable term blanket Policy.

NOTICE

PLEASE READ YOUR POLICY CAREFULLY. THIS IS LIMITED INSURANCE. IT IS AN ACCIDENT ONLY POLICY AND DOES NOT COVER LOSS OR EXPENSES RESULTING FROM SICKNESS, DISEASE OR BODILY INFIRMITY.

Signed for Nationwide Life Insurance Company

Secretary

President

READ YOUR POLICY CAREFULLY. This cover sheet provides only a brief outline of some of the important features of your policy. This cover sheet is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. **IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.**

TABLE OF CONTENTS
(Benefits apply only as shown in the Schedule of Benefits)

Section **Page**

DEFINITIONS

General Definitions

Accident or Accidental: A specific unforeseen event:

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

Aggregate Limit of Liability: The Aggregate Limit shown in the Schedule of Benefits is the maximum amount payable by Us for all Claims incurred for all Insureds under the Policy which are caused by any one Incident that occurs when the Policy is in force. If this limit is not sufficient to pay the total of all such Claims, then the Benefit payable to any one Insured will be determined in proportion to our total aggregate limit of liability. This Aggregate Limit of Liability applies only to Accidental Death and Specific Loss and related Benefits.

Application: The attached Policy application, including any amendments, which is a part of the Policy.

Beneficiary: The one who will receive Benefits payable upon the Insured Person's death. The Insured 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 or Our Agent or Us.

Benefit: The dollar amount payable by Us to a Claimant or Beneficiary under the Policy.

Benefit Period: The period of time during which Covered Expenses must be incurred in order for benefits to be payable, as shown in the Schedule of Benefits or applicable Riders. A benefit period starts on the date of the Covered Accident and ends at the end of the time period shown as the Benefit Period, unless specified elsewhere in the Policy.

Certificate: If required by Your state, this document provides a description of the Coverage available under the Policy.

Claim: A request for payment of Benefits.

Claimant: A person who has filed a Claim for Benefits under the Policy, as the Insured Person (Insured's parent, if a minor), the Insured's legal guardian, the Beneficiary, or a person representing any of the above.

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

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

Covered Activity(ies): The covered event or activities described in the Schedule of Benefits.

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

Eligible Class: A group of people who are eligible for Coverage under the Policy as listed in the Schedule of Benefits.

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

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

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.

Heart and Circulatory Malfunction: A sudden and serious malfunction of the heart or circulatory system, which includes myocardial infarction, cardiac arrest, heart attack, heat exhaustion, coronary thrombosis, cerebral vascular accident (e.g., stroke or aneurysm), and does not include conditions such as hypertension or angina.

Independent Medical Exam: An examination by a Physician of the appropriate specialty for an Insured Person's condition at Our expense. Such examination, scheduled by Us, may be used for the purpose of determining eligibility for insurance or Benefits, including eligibility under the Riders, if any, associated with the Policy.

Incident: Any one event or series of events related to the cause or causes which result in the Loss.

Injury or Injuries: A bodily injury which is:

1. directly and independently caused by specific Accidental contact with another body or object;
2. a source of loss that is sustained while the Insured Person is covered under this Policy and while he or she is taking part in a Covered Activity.

For all Benefits, Injury includes Heart and Circulatory Malfunction, subject to the following conditions:

1. Malfunction must occur before age 65 while the Insured is taking part in a Covered Activity; and
2. The symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to the Insured and within 48 hours of having taken part in a Covered Activity; and
3. Such Insured has not, within one year prior to the date of participation in the Covered Activity, been medically diagnosed with, or received any medication for, any myocardial infarction, angina pectoris, coronary thrombosis, hypertension, heart attack, or a cerebral vascular incident.

For the Accident Medical Expense Benefit, Injury also includes repetitive motion injuries or aggravation of such injuries resulting from participation in a Covered Activity. Repetitive motion injuries are injuries such as, but not limited to, strains, sprains, hernias, tennis elbow, tendonitis, bursitis, and muscle tears. The repetitive motion injury must be diagnosed by a Physician and occur within 30 days of participation in a Covered Activity.

All Injuries sustained in one Accident, including all related conditions and recurrent symptoms of these Injuries will be considered as one Injury.

Insured Person or Insured: An Eligible Person insured under the Policy.

Loss Period: The period of time within which the first expense must be Incurred following an Accident for Benefits to be payable for the Injury sustained.

Participating Organization: An organization which:

1. elects to offer coverage under the Policy by completing a Participating Organization Application that has been accepted by Us;
2. completes a participation agreement with the Policyholder; and
3. remits the required Premium when due, if applicable.

Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate State Regulatory Agency to perform a particular service which is covered under the Policy, and who is not:

1. the Insured Person;
2. a Family Member of the Insured Person; or
3. a person employed or retained by the Policyholder.

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

Policy Term: The period of time the Policyholder is covered by the Policy. The Policy Term is shown in the Schedule of Benefits.

Policyholder: The organization who has contracted with Us to provide Benefits to the Insured Person. To the extent that a Participating Organization is applicable, the term Policyholder can be deemed to include the Participating Organization(s), unless otherwise specified in the Policy.

Premium: The periodic fee required to maintain Coverage for each Insured Person in accordance with the terms of the Policy.

Proof: Evidence satisfactory to Us that a person has satisfied the conditions and requirements for a Benefit.

Provider: Any Physician, health professional, Health Care Facility or other person or recognized entity licensed to provide medical services to Insured Persons.

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

Sickness: An illness, disease or condition, including the pregnancy, childbirth and related medical conditions of an Insured Person, that impairs an Insured Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident.

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 applicable law.

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

Written or **Writing**: A record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your:** The plan sponsor or Policyholder named in the Schedule of Benefits.

Other terms are defined elsewhere under the Policy.

Additional Definitions for the Accident Medical Expense Benefit and any applicable Riders

Ambulance Services: Professional ground and air Ambulance Services to transport the Insured Person from the place where the Covered Accident occurred to the nearest medically appropriate facility; and from the nearest medical facility to another appropriate medical facility, if a Physician specifies in writing that such transport is Medically Necessary.

Chiropractic Services: Includes all therapeutic, adjustment, and manipulation services and modalities (i.e., hot packs, cold packs and ultrasounds, etc.) administered by a Provider acting within the scope of their license.

Confinement/Confined: An uninterrupted stay following admission to a Health Care Facility due to an Accidental Injury. The re-admission to a Health Care Facility for the same or related Accidental Injury, within a 72-hour period, will be considered a continuation of the same period of confinement. Confinement/Confined does not include observation, which is the review or assessment, of less than 24 hours, of a person's Injury that does not result in admission to a Health Care Facility.

Custodial Care: A level of routine maintenance and supportive care that is primarily for the purpose of attending to the activities of daily living 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. Custodial Care may not be provided by the Insured Person's Family Member unless specifically agreed to in writing by Us. Custodial Care does not include Home Health Care services or treatment.

Deductible: The amount of Covered Expense that must be Incurred by the Insured before any Benefits are payable by Us. The Deductible will apply as specified in the Schedule of Benefits or any endorsements to this Policy.

Deductible Incurral Period: The period of time, starting on the date of the covered Accident, within which the Insured must satisfy the Deductible before Benefits will be payable for subsequent Covered Expenses Incurred as a result of the Accidental Injury.

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

Durable Medical Equipment: A device which:

1. is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Injury and is able to withstand repeated use;
2. is used exclusively by the Insured;
3. is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. can be expected to make a meaningful contribution to treating Insured's Injury; and
5. is prescribed by a Physician and is Medically Necessary for rehabilitation.

Expenses Incurred: See Incurs or Incurred.

Home Health Aide: A person who provides care of a medical or therapeutic nature and who reports to, and is under the direct supervision of, a Home Health Care Agency.

Home Health Care Agency: A business that provides Home Health Care Services and is licensed by the appropriate state licensing authority.

Home Health Care Services: The provision of a health service for payment or other consideration in a patient's residence, instead of an otherwise required Hospital or nursing home confinement, under a plan of care established, approved in writing, and reviewed and certified at least once every two months by the attending Physician as necessary for medical purposes. Home Health Care Services includes:

1. **part-time or intermittent skilled nursing services provided by a Nurse;**

2. **part-time or intermittent Home Health Aide services which provide supportive services in the home under the supervision of a registered Nurse or a physical therapist;**
3. Physical, respiratory, occupational, and speech therapy; and
4. the furnishing of medical equipment supplies other than drugs and medicines.

Each visit by a Nurse or Home Health Care Agency employee constitutes a Home Health Care visit and each four hours of Home Health Aide services constitutes a Home Health Care visit. If services extend beyond four hours, each four hours or portion of that period is considered as one Home Health Care visit. Home Health Care Services does not include Custodial Care services or treatment.

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).

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; or
4. A birthing center.

Incurs or Incurred: Covered Expenses for:
1. services and treatments actually received within the applicable Benefit Period; and
2. medical supplies actually purchased, received, and utilized within the applicable Benefit Period. The terms “Incurs” and “Incurred Expenses” do not include expenses deferred beyond the applicable Benefit Period.

Inpatient: Confinement of 24 hours or greater.

Loss: Medical Expenses Incurred that are caused by Injury and which are payable under the Policy’s terms and Conditions.

Medically Necessary: Services or supplies that are:
1. appropriate and necessary for the symptoms, diagnosis, or treatment of the Injury;
2. provided for the diagnosis or direct care and treatment of the Injury;
3. consistent with generally accepted professional standards of care within the organized medical community;
4. not primarily for the convenience of the Insured Person or Insured Person’s Physician, or another health care Provider; and
5. the most appropriate supply or level or service which can safely and effectively be provided.

Mental and Nervous Disorders: Nervous, emotional, and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and its successor, as a mental disorder on the date of medical care or treatment is rendered to an Insured Person by a Physician and to the extent that the mental or nervous disorder is a result of a covered Accidental Injury as determined by a Physician.

Nurse: A licensed registered nurse (R.N.) or licensed practical nurse (L.P.N.) who:
1. is properly licensed or certified to provide medical care under the laws of the state where the nurse practices;
2. provides medical services which are within the scope of the nurse’s license or certificate;
3. is not a Family Member of the Insured Person; and
4. is not a person employed or retained by the Policyholder.

Outpatient: Care or treatment received from a Provider to which the Insured Person is not admitted.

Physical Therapy: Includes but is not limited to acupuncture, physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form, or massage administered by a Provider acting within the scope of their license. Physical Therapy does not include Chiropractic Services.

Physician Services: Services provided by a Physician, including expenses for surgery, assistant surgeon, consultations or second opinions, Physician's visits, and anesthesia and its administration.

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

Skilled Nursing Care: Services that are certified as Medically Necessary by a Physician and are not intermediate, domiciliary, Custodial or retirement 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.

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

Reasonable Charge (R&C): The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred. The most common charge means the lesser of:

1. the actual amount charged by the Provider; or
2. the negotiated rate, if any; or
3. the fee most often charged for in the geographical area where the service was performed.

The Reasonable Charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 75th percentile of FairHealth schedules. The Insured Person may be responsible for the difference between the Reasonable Charge and the actual charge from the Provider.

For a Provider who has a reimbursement agreement, the Reasonable Charge is equal to the amount that constitutes payment in full under any reimbursement agreement with Us, either directly or indirectly through a third party. If a Provider accepts as full payment an amount less than the rate negotiated under the reimbursement agreement, the lesser amount will be the maximum Reasonable Charge.

ADMINISTRATIVE PROVISIONS

Premium

The Premium rates, and the method and timing of premium payments, are as agreed upon by the Policyholder and Us. Premiums must be paid to Our Home Office or to one of Our representatives.

Policy Terminations

This Policy can be terminated at any time by written notice mailed or delivered by Us to the Policyholder or by the Policyholder to Us. Such notice must be provided at least 31 days in advance of the termination date.

We may not terminate the Policy before its first anniversary, unless the Policyholder does not perform its contractual duties. If We terminate the Policy, notice will be either mailed or delivered to the Policyholder at the last address on file with Us. A copy of such notice may also be sent to the Policyholder's agent, if any, at his or her last address on file with us. Termination will become effective on the date stated in the notice or the 31st day after we mail or deliver the notice, whichever is later.

If the Policyholder terminates the Policy, termination will become effective at 12:01 a.m. local time, based on the Policyholder's address, when We receive notice or the date specified in the notice, whichever is later.
In either event, We will promptly return any unearned Premium paid or the Policyholder will promptly pay any earned Premium which has not been paid.

Neither termination of the Policy nor termination of the Insured Person's coverage under the Policy shall prejudice the settlement of any Claim for Loss where the Accident precipitating the Loss occurred on or before the date of termination.

Term of an Insured Person's Coverage

A person's coverage begins on the later of:

1. the Effective Date of the Policy; or
2. the Effective Date of the Participating Organization, if applicable; or
3. when he or she becomes an Eligible Person.

An Insured's coverage ends on the first of these to occur:

1. when he or she is no longer an Eligible Person; or
2. the end of the last day for which Premium has been paid; or
3. the date the Insured dies; or
4. the termination date of the Participating Organization, if applicable; or
5. the termination date of the Policy.

Termination will not affect a Claim which occurs before the coverage ends.

BENEFIT PROVISIONS

Maximum Benefit Amounts

The Maximum Benefit Amounts which apply to an Insured Person are shown in the Schedule of Benefits.

ACCIDENT MEDICAL EXPENSE BENEFITS

If, as a result of an Accidental Injury which occurs while participating in a Covered Activity, an Insured incurs Covered Expenses during the Benefit Period specified in the Schedule of Benefits, we will pay:

1. Covered Expenses Incurred that exceed any applicable Deductible, only if the Deductible is met within the Deductible Incurral Period specified in the Schedule of Benefits; and
2. as long as the first expense has been Incurred within the Loss Period specified in the Schedule of Benefits; and
3. until the total paid for Covered Expenses Incurred equals any applicable Benefit percentage, Benefit sub-limit, or maximum shown in the Schedule of Benefits; or
4. until the end of the Benefit Period shown in the Schedule of Benefits; or
5. until Benefits paid equal the Maximum Benefit Amount for the Accident Medical Expense Benefits shown in the Schedule of Benefits.

Covered Expenses for this Benefit means the Medically Necessary and Reasonable Charges for services, supplies, and treatment provided or prescribed by a Physician for which an Insured Person is required to pay, except as may be limited in the Schedule of Benefits and subject to all applicable conditions, exclusions and limitations.

We will pay Covered Expenses Incurred for dental treatment as a result of Injury to a Sound Natural Tooth. For dental services, there is often more than one Service that can be used to treat a dental problem. In determining the Benefits, 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 commonly accepted standards of the American Dental Association. The Insured Person and his or her Provider 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 Benefits payable for Covered Expenses for the least costly Service. We will not pay the excess amount.

When multiple surgeries are performed through the same incision at the same operative session, We will pay an amount not to exceed the Benefit for the most expensive procedure being performed.

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT

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

1. The Loss is caused solely by an Accident; and
2. The Loss is not excluded by the terms of the General Exclusions section of this Policy; and
3. The Accident must occur while the Insured Person is participating in a Covered Activity; and
4. The Loss must occur within 180 days after the date on which the Accident occurred.

Schedule of Losses

We will pay a percentage of the Principal Sum(s) listed in the Schedule of Benefits for the Benefit as described in the table below, subject to all of the terms and limitations of the Policy:

Nature of Loss	Percentage of Principal Sum
Life	100%
Both arms or both legs	100%
Both hands and both feet	100%
One arm and one leg	100%
One hand and one foot	100%
Either both hands or both feet	100%
Speech and hearing in both ears	100%
The sight of both eyes	100%
The sight of one eye and either one hand or one foot	100%
Either one arm or one leg	75%
Either one hand or one foot	50%
Speech or hearing in both ears	50%
Sight of one eye	50%
Hearing in one ear	25%
Both the thumb and index finger of one hand	25%

If more than one Loss results from any one Accident, only one amount, the largest, will be paid.

Definitions for this Accidental Death and Specific Loss Benefit

Loss: Loss of life or a Specific Loss as shown in the Schedule of Losses (above) which is payable under the Policy's terms and Conditions.

Specific Loss: Means, with regard to:

1. a natural arm or leg, complete severance at or above the elbow or knee joint;
2. a natural hand or foot, complete severance at or above the wrist or ankle joint;
3. a natural thumb and fingers, complete severance at or above the metacarpophalangeal joints;
4. an eye, the complete and irrecoverable loss of sight;
5. speech, the complete and irrecoverable loss of speech;
6. hearing, the complete and irrecoverable loss of hearing of an ear.

EXCLUSIONS

General Exclusions The following exclusions apply to any and all Benefits and any applicable Riders, unless otherwise specifically referenced.

We will not pay Benefits for:

1. An Injury or Loss that is:
   a. caused by war or any act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of military nature (which does not include acts of terrorism);
   b. caused while the Insured is serving full-time active duty (more than 31 days) in any Armed Forces;
   c. caused by participating in a riot or violent disorder;
   d. the result of an Insured's taking part in committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;
   e. the result of the Insured being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Physician and taken according to the Physician's instructions) as defined by the law of the jurisdiction in which the Accidental Injury occurred. Conviction is not necessary for determination of being "under the influence."; or
   f. intentionally self-inflicted, including suicide or attempt thereof, while sane or insane.
2. An Injury or Loss that is the result of travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a commercial aircraft, or as a passenger in a Policyholder chartered provided such aircraft has a valid and current airworthiness certificate and is operated by a duly licensed or certified pilot, and while such aircraft is being used for the sole purpose of transportation and such travel is listed as a Covered Activity in the Schedule of Benefits.
3. Any Accident where the Insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
4. An Accident that occurs while:
   a. 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;

b. riding, driving, or testing a motorized vehicle used in a race or speed contest, sport, exhibition work or test driving. Motorized Vehicle for purposes of this provision means any self-propelled vehicle or conveyance, including 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,

unless such activity is specifically listed as a Covered Activity in the Schedule of Benefits.

5. Medical or surgical treatment, diagnostic or preventative care of any Sickness, except for treatment of pyogenic infection that results from an Accidental Injury or a bacterial infection that results from the Accidental ingestion of contaminated substances.
6. Any Heart or Circulatory Malfunction, whether or not known or diagnosed, except as may be otherwise covered under the Policy or unless the immediate cause of such malfunction is external trauma.

Additional exclusions for the Accident Medical Expense Benefit and any applicable Riders

We will not pay Benefits for:

1. Expenses Incurred for services or treatment rendered by a Physician, Nurse or any other Provider who is:
   a. employed or retained by the Policyholder, or its subsidiaries or affiliates;
   b. the Insured, or the Insured's Family Member.
2. Expenses Incurred for charges which the Insured would not have to pay if he/she did not have insurance or for which no charge is made.
3. Expenses Incurred for charges which are in excess of Reasonable Charges.
4. Expenses Incurred for any condition covered by any Workers' Compensation Act, Occupational Disease law or similar law.
5. That part of medical expenses payable by any automobile insurance Policy without regard to fault.
6. Expenses Incurred for any treatment that is considered to be experimental by the American Medical Association (AMA) or the American Dental Association (ADA).
7. Expenses Incurred for the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids, unless Injury has caused impairment of sight or hearing or unless repair or replacement of existing eye glasses, contact lenses or hearing aids is necessary as a result of a covered Injury.
8. Expenses Incurred for new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, expect for repair or replacement as a result of Injury up to the Dental Maximum shown in the Schedule of Benefits, if applicable.
9. Expenses Incurred for personal comfort or convenience items including Hospital telephone charges, television rentals, or guest meals.
10. Expenses Incurred for or in connection with Custodial Care, unless otherwise specified in the Schedule of Benefits.
11. Expenses Incurred for supervision of an anesthetist.
12. Expenses Incurred for Durable Medical Equipment rental in excess of the purchase price.
13. Expenses Incurred for subsequent repairs and replacement of prosthetic devices and orthopedic braces and appliances.

SUBROGATION AND RECOVERY RIGHTS

Right of Recovery

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

Right to Subrogation

We shall be subrogated to all rights of recovery which any Insured Person has against any Third Party to the extent of payments for Benefits made by Us to or for benefit of an Insured Person. The Insured Person shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to Us.

If the Insured suffers an Injury through the wrongful act or omission of a Third Party for which the Third Party is found liable, and if Benefits are paid under this Policy due to such Injury, then We will be entitled to a refund of all Benefits We have paid from such recovery, as permitted by law. The refund of Benefits shall be allowable to the extent the Insured recovers or may recover for the same Injury from another plan, including a Third Party or its insurer. Further, We have the right to offset subsequent Benefits payable to the Insured under the Policy against such recovery.

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

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

Right to Reimbursement

If Benefits are paid under this plan and any person recovers from a Third Party by settlement, judgment or by operation of primary Coverage, We have a right to recover, as permitted by law, from that person an amount equal to the amount We paid. However, We will reimburse the Insured Person for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

Limitation to Our Recovery Rights

We may exercise Our Right to Subrogation against Third Parties unless We are precluded from enforcing such right where a responsible Third Party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise our Right to Reimbursement.

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

Definitions for this Subrogation and Recovery Rights Provision

Third Party(ies): Any person, firm, or corporation other than the Insured Person or the Policyholder. The Policyholder will be considered a Third Party only if the Policyholder's gross negligence has or may have caused, contributed to or aggravated the Injury or condition for which the Insured claims an entitlement to Policy Benefits.

CLAIM PROVISIONS

Notice of Claim

Written Notice of Claim must be given to Us or Our authorized representative within 30 days after a covered Loss starts, or as soon thereafter as is reasonably possible. Failure to provide notice within the required time period will not reduce or invalidate the claim if it was not reasonably possible to give such notice and the notice was given as soon as reasonably possible. Notice should include: (1) the Policy number; (2) the Policyholder's name and address; (3) the Covered Group's name and address; (4) the Insured's name and address; and (5) the Claimant's name and address.

Claim Forms

Claim forms are provided at the time the Policy is issued. Additional Claim forms will be sent to the name and address requested within 15 calendar days after a written notice of Claim is received by Our Home Office or one of Our representatives. If not, the Proof of loss requirements can be met without using Our forms. Simply send a written statement indicating the date of the Injury as well as the nature and extent of the loss to Our Home Office or to one of Our representatives. Proof of loss must be sent within the time limits stated in the next paragraph.

Proof of Loss

Written Proof of loss must be sent to Our Home Office or to one of Our representatives within 365 days after: (1) the end of any period of Inpatient Confinement for which Claim is made; or (2) the date of Loss on any other Claim. Failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible. 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. We retain the right to make subsequent requests for Proof of loss if required to accurately evaluate and process the Claim. Failure of a Claimant to cooperate with Us in the administration of a Claim may result in the termination of a Claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether Benefits are payable or the actual amount due.

Payment of a Claim

We will pay Loss of life Benefits to the Insured's Beneficiary on file with Us at time of payment. If more than one Beneficiary is shown, We will pay the applicable percentage specified to each. If no amount and/or percentage are specified, We will divide the death Benefits equally among those Beneficiaries living at the time of the Insured's death. We are not responsible for the validity of a Beneficiary designation or change. If there are no such Beneficiaries on file, or if none are living at the time of the Insured's death, We will pay the death Benefits to: (1) the Insured's estate; or (2) at Our option, to one or more of the first surviving class of the following classes of successive preference Beneficiaries — the Insured's surviving: (a) spouse; (b) children; (c) parents; or (d) brothers and sisters, equally.

All other Benefits that are not assigned will be paid to the Insured if living; otherwise, at Our option, to those as shown in the paragraph immediately above.

If payment is to be made to: (1) an Insured's estate; or (2) to an Insured or Beneficiary who is a minor or otherwise not competent to give a valid release, We may pay up to $1,000 to the Insured's parent or legal guardian, to a person supporting the Insured, or to any relative by blood or by marriage of either the Insured or his or her Beneficiary whom We consider to be entitled to the payment.

Benefits will be payable to the Insured or the medical services Provider if We have received a valid assignment by the Insured.

Subject to any written direction of the Insured, or of the legal or natural guardian of the Insured if the Insured is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, Hospital or nursing service may, at Our option, and unless We are requested in writing not later than the time for filing Proofs of Loss, be paid directly to the Hospital or person rendering such services If payment is made to the Insured, in no event will pay any amount greater than the amount actually paid by the Insured.

It is not required that a service be furnished by a specific Provider. Payments made by Us in good faith satisfy Our legal duty to the extent of the payment. All payments made by Us will be made in United States dollars.

Time of Payment

After receiving proper written Proof of loss, We will pay the periodic Benefits due, no less often than monthly (unless otherwise stated in the Policy), while the loss and our liability continue. When Our liability ends, We will pay any balance still due after We receive the proper written Proof of loss. Benefits for other losses (including Covered Expenses) will be paid within 30 days after We receive proper written Proof of loss, or sooner if required by state law. If We fail to pay the benefit due within this time period, any applicable interest will accrue at the interest rate required by the state.

Assignment

We are not bound by an assignment of Benefits until We or one of Our representatives receives it in writing from the Insured (Insured's parent, if a minor) or his or her legal guardian. We are not responsible for its validity.

Physical Examination and Autopsy

We reserve the rights to have a Physician of Our choice examine the Insured whose condition is the basis of a Claim. This may be done as often as reasonably necessary while a Claim is pending or while We are paying Benefits. We may also require an autopsy, unless forbidden by law. These will be at Our expense.

Free Choice of Physician

The Insured has a free choice of a Physician, Hospital, or other eligible Provider. The Physician-patient relationship will be maintained.

Common Accident

If the Insured and his or her Beneficiary die from the same Accident without enough evidence that both died other than at the same time, the Insured's Benefits will be paid as if he or she died last.

Legal Action

No action at law or in equity to recover under the Policy may be brought against Us before 60 days after the time written Proof of loss has been sent as required by the Policy. No such action may be brought more than 3 years after the time written Proof of loss is required to be sent or after the expiration of the applicable statute of limitations, whichever is greater.

Recovery of Overpayment

Payments made by Us which exceed the appropriate amounts payable are recoverable by Us from or among any persons or other entities to whom such payments were made.

GENERAL PROVISIONS

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.

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.

Clerical Error
Any clerical error by the Policyholder or 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.

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. However, any such provision is modified only for an Insured Person who is a permanent resident of the state at the time Covered Expenses are actually incurred as defined herein.

Entire Contract
The entire contract consists of:

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

All statements made in the Application, in the absence of fraud, are representations and not warranties. No statement made by the Policyholder or 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 the Policyholder.

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.

Individual Certificates
When the law requires it, we will make a Certificate available to each Insured Person under this Policy. Certificates will state the insurance protection to which a Insured Person is entitled and to whom the Benefits are payable.

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.

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

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

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.

Workers' Compensation Not Affected
The Policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

NATIONWIDE LIFE INSURANCE COMPANY
Columbus, Ohio

Issues this rider to:
Policyholder: LIVINGSTON COUNTY SCHOOLS
Policy Number: JXS0000028331700
Rider Number: 1

EXCESS BENEFITS RIDER

The Effective Date of this rider is the Effective Date of the Policy to which this rider is attached. It applies only with respect to Accidents or Sicknesses that occur on or after that date. The Policy/Certificate is amended as described below. All other terms, provisions, limitations and exclusions remain unchanged except as specifically noted within this Benefit Rider.

We will not pay Benefits under the Basic Accident Medical Expense Benefits for Covered Expenses to the extent that they are collectible under another Health Care Plan.

Covered medical expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with Policy provisions or requirements. We will pay for Covered Expenses denied under any other Health Care Plan as being out of network or out of the service area, subject to all the terms and limitations of the Benefit.

Eligible medical expenses payable under any Health Care Plan will be used to satisfy or reduce the Deductible.

When Benefits under any other Health Care Plan are covered under this Policy, and coverage under this Policy and the other Health Care Plan are excess, we will pay a pro rata share of the total amount of Covered Expenses. In no case will the total benefits payable exceed 100% of the Covered Expenses. Our pro rata share will be based on the total of Benefits payable under this Policy in proportion to the total of Benefits payable by all Health Care Plans for the same Covered Accident.

Definitions for this Excess Benefits Rider

Health Care Plan: Any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care, disability benefits or repatriation of remains. A Health Care Plan includes group, ERISA, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured agreements or arrangements;
4. coverage provided through Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and other prepayment, group practice and individual practice plans;
5. medical benefits provided under automobile “fault”-type contracts;
6. medical benefits provided by any government plan or coverage or other benefit law, except:
   a. a state-sponsored Medicaid plan; or
   b. a plan or law providing benefits only in excess of any private or non-governmental plan;
7. other valid and collectible medical or health care benefits or services.

Signed for Nationwide Life Insurance Company

Secretary

President

000179349 / JXS0000028331700

K&K INSURANCE

SPECIALTY BENEFITS, INC.
an affiliate of K&K Insurance Group, Inc.

Nationwide

STUDENT OR ATHLETE ACCIDENT CLAIM FORM
Excess Coverage
K-12 ACCOUNTS

CLAIMS DEPARTMENT
1712 Magnavox Way, P.O. Box 2338 | Fort Wayne, IN 46801-2338
Ph: 800-237-2917 Fax: 312-381-9077 California License #0334819
www.kandkinsurance.com

INSTRUCTIONS FOR FILING

NOTE: Claim Form must be fully completed and signed. File your claim promptly. Failure to do so could result in a denial of coverage.

Basic Procedures for Submitting Statement of Claim

1. A school official will complete their portion and then give the claim form to the student's or athlete's parent(s)/guardian(s) for completion.
2. The student's or athlete's parent(s)/guardian(s) will complete the appropriate portion of the form. Attach any related medical bills and primary insurance explanation of benefits and forward to K&K Insurance Group, Inc.

To the Student or Athlete/Parent/Guardian

If you are attaching related medical bills, these bills must show the patient's name, condition (diagnosis), type of treatment given, date the expense was incurred and the charges made. For hospital charges, this would be a UB04 and for the physician/ancillary charges, this would be a CMS1500. The medical providers may also bill K&K Insurance Group, Inc. direct at the address above.

SECTION I – TO BE COMPLETED BY CLAIMANT'S PARENT(S)/GUARDIAN(S)

1. Student's Name Last: _____ First: _____ MI: _____
2. Date of Birth: _____ SS# _____ Sex: O Male O Female
3. Student's grade in school: _____
4. Home Address Street: _____
   City: _____ State: _____ Zip: _____
   Parent(s)/Guardian(s) Home Phone: _____
5. Date of Accident: _____ Time of Accident: _____ O AM O PM
   Nature of Injury: _____ Describe exactly how accident happened: _____
   _____
6. Nature of activity and location during which the injury occurred (check all boxes which apply):

O Pre-Kindergarten	O Elementary School	O Middle School
O High School	O Cafeteria	O Classroom Activities
O Interscholastic Sports	O Intramural Sports	Name of Sport, if applicable: _____
O Club Sports	O Physical Education Class	O Other Activity (specify) _____
O During Practice	O During Play	O During Travel To or From the Event

   Nature of Your Participation:

O Student	O Volunteer	O Student/Manager
O Athletic Participant	O Cheerleader	O Band Member

   O Other (specify) _____
7. Transfer Student? O Yes O No
   If yes, please identify the former school name: _____
8. Name, address and phone number of physician who first treated you: _____
   _____

9. Have you had a similar injury in the past? O Yes O No

   If yes, describe and give dates: _____

10. Name, address and phone number of physician who treated you for previous injury: _____

    _____

11. Are you covered by any other medical expense benefits plan? O Yes O No

    If yes, give the names of the plan(s) and the person(s) through whom you are insured and their relationship to you:

    _____

IF YOU HAVE NO OTHER INSURANCE ON YOUR CHILD, BUT YOU AND/OR YOUR SPOUSE ARE EMPLOYED FULL TIME, PLEASE PROVIDE A STATEMENT FROM THE EMPLOYER(S) INDICATING YOUR CHILD IS NOT COVERED BY ANY INSURANCE OFFERED THERE.

ALL BENEFITS WILL BE MADE PAYABLE TO PROVIDERS OF SERVICE INVOLVED, UNLESS ACCOMPANIED BY PAID RECEIPTS.

THIS IS EXCESS MEDICAL COVERAGE.

I hereby authorize any physician, hospital, or other medically related facility, insurance company, or other organization, institution or person that has any records of knowledge of me, and/or the above named claimant, to disclose, whenever requested to do so by K&K Insurance/Specialty Benefits and/or Nationwide Life Insurance Company or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.

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

Date _____ Parent/Guardian Signature _____

SECTION II (TO BE COMPLETED BY PARTICIPATING SCHOOL)

FAILURE TO COMPLETE THIS FORM IN FULL MAY RESULT IN AN UNNECESSARY DELAY IN THE PROCESSING OF THIS CLAIM.

1. Student's Name Last: _____ First: _____ MI: _____
2. Date of Accident _____
3. Activity _____
4. Nature of Injury _____
5. Name of Participating SCHOOL SYSTEM or SCHOOL DISTRICT _____
6. Name of participating SCHOOL _____
7. I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

   SIGNATURE OF SCHOOL OFFICIAL: _____

   PRINTED NAME/TITLE: _____

   PHONE: _____ FAX: _____

   EMAIL: _____ DATE: _____

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

Date _____ Policyholder (School Official) Signature _____

000179349 / JXS0000028331700

CLAIMS DEPARTMENT
1712 Magnavox Way, P. O. Box 2338 | Fort Wayne, IN 46801-2338
Ph: 800-237-2917 | Fax: 312-381-9077 California License #0334819
www.kandkinsurance.com

OTHER INSURANCE QUESTIONNAIRE

NAME OF CLAIMANT: _____ INTERNATIONAL STUDENT O Yes O No

EMANCIPATED STUDENT: O Yes O No OVER AGE 26 AND NO LONGER DEPENDENT ON PARENT: O Yes O No

NAME OF INSURED: _____ POLICY NO: _____

FATHER	MOTHER
IS FATHER DECEASED? O Yes O No	IS MOTHER DECEASED? O Yes O No
IS FATHER LEGALLY RESPONSIBLE? O Yes O No	IS MOTHER LEGALLY RESPONSIBLE? O Yes O No
FATHER'S NAME (if injured is a minor) _____	MOTHER'S NAME (if injured is a minor) _____
SOCIAL SECURITY #: _____	SOCIAL SECURITY #: _____
EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No	EMPLOYED? O Yes O No SELF-EMPLOYED? O Yes O No
DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O No	DISABLED ON MEDICAID OR OTHER PUBLIC ASSISTANCE? O Yes O No
EMPLOYER NAME: _____	EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____	EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: ( ) _____	PHONE: ( ) _____
CONTACT PERSON: _____	CONTACT PERSON: _____
Do you have group medical insurance coverage through your employment? O Yes O No	Do you have group medical insurance coverage through your employment? O Yes O No
If no, please be advised K&K may contact your employer to verify no primary insurance is in force.	If no, please be advised K&K may contact your employer to verify no primary insurance is in force.
INSURANCE COMPANY: _____	INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____	INSURANCE COPANY ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO)	TYPE OF PLAN: O HEALTH MAINTENANCE ORGANIZATION (HMO)
O PREFERRED PROVIDER ORGANIZATION (PPO)	O PREFERRED PROVIDER ORGANIZATION (PPO)
O STANDARD MEDICAL AND HOSPITALIZATION COVERAGE	O STANDARD MEDICAL AND HOSPITALIZATION COVERAGES
O OTHER (describe) _____	O OTHER (describe _____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE. I UNDERSTAND THAT IT IS A CRIME TO INTENTIONALLY ATTEMPT TO DEFRAUD OR KNOWINGLY FACILITATE A FRAUD AGAINST AN INSURER BY FILING INFORMATION CONTAINING FALSE OR DECEPTIVE STATEMENTS. ANY QUESTIONS ON THIS FORM NOT ANSWERED TRUTHFULLY CAN RESULT IN A CRIME.

PARENT/GUARDIAN/FATHER SIGNATURE: _____ PARENT/GUARDIAN/MOTHER SIGNATURE: _____

DATE: _____ DATE: _____

Rev. 5/2017

Nationwide®
is on your side

FACTS | WHAT DOES NATIONWIDE DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number, government issued identification, and contact information • Policy, account, and contract information • Credit reports and other consumer reports
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Nationwide chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Nationwide share?	Can you limit this sharing?
For our everyday business purposes— such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes— to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes— information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes— information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	Yes	Yes

To limit our sharing	• Call us toll free at 1-866-280-1809 and our menu will prompt you through your choices. • If you have previously opted out, your preference remains on file and you do not need to opt out again. • Please have your account or policy number handy when you call. **Please note**: If you are a *new* customer, we can begin sharing your information 30 days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	1-800-237-2917

Who we are	
Who is providing this notice?	Nationwide Life Insurance Company
What we do	
How does Nationwide protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state law. These measures include computer safeguards and secured files and buildings. We limit access to your information to those who need it to do their job.

How does Nationwide collect my personal information?	We collect your personal information, for example, when you: • Apply for insurance • Make a payment or file a claim • Conduct business with us We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal and state law gives you the right to limit only: • Sharing for affiliates' everyday business purposes—information about your creditworthiness; • Affiliates from using your information to market to you; and • Sharing for nonaffiliates to market to you. State laws and individual companies may give you additional rights to limit sharing. See below for more information.
What happens when I limit sharing for an account I hold jointly with someone else?	Your choices will apply to everyone on your account.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. These companies include Nationwide Life Insurance Company, Nationwide Bank, and Nationwide Property and Casualty Insurance Company. Visit nationwide.com for a list of affiliated companies.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

Other important information

California Residents: We currently do not share information we collect about you with affiliated or nonaffiliated companies for their marketing purposes. Therefore, you do not need to opt out.

Nevada Residents: You may request to be placed on our internal Do Not Call list. Send an email with your phone number to privacy@nationwide.com. You may request a copy of our telemarketing practices. For more on this Nevada law, contact Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; Phone number: 1-702-486-3132; email: BCPINFO@ag.state.nv.us.

Vermont Residents: For Vermont customers only. We will not share your personal information for marketing purposes with the Nationwide family of companies or third parties without your authorization, except as permitted by law.

AZ, CA, CT, GA, IL, ME, MA, MT, NV, NJ, NM, NC, ND, OH, OR, and VA Residents: The Term "Information" means information we collect during an insurance transaction. We will not use your medical information for marketing purposes without your consent. We may share information with others, including insurance regulatory authorities, law enforcement, consumer reporting agencies, and insurance-support organizations without your prior authorization as permitted or required by law. Information we obtain from a report prepared by an insurance-support organization may be retained by that insurance-support organization and disclosed to others.

Accessing your information
You can ask us for a copy of your personal information. Please send your request to the address below and have your signature notarized. This is for your protection so we may prove your identity. Please include your name, address, and policy number. You can change your personal information at Nationwide.com or by calling your agent. We can't change information that other companies, like credit agencies, provide to us. You'll need to ask them to change it.

K&K Insurance Group, Inc.
Attn: Privacy Manager
1712 Magnavox Way P.O. Box 2338 Fort Wayne, IN 46801-2338