BROCHURE OF COVERAGE

Blanket Accident & Sickness Plan
a Non-Renewable Term Policy

For Students Attending

UNIVERSITY of ST. FRANCIS
Joliet and Albuquerque Campuses

2014 • 2015

Policy Form No. 302-003-1212 - Joliet Campus
Policy Form No. 302-003-3012 Albuquerque Campus

Underwritten by:
Nationwide Life Insurance Company
Home Office: Columbus, Ohio

SERVICING AGENT:

ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

28085 Ashley Circle, Suite 201
Libertyville, IL 60048-9658
Phone: (800) 452-5772
Fax: (847) 281-8813

Z-76-80IL

INTRODUCTION

The University is making available a plan of blanket accident and sickness insurance (hereinafter called “plan” or “Plan”) underwritten by Nationwide Life Insurance Company and administered by Student Assurance Services, Inc. This brochure provides a general summary of the insurance coverage; the Schedule of Benefits is not all inclusive of eligible benefits payable under this plan. Keep this brochure as no individual policy will be issued. This summary is not a contract; the Master Policy is issued to the University and available upon request. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

The insurance plan provides continuous protection, 24 hours a day, anywhere in the world during the period of coverage for which the proper premium has been paid. Coverage is not automatically renewed. Students must re-enroll when coverage terminates to maintain continuous coverage.

SUMMARY OF PLAN BENEFITS

- The policy maximum benefit is unlimited.
- The in-network out-of-pocket maximum is $6,350 per person.
- Benefits are subject to a deductible $100 per person, per policy year.
- Repatriation and medical evacuation benefits providing 24-hour assistance services are included.
- A 24-hour nurse line program providing phone-based health information is included.
- To maximize savings and reduce out-of-pocket expenses, select a PHCS by Multiplan in-network provider. These providers have agreed to provide services at discounted rates.
- Catamaran drug program is included, subject to copays of $25 for each generic drug and $50 for each brand drug.

For assistance and questions about insurance benefits or problems:

Associated Insurance Plans International, Inc.
Post Office Box 189
Libertyville, Illinois 60048
Phone: (800) 452-5772
Email: **office@aipstudentinsurance.com**
website: **www.MyUSFInsurance.com**

For assistance and questions about claim status, ID cards, and claim processing:

Student Assurance Services, Inc.
Post Office Box 196
Stillwater, MN 55082
Phone: (800) 328-2739

OTHER CONTACT INFORMATION:

Preferred Provider Directory or Questions
PHCS by Multiplan
www.MyUSFInsurance.com

Preferred Pharmacy Directory or Questions
Catamaran
www.MyUSFInsurance.com

SAS Plan Number:
12-61-0080-016-609-4 - Joliet Campus
12-61-0076-016-609-4 Albuquerque Campus

STUDENT ELIGIBILITY

Joliet Campus:
All traditional students registered for 12 or more credit hours are required to enroll in the insurance plan, and the cost of coverage will be included in the student's tuition bill.

Joliet students may waive enrollment in the insurance plan if evidence of other comparable coverage is provided and the student completes an online waiver form prior to the **fall semester waiver deadline date of September 12, 2014**. For new students registering for **spring semester, the waiver deadline date is February 1, 2015.** Students who initially waive coverage may not enroll in the insurance plan at a later date, unless the student qualifies for late enrollment.

Albuquerque Campus:
All nursing and clinicial students are required to enroll in the insurance plan, and the cost of coverage will be included in the student's tuition bill.

Albuquerque students may waive enrollment in the insurance plan if evidence of other comparable coverage is provided to the University by the waiver deadline dates shown on page 4.

The following students are not eligible to enroll in the insurance plan: students enrolled exclusively in online courses or whose enrollment consists entirely of short-term courses; students taking distance learning, home study, correspondence, television courses, or courses taken for audit do not fulfill the eligibility requirements that the student actively attend classes. The online restriction does not apply to students who are completing their degree requirements while engaged in practical training.

Students must be actively attending classes for at least the first 31 days beginning with the first day for which coverage is effective. Any student withdrawing from the University during the first 31 days after the effective date of coverage shall not be covered under the insurance plan. A full refund of premium will be made, minus the cost of any claim benefits paid by the Policy. Students who graduate or withdraw from the University after 31 days, whether involuntarily or voluntarily, will remain covered under the Policy for the term purchased and no refund will be allowed.

The Plan Administrator reserves the right to determine if the student has met the eligibility requirements. If the Plan Administrator later determines the eligibility requirements have not been met, its only obligation is to refund the premium.

ID CARDS

An ID card will be mailed to the student's address on file approximately 2 weeks after the enrollment form and premium payment are received. Students do not need an ID card to be eligible to receive benefits under the Policy. For lost ID cards, request an ID card from the website.

PREMIUM

Payment of Premium/Due Date: The premium, charges and fees must be paid to Plan Administrator prior to the start of the term for which coverage is selected, or to the University collecting premium payments as agreed upon by the University and Plan Administrator. In no event will coverage become effective prior to the date of enrollment or before required premium is received.
Returned or Dishonored Payment: If a check or credit card payment for the premium is dishonored for insufficient funds, a reasonable service charge may be charged to the insured which will not exceed the maximum specified under state law. A dishonored check or credit card payment shall be considered a failure to pay premium and coverage shall not take effect.
Premium Refund Policy: A prorated refund, less any claims paid, will be issued only for the following situations below. Any refund provided may be subject to a $25 administration fee.

- Students who withdraw from the University within the first 31 days following their effective date of coverage; or
- Students who have entered into full-time active duty military service for any country; or
- Students who are non-immigrant foreign nationals who have permanently left the North American Continent for their home country.

All premium refund requests must be made in writing and include any proof (such as airline ticket) and date of occurrence. Refund requests should be sent to:

Student Assurance Services, Inc.
P.O. Box 196 • Stillwater, MN 55082-0196

JOLIET CAMPUS
PERIODS OF COVERAGE AND
WAIVER PERIOD DEADLINE DATES

TERM	DATE COVERAGE BEGINS	DATE COVERAGE ENDS	WAIVER PERIOD DEADLINE DATE
FALL	08-01-2014	01-31-2015	09-12-2014
SPRING/SUMMER	02-01-2015	07-31-2015	02-01-2015
SUMMER	05-01-2015	07-31-2015	06-01-2015

Important: Enrollment forms and premium payments received after the waiver period deadline date are not accepted except for late enrollment.

JOLIET CAMPUS
2014-2015 PREMIUM SCHEDULE

	Fall	Spring/Summer	Summer
Student Only	$631.00	$631.00	$216.00

All premium includes an agent service fee.

ALBUQUERQUE CAMPUS
PERIODS OF COVERAGE AND
WAIVER PERIOD DEADLINE DATES

TERM	DATE COVERAGE BEGINS	DATE COVERAGE ENDS	WAIVER PERIOD DEADLINE DATE
FALL INTER-TERM	08-01-2014	09-21-2014	09-01-2014
FALL QUARTER	09-22-2014	01-06-2015	10-22-2014
WINTER QUARTER I	01-07-2015	04-05-2015	02-06-2015
WINTER QUARTER II (Graduating Clinical Students)	01-07-2015	04-25-2015	02-06-2015
SPRING QUARTER	04-06-2015	06-28-2015	05-06-2015
SUMMER INTER-TERM	06-29-2015	07-31-2015	07-10-2015

Important: Enrollment forms and premium payments received after the waiver period deadline date are not accepted except for late enrollment.

ALBUQUERQUE CAMPUS 2014-2015 PREMIUM SCHEDULE

	Fall Interterm	Fall Quarter	Winter Quarter I	Winter Quarter II	Spring Quarter	Summer Interterm
Student	$ 223.00	$ 459.00	$ 383.00	$ 468.00	$ 360.00	$ 141.00

All Premium includes an agent service fee.

LATE ENROLLMENT

Students may enroll after the enrollment period deadline date only if there is a qualifying event. Qualifying events include involuntary loss of coverage under another insurance plan. The insured must notify the Plan Administrator immediately when eligible for late enrollment. Coverage is effective upon enrollment and receipt of premium.

Involuntary Loss of Coverage: If the insured chose not to enroll in the insurance plan when first eligible as a result of coverage under another insurance plan, the insured may enroll if the Plan Administrator is notified in writing and the enrollment and premium are received no later than 31 days after the involuntary loss of coverage under the other insurance plan. This does not apply if the other insurance plan was voluntarily terminated.

EFFECTIVE AND TERMINATION DATES OF COVERAGE

Coverage becomes effective on the later of the following dates:

- The Master Policy effective date August 01, 2014, at 12:01 a.m.,
- The first day of the term for which the proper premium is paid;
- 12:01 a.m. following the date the proper premium is received by the University or Servicing Agent.

Coverage will terminate on the earliest of the following dates:

- the Master Policy termination date July 31, 2015, at 11:59 p.m.;
- the last day of the term of coverage for which the proper premium is paid;
- the date a foreign national permanently departs for their home country;
- the date the insured enters into full time active military service;
- the date the premium for insurance coverage is due and unpaid.

IMPORTANT: Coverage is not automatically renewed. Students are responsible for keeping the Policy in force.

Extension of Benefits

The coverage provided under the Policy ceases on the insured's termination date, except for the following situation:

- The insured is hospital confined on the termination date from a covered injury or sickness for which benefits were paid before the termination date. The covered expenses for the injury or sickness will continue to be paid for a period of 90 days or until date of discharge, whichever is earlier.

Note: After the extension of benefits provision has been exhausted, all benefits cease to exist and under no circumstances will further benefits be paid.

CONTINUATION OF COVERAGE FOR JOLIET CAMPUS ONLY:

The right to continue this coverage is available to an insured who attended Joliet Campus and who is no longer an eligible person due to graduation as outlined in the Student Eligibility section of the brochure. Application for continued coverage for the insured must be made within thirty-one (31) days of termination of coverage. If continuous coverage is maintained, coverage may be continued for an additional 9 months. Continuation of coverage ends when the Policy terminates. Continuation will be subject to the terms of the Policy and any limitations as noted in the Schedule of Benefits. The cost is $290 per month. The cost of insurance for the continuation plan must be paid in advance for the entire continuation period selected. No re-enrollment is permitted once the original term of coverage selected has expired. For premium and eligibility information, please contact the Plan Administrator at (800) 328-2739.

SCHEDULE OF BENEFITS

	IN-NETWORK	OUT-OF-NETWORK
Policy Year Maximum Benefit	Unlimited	Unlimited
Deductible - per person, per policy year additional deductibles and copays may apply	$100	$100
Insurer Percentage - plan pays	80% of Preferred Allowance (PA)	60% of Reasonable & Customary (R&C)
Out-of-Pocket Maximum - per policy year, applies to in-network only; deductibles, copays (including Rx) and coinsurance paid by insured contribute toward the out-of-pocket maximum; once this maximum is met, the plan pays in-network eligible expenses at 100% of PA	$6,350 per insured See page 9	None
Student Health Benefits	None	
INPATIENT		
Room & Board (paid at the daily semi-private room rate)	80% of PA	60% of R&C
Intensive Care	80% of PA	60% of R&C
Hospital Miscellaneous includes meals and prescribed diets, diagnostic imaging, laboratory, pharmaceuticals administered while an inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical or non-surgical event, preadmission testing and inpatient rehabilitation.	80% of PA	60% of R&C
Physician Visits - 1 visit per day; physician visit not paid same day as surgery	80% of PA	60% of R&C
Consulting Physician - 1 visit per day	80% of PA	60% of R&C
Skilled Nursing and Sub-Acute Care Facilities	80% of PA	60% of R&C
SURGERY BENEFITS (INPATIENT AND OUTPATIENT)		
Surgeon's Fees	80% of PA	60% of R&C
Assistant Surgeon - Inpatient	80% of PA	60% of R&C
Assistant Surgeon - Outpatient	25% of Surgeon's Payments	25% of Surgeon's Payments
Anesthesia Services	80% of PA	60% of R&C
Outpatient Surgical Miscellaneous (includes facility fee, supplies, drugs, diagnostic imaging, x-rays, laboratory and other miscellaneous items used with surgical event)	80% of PA	60% of R&C
General Anesthesia for Dental Services	80% of PA	60% of R&C
Reconstructive Surgery	80% of PA	60% of R&C
Organ Transplant Surgery	80% of PA	60% of R&C

When multiple surgeries are performed through the same incision at the same operative session, the plan pays an amount not to exceed the benefit for the most expensive procedure being performed.

When multiple surgeries are performed through one or more incisions at the same operative session, the plan pays an amount not to exceed the benefit for the most expensive procedure being performed. The benefit for the primary or most expensive procedure or less expensive procedure is 50% of the benefit otherwise payable for each subsequent procedure

SCHEDULE OF BENEFITS Continued	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT		
Wellness/Preventive & Immunizations (only services listed on page 18, includes STD screenings) - plan deductible and copay are waived	100% of PA	60% of R&C
Physician Office Visits (includes specialist/consultants) - 1 visit per day, not paid same day as surgery	80% of PA	60% of R&C
Diagnostic Imaging and X-ray Services	80% of PA	60% of R&C
PET Scan, CT Scan, and MRI	80% of PA	60% of R&C
Infusion or Injections (performed in health care facility or physician office)	80% of PA	60% of R&C
Laboratory Services	80% of PA	60% of R&C
Chemotherapy and Radiation Therapy	80% of PA	60% of R&C
Medical Emergency Room (visit to the emergency room for treatment of an emergency condition) – **$250 copay per visit,** waived if admitted, in-network deductible applies	80% of PA	80% of R&C
Urgent Care Facility (non-emergency services) - **$250 copay per visit**, waived if admitted	80% of PA	80% of R&C
Emergency Medical Transportation Services	80% of PA	80% of R&C
OTHER SERVICES (INPATIENT AND OUTPATIENT)		
Prescription Drugs The pharmacy benefit network is Catamaran; 30-day supply per prescription; copays do not apply to generic contraceptives and preventive/wellness prescriptions; one copay per 30-day supply; in-network deductible is waived	100% or PA after: $25 copay per generic drug $50 copay per brand drug See page 13	60% of R&C after: $25 copay per generic drug $50 copay per brand drug
Allergy Testing & Treatment (includes testing/injections/treatment)	80% of PA	60% of R&C
Diabetes Treatment and Education	80% of PA	60% of R&C
Durable Medical Equipment/Prosthetic Appliances	80% of PA	60% of R&C
Habilitative/Rehabilitative (includes physical, occupational and speech therapies) - 1 visit per day	80% of PA	60% of R&C
Chiropractic Care – 1 visit per day; **limited to 20 visits per policy year**	80% of PA	60% of R&C
Home Health Care	80% of PA	60% of R&C
Hospice	80% of PA	60% of R&C
Dental Injury (treatment due to injury to sound, natural teeth; does not include damage from biting or chewing; includes extraction of completely bony impacted teeth)	80% of PA	60% of R&C
Private Duty Nurse	80% of PA	60% of R&C
Club and Intramural Sports	Paid as any other Injury	
Maternity Services (including but not limited to: pre and post natal care, hospital services, diagnostic services at physician office and routine newborn care and inpatient newborn care)	Paid as any other Sickness	

SCHEDULE OF BENEFITS Continued	IN-NETWORK	OUT-OF-NETWORK

Pediatric Dental (coverage for insureds up to age 19) - includes coverage for preventive & diagnostic, basic restorative, major, and *medically necessary* orthodontia services. Waiting periods and other limitations may apply. Pre-authorization may be required for major and orthodontic care. Benefits are subject to the medical deductible and out-of-pocket maximum. Please see policy for details on coverage. Medically Necessary Orthodontics means the patient must have a severe and handicapping malocclusion. This means the child's condition must be severe enough to impact their ability to function such as having trouble eating and/or speaking.

Routine Vision Exam – (coverage for insureds up to age 19). Includes 1 pair of glasses (lenses and frames) per policy year or contact lenses in lieu of eyeglasses	100% up to $150; 50% thereafter.
Treatment Outside United States	60% of Actual Charge

MENTAL HEALTH AND ALCOHOLISM OR DRUG ABUSE	
Inpatient for Mental Conditions	Paid as any other Sickness
Outpatient for Mental Conditions	Paid as any other Sickness
Inpatient for Alcoholism/Drug Abuse	Paid as any other Sickness
Outpatient for Alcoholism/Drug Abuse	Paid as any other Sickness

OTHER SCHEDULED BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT

If the specific loss occurs within 180 days from date of Injury, the Policy shall pay one of the following (the largest applicable amount):

Accidental Death ..... $ 10,000
Single Dismemberment or Loss of One Eye ..... $ 10,000
Double Dismemberment or Loss of Both Eyes..... $ 10,000

The benefit paid will be in addition to any other benefits paid for the injury. Dismemberment means, at a minimum, the severance of a hand or foot above the wrist or ankle joint. Loss of eye means entire and irrecoverable loss of vision in the eye.

ADDITIONAL PROGRAMS

***GLOBAL EMERGENCY SERVICES** (Travel Assistance) .....see details on page 13-14
****ASK MAYO CLINIC*** (Nurse Line) .....see details on page 14

***Note: These additional programs are not underwritten by Nationwide Life Insurance Company, but provided by independent vendors and are included if students participate in the insurance plan.**

EXPLANATION OF BENEFITS

BENEFIT PAYMENTS

Benefits are payable only for covered expenses incurred during the policy period. No benefits are payable for covered expenses incurred prior to or after the insured's effective or termination dates respectively. Covered expenses are payable at the in-network insurer percentage for the preferred allowance or the out-of-network insurer percentage for the provider reasonable and customary charges. The Policy may contain benefit-level maximums for a covered expense, as outlined in the Schedule of Benefits. The insured is responsible for the deductible, copay, coinsurance and the balance of expenses not paid by the Policy.

PRECERTIFICATION AND REFERRALS

This insurance plan does not require pre-certification or referrals for emergency services, to obtain access to providers specializing in obstetrics or gynecology, or any covered service prior to the date the service is performed. Covered services will be evaluated for benefits when the claim is submitted to the Plan Administrator for payment. A verbal explanation of benefits does not guarantee payment of claims.

PAYMENT DEFINITIONS

Covered services payable under the Policy, are subject to the following payment provisions as described below.

Coinsurance is the insured's share of the costs, calculated as a percentage, after the Policy pays the insurer percentage.

Copay is the fixed dollar amount the insured must pay for specified covered expenses, each time the covered service is received.

Deductible is the amount subtracted from covered expenses before benefits are considered. Each insured person or family must satisfy the deductible. A deductible may be required for each injury or sickness, once per policy period, or each time the covered service is received.

Insurer Percentage is the percentage of covered expenses the Policy pays, after the deductible or copay is satisfied. Refer to the Schedule of Benefits for the amount.

Out-of-Pocket Maximum is the amount the insured must satisfy before covered expenses are payable at 100% of the in-network preferred allowance for remainder of policy period. The out-of-pocket maximum does not apply to out-of-network expenses, non-covered medical expenses and elective services.

MEDICAL NECESSITY and MEDICAL APPROPRIATENESS DETERMINATION

The Company reserves the right to review claims and establish standards and criteria to determine if a covered service is medically necessary and/or medically appropriate. Benefits will be denied by the Company for covered services that are not medically necessary and/or medically appropriate. In the event of such a denial, the insured will be liable for the entire amount billed by that provider. The insured has the right to appeal any adverse decision as outlined in the Appeals and Complaint section of this brochure.

Covered Services are medically necessary if they are:

- Required to meet the health care needs of the insured; and
- Consistent (in scope, duration, intensity and frequency of treatment) with current scientifically based guidelines of national medical or research organizations or governmental agencies; and
- Consistent with the diagnosis of the condition; and
- Required for reasons other than the comfort or convenience of the insured or provider; and
- Of demonstrated medical value and medical effectiveness.

EXPLANATION OF BENEFITS cont.

A covered service is medically appropriate if it is rendered in the most cost-effective manner and type of setting appropriate for the care and treatment of the condition. When specifically applied to hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- is experimental/investigational or for research purposes;
- is provided solely for educational purposes or the convenience of the patient, the patient's family, physician, hospital or any other physician; exceeds in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- could have been omitted without adversely affecting the patient's condition or the quality of medical care;
- involves treatment with or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA). If the prescribed drug is recognized as safe and effective for the treatment of a sickness or injury by one or more of the Standard Medical Reference Compendia or in the medical literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific sickness or injury, coverage will be provided, subject to the exclusions and limitations of the Policy;
- can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

If the insured has other insurance and pre-certification is required, this coverage will consider the services authorized by the primary carrier as medically necessary and process the insured's claim accordingly unless otherwise excluded under the Policy. If the insured has any questions or concerns about whether a particular service, supply, or treatment is medically necessary or medically appropriate, contact the Plan Administrator.

GENERAL EXCLUSIONS AND LIMITATIONS

Unless specifically included, no Benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. Eyeglasses, contact lenses, routine eye refractions, eye examinations except in the case of injury, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery or orthoptic therapy, visual training or radial keratotomy or similar surgical procedures to correct vision, except as provided in Schedule of Benefits.
2. Hearing Screenings or hearing examinations or hearing aids and the fitting or repairing or replacement of hearing aids, except in the case of Accident or Injury or as provided in the Schedule of Benefits.
3. Vaccines and immunizations (except as provided in the Schedule of Benefits): a) required for travel; and b) required for employment.
4. Treatment (other than surgery) of chronic conditions of the foot including weak feet, fallen arches, flat foot, pronated foot, subluxations of the foot, foot strain, care of corns, calluses, toenails or bunions (except capsular or bone surgery), any type of massage procedure on or to the foot, corrective shoes and shoe inserts.
5. Cosmetic treatment, cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that the Company determines to be furnished primarily to improve appearance rather than a physical function or control of organic disease or for treatment of an Injury that is covered under the Schedule of Benefits. Improvements of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts; sagging eyelids; prominent ears; skin scars; warts, non-malignant moles and lesions; hair growth; hair removal; correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants including gynecomastia (except for correction or deformity resulting from mastectomies or lymph node dissections); lipectomy services and supplies related to surgical suction assisted lipectomy; rhinoplasty; nasal and sinus surgery; and deviated nasal septum, including submucous resection except when medically necessary treatment of acute purulent sinusitis. This exclusion does not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, Injury, infection or other diseases of the involved part.
6. Sexual/gender reassignment surgery, including, but not limited to, hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, phalloplasty, orchiectomy, penectomy, vaginoplasty, clitoroplasty, labiaplasty or any treatment of gender identity disorders, including hormone replacement therapy. This exclusion does not include related mental health counseling.
7. Treatment, service, or supply which is not medically necessary for the diagnosis, care or treatment of the sickness or injury involved. This applies even if they are prescribed, recommended or approved by the student health center or by the person's attending physician or dentist.
8. Treatments which are considered to be unsafe, experimental, or investigational by the American Medical Association (AMA), and resulting complications.
9. Dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth, except as provided in the Schedule of Benefits.
10. Injury sustained while (a) participating in any interscholastic, intercollegiate, professional, semi-professional, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition.
11. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance whether or not claim is made for such benefits or if the insured is not properly licensed to operate the motor vehicle within the jurisdiction in which the accident takes place. This exclusion will not apply to passengers if they are insured under the Policy.
12. Injury occurring in consequence of riding as a passenger or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline or as a passenger in a policyholder owned leased chartered or operated aircraft or as a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.

GENERAL EXCLUSIONS AND LIMITATIONS cont.

13. Reproductive/Infertility services, except as provided herein.

14. Services provided normally without charge by the health service of the policyholder or services covered or provided by a student health fee.

15. Under the Prescription Drug Benefit, any drug or medicine:
    - obtainable over the counter (OTC);
    - for the treatment of alopecia (hair loss) or hirsutism (hair removal);
    - for the purpose of weight control;
    - anabolic steroids used for body building;
    - for the treatment of infertility;
    - sexual enhancement drugs;
    - cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or treatment of acne except as specifically provided in the Policy;
    - treatment of nail (toe or finger) fungus;
    - refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
    - for an amount that exceeds a 30 day supply
    - drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
    - purchased after coverage under the Policy terminates;
    - consumed or administered at the place where it is dispensed;
    - if the FDA determines that the drug is:
      I. contraindicated for the treatment of the condition for which the drug was prescribed; or
      II. experimental for any reason.

16. Treatments which do not meet the national standards for mental health professional practice; telemedicine, methadone maintenance or treatment.

17. For injury caused by, contributed to or resulting from the covered person’s intoxification, use of illegal drug or legal medicines that are not taken in the dosage or for the purpose as prescribed by the covered person’s physician.

18. Injuries sustained as a result of intentional self-inflicted injury or any attempt at intentional self-inflicted injury.

19. Services for the treatment of any injury or sickness incurred while committing or attempting to commit a felony; or while taking part in an insurrection or riot; or fighting, except in self-defense.

20. Injury or sickness for which benefits are paid or payable under any workers’ compensation or occupation disease law or act, or similar legislation.

21. War or any act of war, declared or undeclared; or while in the armed forces of any country.

22. Obesity treatment, except as provided herein.

23. Treatment received in the covered person’s home country outside of the United States of America, except as provided in the Schedule of Benefits.

24. Acupuncture.

25. Diagnosis and treatment of sleep disorders including but not limited to apnea monitoring, sleep studies, and oral appliances used for snoring, except treatment and appliances for documented obstructive sleep apnea.

26. Elective surgery or treatment.

ADDITIONAL PROGRAMS
(*These programs are not underwritten by Nationwide Life Insurance Company)

PREFERRED PROVIDER NETWORK

Persons insured under the plan may choose to be treated within, or out of, the PHCS by Multiplan preferred provider network. The PHCS by Multiplan preferred provider network consists of hospitals, doctors, and other health care providers, that are organized into a network for the purpose of delivering quality health care at a negotiated fee. If medical treatment is obtained from a PHCS by Multiplan preferred provider, a higher reimbursement will be received toward the insured's covered medical expenses.

When an insured uses the services of a PHCS preferred provider, the covered expenses are payable at the in-network percentage for the preferred allowance. When treatment is received by a non-preferred provider, covered expenses are payable at the percentage for the reasonable and customary charges incurred. The insurer percentage for in-network and out-of-network can be found on the Schedule of Benefits on pages 6-7.

Exception: Benefits will be paid at the in-network percentage for services provided by a non-preferred provider when admission or treatment is necessary in the event of a medical emergency.

The insured is not responsible for the difference between the PHCS preferred provider's usual billed charges and the preferred allowance. The insured is responsible for the coinsurance, any differences due to deductibles, copays, benefit limitations, and exclusions.

In order to use the services of a PHCS preferred provider, the insured must present the student accident and sickness insurance ID card.

A complete listing of PHCS by Multiplan providers is available on the website: **www.MyUSFInsurance.com** or by calling toll free (800) 922-4362. The participation of individual providers is subject to change without notice. It is the insured's responsibility to confirm a provider's participation in the PHCS by Multiplan network when calling for an appointment or at time of visit.

CATAMARAN PHARMACY PROGRAM

When the physician prescribes a drug for covered injury and sickness, the student can purchase the prescription drug at a **Catamaran participating pharmacy** by showing their medical ID card to the pharmacy as proof of coverage. The student pays a copay based on the type of prescription drug purchased; copay amounts are listed in the Schedule of Benefits. For a complete listing of **Catamaran participating pharmacies** visit: **www.MYUSFInsurance.com**. Coverage questions on a specific drug can be obtained from Catamaran at (855) 312-8439.

Refer to exclusion section on page 12 for drugs and medicines excluded under the prescription drug program.

*GLOBAL EMERGENCY SERVICES PROGRAM (TRAVEL ASSISTANCE)

Students who enroll and maintain medical coverage in this insurance plan are eligible for the global emergency services program administered by Scholastic Emergency Services (SES), an Assist America partner. This program provides 24-hour assistance services whenever the student is traveling more than 100 miles away from home, school, or abroad. International students studying in the United States are eligible for services both on and away from campus or while traveling in a country that is not their country of origin.

All assistance services must be arranged and provided by SES; no claims will be accepted for assistance services arranged or provided by anyone other than SES.

Note: This program does not replace medical insurance. All claims for medical expenses should be submitted to the Plan Administrator for consideration. The SES program meets or exceeds the requirements of USIA for international students and scholars. The following services are provided:

1. Medical Consultation, Evaluation & Referral - Calls to the Operations Center are evaluated by medical personnel and referred to the appropriate provider.
2. Foreign Hospital Admission Assistance - SES will guarantee hospital admission outside the United States by validating a student's health coverage or by advancing funds to the hospital. (Any emergency hospital admittance deposit must be repaid within 45 days.)

3. Emergency Medical Evacuation - If adequate medical facilities are not available locally, SES will use whatever mode of transportation, equipment and personnel necessary to evacuate the student or covered family member to the nearest facility capable of providing a high standard of care.
4. Medical Monitoring - SES medical personnel will maintain regular communication with the attending physician and/or hospital and relay information to student's family.
5. Medical Repatriation - If a student still requires medical assistance upon being discharged from a hospital, SES will repatriate him/her to a rehabilitation facility or home, and if necessary will provide a medical or non-medical escort.
6. Prescription Assistance - If a member needs a replacement prescription while traveling, SES will help in filling that prescription.
7. Compassionate Visit - When traveling alone and hospitalized for more than 7 days, economy, round trip, common carrier transportation to the place of hospitalization will be provided for a designated family member or friend.
8. Care of Minor Children - SES will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.
9. Return of Mortal Remains - SES will assist with the logistics of returning a member's remains home in the event of his or her death. This service includes locating the funeral home, arranging the preparation of the remains for transport, procuring required legal documentation, providing the necessary shipping container as well as paying for transport.
10. Legal Referrals - Referrals for interpreters or legal personnel are available.
11. Emergency Trauma Counseling - SES will provide initial telephone-based counseling and referrals to qualified counselors as needed or requested.
12. Lost Luggage or Document Assistance - SES will help members locate lost luggage, documents or personal belongings.
13. Pre-trip Information - SES offers members web-based country profiles that include visa requirements, vaccinations recommendations as well as security advisories for any travel destination.

For assistance call SES Operations Center toll free
inside the U.S. (877) 488-9833 or
outside the U.S. (609) 452-8570 or
email medservices@assistamerica.com.

***ASK MAYO CLINIC**

Students who enroll and maintain medical coverage in this insurance plan have access to a 24-hour nurse line administered by *Ask Mayo Clinic*. This program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness. Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. *Ask Mayo Clinic* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *Ask Mayo Clinic* 24-hour nurse line toll free number will be on the ID card.

DEFINITIONS

Accident: An event that is sudden, unexpected, and unintended, and over which the covered person has no control.

Alcoholism: Physical dependence on alcohol to the extent that stopping alcohol use will bring on withdrawal symptoms. Treatment, including rehabilitation and detoxification, must be provided by or under the clinical supervision of a physician or licensed psychologist. The services must be provided in one of the following:

- The physician's or psychologist's office;
- A hospital;
- A community mental health center or alcoholism treatment facility approved by the Joint Commission on Accreditation of Hospitals or certified by the State Department of Health.

Ambulatory Surgical Center: A facility which meets licensing and other legal requirements and which: 1) is equipped and operated to provide medical care and treatment by a physician; 2) does not provide services or accommodations for overnight stays; 3) has a medical staff that is supervised full time by a physician; 4) has full-time services of a licensed registered nurse (R.N.) at all times when patients are in the facility; 5) has at least one operating room and one recovery room and is equipped to support any surgery performed; 6) has x-ray and laboratory diagnostic facilities; 7) maintains a medical record for each patient; 8) and has a written agreement with at least one hospital for the immediate transfer of patients who develop complications or need confinement.

Brand Name Prescription Drugs: Drugs for which the drug manufacturer's trademark registration is still valid, and who's trademarked or proprietary name of the drug still appears on the package label.

Company: Nationwide Life Insurance Company.

Confinement/Confined: An uninterrupted stay following admission to a health care facility. The re-admission to a health care facility for the same or related condition, within a 72 hour period, will be considered a continuation of the confinement. Confined/confinement does not include observation, which is a review or assessment of 18 hours or less, of a person's condition that does not result in admission to a hospital or health care facility.

Covered Charge or Covered Expense: Means those charges for any treatment, services or supplies: (a) for network providers not in excess of the preferred allowance; (b) for non-network providers not in excess of the charges of the reasonable and customary expense therefore; and (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while the Policy is in force as to the covered person.

Covered Person: A person who is eligible for coverage as the insured or as a dependent; who has been accepted for coverage or has been automatically added; for whom the required premium has been paid; and whose coverage has become effective and has not terminated.

Custodial Care: Care that is primarily for the purpose of meeting non-medical personal needs, such as help with the activities of daily living and taking medications. Activities of daily living include, but are not limited to, bathing, dressing or grooming, eating, toileting, walking, and getting in and out of bed. Custodial care can usually be provided by someone without professional medical skills or training.

Drug Abuse: Means any chemical component that one inhales, ingests, injects, or applies to one's body for purposes of non-therapeutic use. Drug abuse does not include alcoholism or alcohol abuse.

Durable Medical Equipment: A device which: 1) is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of sickness or injury and is able to withstand repeated use; 2) is used exclusively by the patient; 3) is routinely used in a hospital but can be used effectively in a non-medical facility; 4) can be expected to make a meaningful contribution to treating the patient's sickness or injury; and 5) is prescribed by a physician and the device is medically necessary for rehabilitation.

DEFINITIONS cont.

Durable medical equipment and medical supplies include, but are not limited to, the following:

a. Mechanical equipment and monitors necessary for the treatment of chronic or acute respiratory failure, (environmental items are excluded);
b. Manual hospital-type beds and mattresses;
c. Canes, crutches, walkers or standard wheelchairs;
d. Oxygen and equipment for its administration;
e. Commode items, i.e. - bedside handrails, shower bench;
f. Electronic larynx and voice prosthesis buttons;
g. Equipment and supplies for the management and treatment of diabetes (except medications);
h. Ostomy/ileostomy supplies;
i. Special pressure pads;
j. Medical elastic stockings (limited to 2 per year);
k. Pumps and supplies to deliver an external product.

Durable medical equipment does not include: 1) comfort and convenience items; 2) equipment that can be used by family members other than the patient; 3) health exercise equipment; and 4) equipment that may increase the value of the patient's residence. Such items that do not qualify as Durable medical equipment include, but are not limited to: modifications to the patient's residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls, or corrective shoes, exercise and sports equipment.

Effective Date: The date coverage becomes effective at 12:01 a.m. on this date. Coverage for dependents will never be effective prior to the insured's coverage.

Elective Treatment: Those services that do not fall under the definition of essential health benefits. Medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the covered person's effective date of coverage. Elective benefits are shown on the Schedule of Benefits, as applicable.

Emergency: An illness, sickness or injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe that a reasonable person would seek care right away to avoid severe harm. Emergency does not include the recurring symptoms of a chronic condition unless the onset of such symptoms could reasonably be expected to result in the above listed complications.

Emergency Medical Transportation Services: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide ground and air transportation to a hospital for emergency care or transportation from one hospital to another for those individuals who are unable to travel to receive medical care by any other means or the hospital cannot provide the needed care, if a physician specifies in writing that such transport is medically necessary. Charges are payable only for transportation from the site of an emergency to the nearest available hospital that is equipped to treat the condition.

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of covered Services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

Expense Incurred: The charge made for a service, supply, or treatment that is a covered service under the Policy. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.

Generic Drugs: A non-brand name drug, which is a pharmaceutical equivalent to a brand name prescription drug, sold at a lower cost.

Health Care Facility: A student health center, hospital, skilled nursing, sub-acute, or other duly licensed, certified and approved health care institution which provides care and treatment for sick or injured persons.

DEFINITIONS cont.

Home Health Care: Services and supplies that are medically necessary for the care and treatment of a covered Illness or accidental Injury and are furnished to a covered person at the covered person's residence. Home health care consists of, but shall not be limited to, the following: 1) Physician-directed Home Health Care follow-up visits provided to a mother or newborn child within 72 hours after the mother's or newborn child's early discharge from an inpatient stay. The Provider conducting the visit must have knowledge and experience in maternity and newborn care; and 2) Care provided in a covered person's home by a licensed, accredited home health care agency. This care must be under the direction of a physician and in conjunction with the need for skilled nursing care and includes, but is not limited to:

- skilled nursing (L.P.N., R.N.) part-time or intermittent care;
- medical social services;
- infusion services;
- part-time or intermittent certified nurse assistant services or home health aide services, which provide support in the home under the supervision of an R.N. or a physical, speech or occupational therapist. A visit of 4 hours or less by a certified nurse assistant or home health aide will count as 1 home health care visit. Each visit by any other home health agency representative will count as 1 home health care visit;
- physical therapy;
- occupational therapy;
- speech therapy.

Hospice: A coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with physical, psychological, spiritual, social, and economic stresses.

Hospital: A facility which provides diagnosis, treatment, and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities. Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include an institution, or part thereof, which is other than incidentally a nursing home, a convalescent hospital, or a place for rest or the aged.

Infusion Services: Services provided in an office or outpatient facility, or by a licensed Infusion or health care agency, including the professional fee and related supplies.

Injection Services: Services provided in an office or outpatient facility, including the professional fee and related supplies. Injection services does not include self-administered injectable drugs.

Injury: Bodily Injury due to a sudden, unforeseeable, external event which results independently of disease, bodily infirmity or any other causes. All injuries sustained in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

Insured: The covered person who is enrolled, and meets the eligibility requirements of the Policyholder's school or dependents of the covered person.

Mental Condition(s): Nervous, emotional, and mental disease, illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor, as a mental condition on the date of medical care or treatment is rendered to a covered person.

Physician: A health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under the Policy, and who is not: 1) the insured person; 2) a family member of the insured person; or 3) a person employed or retained by the policyholder.

Policy Year: The period of 12 months following the Policy's effective date.

DEFINITIONS cont.

Premium: The amount required to maintain coverage for each eligible person and dependent in accordance with the terms of the Policy.

Prescription Drugs: Drugs which may only be dispensed by written prescription under federal law and is: 1) approved for general use by the U.S. Food and Drug Administration (FDA); 2) prescribed by a licensed physician for the treatment of a life-threatening condition, or prescribed by a licensed physician for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the formulary, if any; and 3) the drug has been recognized for treatment of that condition by one of the standard medical reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies, even if the prescribed drug has not been approved by the FDA for the treatment of that specific condition.

The drugs must be dispensed by a licensed pharmacy provider for out of hospital use. Prescription drug coverage shall also include medically necessary supplies associated with the administration of the drug.

Preventive Services:
The preventive services provided by a network provider for periodic health evaluations, immunizations, and laboratory services in connection with periodic health evaluations as specified in the Schedule of Benefits. Benefits are considered based on the following criteria:

1. Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the insured involved;
3. For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. For women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Covered outpatient contraceptive services include but are not limited to: medical services and prescription contraceptives provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. Does not include services related to an abortion.

Cost sharing may apply to services provided during the same visit as the preventive services. For example if a covered preventive service is provided during an office visit and the preventive service is not the primary purpose for the visit, the cost sharing would apply to the office visit. Cost sharing may also apply for treatment that is not a covered preventive service, even if treatment results from a covered preventive service, or for any item or service that has ceased to be a covered preventive service. Reasonable medical management will be used to determine frequency, method, treatment, or setting for a preventive service.

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

- The actual amount charged by the provider;
- The preferred or negotiated rate, if any; or
- The fee often charged for in the geographical area where the service was performed.

The reasonable charge is determined by comparing charges for similar services to a national database adjusted to the geographical area where the services or procedures are performed, by reference to the 80th percentile of Fair Health Inc. schedules. The insured person may be responsible for the difference between the reasonable charge and the actual charge from the provider.

Reconstructive Surgery: Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, disease, or accidental injury occurring while insured under the Policy to either: 1) improve function; or 2) create a normal appearance.

Sickness: Illness, disease or condition, including pregnancy and complications of pregnancy that impairs a covered person’s normal functioning of mind or body and which is not the direct result of an injury or accident. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same sickness.

DEFINITIONS cont.

Skilled Nursing Facility: A place (including a separate part of a hospital) which: regularly provides room and board for person(s) recovering from illness or accidental injury; provides continuous 24 hour nursing care by or under the supervision of a registered nurse; is under the supervision of a duly licensed doctor; maintains a daily clinical record for each patient; is not, other than incidentally, a place for rest, the aged, place of treatment for alcoholism or drug and/or substance abuse or addiction; and is operated pursuant to law.

Sound Natural Tooth: The major portion of the individual natural tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

Sub-Acute Facility: A free-standing facility or part of a hospital that is certified by Medicare to accept patients in need of rehabilitative and skilled care nursing.

Termination Date: The date a covered person's coverage under this policy ends. Coverage ends at 11:59 p.m. on this date.

Urgent Care Facility: A hospital or other licensed facility which provides diagnosis, treatment, and care of persons who need acute care under the supervision of physicians.

COORDINATION OF BENEFITS

The coordination of benefits (COB) provision applies to the Policy when the insured has medical insurance coverage under more than one plan. The order of benefit determination rules govern the order that each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the charges incurred for covered services and supplies. The detailed COB provisions are in the Master Policy.

RESCISSION

The Plan Administrator may rescind your coverage if the insured or insured's dependent commits fraud or makes an intentional misrepresentation of material fact. A notice will be provided at least thirty (30) calendar days before the coverage is rescinded. The insured may appeal any rescission.

CLAIM PROCEDURE

Usually the health care provider will file all necessary bills on the insured's behalf. However, some providers may require payment at the time the service is provided or may send the bill directly to the insured. In these instances, the insured should file a claim and send all itemized medical or hospital bills to the address below.

PRESCRIPTION DRUG CLAIM PROCEDURE

To obtain reimbursement for a prescription drug, the insured will need to present the medical ID card to the in-network pharmacy and pay the required copay. The in-network pharmacy will submit the claim to Catamaran for reimbursement. Refer to the prescription drug program on page 13 for more information. For prescriptions drugs purchased out-of-network, follow the claim procedures above.

Bills must be submitted within 90 days after the date of the injury or sickness, or as soon as reasonably possible. Information to identify the insured must be provided and should include: student name, patient name, address, student ID number or social security number, birthdate, and name of the school.

A company claim form is not required, unless the itemized billing statements do not provide sufficient information to process the claim. The insured can print a company claim form or complete the online claim form from the website **www.MyUSFInsurance.com**.

Send claims or inquiries to:
Student Assurance Services Inc.
P.O. Box 196
Stillwater, MN 55082-0196
(800) 328-2739

The claim office is available for calls between 8:00 a.m. to 4:30 p.m. Central Time, Monday – Friday.

COMPLAINTS AND CLAIM APPEALS

An insured has a right to file a grievance in writing for any provision of services or claim practices of Nationwide Life Insurance Company that offers an insurance plan or its claim administration by the Plan Administrator.

If there is a problem or concern, the insured can first call the customer service toll free number on the ID card. A customer service representative will provide assistance in resolving the problem or concern as quickly as possible. If the insured continues to disagree with the decision or explanation given, a written request may be submitted for a review through the internal grievance process.

The grievance will be reviewed, and a written decision will be mailed. The grievance procedures can be obtained by contacting the Plan Administrator or by visiting our website **www.MyUSFInsurance-mn.com**.

Grievances may be sent to:
Student Assurance Services Inc.
P.O. Box 196 • Stillwater, MN 55082
(800) 328-2739

PRIVACY NOTICE

Nationwide Life Insurance Company and Student Assurance Services, Inc. are committed to maintaining the privacy of the insured person's personal health information and complying with all state and federal privacy laws. A copy of the privacy notice may be obtained by contacting the Plan Administrator at (800) 328-2739 or by visiting our website.