



On Your Side®

NATIONWIDE LIFE INSURANCE COMPANY  
Home Office: 1 Nationwide Plaza, Columbus, Ohio 43215

**SPECIFIED HAZARD INSURANCE POLICY**

Thank you for taking this policy with us.

Policy No 50206440013249001

**INSURING AGREEMENT** – We promise to pay, subject to the terms of this policy, the benefits stated herein. We make this promise and issue this policy to you in exchange for the premium shown in the application. This policy is a legal contract between you and us.

**POLICY TERM AND RENEWAL** – The first policy term starts and ends at 12:01 a.m. standard time at your address on the effective and first renewal dates shown in the application. The contract may be renewed with our consent for future terms of one year each by payment of the premium due at the rates in force for each such renewal. We may terminate the contract on any renewal date by giving you at least 31 days prior written notice.

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**KEY WORDS DEFINED** – When we use these words, we mean:

**You, your, or plan sponsor** – the plan sponsor named in the application.

**We, our, us, or Nationwide** – the Nationwide Life Insurance Company

**Application** – the attached policy application which is part of the contract

**Eligible person** – a person described under (one of) the class(es) of eligible persons listed in the application.

**Insured** – an eligible person insured under the contract

**Covered activities** – the covered activities described in the application

**Injury** – a bodily injury which meets all of the following conditions: (1) it is caused solely by an accident which happens while the contract is in force on the insured and while he or she is taking part in a covered activity; (2) it results in loss or expense covered by the contract; and (3) neither the injury, the loss, nor the expense may result from sickness, disease, or bodily infirmity, or from any cause other than the accident

**Reasonable and customary charges** – (1) reasonable in terms of services, care, or treatment provided; and (2) customary in that charges made by a provider are in line with charges made by providers of similar training and experience for a similar service within the same area

**Doctor** – a person duly licensed and legally qualified to diagnose and treat injury. Such person must be providing services within the scope of his or her license. The term "doctor" does not include the insured

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

## ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT

**Death** – if, as a result of injury, an insured dies within one year from the date of the accident causing the injury, we will pay, subject to the overall maximum for any one accident, the death benefit which applies less any specific loss benefit paid because of the same accident. The one year limit does not apply in a Pennsylvania contract.

**Specific loss** – if, as a result of injury, an insured suffers a specific loss within one year from the date of the accident causing the injury, we will pay, subject to the overall maximum for any one accident, a benefit based on the face amount which applies to the insured as specified in the table below.

For the Loss of:	Percent of the Face Amount
Each Arm	75%
Each Leg	75%
Each Hand	50%
Each Foot	50%
Sight of Each Eye	50%
Speech	50%
Hearing of Each Ear	25%
Thumb and Index Finger of the Same Hand	25%

Specific loss means the total, permanent, and irrecoverable loss of:

- (1) a natural arm or leg severed at or above the elbow or knee joint;
- (2) a natural hand or foot severed at or above the wrist or ankle joint;
- (3) the entire sight of an eye, entire speech, or entire hearing of an ear; or
- (4) a natural thumb and index finger severed at or above the joints which attach them to the hand

The total payment for all of the specific losses of an insured because of any one accident will not be more than the face amount shown in the application. No specific loss benefit will be paid if the death benefit applies. The loss of the thumb and index finger of the same hand benefit will not be paid if the loss of the hand or arm benefit applies. The loss of the hand or foot benefit will not be paid if the loss of the arm or leg benefit applies.

The overall maximum for any one accident is shown in the application. This is the maximum amount payable by us for all death and specific loss claims incurred for all insureds under the contract which are caused by any one accident. If this is not enough to pay the total of all such claims, then the amount we will pay for the death or specific loss of any one insured will be his or her proportional share of this amount.

**ACCIDENT MEDICAL EXPENSE BENEFIT** – If, as a result of injury, an insured incurs covered expenses starting within 90 days from the date of the accident causing the injury, we will pay, less the deductible (if any) shown in the application and not to exceed the maximum benefit amounts shown therein, all covered expenses incurred within 3 years from such date

**Covered expenses** mean the reasonable and customary charges for local professional ambulance service to or from a hospital and/or surgical center as well as the following reasonable and customary charges for treatment, services, and supplies provided or prescribed by doctor:

- (1) hospital or surgical center care;
- (2) medical treatment;
- (3) nursing care provided by a licensed nurse;
- (4) X-rays and lab exams;
- (5) prescription drugs and therapeutic services and supplies;
- (6) dental treatment as a result of injury to sound, natural teeth; and
- (7) the following licensed home health care agency services and supplies provided instead of an otherwise required hospital or skilled nursing home confinement: (a) physical, occupational, respiratory, and speech therapy, (b) the services of a home health aide, and (c) medical supplies

If the application indicates that the excess plan applies, we will not pay benefits for, nor can the deductible (if any) be satisfied by, covered expenses to the extent that they are collectible under:

- (1) another insurance contract or prepayment plan;
- (2) a trusteed, union, employee, or employee benefit plan;
- (3) Workers' Compensation (or similar occupational law); or
- (4) a government plan (except Medicaid and other public assistance plans), including one set forth by statute (such as Medicare).

## CLAIMS INFORMATION

**When must we receive notice?** Written notice of claim must be given within 30 days after a covered loss occurs or expense starts or it must be given as soon as reasonably possible. The notice must be sent to the servicing group claims office, our Home office, or to one of our agents. It should include your policy number and the name of the insured.

**How are claim forms obtained?** We will send forms to persons who ask for them within 15 days after notice of claim is given. If we do not, written proof (including the event, nature, and extent of loss) may be sent to us without using our forms. This proof must meet the terms of the next paragraph.

**When must we receive proof of loss?** Written proof must be given to us: (1) within 90 days after the end of any period of disability or hospital confinement for which claim is made; or (2) within 90 days after the date of loss on any other claim.

If it is not reasonably possible to give such proof, it should be given as soon as reasonably possible; but no later than one year from the time it is otherwise due. The one year limit is waived if the insured is legally incapable of giving such proof.

**When will we pay claims?** First we need written proof of loss. Then all benefits due the insured for loss of time because of total disability will be paid monthly as long as we are liable. Any balance not paid when our liability ends will be paid as soon as we receive proper written proof.

Benefits due for other losses will be paid when we receive proper written proof.

**To whom will we pay claims?** We will pay loss of life benefits to the insured's designated beneficiary in effect at the time of payment. If none is then in effect, or if the beneficiary dies first, we will pay the benefits to the insured's estate or, at our option, to one or more of the first surviving class of the following classes of successive preference beneficiaries: the insured's surviving spouse, children, parents, or brothers and sisters. This will, to the extent paid, release us from further liability. Other benefits will be paid to the insured except that those unpaid at death may, at our option, be paid to either the insured's estate or beneficiary.

If the insured is a minor or is not competent to give a valid release, we may pay an amount otherwise payable to the insured to his or her parents, guardian, or to a person supporting the insured.

If payment is to be made to the insured's estate or to a beneficiary who is either a minor or is not competent to give a valid release, we may pay up to \$1,000 to someone related to either the insured or to his or her beneficiary by blood or marriage whom we consider to be entitled to the payment. Such payment made by us in good faith will fully discharge us to the extent of the payment.

We may pay coverage expenses to the hospital or person providing the service, unless the insured states otherwise in writing by the time proofs of loss are filed. It is not required that a service be provided by any one hospital or person.

**How may the beneficiary be changed?** The insured may change his or her beneficiary. The beneficiary's consent is not needed unless the designation is irrevocable. Changes may be made during the insured's lifetime by written notice to us at our Home Office.

A change will take effect when the notice is signed, whether or not the insured is living when we receive it. The change will not prejudice a payment made or action taken by us before we receive it at our Home Office.

**Can a physical exam be required?** Yes. We have the right to have a doctor examine a person whose condition is the basis of a claim. This may be done as often as is reasonably necessary while a claim is pending. This will be at our expense.

**Is there a free choice of a doctor?** Yes. The insured will have a free choice of a doctor. The doctor - patient relationship will be maintained.

**What if there is a common accident?** If an insured and his or her beneficiary die from the same accident without enough evidence that they died other than at the same time, the insured's benefits will be paid as if he or she died last.

**SOUTH CAROLINA SPECIFIED HAZARD POLICY AND CERTIFICATE RIDER**

**NATIONWIDE LIFE INSURANCE COMPANY**  
Columbus, Ohio

issues this rider to

**THE PLAN SPONSOR REFERRED TO ON THE FIRST PAGE  
OF THE POLICY OR CERTIFICATE TO WHICH THIS RIDER IS ATTACHED**

This rider is subject to all of the terms of the policy and certificate.

The effective date of this rider is the effective date of the policy or certificate

The policy or certificate is amended as follows:

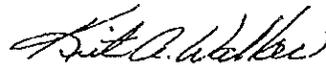
- 1 The second paragraph of the Death and Specific Loss Benefit provision is replaced by the following:

**Specific loss** – means the total, permanent, and irrecoverable loss of: (1) a natural arm or leg severed at or above the elbow or knee joint; (2) a natural hand or foot severed at or above the wrist or ankle joint (if a South Carolina contract, loss of hand means loss at or above the wrist or loss of the four entire fingers); (3) the entire sight of an eye, entire speech, or entire hearing of an ear; or (4) a natural thumb and index finger severed at or above the joints which attach them to the hand

2. Reference to "sound natural teeth" in the second paragraph of the Medical Expense Benefit provision is changed to read "natural teeth."
- 3 The second and third paragraphs of the **CLAIMS INFORMATION** provision entitled "To whom will we pay claims?" are replaced by the following:

If payment is to be made to the insured's estate or to an insured or beneficiary who is either a minor or is not competent to give a valid release, we may pay to up to \$1,000 to someone related to either the insured or his or her beneficiary by blood or marriage whom we consider to be entitled to the payment. Such payment made by us in good faith will fully discharge us to the extent of the payment

**NATIONWIDE LIFE INSURANCE COMPANY**



President



**NATIONWIDE LIFE INSURANCE COMPANY**

Home Office: Columbus, Ohio

**SPECIFIED HAZARD INSURANCE COMPANY**

We issue this certificate to you as evidence of your coverage

**INSURING AGREEMENT** – We promise to pay, subject to the terms of the Specified Hazard Insurance Policy issued to your plan sponsor, the benefits stated herein. We make this promise and issue this certificate to you in exchange for the premium paid by your plan sponsor. The policy is a legal contract between your plan sponsor and us.

**SCHEDULE OF BENEFITS**

The benefits included are only those with a specific amount shown below each Benefit listed in the schedule. The word "None" under an item means it is not included.				
<b>Accidental Death and Specific Loss with a \$250,000 overall maximum for any one accident.</b>		<input checked="" type="checkbox"/> Primary Plan  <input type="checkbox"/> Excess Plan	<b>Medical Expense</b>	<b>Weekly Accident Income starting on the _____ day of disability for up to _____ weeks</b>
<b>Accidental Death</b>	<b>Specific Loss (Face Amount)</b>	<b>Deductible</b>	<b>Overall Maximum</b>	
\$ 7,500	\$ 15,000		\$ 25,000	\$ 0

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**KEY WORDS DEFINED** – When we use these words, we mean:

**We, our, or us** – the Nationwide Life Insurance Company.

**You or your** – an eligible person insured under the contract.

**Covered activities** –

Recreational activities (which includes arts and crafts and excludes tackle football, soccer, hockey, and lacrosse for phi codes 730 and 731) sponsored and directly supervised by the plan sponsor

**Injury** – A bodily injury which meets all of the following conditions: (1) it is caused solely by an accident which happens while you are insured under the contract and while you are taking part in a covered activity; (2) it results in loss or expense covered by the contract; and (3) neither the injury, the loss, nor the expense may result from sickness, disease, or bodily infirmity, or from any cause other than the accident.

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**TERM OF A PERSON'S COVERAGE** – Your coverage begins on the later of: (1) the effective date of the contract; or (2) when you become an eligible person.

Your coverage ends on the first of these to occur: (1) when you are no longer an eligible person; or (2) the date to which premium has been paid; or (3) the termination date of the contract.

Termination of coverage will not affect a claim which occurs before the coverage ends

**EXCLUSIONS AND LIMITATIONS** – We will not pay benefits for covered expenses incurred for: (1) the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids; (2) treatment by a person employed or retained by the plan sponsor or its subsidiaries or affiliates and for which no charge is normally made; or (3) care or treatment by a person who ordinarily lives in your home or is a parent, grandparent, spouse, brother, sister, or child of either you or your spouse.

Nor will we pay benefits for loss or covered expenses resulting from: (4) intentional self-destruction or an attempt at it, or intentional self-inflicted injury while sane or insane (if a Missouri contract, while sane); (5) war or an act of war, declared or undeclared; or (6) air travel unless you are a passenger on a regularly scheduled flight of a properly licensed commercial airline.

#### **CLAIMS INFORMATION**

**When must we receive notice?** Written notice of claim must be given within 30 days after a covered loss occurs or expense starts or it must be given as soon as reasonably possible. The notice must be sent to the servicing group claims office, our Home Office, or to one of our agents. It should include your plan sponsor's policy number and your name.

**How are claims forms obtained?** We will send forms to persons who ask for them within 15 days after notice of claim is given. If we do not, written proof (including the event, nature, and extent of loss) may be sent to us without using our forms. This proof must meet the terms of the next paragraph.

**When must we receive proof of loss?** Written proof must be given to us: (1) within 90 days after the end of any period of disability or hospital confinement for which claim is made; or (2) within 90 days after the date of loss on any other claim.

If it is not reasonably possible to give such proof, it should be given as soon as reasonably possible; but no later than one year from the time it is otherwise due. The one year limit is waived if you are legally incapable of giving such proof.

**When will we pay claims?** First we need written proof of loss. Then all benefits due you for loss of time because of total disability will end monthly as long as we are liable. Any balance not paid when our liability ends will be paid as soon as we receive proper written proof.

Benefits due for other losses will be paid when we receive proper written proof.

**To whom will we pay claims?** We will pay loss of life benefits to your designated beneficiary in effect at the time of payment. If none is then in effect, or if the beneficiary dies first, we will pay the benefits to your estate or, at our option, to one or more of the first surviving class of the following classes of successive preference beneficiaries: your surviving spouse, children, parent, or brothers and sisters. This will, to the extent paid, release us from further liability. Other benefits will be paid to you except that those unpaid at death may, at our option, be paid to either your estate or beneficiary.

If you are a minor or are not competent to give a valid release, we may pay an amount otherwise payable to you, to your parents, guardian, or to a person supporting you.

**SOUTH CAROLINA SPECIFIED HAZARD POLICY AND CERTIFICATE RIDER**

**NATIONWIDE LIFE INSURANCE COMPANY**  
Columbus, Ohio

issues this rider to

**THE PLAN SPONSOR REFERRED TO ON THE FIRST PAGE  
OF THE POLICY OR CERTIFICATE TO WHICH THIS RIDER IS ATTACHED**

This rider is subject to all of the terms of the policy and certificate

The effective date of this rider is the effective date of the policy or certificate.

The policy or certificate is amended as follows:

- 1 The second paragraph of the Death and Specific Loss Benefit provision is replaced by the following:

**Specific loss** – means the total, permanent, and irrecoverable loss of: (1) a natural arm or leg severed at or above the elbow or knee joint; (2) a natural hand or foot severed at or above the wrist or ankle joint (if a South Carolina contract, loss of hand means loss at or above the wrist or loss of the four entire fingers); (3) the entire sight of an eye, entire speech, or entire hearing of an ear; or (4) a natural thumb and index finger severed at or above the joints which attach them to the hand.

- 2 Reference to "sound natural teeth" in the second paragraph of the Medical Expense Benefit provision is changed to read "natural teeth"
- 3 The second and third paragraphs of the **CLAIMS INFORMATION** provision entitled "To whom will we pay claims?" are replaced by the following:

If payment is to be made to the insured's estate or to an insured or beneficiary who is either a minor or is not competent to give a valid release, we may pay to up to \$1,000 to someone related to either the insured or his or her beneficiary by blood or marriage whom we consider to be entitled to the payment. Such payment made by us in good faith will fully discharge us to the extent of the payment

**NATIONWIDE LIFE INSURANCE COMPANY**



President



**Nationwide®**  
*On Your Side*

## NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

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

The terms of this Notice of Privacy Practices apply to Nationwide Life Insurance Company®, National Casualty Company and the area within Nationwide Mutual Insurance Company® that performs healthcare functions. In this Notice, "Nationwide" or "We" means the healthcare functions of Nationwide Life Insurance Company, which is a hybrid covered entity, the healthcare functions of National Casualty Company, and Nationwide Mutual Insurance Company, a business associate. As permitted by law, Nationwide will share protected health information (PHI) of members as necessary to carry out treatment, payment, and healthcare operations.

We are required by HIPAA and certain state laws to maintain the privacy of our members' PHI and to provide members with notice of our legal duties and privacy practices with respect to their PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. Copies of the revised notices will be mailed to all current plan members or insureds.

**Protected health information (PHI)** that is the subject of this Notice is information that is created or received by Nationwide; and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. It includes information of persons living or deceased.

### USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

**Your Authorization.** Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing, unless we have taken any action in reliance on the authorization.

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

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

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

**Business Associates.** Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide some of your PHI to one or

**Communications With You** You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI information from us by alternative means or at alternative locations. A request form can be obtained by writing your designated contact

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

#### **CONTACT INFORMATION**

If you have any questions about this statement, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling the telephone number on your ID card if applicable, or mail your request to:

Nationwide Specialty Health<sup>SM</sup>  
Administered by Consolidated Health Plans  
PO Box 1970  
Springfield, MA 011001

As a member, you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means

#### **EFFECTIVE DATE**

This Nationwide HIPAA Notice of Privacy Practices is effective April 14, 2003.

Nationwide, the Nationwide framework, and On Your Side are federally registered service marks of Nationwide Mutual Insurance Company. Nationwide Specialty Health is a service mark of Nationwide Mutual Insurance Company.

NH-0524-1A (10/07)

# Nationwide® Privacy Statement

Thank you for choosing your health coverage from Nationwide.

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

## **Confidentiality and security**

We follow all data security laws. We protect your information by using physical, technical, and procedural safeguards. We limit access to your information to those who need it to do their jobs. Our business partners are also legally bound to use your information for our purposes only. They may not share it or use it in any other way.

## **Collecting and using your personal information**

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

We may share the following types of information:

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

## **Sharing your information for business purposes**

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

## **Sharing your information for marketing purposes**

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

## **Using your medical information**

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

## **Accessing your information**

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



**Nationwide®**  
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Nationwide Specialty Health™