Nationwide Life Insurance Company

Home Office: One Nationwide Plaza, Columbus, Ohio 43215
Administrative Office: Nationwide Employee Benefits, Covington, LA 70434

CERTIFICATE OF COVERAGE FOR VOLUNTARY GROUP CRITICAL ILLNESS/SPECIFIED DISEASE

INSURING AGREEMENT

The Nationwide Life Insurance Company (Hereafter called We, Us or Our in the Policy) has issued a Policy covering certain Eligible Classes of the Policyholder.

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

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

NOTICE CONCERNING YOUR CERTIFICATE

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

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

Signed for Nationwide Life Insurance Company

Secretary President

NON-PARTICIPATING

THIS CERTIFICATE PROVIDES CRITICAL ILLNESS BENEFITS ONLY AND DOES NOT PROVIDE FOR ANY OTHER ILLNESS OR CONDITION. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. IT IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

PLEASE READ YOUR CERTIFICATE CAREFULLY. KEEP IT IN A SAFE PLACE.

THIS POLICY IS NOT A MEDICARE SUPPLEMENTAL POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE 'GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE' AVAILABLE FROM YOUR AUTHORIZED REPRESENTATIVE.

TABLE OF CONTENTS

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SCHEDULE OF BENEFITS FOR VOLUNTARY GROUP CRITICAL ILLNESS/SPECIFIED DISEASE

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

Policyholder:	Nationwide Mutual Insurance Company
Policy Effective Date:	January 1, 2022
Policy Number:	NE00005
Policyholder Address:	One Nationwide Plaza Columbus, OH 43215
Policy Anniversary Date:	January 1st
Certificate Effective Date:	January 1, 2025
Eligible Classes:	All Actively at Work
Eligibility Waiting Period:	If you are in an Eligible Class on or before the Policy Effective Date: None If you are entering an Eligible Class after the Policy Effective Date: None
Contribution Type:	Voluntary
Method of Premium Payment:	Remitted by You to Us or Our Agent
Plan Year:	Calendar Year
Benefit Waiting Period:	None

CRITICAL ILLNESS BENEFIT

Your Benefit Amount You elected: $10,000 or $20,000.

Guaranteed Issue Benefit Amount for You: $10,000 or $20,000.

Covered Spouse or Domestic Partner Benefit Amount: 50% of Your Benefit Amount.

Covered Child(ren) Benefit Amount: 50% of Your Benefit Amount.

Per Person Lifetime Benefit Maximum Payout: 300% of a Covered Person's Benefit Amount shown above for all Benefit payments combined for all Critical Illnesses.

COVERED CRITICAL ILLNESS(ES) AND BENEFIT MAXIMUMS

Covered Critical Illness	Percent of the Benefit Amount	Recurrence Benefits Maximum Number and Percent of Benefit	
Coronary Heart Disease – Diagnosis 1	100%	Unlimited	25%
Coronary Heart Disease – Diagnosis 2	25%	Unlimited	25%
End Stage Renal Failure	100%	N/A	N/A
Heart Attack	100%	Unlimited	25%
In Situ Cancer (non-Invasive)	25%	Unlimited	25%
Invasive Cancer	100%	Unlimited	25%
Major Organ Failure *(including heart)*	100%	Unlimited	25%
Stroke	100%	Unlimited	25%

Additional Benefits rider(s) attached at issuance: Progressive Disease Benefit Rider

GENERAL DEFINITIONS

Activity(ies) of Daily Living (ADLs): Certain basic daily tasks necessary to maintain a Covered Person's health and safety. In this Certificate ADLs refer to the activities described below.

1. Transfer and mobility - The ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment.
2. Continence - The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter, urostomy, or colostomy bag).
3. Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. Toileting - Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene tasks.
5. Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
6. Bathing - Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.

Actively at Work: as defined by the Policyholder.

Age: Your and Your Eligible Dependent(s) Age at Your and Your Eligible Dependent(s) last birthday.

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

Benefit Amount: The total Benefit for a Covered Person on which the percent of Benefit is payable for a Diagnosis of a Critical Illness, as applicable. The Benefit Amount is shown in the Schedule of Benefits.

Benefit: The dollar amount payable by Us in one lump sum payment following receipt of a Proof of Loss.

Benefit Waiting Period: The period following a Covered Person's Effective Date or request for an increase in Coverage during which Benefits are not payable, as described in the Schedule of Benefits.

Calendar Year: For the first year, the period of time that begins on the Effective Date and ends on December 31st. For subsequent years, the period of time that begins on January 1st and ends December 31st.

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

Child or Children: See definition of Eligible Dependent.

Claim: A request for payment of covered Benefits.

Claimant: A person who has filed a Claim for Benefits under the Policy, as a Covered Person.

Clinical Diagnosis: A Diagnosis by a qualified Doctor based on clinical evidence, which includes documentation of clinical exam, clinical impression, imaging studies or diagnostic test results. Clinical Diagnosis must include recommendations for treatment. In the case where Clinical Diagnosis is required to confirm a Critical Illness and the date the Doctor first documents the Diagnosis.
We will accept a Clinical Diagnosis only if the following conditions are met:

- A Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
- There is medical evidence to support the Diagnosis; and
- A Doctor is treating the Covered Person for Invasive Cancer.

Contributory: You pay a portion or all of the Premium for Coverage. The maximum amount that You may be required to contribute to the cost of Your Coverage shall not exceed the Premium charged.

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

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

Critical Illness: Covered Critical Illnesses as listed in the Schedule of Benefits or applicable riders.

Date of Diagnosis: The date that a Diagnosis is made by a qualified Doctor through the use of clinical and/or laboratory findings as supported by the Covered Person's medical records. Details are specified under each Critical Illness definition.

Dependent or Covered Dependent: Your Eligible Dependent who is a Covered Person under the Policy subject to the terms and conditions of the Policy.

Diagnosis: The definitive establishment of the Critical Illness, as defined herein, using clinical and/or laboratory findings. The Diagnosis must be made by a qualified Doctor.

Disability: You are unable to work and are unable to perform the substantial and material duties of Your Own Occupation.

Doctor: A person who is:

1. Licensed as a provider of medical services by the state in which the provider practices;
2. Acting within the scope of his or her license and a board-certified specialist where required under the Policy;
3. Legally qualified to diagnose and treat a Critical Illness or perform the applicable Procedure; and
4. Not one of the following:
   - ☐ A person who ordinarily resides in Your household;
   - ☐ An Immediate Family Member or a business partner;
   - ☐ The Policyholder or someone retained by the Policyholder.

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

1. For at least 6 consecutive months prior to Your Domestic Partner's Effective Date of Insurance, You and Your Domestic Partner, are and have been each other's sole Domestic Partner and have maintained the same principal place of residence;
2. Your Domestic Partner is at least 18 years of age;
3. You and Your Domestic Partner are not married or related by blood;
4. You and Your Domestic Partner are jointly responsible for each other's welfare and financial obligations; and
5. You and Your Domestic Partner are not legally married to anyone else.

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

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

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

Eligible Dependent: Includes:

1. Your Spouse/Domestic Partner, under the age 70 (if not legally divorced from You); and
2. Your or Your Spouse's/Domestic Partner's Child from the moment of birth, until the Child attains age 26.

Children include natural children, stepchildren, adopted children, children Placed for Adoption, children appointed to Your custody by a court order, who are dependent upon You for support. Adopted children include a child where You have assumed and retained a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Such child is no longer considered an Eligible Dependent upon the termination of that legal obligation. The term Eligible Dependent does not include any person who:

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

Eligible Person: A person who a residence of the United States and belongs to an Eligible Class as described in the Schedule of Benefits.

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

Enrollment Period: A period of time agreed to by the Policyholder and Us during which either: 1) an Eligible Person may

enroll for insurance under the Policy if he or she did not enroll when initially eligible; or 2) if a Covered Person is currently enrolled, he or she may increase, decrease, or terminate his or her insurance.

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

Guaranteed Issue: An amount of insurance for which We do not require Proof of Insurability.

Hospital: An institution that:

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

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

1. A rest or nursing home, home for the aged or convalescent home;
2. A skilled nursing facility;
3. an extended care facility;
4. An outpatient surgery center;
5. A hospice or a place for custodial care, or
6. A birthing center.

Immediate Family Member: Your Spouse or Domestic Partner and Your or Your Spouse's or Domestic Partner's children, brothers, sisters, uncles, aunts, in-laws, grandparents, and parents.

Initial Enrollment Period: The period of time determined by the Policyholder during which an Eligible Person may first enroll for insurance under the Policy. The number of days You have to enroll is shown in the Schedule of Benefits.

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

Intensive Care Unit: A Hospital unit, including a coronary care unit, in which patients are grouped in an area where:

1. facilities and staff are tailored to the special needs of the seriously ill;
2. 24-hour per day care by registered nurses is provided; and
3. lifesaving drugs and equipment are always at hand.

Such units must render care more intensive than is rendered in the general surgical or medical nursing units which treat most of the Hospital's inpatients.

Non-Contributory: You pay no portion of the Premium for Coverage.

Pathological Diagnosis: A Diagnosis of Invasive Cancer or In Situ Cancer based on a microscopic study of fixed tissue or preparations from the blood systems. This type of Diagnosis must be done by a qualified Doctor whose Diagnosis of Invasive Cancer or In Situ Cancer conforms to the standards set by the American College of Pathology.

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

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

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

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

Policy Year: For the first year, it is the period of time that begins on the Policy Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary.

Policyholder: The entity named in the Schedule of Benefits who has contracted with Us to provide Coverage under the Policy.

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

Prior Plan: The Covered Person's Group Critical Illness coverage that was in effect on the date immediately preceding the Effective Date of this Certificate.

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

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

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

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

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

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

Schedule of Benefits: Shows the amount of Benefits provided under the Policy and other eligibility and enrollment information.

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

Spouse: Your lawful Spouse who is an Eligible Dependent.

Substantial Assistance: Hands-on assistance and stand-by assistance as described below. For the purposes of the Policy "stand-by assistance" will be used to determine that Substantial Assistance by another person is required by the Covered Person to perform Activity(ies) of Daily Living.

1. "Hands-on Assistance" means the physical assistance of another person without which a Covered Person would be unable to perform the ADL.
2. "Stand-by Assistance" means the presence of another person within a Covered Person's arm's reach, to prevent, by physical intervention, injury to the Covered Person while he or she performs an Activity of Daily Living (such as being ready to catch him or her if he or she falls while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the Covered Person's throat if he or she chokes while eating).

Treatment Free: The Covered Person is no longer receiving treatment or medical advice from a qualified Doctor or being prescribed or taking medication for a Critical Illness, other than routine checkups or maintenance medication for that Critical Illness. For the purpose of this definition, maintenance medication is systemic medication meant to decrease the risk of Recurrence (see Recurrence Benefit provision in this Certificate) and not meant to treat a Critical Illness that is still present.

Voluntary: An optional insurance program offered to You through the Policyholder where You pay all of the Premium for Coverage.

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.

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

You and Your, Yourself: The Insured Person.

CRITICAL ILLNESS DEFINITIONS

Coronary Heart Disease: A narrowing or blockage of one or more coronary arteries resulting from plaque buildup.

Date of Diagnosis - 1: The date a qualified Doctor recommends the Insured undergo a surgical Procedure of either a coronary artery bypass using either a saphenous vein or internal mammary artery graft or valve replacement.

Date of Diagnosis – 2: The date a qualified Doctor recommends the Insured undergo a catheterization procedure of balloon angioplasty or stent placement.

End Stage Renal Failure: A chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis is started, or renal transplant is required.

Date of Diagnosis: the earliest of the following:

- ☐ The date a qualified Doctor recommends regular hemodialysis or peritoneal dialysis to sustain life; or
- ☐ The date an Insured is placed on the UNOS list for a kidney transplant.

Heart Attack (Myocardial Infarction): The ischemic death of a portion of the heart muscle due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be based on both:

1. New clinical presentation and electrocardiographic changes consistent with an evolving Heart Attack; and
2. Serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

For the purposes of this Benefit, the following do not meet the definition of Heart Attack:

- ☐ An established (old) heart attack;
- ☐ Angina;
- ☐ Atherosclerotic heart disease;
- ☐ Cardiac arrest (including arrhythmias);
- ☐ Congestive heart failure;
- ☐ Coronary artery disease; and
- ☐ Any other disease, injury or dysfunction of the cardiovascular system.

Date of Diagnosis: The date the death of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack Condition definition and as Diagnosed by a qualified Doctor.

If a Heart Attack results in death, an autopsy confirmation or death certificate verifying the Heart Attack as the cause of death will be accepted.

In Situ Cancer (Non-Invasive Cancer): A malignant tumor, which is classified as Stage 0, where the tumor cells lie within the tissue of origin without having invaded neighboring tissue. In Situ Cancer includes:

1. Early prostate cancer Diagnosed as T1N0M0 or equivalent staging;
2. Carcinoid of the appendix;
3. Any tumor of the prostate classified as T1N0M0 under TNM Classification;
4. Any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Classification and is one centimeter or less in diameter, *unless there is metastasis;*
6. Any papillary tumor of the bladder classified as Ta under TNM Classification;
7. Any malignant tumor classified as less than T1N0M0 under TNM Classification;
8. Stage 0 transitional carcinoma in the urinary bladder;
9. Chronic Lymphocytic Leukemia (CLL), less than Stage III, as defined by RAI classification.

For the purposes of this Benefit, the following do not meet the definition of In Situ Cancer:

1. Skin Cancer;
2. Any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
3. Any tumor in the presence of human immuno-deficiency virus.

Date of diagnosis: The date In Situ Cancer (Non-invasive) is diagnosed according to a Pathological Diagnosis. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Invasive Cancer: A disease which is identified by the presence of malignant cells or a malignant tumor, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Leukemia, Hodgkin's disease, carcinoma, sarcoma, malignant tumor, malignant melanoma and lymphomas are included.

For the purposes of this Benefit, the following do not meet the definition of Invasive Cancer:

1. Any In Situ Cancer (Non-Invasive Cancer), as defined;
2. Skin Cancer;
3. Any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
4. Any tumor in the presence of human immuno-deficiency virus.

Date of diagnosis: Invasive Cancer must be diagnosed according to a Pathological Diagnosis. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Major Organ Failure: The clinical evidence of major organ(s) failure is severe enough that it requires the malfunctioning organ(s) or tissue of the Covered Person to be replaced with an organ(s) or tissue from a suitable human donor (excluding the Covered Person) under generally accepted medical Procedures. The organs and tissues covered by this definition are limited to: heart, liver, lung(s), small intestine, pancreas, pancreas-kidney or bone marrow. In order for the Major Organ Transplant to be covered under this Policy, the Covered Person must be registered and accepted by the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). If the Covered Person is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS or NMDP list, the network requirement will be waived.

If an Insured is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid.

The Policy will not pay benefits for a Major Organ Failure:
1. involving transplants of parts of organs, tissues or cells;
2. performed outside the United States;
3. involving implantation of mechanical devices or mechanical organs;
4. involving stem cell generated transplants (other than for a bone marrow transplant);
5. involving islet cell transplants; or
6. involving bone marrow transplanted from the same Covered Person.

Date of Diagnosis: The date the Insured is Diagnosed with a Major Organ Failure by a qualified Doctor and placed on the UNOS list for organ transplant(s).

Skin Cancer: a cancer that forms in the tissues of the skin. The following are considered Skin Cancers: basal cell carcinoma; squamous cell carcinoma of the skin; melanoma in situ; melanoma that is Diagnosed as Stage 1A melanomas under TNM staging. These Conditions are not payable under In Situ Cancer or Invasive Cancer Benefit.

Date of Diagnosis: The date a qualified Doctor Diagnosis the skin biopsy as a Skin Cancer.

Stroke: The sudden death of brain cells due to lack of oxygen, caused by blockage of blood flow or rupture of an artery to the brain. For the purposes of this Benefit, the following do not meet the definition of Stroke: Transient ischemic attack (mini stroke); head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded.
If a Stroke results in death, an autopsy confirmation or death certificate verifying the stroke as the cause of death will be accepted.

Date of Diagnosis: The date a Stroke occurs, and the diagnosis supported by:
1. Neurological deficits persisting for at least 30 days after the Stroke including but not limited to impaired motor function, altered sensation, vision loss, difficulty swallowing, or cognitive impairment confirmed by a qualified Doctor; and
2. Confirmatory neuroimaging studies consistent with the diagnosis of a Stroke.

COVERED PERSONS PREMIUMS

When are Your Premiums due?

The first Premium for each Covered Person is due on the date he or she becomes Effective under the Policy. Each Premium after the initial Premium is due at the end of the period for which his or her preceding Premium was paid.

What happens if You are late with a Premium payment?

A Grace Period of 31 days from the Premium due date is allowed for each Covered Person for payment of each Premium due after the initial Premium. The Covered Person's insurance will be continued during the Grace Period. If the Covered Person incurs a covered loss during the Grace Period, You will be liable to Us for payment of any Premium accruing during the period We continued Coverage for You and Your Covered Dependents.

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

WHEN COVERAGE BEGINS AND ENDS

Who is eligible?

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

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

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

When do You enroll?

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

Eligible Person: An Eligible Person who has met all eligibility requirements of the Policyholder prior to the Policy Effective Date may request enrollment during the Initial Enrollment Period that precedes the Policy Effective Date. After the Policy Effective Date, a new or newly hired Eligible Person must request enrollment no later than 30 days after the date of hire. An Eligible Person who does not enroll as indicated above may not enroll until the next Enrollment Period, unless there is a Change in Family Status as described below.

Eligible Dependent: If the Policy provides for Dependent Coverage, an Eligible Person may request enrollment of his or her Dependents at the time he or she requests enrollment for himself per the above. After the Policy Effective Date, a new Eligible Person must request enrollment for their Eligible Dependents no later than 30 days after the end of the Eligibility Waiting Period. The Dependent may not enroll until the next Enrollment Period unless there is a Change in Family Status, as described below. If You acquire a new Dependent, as an Insured Person, You may request enrollment per the Change in Family Status provision below. Proof of the Dependent relationship may be required by Us.

Change in Family Status: Eligible Persons may enroll themselves or any Eligible Dependent or change their Coverage outside of an Enrollment Period if a change in family status occurs, provided an Enrollment Form is received within 60 days of the event. A change in family status event means any of the following:

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

Enrollment Period: We and the Policyholder may provide for an Enrollment Period during the Policy Year. Eligible Persons may enroll themselves and their Eligible Dependents during an Enrollment Period as if they were a newly Eligible Person. They may also increase, decrease, or terminate coverage during such Enrollment Period, in accordance with the **When may You change Your Insurance?** provision. {*section amended by GCI OH L24 002 0122}*

When will Your Coverage begin?

If the Policyholder requires You to contribute toward the cost of all or part of the insurance, no such Contributory insurance will become effective for You before the first Premium is paid.

Subject to Your enrollment and payment of any Contributory portion of the Premium due, insurance is effective at 12:01 AM at the main office of the Policyholder on:

1. the Policy Effective Date; or
2. the date an Eligible Person enrolls, if an Eligible Person enrolls for Coverage after the Policy Effective Date; or
3. the beginning of the next Policy Year following the date an Eligible Person enrolls for Coverage during the Enrollment Period.

Notwithstanding the above, if You are not Actively at Work on the date Your insurance Coverage would begin, Your insurance will begin on the date You come back to Active Work. {*section amended by GCI OH L24 002 0122}*

When will Coverage begin for Your Dependents?

Subject to the enrollment procedure described in the **When do You enroll?** provision above and payment of any Contributory portion of the Premium due, and satisfactory Proof of Insurability, if required, Your Dependents will become insured on the same date and at the same time as You.

If You acquire additional Dependents due to Change of Family Status after Your Effective Date of Coverage and ***have*** Dependent Coverage, and provided You enroll Your Eligible Dependents as indicated above, the Effective Date of the newly acquired Dependents will be the first of the month following the date You complete and Sign the Enrollment Form requesting Coverage, subject to timely payment of any Premium due.

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

1. for Your Spouse/Domestic Partner, the first of the month following the date of the event causing eligibility;
2. for newborn children from the moment of birth;
3. for adopted children the date of Placement for Adoption;
4. for all other Eligible Dependents, the first day of the month following the date You enroll such Dependent;

subject to payment of any Premium due. If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such Child shall take effect on the date of enrollment, if We are notified in accordance with our enrollment guidelines and once the required Premium, if any, has been paid.

Newborn Children: Your newborn child will be covered for the first 60 days following their birth. To continue Coverage beyond that 60 day period, You must enroll the Child at any time during the 60 day period. Any required Premium must be paid when due from the date of birth. Otherwise, Coverage for that Child will terminate as soon as the 60-day period expires.

The Policyholder may require You to contribute toward the cost of all or part of Your Dependent(s) insurance. If so, the only Eligible Dependent who may become insured before You agree to those contributions is Your newborn Child. The form for this agreement may be obtained from the Policyholder.

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

If any Eligible Dependent, other than a newborn Child, is confined, due to an injury or illness, in a Hospital or other medical facility on the date insurance would otherwise begin, Coverage will be deferred until 30 days following the end of the Eligible Dependent's confinement and become effective on the first day following the date the Dependent is no longer confined as long as Your Coverage is in effect.

When may You change Your Benefits?

You may change Your Benefits in the following situations:

1. Enrollment Period: Each year During the Enrollment Period You may, provided You are then Actively At Work, elect to:

a. increase Your and Your Covered Dependent's insurance Benefits;
b. decrease Your and Your Covered Dependent's insurance Benefits;
c. keep the same insurance Benefits You currently have for Yourself and Your Covered Dependents;
d. terminate Your insurance Benefits for Yourself and/or Your Covered Dependents.

If You do not elect to enroll or to increase the Benefits during the annual Enrollment period, You will not be eligible to elect Benefits until the following annual enrollment period unless you have a Change in Family Status.

When will We change Benefits?

Change in Eligible Class: The amount or cost of Your Benefit and Your Eligible Dependents may change if You become insured under a different Eligible Class.

If the change would increase the amount of insurance, the increase takes effect on the next Policy Anniversary following

the latest of the date:

1. The change occurred;
2. The Policyholder tells Us in Writing about a change in Eligible Class;
3. We approve any Proof of Insurability required for a Benefit increase; or
4. The Premium is paid based on the change.

If You are not Actively at Work, such change will be effective on the first day on which You return to work.

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

When will Coverage end?

Subject to the Portability of Insurance Section, all of Your insurance under the Policy will terminate at 12:01 AM. at the Home Office of the Policyholder on the earliest of the following dates:

1. The date Your employment terminates.
2. The end of the month following six months when You are not Actively at Work due to an illness or injury;
3. The date the Policy terminates;
4. The date Your employer ceases to be an affiliated employer with the Policyholder;
5. The date You cease to be an Eligible Person;
6. The last day of the period for which Premium was paid, if a Premium is not paid when due;
7. The date in which the Policy is changed to end the insurance for Your Eligible Class;
8. The date You retire unless Your insurance is continued in a retired Eligible Class as defined by the Policyholder and as shown in the Schedule of Benefits;
9. The last day of the Calendar Year following the date of Your 70th birthday;
10. The date You reach the Per Person Lifetime Benefit Maximum Payout; or
11. The date of Your death.

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

All Coverage ends when the Group Policy terminates. ***{section amended by GCI OH L24 002 0122}***

When will Coverage end for Your Dependent?

Your Dependent's insurance under the Policy will terminate at 12:01 AM at the Home Office of the Policyholder on the earliest of the following dates:

1. The date the Policy terminates;
2. The last date of the Calendar Year following the date the Dependent attains age 26;
3. The date You cease to be insured under the Policy;
4. The date You cease to be in an Eligible Class for Dependent Coverage;
5. The last day of the period for which Premium was paid, if a Premium is not paid when due;
6. The date the Policy is changed to end the insurance for Your Eligible Class;
7. The date that the Dependent enters full-time active duty in the armed forces of any country or international authority;
8. For Your Dependent Spouse/Domestic Partner, the last date of the Calendar Year following the date of his or her 70th birthday;
9. The date You retire;
10. The date the Covered Dependent reaches the Per Person Lifetime Benefit Maximum Payout; or
11. The date of Your death;
12. The date of Covered Dependent's death.

Handicapped Dependent Children: Insurance will continue for a handicapped child who has attained the limiting age for Eligible Dependents, if such child is intellectually or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered under Our Policy or the Prior Plan on the day immediately prior to attaining the limiting age. Proof of incapacity must be furnished to Us by the end of the calendar year of attainment of the limiting age. Failure to provide Proof during this time period will result in termination of Coverage for that Dependent.

Notice Required When Your Coverage Terminates: The Policyholder must inform our agent or Us within the 31 days of the date Your Coverage terminates for any reason. Failure to provide notice will not continue Your insurance past the time it would have otherwise ended. In the event Premiums have been paid to Us on Your behalf after Your Coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up 12 Policy month(s) or to the last Policy Anniversary, whichever is less. If We are not notified that Your Coverage is terminated, and We pay any Benefits after the date Your Coverage terminated, You will be responsible for payment of all Premiums due through the Policy month in which Benefits were paid. ***{section amended by GCI OH L24 002 0122}***

What happens if You return to Active Work/eligible status?
After release from active duty: If Your insurance or Your Eligible Dependent's insurance ends due to Your being called or ordered to full-time active duty in the armed forces of any country or international authority, such insurance will be reinstated when You return to Active Work.

BENEFITS

What benefits are payable for a Critical Illness?
Subject to all the terms and conditions of the Policy, the Benefit Amount will be paid in a lump sum for each covered Critical Illness, as shown in the Schedule of Benefits, subject to the Per Person Lifetime Benefit Maximum Payout, and if:

1. The Date of Diagnosis occurs after the Covered Person's Effective Date and while Coverage is in force under this Certificate, subject to any applicable Benefit Waiting Period and Pre-existing Condition limitation; and
2. The Critical Illness satisfies the definition for that condition, as defined herein.

If a named Critical Illness is contributed to or caused by another named Critical Illness, We will pay only one Benefit. The Benefit paid will be the larger of the two.

How does the Benefit Waiting Period impact the Benefit payable?
Benefits will not be paid for a Critical Illness that would otherwise be covered if:

1. The Date of Diagnosis for that Critical Illness is during the Benefit Waiting Period; or
2. A Covered Person seeks treatment or medical advice for symptoms of a covered Critical Illness during the Benefit Waiting Period.

You may return the Certificate for a full premium refund and the Coverage will be terminated. You must notify Us in Writing of the termination request within 30 days of the end of the Benefit Waiting Period.

Additional Critical Illness Benefit: If a Covered Person received Benefits for a Critical Illness, he or she will receive Benefits for a different Critical Illness as long as:

1. the Date of Diagnosis for each Critical Illness is separated by at least 6 consecutive months; and
2. the new Covered Critical Illness is medically unrelated to the first Covered Critical Illness and is not a Pre-existing Condition, if applicable.

We will pay the Percent of the Benefit Amount shown in the Schedule of Benefits, up to the Percent of Benefit, or the Per Person Lifetime Benefit Maximum Payout shown in the Schedule of Benefits.

How does the Per Person Lifetime Benefit Maximum Payout impact the Benefits payable?
The Per Person Lifetime Benefit Maximum Payout is shown in the Schedule of Benefits. Once the Per Person Lifetime Benefit Maximum Payout is met for a Covered Person, no additional benefits are payable for that Covered Person. If the Covered Person is You, the Coverage will terminate for You and Your Covered Dependents.

Recurrence Benefit
A Recurrence Benefit is only available if an initial Benefit has been paid under this Certificate for that Critical Illness or the Prior Policy, if applicable, if the Prior Policy also included a Recurrence Benefit for that Critical Illness. We will pay a Recurrence Benefit if a Covered Person is Diagnosed for a Critical Illness a second time, provided:

1. The second Diagnosis follows the first by more than 12, consecutive months; and
2. The Covered Person has been Treatment Free during the 12, consecutive month period prior to the second Diagnosis; and
3. The second Diagnosis occurs while the Covered Person's Coverage is in effect.

The Maximum Recurrence Benefit is shown in the Schedule of Benefits and is subject to the Per Person Lifetime Benefit Maximum Payout.

This Benefit is available unlimited times for a Covered Person during his or her lifetime. No other Recurrence Benefits are payable. The Recurrence Benefit is shown in the Schedule of Benefits.

Are there limitations on conditions for which a Covered Person was treated prior to the Effective Date of his or her Coverage?
Yes, there are limits on Pre-existing Conditions under the Policy.

What is a Pre-existing Condition and how does it impact the Benefits payable?
A Pre-existing Condition is any illness or injury for which, within the 12 months prior to the Covered Person's Effective Date:

1. Symptoms existed that would cause a person to seek treatment or consult a qualified Doctor;
2. Treatment or medical advice is received from a qualified Doctor;
3. Medicine or drugs were taken or prescribed; or
4. Other care or services were received from a qualified Doctor, including diagnostic measures.

No Benefits are payable for a Critical Illness that is a Pre-existing Condition when the Date of Diagnosis occurs in the first 12 consecutive months following the Covered Person's Effective Date of coverage, unless the Covered Person has been Treatment Free for 12 consecutive months any time after their Effective Date.

If the initial Benefit for a Critical Illness is denied under the Policy in accordance with the applicable Pre-existing Condition limitation, any subsequent Diagnosis of that Critical Illness that occurs while the Covered Person's Coverage is in effect will be paid, provided:

1. The subsequent Diagnosis follows the initial Diagnosis by more than 12 consecutive months; and
2. The Covered Person has been Treatment Free during the 12, consecutive month period prior to the subsequent Diagnosis.

With respect to a benefit increase, We will not pay the increased benefit amount for a Critical Illness that is caused by or results from a Pre-existing Condition, if the Date of Diagnosis occurs during the first 12 consecutive months after such increase.

PORTABILITY OF INSURANCE

May You continue insurance after termination of eligibility?
Portability of insurance is the continuation of some or all of the Policy's coverage after termination of Your employment or eligibility under Your Eligible Class while the Policy is in force. You must pay the premium for the Portable Coverage directly to Us. The premium will be based on: (a) Your and/or Your Dependent's rate class under the new Eligible Class; and (b) Your or Your surviving Spouses or Domestic Partner's age bracket.

You may port:
1. Your Coverage;
2. Your Coverage and Coverage of Your Spouse/Domestic Partner;
3. Your Coverage and all of Your Eligible Dependents; or
4. If You are a single parent, Your Coverage and all of Your Dependent Children.

To be eligible to port, a Dependent must be Covered under the Policy on the day Your Coverage under the Policy ends.

Who may become insured under the Portable Coverage Option?
The Eligible Class(es) of persons who may be insured are those who satisfy all of the following conditions.
1. You are insured by Us for at least 12 consecutive months prior to the date Your Coverage under the Policy terminates.
2. Your Critical Illness insurance under this Policy has ended due to termination of Your employment or termination of Your Eligible Class of Coverage prior to termination of the Policy.
3. You are under 65 years of age.
4. You did not terminate employment due to a Disability or covered Critical Illness.
5. You have not attained Your Retirement Date.

Your Covered Spouse and Covered Dependents will also be allowed to apply for Portable Coverage so long as You elect Portable Coverage, the Covered Dependent(s) are under 65 years of age and are otherwise eligible under the Eligible Dependent definition.

How and when will insurance continue?
To elect portability for Yourself and Your Covered Dependents, You must elect by Written application to continue Coverage under this provision within the 31 day period immediately following the date on which Your Coverage under this Certificate terminates.

If the Premium and application are received by Us within this period, Portable Coverage will take effect immediately following the date of termination.

An application to become insured must be completed on a form approved for that purpose by Us. It must be received by Us at Our Administrative Office within the 31day time period.

Once enrolled, You or Your surviving Spouse/Domestic Partner will receive a new certificate issued under a separate Eligible Class of the Policy. The Benefits provided will be substantially similar, however the terms and conditions of coverage will not be the same terms and conditions that are applicable to Coverage under this Certificate. In addition, not all Benefits may be available for Portable Coverage. It is important that You read Your Portable Coverage Certificate carefully.

How much insurance can be ported?
For You: The amount of insurance You can port is the Benefit Amount for which You are covered under the Policy and reduced by any Benefit Amounts paid under this group Policy.

For Your Covered Dependents: The amount of insurance You can port for each Covered Dependent is the Benefit Amount for which he or she is covered under the Policy and reduced by any Benefit Amounts paid under this group Policy on behalf of the Dependent.

We will give a Covered Person credit for satisfaction or partial satisfaction of any time periods under the Policy.

When do Portable Coverage and Portable Coverage Eligibility end?
Any Portable Coverage in effect, and all eligibility for new Portable Coverage ends at 12:01 AM on the earliest date shown below:
1. On the last day of the period for which Premiums have been paid, in accordance with the Grace Period;
2. On the date You enter full-time active duty in the armed forces of any country or international authority;
3. On the date on which You request in Writing to have the insurance terminated;
4. The date You reach the Per Person Lifetime Benefit Maximum Payout;
5. On the date You attain Your Retirement Date;
6. On Your 70th birthday;
7. On the date of Your death.

Any Dependent's Portable Coverage in effect, and all eligibility for new Dependent Portable Coverage ends on the earliest date shown below:

1. On the last day of the period for which Premiums have been paid in accordance with the grace period;
2. On the date the Dependent enters full-time active duty in the armed forces of any country or international authority;
3. On the date on which You request in Writing to have the insurance on Your Dependents terminated;
4. On the date the Dependent ceases to be an Eligible Dependent as defined in the Policy;
5. On the date the Covered Dependent reaches the Per Person Lifetime Benefit Maximum Payout;
6. On the date of the termination of the Policy or Your Eligible Class.

Your Portable Coverage is governed by the Group Policy and will be terminated when the Group Policy terminates.

You or Your legal representative must notify Us in Writing within 31 days after the date on which an event described above occurs.

Portable Coverage that has been terminated cannot be reinstated.

If You elect Portable Coverage and You again become an Eligible Person of the Policyholder, Your Portable Coverage will end when You become eligible under the Policyholder's Policy.

Definitions for the Portability of Insurance provision:

Retirement Date: The date You begin receiving retirement Benefits which You are eligible to receive as a result of past employment, whether or not the retirement Benefits were funded in whole or in part by a previous employer. This also includes retirement income from any federal, state, municipal or association plan.

Portable Coverage: The insurance Coverage for which you are eligible in accordance with the Portability of Insurance provision of this Policy, which is provided by a new Certificate issued under the Policy.

EXCLUSIONS AND LIMITATIONS

Benefits are not provided for a Critical Illness resulting in whole or in part from, or contributed to one or more of the following:

1. While committing or attempting to commit a felony or engaging in any illegal occupation, riot or insurrection;
2. Due to an act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
3. If the Date of Diagnosis is while the Covered Person is incarcerated;
4. Suicide or any attempt at suicide while sane or insane or self-inflicted injury;
5. Serving in the armed forces or any auxiliary union of the armed forces of any country;
6. Voluntarily taking or using any drug, medication or sedative unless it is:
   a. Taken or used as prescribed by a Doctor; or
   b. An 'over the counter' drug, medicine or sedative taken according to the package directions;
7. A Covered Person's involvement in an incident where he or she is legally intoxicated at the time of the incident when operating a motor vehicle. "Legally intoxicated" means that the Covered Person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.
8. For which the Covered Person's or Dependent's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to the Effective Date of insurance, subject to any Pre-existing provision;
9. For a Diagnosis made outside of the United States, unless the Diagnosis or Procedure was confirmed by a qualified Doctor practicing within the United States. In this situation the Date of Diagnosis will be deemed to be the date it is made outside of the United States;
10. With respect to a Dependent who is a Child, that is caused by or contributed to by a congenital defect.

CLAIMS PROVISIONS

Submitting Claims and Receiving Reimbursement

How to submit a Claim: Written notice of Claim must be given to Us within 20 days after the Date of Diagnosis 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. The Claim form is available from the Policyholder or can be requested from Us. Upon receipt by Us of the request for claims forms, We will send Claim forms to the Claimant or You. The Covered Person must fill out the Claim form and then give it to the attending qualified Doctor. The qualified Doctor should fill out his or her section of the form and send it directly to Us. If such forms are not sent to You or the Claimant within 15 days, You or the Claimant will meet the proof of loss requirements below if We are given Written proof of the nature and extent of the loss including the treatment performed.

When to submit a claim: Proof of Loss must be provided within 90 days from the Date of Diagnosis We will not deny or reduce any Claim filed after 90 days from the Date of Diagnosis if:

1. it was not reasonably possible to file the Claim within that 90-day period. And
2. the Claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us in a reasonable time, and in no event later than one year after it is due, unless You are legally incapable of doing so.

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

When and to whom will the Claim be paid? After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims immediately or within 30 days, or as required by Your state, after receipt of satisfactory Proof of Loss.

In the event of Your death, any unpaid Benefits will be paid in equal shares to the first of the following categories of surviving beneficiaries:

1. legal Spouse;
2. natural, legally adopted children or placed for adoption;
3. mother and father;
4. brother and sister;
5. estate.

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

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

COMPLAINT AND APPEAL PROCEDURES

What if You have questions about Claim payments?

If you have any questions about a specific Claim payment, or denial, You should contact Us in writing or by telephone within 30 days of receiving payment or written statement denying Your claim.

What if You don't agree with a Claim denial?

If We send You a written statement denying Your Claim in whole or in part, You may submit a written appeal to Us that outlines Your concerns and Your efforts to resolve the matter. The appeal must be filed within 90 days of the receipt of denial. A written decision with respect to the appeal shall be sent to You within 60 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

Please send to:
Nationwide Employee Benefits
P.O. Box 1910
Covington, LA 70434

If You are not satisfied by the appeal response or for any reason, You may write to the State Department of Insurance. Describe the circumstances and Your complaint.

Ohio Department of Insurance
Consumer Services Division
50 West Town Street, Third Floor - Suite 300
Columbus, Ohio 43215
(614)-644-2673, toll free 1-800-686-1526
http://insurance.ohio.gov

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS

Assignment: We will recognize any assignment made by You under the Policy provided it is in Writing and Signed and a copy is on file with Us. No assignment of this is binding upon Us unless We agree to it in Writing and not until it is filed with Us. We and the Policyholder assume no responsibility for the validity or effect of an assignment.

Changes to Policy: The Policy may be amended at any time by Written agreement between the Policyholder and Us, without the consent of or notice to any other individual. Any Amendment to the Policy must be in writing and be attached to it. The Amendment must bear the signature or a reproduction of the signature of Our President, a Vice President, or Secretary.

Incontestability: We will not use misrepresentations made by a Covered Person in a Written application to contest the validity of the Coverage with respect to which such statement was made, after such Coverage has been in force prior to the contest for a period of two years during the Covered Person's lifetime, unless the misrepresentations are material and fraudulent. This section does not prevent Us from using at any time a defense based on:

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

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

Errors: You must be properly insured under the Policy. Any clerical error or omission by the Policyholder or by Us will not cause You to become Insured. Any clerical error or omission by the Policyholder or by Us will not cancel insurance that should validly continue nor continue insurance that should be validly terminated. The requirements of the Policy must be properly met for any change in the amount of Your insurance to take effect.

Legal Actions: No legal action may be brought against Us to recover Policy Benefits until at least 60 days after the required Written notice of loss is submitted to Us. No such action may be brought more than 3 years after the time Written Proof of Loss is required by the Policy to be given or as required by law.

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

1. Your Coverage would not have been approved except for Your misrepresentation; and
2. Your misrepresentation is contained in a Written instrument Signed by You; and
3. We give You or Your representative a copy of the Written instrument that contains Your misrepresentation upon denial.

Misstatement of Age or Fact: If a Covered Person's age or any other fact was misstated, We will use the correct facts to determine whether he or she is insured and if so, for what amount and duration. We will adjust Premium rates to the Covered Person's correct age. We may make this change back to the date Coverage became effective based on the misstated information.

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

Overpayments

We have the right to recover from a Covered Person or recipient of benefits any amount that We determine to be an overpayment. The Covered Person or recipient of benefits has the obligation to refund to Us any such amount. If benefits are overpaid on any Claim, the Covered Person or recipient of benefits must reimburse Us within 30 days. If reimbursement is not made in a timely manner, We have the right to:

1. recover such overpayments from:
   a) the Covered Person or recipient of benefits;
   b) any other person to or for whom payment was made; and
   c) the Covered Person's estate;
2. reduce or offset against any future benefits payable to the Covered Person or his/her survivors until full reimbursement is made;
3. refer the Covered Person's or recipient of benefits' unpaid balance to a collection agency; and/or
4. pursue and enforce all legal and equitable rights in court.

PROGRESSIVE DISEASE BENEFIT RIDER

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

Issues this Rider to: THE POLICYHOLDER REFERRED TO ON THE COVER PAGE OF THE POLICY/CERTIFICATE TO WHICH THIS RIDER IS ATTACHED AND MADE A PART THEREOF.

The Effective Date of this Rider is the Effective Date of the January 1st, 2022. It applies only on or after the Effective Date of this Rider. 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.

Progressive Disease(s):	
Covered Critical Illness	**Percent of the applicable Benefit Amount stated in the Schedule of Benefits**
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Motor Neuron Disease	100%
Muscular Dystrophy	100%
Multiple Sclerosis (MS)	100%

The Benefits included in this Rider are not eligible for any Recurrence Benefit. These Benefits do apply to the Per Person Lifetime Benefit Maximum Payout shown in the Schedule of Benefits.

Critical Illness Definition(s):

Advanced Alzheimer's Disease: The Covered Person must exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. It must result in significant reduction in mental and social functioning such that the Covered Person requires Substantial Assistance in performing at least two of the six Activities of Daily Living. No other dementing brain disorders or psychiatric illnesses shall meet the definition of Advanced Alzheimer's Disease, nor will they be considered a Critical Illness.

Date of Diagnosis:
The date the Covered Person is unable to perform 2 or more of the six Activities of Daily Living due to Advanced Alzheimer's Disease as Diagnosed by a qualified Doctor.

Advanced Parkinson's Disease: Parkinson's Disease staged at 3 or more on the Hoehn and Yahr staging scale or an equivalent stage on a different scale by a qualified Doctor. It must result in significant reduction in mental and social functioning such that the Covered Person requires Substantial Assistance in performing at least two of the six Activities of Daily Living. No other degenerative brain disorders, including atypical parkinsonian syndromes or psychiatric illnesses, shall meet the definition of Advanced Parkinson's Disease, nor will they be considered a Critical Illness.

Date of Diagnosis:
The date the Covered Person is unable to perform 2 or more of the six Activities of Daily Living due to Parkinson's Disease as Diagnosed by a qualified Doctor.

Motor Neuron Disease: An unequivocal Diagnosis of one of the following motor neuron diseases: amyotrophic lateral sclerosis (A.L.S. or Lou Gehrig's Disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy. Coverage is limited to the conditions listed and all other variations of motor neuron disease are excluded. It must result in significant reduction in mental and social functioning such that the Covered Person requires Substantial Assistance in performing at least two of the six Activities of Daily Living.

Date of Diagnosis:
The date the Covered Person is unable to perform 2 or more of the six Activities of Daily Living due to any of the above Motor Neuron Diseases as Diagnosed by a qualified Doctor.

Muscular Dystrophy: When a group of hereditary and non-hereditary muscle diseases that weaken the musculoskeletal system and hamper locomotion confirmed by electromyography and muscle biopsy.

Date of Diagnosis:
The date the Covered Person is Diagnosed by a qualified Doctor to have Muscular Dystrophy.

Multiple Sclerosis (MS): A chronic disease involving damage to the protective sheaths of nerve cells in the brain and spinal cord. Symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision and severe fatigue. It must result in significant reduction in mental and social functioning such that the Covered Person

requires Substantial Assistance in performing at least two of the six Activities of Daily Living. Eventually the disease can cause the nerves themselves to deteriorate or become permanently damaged.

Date of Diagnosis:
The date the Covered Person is unable to perform 2 or more of the six Activities of Daily Living due to Multiple Sclerosis (MS) as Diagnosed by a qualified Doctor.

Signed for Nationwide Life Insurance Company

Secretary President

Nationwide Life Insurance Company
One Nationwide Plaza, Columbus, Ohio 43215

AMENDMENT NUMBER 1

This Amendment forms a part of the Policy/Certificate to which it is attached and amends such Policy/Certificate in the manner indicated for Ohio residents only. Anything specifically stated in this Amendment overrides anything to the contrary in the Policy/Certificate and will be subject to all other parts of the Policy/Certificate.

1. The following notice is added to the **Cover Page** of the Certificate:

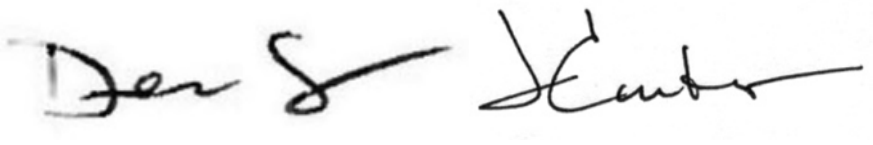
   Notice to Ohio Residents: Holders of Certificates furnished by any insurer to a resident of Ohio in connection with, or pursuant to any provisions of, any group sickness and accident policy which ensures residents of Ohio are entitled to all the protections afforded them under Ohio law, including without limitation, Title XXXIX of the Ohio Revised Code.

This Amendment is hereby accepted and deemed valid on the Effective Date of the Policy/Certificate.

Payment of Premium on or after the Effective Date of the Amendment shall constitute acceptance by the Policyholder of the Plan modifications contained herein.

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

Signed for Nationwide Life Insurance Company



Secretary President

Nationwide Life Insurance Company

Home Office: One Nationwide Plaza, Columbus, Ohio 43215

Governing Jurisdiction: The Policy is delivered in and governed by the laws of the state of Ohio.

If You do not reside in the Governing Jurisdiction state, Your Certificate is hereby amended as stated below to comply with the laws of Your state of residence. Only those references in this amendment to benefits, provisions or terms actually included in Your Certificate will apply to You.

This addendum is attached to and made part of the Certificate that forms part of the Policy. All other provisions of Your Certificate remain unchanged.

Notice for residents of Arizona

The following changes affect Your Certificate of Coverage (per GCI AO L25 000 1119):

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

Notice for residents of Arkansas

The following changes affect Your Certificate of Coverage *(per GCI AR L24 001 1119)*:

When will Coverage begin for Your Dependent? paragraph #5 is added:

> **With regard to a Child Placed for Adoption, the** Enrollment Form must be completed prior to the Placement. If You did not elect Dependent Coverage before the Placement of a Child, Coverage on that Child will not be denied, with respect to Critical Illness Insurance if You notify Us in Writing of the Placement of such Child and make any Premium payment due toward the cost of Dependents Coverage, within 60 days of the date of Placement. If You already have Dependent Coverage for one Dependent, Dependent Coverage for a Child Placed for Adoption will be added without Proof of Insurability. However, We require You to notify Us of additional Dependents within 60 days of the date of Placement for Adoption to assure accurate claims handling. Coverage shall begin from the moment of birth if the petition for adoption and application for Coverage is filed within 60 days after the birth of a Child being adopted. The Policyholder may require You to contribute toward the cost of all or part of Your Dependent(s) insurance. If so, the only Eligible Dependent who may become insured before You agree to those contributions is Your newborn Child. The form for this agreement may be obtained from the Policyholder. If You Sign the Enrollment Form more than 60 days after You became eligible for Dependent insurance, such Contributory insurance will be deferred until the first of the month following the date We approve Written Proof of Insurability for each Eligible Dependent.

What is a Pre-existing Condition and how does it impact the Benefits payable? is amended as follows:

A Pre-existing Condition is any illness or injury for which, within the 12 months prior to the Covered Person's Effective Date:

1. Treatment or medical advice is received from a qualified Doctor;
2. Medicine or drugs were taken or prescribed; or
3. Other care or services were received from a qualified Doctor, including diagnostic measures.

When will Coverage end for Your Dependent? the **Handicapped Dependent Children** provision is amended as follows:

> *Handicapped Dependent Children:* Insurance will continue for a handicapped child who has attained the limiting age for Eligible Dependents, if such child is unwed and intellectually or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered under Our Policy or the Prior Plan on the day immediately prior to attaining the limiting age. Proof of incapacity must be furnished to Us by the end of the calendar year of attainment of the limiting age. Failure to provide Proof during this time period will result in termination of Coverage for that Dependent.

If We request notice of incapacity, it will be at Our expense.

A Consumer Information Notice added:

You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

Notice for residents of Florida

The following changes affect Your Certificate of Coverage (per GCI FL L25 000 1119):

The benefits of the certificate providing your coverage are governed primarily by the law of a state other than Florida.

Notice for residents of Idaho

The following changes affect Your Certificate of Coverage (per GCI ID L25 000 1119):

Cover page includes the following notices:

RIGHT TO EXAMINE CERTIFICATE: This Certificate can be returned for any reason within 10 days after it is received by You. The Certificate should be returned by mail or in person to Us. Any premium paid will be refunded and the Certificate will be treated as if it were never issued.

THE POLICY IS RENEWABLE AT THE OPTION OF THE POLICYHOLDER SUBJECT TO THE TERMS AND CONDITIONS OF THE POLICY.

Definitions are added or revised:

Congenital Anomaly: A condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term 'significant deviation' is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

Eligible Dependent: modified:

2. "or an unmarried child of any age who is medically certified as disabled and Dependent upon You".

Placement for Adoption; Placed for Adoption; Placement: Physical placement in Your care, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when You sign an agreement for adoption of such child and sign an agreement assuming financial responsibility for such child.

Coronary Heart Disease: A narrowing or blockage of one or more coronary arteries resulting from plaque buildup.

Date of Diagnosis: The date a qualified Doctor makes a Diagnosis of a narrowing or blockage of at least 70% of one or more major arteries. Angiographic evidence to support the narrowing/severity of the blockage is required.

End Stage Renal Failure: A chronic irreversible failure of both kidneys to function.

Date of Diagnosis: The date a qualified Doctor makes a Diagnosis of End Stage Renal or kidney failure.

Major Organ Failure: The Insured is Diagnosed with any end-stage disease of the heart, liver, lung(s), small intestine, pancreas, pancreas-kidney or bone marrow that has resulted in the chronic and irreversible failure of the organ to function. ***Date of Diagnosis:*** The date the Insured is Diagnosed with a Major Organ Failure by a qualified Doctor.

When will Coverage begin for Your Dependents? the last 3 paragraphs are revised:

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

1. for Your Spouse/Domestic Partner, the first of the month following the date of the event causing eligibility;
2. for all other Eligible Dependents, the first day of the month following the date You enroll such Dependent; subject to payment of any Premium due. If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such Child shall take effect on the date of enrollment, if We are notified in accordance with our enrollment guidelines and once the required Premium, if any, has been paid.

Newborn/Adopted Children: Any newborn child born to You or Your Spouse or Your Domestic Partner or newborn child adopted by You or Your Spouse or Your Domestic Partner is covered from the moment of birth for 60 days or until released from the Hospital, if later. A Child adopted by You is covered for 60 days from the date the Child is Placed for Adoption. If You did not elect Dependent Coverage before the birth or Placement of a Child, Coverage on that Child will not be denied, with respect to Critical Illness Insurance, if You notify Us in writing of the birth or Placement of such Child and make any Premium payment due toward the cost of Dependents Coverage 60 days from the date of birth or Placement. If You already have Dependent Coverage for one Dependent, Dependent Coverage for a newborn or Child Placed for Adoption will be added without Proof of Insurability. However, We require You to notify Us of additional Dependents 60 days of the date of birth or Placement for Adoption to assure accurate claims handling.

The Policyholder may require You to contribute toward the cost of all or part of Your Dependent(s) insurance. If so, the only Eligible Dependent who may become insured before You agree to those contributions is Your newborn Child, a newborn adopted Child or a Child Placed for Adoption. The form for this agreement may be obtained from the Policyholder. The due date for payment of any additional Premium, if required, shall be not less than 31 days following receipt by the Insured of a billing for the required Premium.

When will Coverage end? bullet #12 is added:

12.The date We receive Written notice from You or the Policyholder telling Us to terminate Coverage, or the date requested in that notice, whichever is later. We will give You a refund of the pro rata Premium if termination is not at the end of a month for which premium was paid.

Are there limitations on conditions for which a Covered Person was treated prior to the Effective Date of his or her Coverage? is revised:

Yes, there are limits on Pre-existing Conditions under the Policy. This provision does not apply to Newborn or newly adopted children who become covered after the Covered Person's Effective Date.

What is a Pre-existing Condition and how does it impact the Benefits payable? is revised:

A Pre-existing Condition is any illness or injury for which, within the 6 months prior to the Covered Person's Effective Date:

1. Treatment or medical advice is received from a qualified Doctor;
2. Medicine or drugs were taken or prescribed; or
3. Other care or services were received from a qualified Doctor, including diagnostic measures.

Who may become insured under the Portable Coverage Option? is revised:

The Eligible Class(es) of persons who may be insured are those who satisfy all of the following conditions.

1. Your Critical Illness insurance under this Policy has ended due to termination of Your employment or termination of Your Eligible Class of Coverage prior to termination of the Policy.
2. You are under 65 years of age.
3. You did not terminate employment due to a Disability or covered Critical Illness.
4. You have not attained Your Retirement Date.

EXCLUSIONS AND LIMITATIONS is replaced with:

Benefits are not provided for a Critical Illness resulting in whole or in part from, or contributed to one or more of the following:

1. While committing or attempting to commit a felony or engaging in any illegal occupation, riot or insurrection;
2. Due to an act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
3. Suicide or any attempt at suicide while sane or insane or self-inflicted injury;
4. Serving in the armed forces or any auxiliary union of the armed forces of any country;
5. Mental or emotional disorders, alcoholism or drug addiction;
6. For which the Covered Person's or Dependent's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to the Effective Date of insurance, subject to any Pre-existing provision. This does not apply to congenital anomalies of a Covered Dependent Child;
7. For a Diagnosis made outside of the United States, unless the Diagnosis or Procedure was confirmed by a qualified Doctor practicing within the United States. In this situation the Date of Diagnosis will be deemed to be the date it is made outside of the United States.

The following changes affect Your Schedule of Benefits *(per GCI ID L26 000 1119)*:

Covered Critical Illness	Percent of the Benefit Amount	Recurrence Benefits Maximum Number and Percent of Benefit	
Coronary Heart Disease	100%	Unlimited	25%
End Stage Renal Failure	100%	N/A	N/A
Heart Attack	100%	Unlimited	25%
In Situ Cancer (non-Invasive)	25%	Unlimited	25%
Invasive Cancer	100%	Unlimited	25%
Major Organ Failure *(including heart)*	100%	Unlimited	25%
Stroke	100%	Unlimited	25%

Additional Benefits rider(s) attached at issuance: Progressive Disease Benefit Rider

Notice for residents of Kansas
The following changes affect Your Certificate of Coverage *(per GCI KS L24 001 1119)*:

When will Coverage begin for Your Dependents? a fifth paragraph is added after *Newborn Children*:

Adopted Children: A Child adopted by You is covered for the first 60 days from either:

1. the date of birth, if a petition for adoption is filed within 60 days of the birth of such child; or
2. from the date of Placement for Adoption, if a petition for adoption is filed within 60 days of Placement of such Child.

Such Coverage shall continue unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS, the following changes are made:

a. The provision entitled **Legal Actions** is revised to read:

Legal Actions

No legal action may be brought against Us to recover Policy Benefits until at least 60 days after the required written Notice of Loss is submitted to Us. No such action may be brought more than 5 years after the time written Proof of Loss is required by the Policy to be given or as required by law.

b. The provision entitled **Overpayments** is deleted in its entirety.

c. The following provision is added:

Errors Related to Your Coverage

We have the right to recover from a Covered Person or recipient of Benefits any amount that We determine to be an overpayment. The Covered Person or recipient of Benefits has the obligation to refund to Us any such amount. If Benefits are overpaid on any claim, the Covered Person or recipient of Benefits has the responsibility to reimburse Us within 30 days. We have the responsibility to make additional payments to the Covered Person or recipient of Benefits if any underpayments have been made.

Notice for residents of Louisiana
The following changes affect Your Certificate of Coverage *(per GCI LA L24 001 1119)*:

Eligible Dependent Definition is modified by adding:

4.Your or Your Spouse's/Domestic Partner's unwed Child until attaining age 26 who is a Full-time Student and who develops a mental or nervous condition, problem, or disorder that renders the Child, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by Us, unable to attend school as a Full-time student and from holding self-sustaining employment.

Children include natural children, stepchildren, adopted children, grandchildren in the legal custody of and residing with the grandparent, children Placed for Adoption, children appointed to Your custody by a court order, or foster children who are dependent upon You for support. Adopted children include a child where You have assumed and retained a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Such child is no longer considered an Eligible Dependent upon the termination of that legal obligation. Children also includes any unmarried Child who is placed in Your home following execution of an act of voluntary surrender in favor of You or Your legal representative effective on the date on which the act of voluntary surrender becomes irrevocable.

EXCLUSIONS AND LIMITATIONS are revised as follows:

3. If the Date of Diagnosis is while the Covered Person is incarcerated, unless the Covered Person has not been adjudicated or convicted of a criminal offense.

Notice for residents of Minnesota
The following changes affect Your Certificate of Coverage *(per GCI MN L25 000 1119)*:

Cover page includes the following notices:

THIS IS NON-QUALIFIED COVERAGE.

When will Coverage begin for Your Dependents? will be revised as follows:

Newborn Children/Adopted Children: Your newborn child or newly adopted child will be covered for the first 60 days following their birth or Placement. Newborn child includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. Any required Premium must be paid when due from the date of birth or Placement. Otherwise, Coverage for that Child will terminate as soon as the 60-day period expires.

EXCLUSIONS AND LIMITATIONS section is revised by **removing** the following exclusion:

#4. Suicide or any attempt at suicide while sane or insane or self-inflicted injury.

Notice for residents of Missouri
The following changes affect Your Certificate of Coverage *(per GCI MO L25 000 1119)*:

COVERED PERSONS PREMIUMS to include the following provision:

Will Premium rates change?
We may change premium rates at any time for reasons which affect Our risk assumed, including but not limited to the following:

a. Changes occur in the Coverage levels;
b. Changes occur in the overall use of Benefits by all Covered Persons;
c. Changes occur in other risk factors; or
d. A new law or change in existing law that is enacted which affects the risk assumed.

The change in premium rates will be made on a class basis according to Our underwriting risk assessments. We will notify You in Writing at least 30 days before a premium rate is changed.

3. What is a Pre-existing Condition and how does it impact the Benefits payable? first paragraph is revised as follows:

A Pre-existing Condition is any illness or injury for which, within the 12 months prior to the Covered Person's Effective Date:
1. Treatment or medical advice is received from a qualified Doctor;
2. Medicine or drugs were taken or prescribed; or
3. Other care or services were received from a qualified Doctor, including diagnostic measures.

4. EXCLUSIONS AND LIMITATIONS section is revised as follows:

#4. Suicide or any attempt at suicide while sane or self-inflicted injury.
#5. Serving in the armed forces or any auxiliary union of the armed forces of any country. Upon notice to Us of entry into such service, the pro rata unearned premiums shall be refunded.

Notice for residents of Montana
The following changes affect Your Certificate of Coverage *(per GCI MT L25 000 1119)*:

Cover Page:
Final interpretation is governed by the Policy, unless the Policy was issued in a state other than Montana, in which case, the Certificate controls. You may review the Policy at the Policyholder's address during normal business hours. This Certificate replaces any and all Certificates previously issued for the Eligible Classes under the Policy. This Certificate describes the Policy in detail.

10 Day Right to Examine Certificate: There is a 10 day right to review this Certificate. If You decide not to keep it, it may be returned to the Policyholder, its agent or to Us within 10 days of the original Certificate Effective Date. In that event, We will consider it void from the Certificate Effective Date and refund all Premium paid. Any Claims paid during the initial 10 day period will be deducted from the refund.

NOTICE TO BUYER: THIS IS A CRITICAL ILLNESS/SPECIFIED DISEASE CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

When will Coverage end for Your Dependent? Is modified:
Disabled Dependent Children: Insurance will continue for a child with a disability who has attained the limiting age for Eligible Dependents, if such child is intellectually or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered under Our Policy or the Prior Plan on the day immediately prior to attaining the limiting age. Proof of incapacity must be furnished to Us by the end of the calendar year of attainment of the limiting age. Failure to provide Proof during this time period will result in termination of Coverage for that Dependent.

Exclusions are modified:
#1 - While committing or attempting to commit a felony that results in a conviction, or engaging in any illegal occupation, riot or insurrection.
#4 - Suicide or any attempt at suicide while sane or self-inflicted injury.
#6 is removed.

Submitting Claims and Receiving Reimbursement
How to submit a Claim: Written notice of Claim must be given to Us within 6 months after the Date of Diagnosis or as soon thereafter as is reasonably possible.

When and to whom will the Claim be paid? After receiving Written Proof of Loss and Premium payment, We will pay or deny all Benefits. We will pay or deny all Claims or any portion of any Claims immediately or within 30 days, or as required by Your state, after receipt of the Claim. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing that the Claim is contested or denied, within 30 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within 60 days. If We fail to pay a Claim for which We are liable within these timeframes, We will pay an amount equal to the amount of the Claim due plus 10% annual interest calculated from the date on which the Claim was due. For purposes of calculating the amount of interest, a Claim is considered due 30 days after Our receipt of the Proof of Loss or 60 days after receipt of the Proof of Loss if We made a reasonable request for information or documents. Interest payments will be made to the person who receives the claims payment. Interest is payable if the amount of interest due on a claim exceeds $5.00.

COMPLAINT AND APPEAL PROCEDURES

What if You have questions about Claim payments?

If you have any questions about a specific Claim payment, or denial, You should contact Us in writing or by telephone within 30 days of receiving payment or written statement denying Your claim.

What if You don't agree with a Claim denial?

If We send You a written statement denying Your Claim in whole or in part, You may submit a written appeal to Us that outlines Your concerns and Your efforts to resolve the matter. The appeal must be filed within 90 days of the receipt of denial. A written decision with respect to the appeal shall be sent to You within 60 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

If You are not satisfied by the appeal response or for any reason, You may write to the State Department of Insurance. Describe the circumstances and Your complaint.

Montana Commissioner of Securities and Insurance
840 Helena Ave, Helena, MT 59601
406-444-2040
https://csimt.gov/

General provisions modified:

Notice to Policyholder

Written notice given by Us to an authorized representative of the Policyholder shall be deemed notice to all affected Covered Persons in the administration of the Policy. We will give certificate holders notification for Policy and rate changes and termination notices.

Freedom of Choice in Selection of Practitioner

You have full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist, speech-language pathologist, audiologist, licensed addiction counselor, or advanced practice registered nurse for treatment of any illness or injury within the scope and limitations of the person's practice.

Telehealth

Conditions diagnosed by means of Telehealth are payable under the Policy if it is otherwise covered by this Certificate. For the purpose of this Certificate, Telehealth means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is used by a health care provider or health care facility to deliver health care services; and delivered over a secure connection that complies with state and federal privacy laws.

Notice for residents of New Hampshire

The following changes affect Your Certificate of Coverage and Schedule of Benefits *(per GCI NH L25 000 0222)*:

The Cover page of the Certificate is revised as follows:
Added to the heading: 1-800-654-3826 ▪ www.nationwide.com for Home Office information.

Disclosures are added:

30 Day Free Look: This Certificate may, at any time within 30 days after its receipt by You, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the Certificate will be deemed void from the beginning, and any premium paid on it will be refunded.

Disclosure revised:

This is a Limited Policy - Read it Carefully

NOTICE TO BUYER: THIS IS AN ANCILLARY HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY.

Definitions- are revised as follows:

Active Work/Actively at Work: You are performing the normal duties of Your regular occupation and working Your normal hours. You must be working at least the number of a minimum of 15 hours per week as defined by the Policyholder on a full–time or a part-time basis and must be paid regular earnings.
Your work site must be:

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

You are not considered Actively at Work when You are off work or lose time due to illness, injury, Leave of Absence, strike or lay-off when You are taking emergency leave, Leave of Absence not related to Your Critical Illness, military leave (unless otherwise required by USERRA, unpaid leave or other similar absence set forth by the Policyholder (paid of unpaid) . Paid days off will count as Actively at Work if You were fully capable of performing the normal duties of Your regular occupation during the paid days off, provided You were Actively at Work on the last working day prior to the paid days off.

Removed - Calendar Year: For the first year, the period of time that begins on the Effective Date and ends on December 31st. For subsequent years, the period of time that begins on January 1st and ends December 31st.

Critical Illness: means a Diagnosis of a condition listed below in the Critical Illness definitions and listed in the Schedule of Benefits or applicable riders.

Eligible Dependent: Includes:

1. Your Spouse/Domestic Partner under age 70 (if not legally separated or divorced from You or in the process of dissolving a Domestic Partnership); and
2. Your or Your Spouse's/Domestic Partner's Child from the moment of birth, until the Child attains age 27.

Spouse: Your lawful Spouse or Domestic Partner, under New Hampshire law who is an Eligible Dependent.

End Stage Renal Failure: A chronic irreversible failure of both kidneys to function.

Date of Diagnosis: The date a qualified Doctor Diagnosed End Stage Renal Failure.

Major Organ Failure: The clinical evidence of major organ(s) failure is severe enough that it requires the malfunctioning organ(s) or tissue of the Covered Person to be replaced with a partial or full organ(s) or tissue from a suitable human donor (excluding the Covered Person) under generally accepted medical Procedures. The organs and tissues covered by this definition are limited to: heart, liver, kidney, lung(s), small intestine, pancreas, pancreas-kidney or bone marrow. In order for the Major Organ Transplant to be covered under this Policy, the Covered Person must be registered and accepted by the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). If the Covered Person is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS or NMDP list, the network requirement will be waived.

If an Insured is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid.

The Policy will not pay benefits for a Major Organ Failure:

1. performed outside the United States;
2. involving implantation of mechanical devices or mechanical organs;
3. involving stem cell generated transplants (other than for a bone marrow transplant);
4. involving islet cell transplants; or
5. involving bone marrow transplanted from the same Covered Person.

Date of Diagnosis: The date the Insured is Diagnosed with a Major Organ Failure by a qualified Doctor and placed on the UNOS list for organ transplant(s).

Under When do You enroll? the fourth paragraph is amended as follows:

Change in Family Status: Eligible Persons may enroll or change their Coverage outside of an Enrollment Period if a change in family status occurs, provided an Enrollment Form is received within 60 days of the event. A change in family status event means any of the following:

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

Under the Benefits provision the following are revised**:**

Recurrence Benefit - Bullets #1 and #2 are revised:

1. The second Diagnosis follows the first by 6 consecutive months; and
2. The Covered Person has been Treatment Free during the 6 consecutive month period prior to the second Diagnosis.

What is a Pre-existing Condition and how does it impact the Benefits payable? the provision is revised as follows:

A Pre-existing Condition is any illness or injury for which, within the 6 months prior to the Covered Person's Effective Date:

1. Treatment or medical advice is received from a qualified Doctor;
2. Medicine or drugs were taken or prescribed; or
3. Other care or services were received from a qualified Doctor, including diagnostic measures.

No Benefits are payable for a Critical Illness that is a Pre-existing Condition when the Date of Diagnosis occurs in the first 6 consecutive months following the Covered Person's Effective Date of coverage, unless the Covered Person has been Treatment Free for 6 consecutive months any time after their Effective Date.

If the initial Benefit for a Critical Illness is denied under the Policy in accordance with the applicable Pre-existing Condition limitation, any subsequent Diagnosis of that Critical Illness that occurs while the Covered Person's Coverage is in effect will be paid, provided:

1. The subsequent Diagnosis follows the initial Diagnosis by more than 12 consecutive months; and
2. The Covered Person has been Treatment Free during the 12, consecutive month period prior to the subsequent Diagnosis.

With respect to a benefit increase, We will not pay the increased benefit amount for a Critical Illness that is caused by or results from a Pre-existing Condition, if the Date of Diagnosis occurs during the first 6 consecutive months after such increase.

EXCLUSIONS AND LIMITATIONS is replaced with:

1. Participation in a felony, riot or insurrection;
2. Due to an act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
3. Suicide or any attempt at suicide while sane or insane or intentional self-inflicted injury.
4. Serving in the armed forces or any auxiliary union of the armed forces of any country;
5. Voluntarily taking or using any drug, medication or sedative unless it is:
    a. Taken or used as prescribed by a Doctor; or
    b. An 'over the counter' drug, medicine or sedative taken according to the package directions;
6. A Covered Person's involvement in an incident where he or she is legally intoxicated at the time of the incident when operating a motor vehicle. "Legally intoxicated" means that the Covered Person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.
7. For which the Covered Person's or Dependent's Date of Diagnosis for any type of Critical Illness, as defined in the Policy, was prior to the Effective Date of insurance, subject to any Pre-existing provision;
8. For a Diagnosis made outside of the United States, unless the Diagnosis or Procedure was confirmed by a qualified Doctor practicing within the United States. In this situation the Date of Diagnosis will be deemed to be the date it is made outside of the United States;
9. With respect to a Dependent who is a Child, that is caused by or contributed to by a congenital defect.

When and to whom will the Claim be paid? is revised as follows**:**

When to submit a claim: Proof of Loss must be provided within 90 days from the Date of Diagnosis We will not deny or reduce any Claim filed after 90 days from the Date of Diagnosis if:

1. it was not reasonably possible to file the Claim within that 90-day period. And
2. the Claim is filed as soon as it is reasonably possible.

In any event, Proof of Loss must be given to Us in a reasonable time.

When and to whom will the Claim be paid? After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims immediately after receipt of satisfactory Proof of Loss. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 30 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within 30 days.

8. GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS, the following changes are made:

Assignment

We will recognize any assignment made by You under the Policy provided it is in Writing and Signed and a copy is on file with Us. No assignment of this is binding upon Us unless We agree to it in Writing and not until it is filed with Us. We and the Policyholder assume no responsibility for the validity or effect of an assignment. Benefits may not be assigned to a Doctor or other healthcare provider.

Incontestability

We will not use misrepresentations made by a Covered Person in a Written application to contest the validity of the Coverage with respect to which such statement was made, after such Coverage has been in force prior to the contest for a period of two years during the Covered Person's lifetime. This section does not prevent Us from using at any time a defense based on:

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

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

Notice for residents of Oklahoma

The following changes affect Your Certificate of Coverage *(per GCI OK L24 001 1119)*:

When and to whom will the Claim be paid? is revised as follows**:**

When and to whom will the Claim be paid? After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims immediately, after receipt of satisfactory Proof of Loss. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 30 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, immediately.

EXCLUSIONS AND LIMITATIONS bullet #2 is revised as follows:

2. Due to war or acts of war, declared or undeclared, while serving in the military or an auxiliary unit thereto.

Under GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS, the provision for **Overpayments** is revised to include the following paragraph:

The request for reimbursement cannot be made more than 24 months after payment is made. The only exceptions to these 24 months are when payment was made because of fraud committed by the Claimant or health care provider, or if the Claimant or health care provider has otherwise agreed to make a refund to Us for overpayment of a Claim.

Notice for residents of Oregon

The following changes affect Your Certificate of Coverage *(per GCI OR L25 000 1119)*:

The Certificate Cover Page disclosure is revised to comply**:**

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Definitions- the following definition is revised:

Domestic Partner: An individual in a domestic partnership with You which is a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon.

EXCLUSIONS AND LIMITATIONS section is revised:

6. Is removed.
#7. Is removed.

When and to whom will the Claim be paid? is revised as follows**:**

When and to whom will the Claim be paid? After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims immediately, after receipt of satisfactory Proof of Loss. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 30 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, immediately.

Notice for residents of South Carolina
The following changes affect Your Certificate of Coverage *(per GCI SC L24 001 1119)*:

What is a Pre-existing Condition and how does it impact the Benefits payable? the first paragraph of the provision is revised as follows:

A Pre-existing Condition is any illness or injury for which, within the 12 months prior to the Covered Person's Effective Date:
1. Treatment or medical advice is received from a qualified Doctor;
2. Medicine or drugs were taken or prescribed; or
3. Other care or received from a qualified Doctor, including diagnostic measures.

When and to whom will the Claim be paid? is revised as follows**:**

When and to whom will the Claim be paid? After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims within 60 days, or as Your state requires, after receipt of satisfactory Proof of Loss. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 60 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within 60 days.

May We conduct physical examinations and autopsy? is revised as follows:
May We conduct physical examinations and autopsy? We shall have the right and opportunity to have any Covered Person whose Critical Illness is the basis of a Claim undergoes an independent medical exam. This may be done when and as often as We may reasonably require. If the person has died, We may require an autopsy, unless it is prohibited by law. Such examination or autopsy will be at Our expense. The autopsy must be performed in South Carolina.

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS, is revised as follows:

Legal Actions
No legal action may be brought against Us to recover Policy Benefits until at least 60 days after the required Written notice of loss is submitted to Us. No such action may be brought more than 6 years after the time Written Proof of Loss is required by the Policy to be given or as required by law.

Notice for residents of Texas
The following changes affect Your Certificate of Coverage *(per GCI TX L25 000 1119)*:

The Certificate Cover Page disclosures are added**:**

THIS CERTIFICATE IS SUBJECT TO AN INCREASE IN THE PREMIUM AT THE TIME OF RENEWAL AND MAY BE TERMINATED WHEN YOU ATTAIN A CERTAIN AGE.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Definitions- the following definitions are removed or revised as follows:

Removed - Calendar Year: For the first year, the period of time that begins on the Effective Date and ends on December 31st. For subsequent years, the period of time that begins on January 1st and ends December 31st.

Eligible Dependent: the first full paragraph after the bullets is revised:

Children include natural children, stepchildren, adopted children, grandchildren, children Placed for Adoption, a child where You are a party to a suit in which You seek to adopt the child, children for which You must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in Texas, or foster children or ward who are dependent upon You for support.

When will Coverage begin for Your Dependents? is revised as follows:

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

1. for Your Spouse/Domestic Partner, the first of the month following the date of the event causing eligibility;
2. for newborn children from the moment of birth;
3. for adopted children the date of Placement for Adoption or the date You are a party to a suit to adopt a Child, whichever is earlier;
4. for all other Eligible Dependents, the first day of the month following the date You enroll such Dependent;

subject to payment of any Premium due. If Your Dependent is enrolled as a result of a court or administrative order, Coverage for such Child shall take effect on the date of enrollment, if We are notified in accordance with our enrollment guidelines and once the required Premium, if any, has been paid.

When will Coverage end? the following statement is included:

Termination is subject to the Extension of Benefits Provision.

When will Coverage end for Your Dependent? the following statement is included:

Dependent Termination is subject to the Extension of Benefits Provision.

AND the following paragraph revised with:

Handicapped Dependent Children: Insurance will continue for a handicapped child who has attained the limiting age for Eligible Dependents, if such child is unwed and intellectually or physically incapable of earning their own living; and dependent on You for support and maintenance and was covered under Our Policy or the Prior Plan on the day immediately prior to attaining the limiting age. Proof of incapacity must be furnished to Us within 90 days of attainment of the limiting age. Failure to provide Proof during this time period will result in termination of Coverage for that Dependent.

AND the following paragraph provision added:

Extension of Benefits:
The Coverage provided under this Policy ceases on the Covered Person's Termination Date. However, if a Covered Person has a total Disability on the Termination date of the Policy, unless Termination is due to nonpayment of Premiums, We will pay the same Benefits for the duration of the Disability, or for 90 days thereafter, whichever occurs first.

What is a Pre-existing Condition and how does it impact the Benefits payable? the first paragraph of the provision is revised as follows:

A Pre-existing Condition is any illness or injury for which, within the 12 months prior to the Covered Person's Effective Date in which Treatment or medical advice is received from a Doctor.

The EXCLUSIONS AND LIMITATIONS are revised as follows:

1. While committing or attempting to commit a felony or engaging in any illegal occupation, or participation in a riot or insurrection;
4. Suicide or any attempt at suicide while sane or insane or intentional self-inflicted injury;

AND #11 is added:

11. Critical Illness treated by one of the following:
    - A person who ordinarily resides in Your household;
    - An Immediate Family Member or a business partner;
    - The Policyholder or someone retained by the Policyholder.

The Claims Provisions section is revised as follows**:**

Second paragraph of *When to submit a claim:* In any event, Proof of Loss must be given to Us no later than the first anniversary of the date Proof of Loss is otherwise required.

First paragraph of *When and to whom will the Claim be paid?* After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims within 30 days after receipt of satisfactory Proof of Loss. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 15 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested

portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within 60 days.

AND the following added:

Payment for Certain Expenses Incurred by the Texas Department of Human Services
Repayment will be made for the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for You if, under the Policy, You are entitled to payment for medical expenses.

Payment to Conservator Other Than Group Member
We may pay benefits on a child's behalf to a person who is not the Insured Person if an order providing for the appointment of a possessory or managing conservator of the child has been issued by a court in Texas or another state.

A person who is not an Insured Person is entitled to be paid benefits under the Policy only if the person presents Us with a notice that the person is a possessory or managing conservator of the child on whose behalf the claims is made, and a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the Insurance Commissioner that the person is eligible for the benefits.

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS, the **Overpayments** provision adds the following paragraph:

Such deduction may be against any future Claim for Benefits under the Policy made by an Insured Person if Claim payments previously were made with respect to an Insured Person. We would only deduct the amount of an overpayment of a Claim from a payment for a service by a provider who received the overpayment.

Notice for residents of Utah
The following changes affect Your Certificate of Coverage *(per GCI UT L25 000 1119)*:

Definitions- the following definitions are revised as follows:

Eligible Dependent: Includes:

1. Your Spouse/Domestic Partner under age 65 (if not legally separated or divorced from You); and
2. Your or Your Spouse's/Domestic Partner's Child from the moment of birth, until the Child attains age 26;
3. Your or Your Spouse's/Domestic Partner's adopted Child, from the moment of birth if Placement occurs within 30 days of the Child's birth, or from the date of Placement if Placement occurs 30 days or more after the Child's birth.

Placement for Adoption; Placed for Adoption; Placement: The assumption and retention by the Insured Person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

When will Coverage begin for Your Dependents? the following paragraphs are added:

Adopted Children: A newly adopted Child will be covered for the first 60 days following the date of their birth if Placement for Adoption occurs within 30 days of the Child's date of birth, or from the date of Placement if Placement occurs 30 days or more after the Child's birth. To continue Coverage beyond that 60-day period, You must notify Us in writing of the Child's date of Placement, enroll the Child at any time during the 60-day period. Any required Premium must be paid when due from the date of birth. Otherwise, Coverage for that Child will terminate as soon as the 60-day period expires.

Disabled Dependent: Coverage for a Dependent with a disability will be continued beyond the age at which Coverage would otherwise have terminated.

Dependent with a disability means a Child who is and continues to be both:

1. Unable to engage in substantial gainful employment to the degree that the Child can achieve economic independence due to a medically determinable physical or mental impairment, which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and
2. Chiefly dependent upon the Insured for support and maintenance since the Child reached the limiting age.

We may require proof of the impairment and dependency be furnished by the Insured within 30 days of the effective date or the date the Child attains the limiting age, and at any time thereafter, except that We will not require proof more often than annually after the two-year period immediately following attainment of the limiting age. We shall provide coverage for all unmarried dependents with a disability who have been continuously covered, with no break of more than 63 days, since age 26.

Physical Impairment means a physiological disorder, condition, or disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory organs; speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin or endocrine.

Mental Impairment means a mental or psychological disorder such as: an intellectual disability; organic brain syndrome; emotional or mental illness; or specific learning disabilities as determined by Us.

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

A Pre-existing Condition is any illness or injury for which, within the 6 months prior to the Covered Person's Effective Date:

1. Symptoms existed that would cause a person to seek treatment or consult a qualified Doctor;
2. Treatment or medical advice is received from a qualified Doctor;
3. Medicine or drugs were taken or prescribed; or
4. Other care or services were received from a qualified Doctor, including diagnostic measures.

No Benefits are payable for a Critical Illness that is a Pre-existing Condition when the Date of Diagnosis occurs in the first 6 consecutive months following the Covered Person's Effective Date of coverage, unless the Covered Person has been Treatment Free for 6 consecutive months any time after their Effective Date.

If the initial Benefit for a Critical Illness is denied under the Policy in accordance with the applicable Pre-existing Condition limitation, any subsequent Diagnosis of that Critical Illness that occurs while the Covered Person's Coverage is in effect will be paid, provided:

3. The subsequent Diagnosis follows the initial Diagnosis by more than 6 consecutive months; and
4. The Covered Person has been Treatment Free during the 6, consecutive month period prior to the subsequent Diagnosis.

With respect to a benefit increase, We will not pay the increased benefit amount for a Critical Illness that is caused by or results from a Pre-existing Condition, if the Date of Diagnosis occurs during the first 6consecutive months after such increase.

The EXCLUSIONS AND LIMITATIONS #1 is revised as follows:

1. While voluntarily committing or attempting to commit a felony or voluntarily engaging in any illegal occupation, riot or insurrection;

The Claims Provisions section is revised as follows**:**

Second paragraph of *When to submit a claim:* In any event, Proof of Loss must be given to Us in a reasonable time. Failure to give notice or file Proof of Loss as required by this provision does not bar recovery under the Policy if We fail to show We were prejudiced by the failure.

First paragraph of *When and to whom will the Claim be paid?* After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims within 30 days, after We receive Written Proof of Loss. If a Claim or a portion of a Claim is contested by Us, You shall be notified in Writing, that the Claim is contested or denied, within 30 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, within 30 days.

AND add the following:

We may extend this 30-day time period by 15 days if We:

1. determine that the extension is necessary due to matters beyond Our control; and
2. before the end of the 30-day period notify the Covered Person in writing of:
   a. the circumstances requiring the extension of time; and
   b. the date by which We expect to pay the Claim or deny the Claim with a Written explanation for the denial.

If an extension is necessary due to a failure of the Covered Person to submit the information necessary to decide the Claim:

1. the notice of extension shall specifically describe the required information; and
2. We shall give the Covered Person at least 45 days from the day on which he or she receives the notice before We deny the claim for failure to provide the requested information.

If We fail to pay Claims timely, any applicable interest will accrue at the interest rate required by the state.

Notice for residents of Vermont

The following changes affect Your Certificate of Coverage *(per GCI VT L25 000 1119)*:

Cover page – include the following notice:

THE POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.

General Definitions – modified as:

Actively at Work: You are performing the normal duties of Your regular occupation and working Your normal hours. You must be working a minimum of 30 hours per week as defined by the Policyholder on a Full–Time basis and at least a minimum of 17.5 hours per week as defined by the Policyholder on a Part-Time basis and must be paid regular earnings.

Civil Union: Defined as two eligible persons have established a relationship pursuant to Vermont Statute, Title 15, Chapter 23 and are thereby entitled to receive the benefits and protections and be subject to the responsibilities of spouses.

Civil Union Partner: An Eligible Dependent defined as a person with whom You have entered into a Civil Union in accordance with Vermont law.

Eligible Dependent does not require Your Child to be unwed, or foster children to be dependent upon You for support and includes Your Civil Union Partner.

Immediate Family Member – includes Civil Union Partner.

Spouse includes Civil Union Partner.

When Coverage Begins and Ends – is modified as follows:
If there is Dependent Coverage – Civil Union Partner is included throughout.

Handicapped Dependent Children: does not require to be unwed.

Portability of Insurance - Provision does not apply.

Exclusions - The section is replaced as follows:

- Suicide or any attempt at suicide.

Removed completely:
#6 Voluntarily taking or using any drug, medication or sedative unless it is:

a. Taken or used as prescribed by a Doctor; or
b. An 'over the counter' drug, medicine or sedative taken according to the package directions;

Claims Provisions - is replaced with the following:
When and to whom will the Claim be paid? After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims *immediately, and no later than 30 days after receipt of satisfactory Proof of Loss*. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 10-365 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim *immediately, and no later than 30 days after receipt of additional satisfactory Proof of Loss*.

In the event of Your death, any unpaid Benefits will be paid in equal shares to the first of the following categories of surviving beneficiaries:

1. legal Spouse/*Civil Union Partner*;
2. natural, legally adopted children or placed for adoption;
3. mother and father;
4. brother and sister;
5. estate.

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

May We conduct physical examinations and autopsy? We shall have the right and opportunity to have any Covered Person whose Critical Illness is the basis of a Claim undergoes an independent medical exam. This may be done when and as often as We may reasonably require. If the person has died, We may require an autopsy, *unless is the law or your religion forbids it*. Such examination or autopsy will be at Our expense.

Notice for residents of Washington
Cover page:
If there is any conflict between the terms and conditions of the Policy and this Certificate, the Certificate shall be controlling. You may review the Policy at the Policyholder's address during normal business hours. This Certificate replaces any and all Certificates previously issued for the Eligible Classes under the Policy. This Certificate describes the Policy in detail.

Exclusions:
#6 is removed.

When to submit a claim: Proof of Loss must be provided within 90 days from the Date of Diagnosis We will not deny or reduce any Claim filed after 90 days from the Date of Diagnosis if:

1. it was not reasonably possible to file the Claim within that 90-day period. And
2. the Claim is filed as soon as it is reasonably possible.

The claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss written proof covering the occurrence, the character and the extent of the loss for which claim is made.

When and to whom will the Claim be paid? After receiving Written Proof of Loss and Premium payment, We will pay all Benefits. We will pay all Claims or any portion of any Claims immediately, after receipt of satisfactory Proof of Loss. If a Claim or a portion of a Claim is contested by Us, You shall be notified in writing, that the Claim is contested or denied, within 10-365 days after receipt of the Claim by Us. The notice that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from You, We shall pay or deny the contested Claim or portion of the contested Claim, immediately.

COMPLAINT AND APPEAL PROCEDURES

What if You have questions about Claim payments?

If you have any questions about a specific Claim payment, or denial, You should contact Us in writing or by telephone within 30 days of receiving payment or written statement denying Your claim.

What if You don't agree with a Claim denial?

If We send You a written statement denying Your Claim in whole or in part, You may submit a written appeal to Us that outlines Your concerns and Your efforts to resolve the matter. The appeal must be filed within 90 days of the receipt of denial. A written decision with respect to the appeal shall be sent to You within 60 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

Please send to:
Nationwide Employee Benefits
P.O. Box 1910
Covington, LA 70434

If You are not satisfied by the appeal response or for any reason, You may write to the State Department of Insurance. Describe the circumstances and Your complaint.

Washington Department of Insurance
5000 Capitol Blvd., SE
Tumwater, WA 98501
1-800-562-6900
https://www.insurance.wa.gov

GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS

Payment of premiums in the event of a labor dispute: In the event of a suspension of compensation due to a labor dispute, the Insured may pay the premiums as they become due directly to the Policyholder for a period not exceeding six months and at the rate and coverages as the Policy provides.

NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

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

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

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

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

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

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

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

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.

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

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

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

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

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

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

OTHER PRIVACY LAWS AND REGULATIONS

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

RIGHTS THAT YOU HAVE

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

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

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

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

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

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

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

Right for a Personal Representative to Act on your Behalf. You have the right for someone, called a personal representative, to act on your behalf to exercise your rights and make choices about your PHI. Before we act on any requests made by your personal representative, we will verify this person has the authority to act on your behalf, such as through a healthcare power of attorney or legal guardianship.

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 online at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, by emailing OCRComplaint@hhs.gov, or by mailing:

U.S. Department of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW
Washington DC 20201

There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms, or require further assistance with any of the rights explained above, contact us by phone 1-844-413-2681 or mail Healthcomp, Inc Health & Life Administrator PO Box 998 Coveington, LA 07034.

EFFECTIVE DATE

This Notice is effective January 1, 2023