Nationwide Mutual Insurance Company
One Nationwide Plaza
Columbus, Ohio 43215

This Certificate of Insurance describes all of the travel insurance benefits, underwritten by Nationwide Mutual Insurance Company and herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Coverage. It provides You with specific information about the program You purchased. Please contact the Plan Administrator immediately if You believe that the Confirmation of Coverage is incorrect.

This Certificate of Insurance is issued in consideration of the enrollment form and payment of any premium due. All statements in the enrollment forms are representations and not warranties. Only statements contained in a written enrollment form will be used to void insurance, reduce benefits or defend a claim.

NO DIVIDENDS WILL BE PAYABLE UNDER THIS CERTIFICATE.

The President and Secretary of Nationwide Mutual Insurance Company witness this Certificate.

Secretary *President*

TRAVEL PROTECTION CERTIFICATE
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GENERAL DEFINITIONS

Throughout this document, when capitalized, certain words and phrases are defined as follows:

Accident means a sudden, unexpected, unintended, specific event that occurs at an identifiable time and place, but shall also include exposure resulting from a mishap to a conveyance in which You are traveling.

Accidental Injury means Bodily Injury caused by an Accident (of external origin) being the direct and independent cause in the Loss and that 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. The injury must be verified by a Physician.

Bodily Contact Sports means any sport where the objective is to physically render an opponent unable to continue with the competition such as boxing and full contact karate.

Bodily Injury means identifiable physical injury that is caused by an Accident and is independent of disease or bodily infirmity.

Certificate of Insurance means this document, and any endorsements, riders or amendments that will attach during the period of coverage.

Common Carrier means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire. Taxis and limousines are not Common Carriers as defined herein.

Company means Nationwide Mutual Insurance Company.

Confirmation of Coverage means the document that outlines Your benefits and Maximum Benefit amounts.

Deductible means the amount of expenses for covered services and supplies that must be incurred by You before specified benefits become payable.

Domestic Partner means a person with whom You reside and can show evidence of cohabitation (including the shared responsibility for basic living expenses) for at least the previous six (6) months and has an affidavit of domestic partnership, if recognized by the jurisdiction within which You reside.

Effective Date means 12:01 A.M. local time, at Your location, on the day after the required premium for such coverage is received by the Company or its authorized representative.

Extreme Sports means an athletic pursuit that involves a high degree of danger or risk.

Family Member means Your or a Traveling Companion's legal or common law spouse, ex-spouse, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child, step-child, children-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, aunt, uncle, niece or nephew, or Domestic Partner who reside in the United States, Canada or Mexico.

Home Country means the country where You have Your true, fixed and permanent home and principal establishment.

Hospital means a facility that:
(a) holds a valid license if it is required by the law;
(b) operates primarily for the care and treatment of sick or injured persons as in-patients;
(c) has a staff of one or more Physicians available at all times;
(d) provides twenty-four (24) hour nursing service and has at least one registered professional nurse on duty or call;
(e) has organized diagnostic and surgical facilities, either on the premises or in facilities available to the hospital on a pre-arranged basis; and
(f) is not, except incidentally, a clinic, nursing home, rest home, drug or physical rehabilitation facility or convalescent home for the aged, or similar institution.

Insured means the person who enrolled for coverage and whose premium was paid under the Policy.

Land/Sea Arrangements means pre-paid land and/or sea arrangements made by the Travel Supplier.

Loss means Bodily Injury, Sickness or damage sustained by You, while coverage is in effect, in consequence of happening of one or more of the occurrences against which the Company has undertaken to indemnify You.

Maximum Benefit means the largest total amount that the Company will pay under any one benefit for You, as shown on the Confirmation of Coverage.

Medically Necessary means a service or supply that: (a) is recommended by the attending Physician; (b) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (c) could not have been omitted without adversely affecting Your condition or quality of medical care; (d) is delivered at the most appropriate level of care and not primarily for the sake of convenience; and (e) is not considered experimental unless coverage for experimental services or supplies is required by law.

Mountaineering means the sport, hobby or profession of walking, hiking and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

Other Insurance means any one of the following types of policies or plans that provides benefits for Hospital confinement medical expenses for you at the time of Loss on Your Effective Date of coverage, and such policy or plan requires You to pay any applicable Deductible and/or portion of coinsurance: individual, group or blanket insurance plans; HMO's, PPO's, POS's, EPO's, employer organization plans, employee benefit organizational plans, or other arrangements of benefits for persons of a group. Insurance does not include Medicare or Medicaid.

Parachuting means an activity involving the breaking of a free fall from an airplane using a parachute.

Physician means a licensed practitioner of medical, surgical or dental services acting within the scope of his/her license. The treating Physician may not be You, a Traveling Companion or a Family Member.

Policy means the Group Master Policy including the application and any endorsements, riders or amendments that will attach during the period of coverage.

Pre-Existing Condition means an illness, disease, or other condition during the six (6) month period immediately prior to the Effective Date for which You, a Traveling Companion or a Family Member booked to travel with You: 1) exhibited symptoms that would have caused one to seek care or treatment; or 2) received or received a recommendation for a test, examination, or medical treatment; or 3) took or received a prescription for drugs or medicine. Item (3) of this definition does not apply to a condition that is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the six (6) month period before the Effective Date.

Reasonable and Customary Charges means charges commonly used by Physicians in the locality in which care is furnished.

Scheduled Departure Date means the date on which You are originally scheduled to leave on the Trip.

Scheduled Return Date means the date on which You are originally scheduled to return to the point of origin or to a different final destination.

Sickness means an illness or disease of the body that: 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. An illness or disease of the body that begins prior to the Effective Date of coverage is not a Sickness as defined herein and is not covered by this certificate unless it suddenly worsens or becomes acute after the Effective Date.

Sound Natural Teeth means teeth that are whole or properly restored and are without impairment, periodontal or other conditions and are not in need of the treatment provided for any reason other than an Accidental Injury. For purposes of this Certificate, teeth previously restored with a crown, inlay, onlay, or porcelain restoration or treated by endodontics, except amalgam or composite resin fillings, are not considered Sound Natural Teeth.

Travel Arrangements means: (a) transportation; (b) accommodations; and (c) other specified services arranged by the Travel Supplier for the Trip.

Travel Supplier means tour operator, Participating Organization, cruise line, airline, hotel, etc. who has made the land, air and/or sea arrangements.

Trip means a trip or class of trips outside Your Home Country as described on the Confirmation of Coverage.

You or Your refers to the Insured.

GENERAL PROVISIONS

The following provisions apply to all coverages:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

CONTROLLING LAW - Any part of this Certificate that conflicts with the state law where the Certificate is issued is changed to meet the minimum requirements of that law.

GOVERNING JURISDICTION – The insurance regulatory agency and courts of the jurisdiction in which You are located shall have jurisdiction over the individual or group insurance coverage as if such coverage or plan were issued directly to You.

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

ASSIGNMENT - This Certificate is not assignable, whether by operation of law or otherwise, but benefits may be assigned.

WHEN YOUR COVERAGE BEGINS - Provided:
(a) coverage has been elected; and
(b) the required premium has been paid.

All coverage will begin on the later of the Effective Date, or upon Your departure from Your Home Country.

WHEN YOUR COVERAGE ENDS - Your coverage will end at 11:59 P.M. local time on the date that is the earliest of the following:
(a) the date the Policy is terminated;
(b) the Scheduled Return Date as stated on the travel tickets;
(c) the date You return to Your origination point if prior to the Scheduled Return Date;
(d) upon Your return to Your Home Country;
(e) one hundred eighty (180) days after the Effective Date.

EXCESS INSURANCE LIMITATION - The insurance provided by this Certificate shall be in excess of all other valid and collectible insurance or indemnity. If at the time of the occurrence of any Loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of Loss, over the amount of such Other Insurance or indemnity, and applicable Deductible.

PAYMENT OF CLAIMS - The Company, or its designated representative, will pay a claim after receipt of acceptable Proof of Loss.

Benefits for Loss of life are payable to Your beneficiary. If a beneficiary is not otherwise designated by You, benefits for Loss of life will be paid to the first of the following surviving preference beneficiaries:
a) Your spouse;
b) Your child or children jointly;
c) Your parents jointly if both are living or the surviving parent if only one survives;
d) Your brothers and sisters jointly; or
e) Your estate.

All other claims will be paid to You. In the event You are a minor, incompetent or otherwise unable to give a valid release for the claim, the Company may make arrangement to pay claims to Your legal guardian, committee or other qualified representative.

Any payment made in good faith will discharge the Company's liability to the extent of the claim.

The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid by Other Insurance policies. In no event will the Company reimburse You for an amount greater than the amount paid by You.

NOTICE OF CLAIM - Written notice of claim must be given by the claimant (either You or someone acting for You) to the Company or its designated representative within twenty (20) days after a covered Loss first begins or as soon as reasonably possible. Notice should include Your name, the Travel Supplier’s name and the Plan number. Notice should be sent to the Company’s administrative office or to the Company's designated representative.

PROOF OF LOSS - The claimant must send the Company, or its designated representative, Proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PHYSICAL EXAMINATION AND AUTOPSY - The Company, or its designated representative, at its own expense, have the right to have You examined as often as reasonable necessary while a claim is pending. The Company, or its designated representative, also has the right to have an autopsy made unless prohibited by law.

TIME OF PAYMENT OF CLAIMS - Benefits payable under this Certificate for any Loss other than Loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written Proof of such Loss. Subject to due written Proof of Loss, all accrued indemnities for Loss for which this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within thirty (30) days following receipt by the Company of due Proof of Loss. Failure to pay within such period shall entitle the claimant to interest at the rate of six (6) percent per annum from the thirtieth (30th) day after receipt of such proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You or Your assignee shall be notified by the Company or designated representative of any known failure to provide sufficient documentation for a due Proof of Loss within thirty (30) days after receipt of the claim. Any required interest payments shall be made within thirty (30) days after the payment.

ACCIDENTAL DEATH AND DISMEMBERMENT

The Company will pay the percentage of the Principal Sum shown in the Table of Losses when You as a result of an Accidental Injury occurring during the Trip, sustain a Loss shown in the Table below. The Loss must occur within three hundred sixty-five days (365) days after the date of the Accident causing the Loss.

The Principal Sum is shown on the Confirmation of Coverage. If more than one Loss is sustained as the result of an Accident, the amount payable shall be the largest amount of a sustained Loss shown in the Table of Losses.

TABLE OF LOSSES	
Loss of:	Percentage of Principal Sum:
Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
Either hand or foot and sight of one eye	100%
Either hand or foot	50%
Sight of one eye	50%

"Loss" with regard to:

1. hand or foot, means actual complete severance through and above the wrist or ankle joints;
2. eye means an entire and irrecoverable Loss of sight.

EXPOSURE

The Company will pay benefits for covered Losses that result from You being unavoidably exposed to the elements due to an Accident. The Loss must occur within three hundred sixty-five (365) days after the event that caused the exposure.

DISAPPEARANCE

The Company will pay benefits for Loss of life if Your body cannot be located within three hundred sixty-five (365) days after Your disappearance due to an Accident.

ACCIDENT MEDICAL EXPENSE

The Company will reimburse benefits up to the Maximum Benefit shown on the Confirmation of Benefits, if You incur Covered Medical Expenses for Treatment of an Accidental Injury that occurs during the Trip.

Treatment means necessary medical treatment that must be performed during the Trip due to the serious and acute nature of the Accidental Injury.

Covered Medical Expenses are expenses incurred for necessary services and supplies: (a) listed below; and (b) ordered or prescribed by the attending Physician as Medically Necessary for treatment, that are limited to:

(a) the services of a Physician;
(b) charges for Hospital confinement and use of operating rooms;
(c) charges for anesthetics (including administration); x-ray examinations or treatments, and laboratory tests;
(d) ambulance service; and
(e) drugs, medicines and therapeutic services.

The Company will not pay benefits in excess of the Reasonable and Customary Charges. The Company will not cover any expenses provided by another party at no cost to You or already included within the cost of the Trip.

The Company will pay benefits up to the Maximum Benefit shown on the Confirmation of Coverage for dental Treatment for Accidental Injury to Sound Natural Teeth. Both the Accidental Injury and the dental Treatment must occur during the Trip.

If You are Hospitalized due to an Accidental Injury that first occurred during the course of the Trip beyond the Scheduled Return Date, coverage under this benefit will be extended until You are released from the Hospital or until Maximum Benefits under this Certificate have been paid.

SICKNESS MEDICAL EXPENSE

The Company will reimburse benefits up to the Maximum Benefit shown on the Confirmation of Benefits, if You incur Covered Medical Expenses as a result of Treatment of a Sickness that first manifests itself during the Trip.

Treatment means necessary medical treatment that must be performed during the Trip due to the serious and acute nature of the Sickness.

Covered Medical Expenses are expenses incurred for necessary services and supplies: (a) listed below; and (b) ordered or prescribed by the attending Physician as Medically Necessary for treatment, that are limited to:

(a) the services of a Physician;
(b) charges for Hospital confinement and use of operating rooms;
(c) charge for anesthetics (including administration); x-ray examinations or treatments, and laboratory tests;
(d) ambulance service;
(e) drugs, medicines and therapeutic services;
(f) emergency dental treatment for the relief of pain.

The Company will not pay benefits in excess of the Reasonable and Customary Charges. The Company will not cover any expenses provided by another party at no cost to You or already included within the cost of the Trip.

If You are Hospitalized due to a Sickness that first occurred during the course of the Trip beyond the Scheduled Return Date, coverage under this benefit will be extended until You are released from the Hospital or until Maximum Benefits under this Certificate have been paid.

LIMITATIONS AND EXCLUSIONS

The following exclusions apply to Accidental Death & Dismemberment, Accident Medical Expense and Sickness Medical Expense:

Loss caused by or resulting from:

1. Pre-Existing Conditions, as defined in the Definitions;
2. suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane (unless results in the death of a non-traveling Family Member);
3. intentionally self-inflicted injuries;
4. war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not), civil war;
5. participation in any military maneuver or training exercise;
6. piloting or learning to pilot or acting as a member of the crew of any aircraft;
7. participation as a professional in athletics;
8. being under the influence of drugs or intoxicants, unless prescribed and used in accordance with the instructions provided by a Physician;
9. commission or the attempt to commit a dishonest, fraudulent or criminal act;
10. participating in Bodily Contact Sports (football, wrestling, ice hockey, rugby, lacrosse, boxing, full contact karate, hurling and rodeo); skydiving; hang-gliding; Parachuting; Mountaineering; any race; bungee cord jumping; speed contest (speed contest shall not include any of the regatta races); scuba diving unless accompanied by a dive master or if the depth exceeds fifty (50) feet; deep sea diving; spelunking or caving; heliskiing; extreme skiing; Extreme Sports. dental treatment except as a result of an injury to Sound Natural Teeth within twelve (12) months of the injury;
11. pregnancy and childbirth (except for complications of pregnancy); except if Hospitalized;
12. curtailment or delayed return for other than covered reasons;
13. traveling for the purpose of securing medical treatment;
14. services not shown as covered;
15. directly or indirectly, the actual, alleged or threatened discharge, dispersal, seepage, migration, escape, release or exposure to any hazardous biological, chemical, nuclear radioactive material, gas, matter or contamination;
16. care or treatment that is not Medically Necessary;
17. care or treatment for which compensation is payable under Worker's Compensation Law, any Occupational Disease law; the 4800 Time Benefit plan or similar legislation;
18. care or treatment that is payable under any Other Insurance policy;
19. Accidental Injury or Sickness when traveling against the advice of a Physician;
20. cosmetic surgery except for: reconstructive surgery incidental to or following surgery for trauma, or infection or other covered disease of the part of the body reconstructed, or to treat a congenital malformation of a child.
21. canyoning or canyoneering (traveling in canyons using a variety of techniques that may include walking, scrambling, climbing, jumping, abseiling and/or swimming);
22. any expenses incurred in the Home Country.

COORDINATION OF BENEFITS

Applicability

The Coordination of Benefits ("COB") provision applies to This Plan when You have health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan.

The benefits of This Plan:

(a) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(b) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described further in the section entitled Effect on the Benefits of This Plan.

Definitions

Plan is a form of written on an expense incurred basis that provides benefits or services for, or because of, medical or dental care or treatment. "Plan" includes:

(a) group insurance and group remittance subscriber contracts;

(b) uninsured arrangements of group coverage;

(c) group coverage through HMO's and other prepayment, group practice and individual practice Plans; and

(d) blanket contracts, except blanket school accident coverages or a similar group when the Policyholder pays the premium.

“Plan” does not include individual or family:
(a) insurance contracts;
(b) direct payment subscriber contracts;
(c) coverage through HMO’s; or (d) coverage under other prepayment, group practice and individual practice Plans.

This Plan is the parts of this blanket contract that provide benefits for health care expenses on an expense incurred basis.

Primary Plan is one whose benefits for a person’s health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:
(a) the Plan either has no order of benefit determination rules, or it has rules that differ from those in the contract; or
(b) all Plans that cover the person use the same order of benefits determination rules as in this contract, and under those rules the Plan determines its benefits first.

Secondary Plan is one that is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this contract decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan that, under the rules of this contract, has its benefits determined before those of that Secondary Plan.

Allowable Expense is the necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part under any of the Plans involved.

The difference between the cost of a private Hospital room and a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient’s stay in a private Hospital room is medically necessary in terms of generally accepted medical practice.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.

Claim is a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:
(a) services (including supplies);
(b) payment for all or a portion of the expenses incurred; or
(c) a combination of (a) and (b).

Claim Determination Period is the period of time that must not be less than twelve (12) consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:
(a) whether Other Insurance exists; and
(b) how much each Plan will pay or provide.

For the purposes of this contract, Claim Determination Period is the period of time beginning with the Effective Date of coverage and ending twelve (12) consecutive months following the date of Loss or longer as may be determined by the Proof of Loss provision.

Order of Benefit Determination Rules
When This Plan is a Primary Plan, its benefits are determined before those of any other Plan and without considering another Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of any other Plan only when, under these rules, it is secondary to that other Plan.

When there is a basis for a Claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:
(a) the other Plan has rules coordinating its benefits with those of This Plan; and
(b) both those rules and This Plan’s rules, as described below, require that This Plan’s benefits be determined before those of the other Plan.

Rules
This Plan determines its order of benefits using the first of the following rules which applies:

(a) Nondependent/Dependent Rule. The benefits of the Plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan that covers the person as a dependent.

(b) Longer/Shorter Length of Coverage Rule. The benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter time.

To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within twenty-four (24) hours after the first ended. Thus, the start of a new Plan does not include: (a) a change in the amount or scope of a Plan's benefits; (b) a change in the entity that pays, provides or administers the Plan's benefits; or (c) a change from one type of Plan to another. The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

Effect on the Benefits of This Plan When it is Secondary

The benefits of This Plan will be reduced when it is a Secondary Plan so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses, not otherwise paid that were incurred during the Claim Determination Period by the person for whom the Claim is made. As each Claim is submitted, This Plan determines its obligation to pay for Allowable Expenses based on all Claims that were submitted up to that point in time during the Claim Determination Period.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Company has the right to decide which facts are needed. The Company may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts we need to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Company is more than the Company should have paid under this COB provision, the Company may recover the excess from one or more of: (a) the persons we have paid or for whom we have paid; (b) insurance companies; or (c) other organizations.

Non-complying Plans

This Plan may coordinate its benefits with a Plan that is excess or always secondary or that uses order of benefit determination rules that are inconsistent with those of This Plan (non-complying Plan) on the following basis:

(a) If This Plan is the Primary Plan, This Plan will pay its benefits on a primary basis;

(b) if This Plan is the Secondary Plan, This Plan will pay its benefits first, but the amount of the benefits payable will be determined as if This Plan were the Secondary Plan. In this situation, our payment will be the limit of This Plan's liability; and

(c) if the non-complying Plan does not provide the information needed by This Plan to determine its benefits within thirty (30) days after it is requested to do so, the Company will assume that the benefits of the non-complying Plan are identical to This Plan and will pay benefits accordingly. However, the Company will adjust any payments made based on this assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

Nationwide®

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One Nationwide Plaza
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This Certificate of Insurance is issued in consideration of the enrollment form and payment of any premium due. All statements in the enrollment forms are representations and not warranties. Only statements contained in a written enrollment form will be used to void insurance, reduce benefits or defend a claim.

NO DIVIDENDS WILL BE PAYABLE UNDER THIS CERTIFICATE.

The President and Secretary of Nationwide Mutual Insurance Company witness this Certificate.

Secretary *President*

TRAVEL PROTECTION CERTIFICATE
EXCESS COVERAGE

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NATIONWIDE MUTUAL INSURANCE COMPANY
TRAVEL PROTECTION INSURANCE CERTIFICATE

GENERAL DEFINITIONS

Throughout this document, when capitalized, certain words and phrases are defined as follows:

Accident means a sudden, unexpected, unintended, specific event that occurs at an identifiable time and place, but shall also include exposure resulting from a mishap to a conveyance in which You are traveling.

Accidental Injury means Bodily Injury caused by an Accident (of external origin) being the direct and independent cause in the Loss and that 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. The injury must be verified by a Physician.

Actual Cash Value means the lesser of the replacement cost or the purchase price less depreciation.

Additional Expenses means any reasonable expenses for meals and lodging as well as local transportation and essential phone calls that were necessarily incurred as the result of a Hazard and that were not provided by the Common Carrier or other party free of charge.

Bodily Contact Sports means any sport where the objective is to physically render an opponent unable to continue with the competition such as boxing and full contact karate.

Bodily Injury means identifiable physical injury that is caused by an Accident and is independent of disease or bodily infirmity.

Certificate of Insurance means this document, and any endorsements, riders or amendments that will attach during the period of coverage.

Checked Baggage means a piece of baggage that accompanies You for which a claim check has been issued to You by a Common Carrier.

Common Carrier means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire. Taxis and limousines are not Common Carriers as defined herein.

Company means Nationwide Mutual Insurance Company.

Confirmation of Coverage means the document that outlines Your benefits and Maximum Benefit amounts.

Covered Expenses means expenses incurred by You that are for Medically Necessary care or treatment; due to Sickness or Bodily Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary Charges incurred while insured under this Certificate; and that do not exceed the Maximum Benefit limits shown in the Confirmation of Coverage, under each stated benefit.

Deductible means the amount of expenses for covered services and supplies that must be incurred by You before specified benefits become payable.

Domestic Partner means a person with whom You reside and can show evidence of cohabitation (including the shared responsibility for basic living expenses) for at least the previous six (6) months and has an affidavit of domestic partnership, if recognized by the jurisdiction within which You reside.

Economy Fare means the lowest published rate for a one-way economy ticket.

Effective Date means 12:01 A.M. local time, at Your location, on the day after the required premium for such coverage is received by the Company or its authorized representative.

Extreme Sports means an athletic pursuit that involves a high degree of danger or risk.

Family Member means Your legal or common law spouse, ex-spouse, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child, step-child, children-in-law, brother, sister, step-brother, step-sister,

brother-in-law, sister-in-law, aunt, uncle, niece or nephew, or Domestic Partner who reside in the United States, Canada or Mexico.

Hazard means:
a) Any delay of a Common Carrier (including Inclement Weather).
b) Any delay by a traffic accident en route to a departure, in which You or a Traveling Companion is not directly involved.
c) Any delay due to lost or stolen passports, travel documents or money, Quarantine, hijacking, unannounced Strike, natural disaster, civil commotion or riot.
d) A closed roadway causing cessation of travel to the destination of the Trip (substantiated by the department of transportation, state police, etc.).

Home Country means the country where You have Your true, fixed and permanent home and principal establishment.

Hospital means a facility that:
(a) holds a valid license if it is required by the law;
(b) operates primarily for the care and treatment of sick or injured persons as in-patients;
(c) has a staff of one or more Physicians available at all times;
(d) provides twenty-four (24) hour nursing service and has at least one registered professional nurse on duty or call;
(e) has organized diagnostic and surgical facilities, either on the premises or in facilities available to the hospital on a pre-arranged basis; and
(f) is not, except incidentally, a clinic, nursing home, rest home, drug or physical rehabilitation facility or convalescent home for the aged, or similar institution.

Inclement Weather means any severe weather condition that delays the scheduled arrival or departure of a Common Carrier.

Insured means the person who enrolled for coverage and whose premium was paid under the Policy.

Land/Sea Arrangements means pre-paid land and/or sea arrangements made by the Travel Supplier.

Loss means Bodily Injury, Sickness or damage sustained by You, while coverage is in effect, in consequence of happening of one or more of the occurrences against which the Company has undertaken to indemnify You.

Maximum Benefit means the largest total amount that the Company will pay under any one benefit for You, as shown on the Confirmation of Coverage.

Medically Necessary means a service or supply that: (a) is recommended by the attending Physician; (b) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (c) could not have been omitted without adversely affecting Your condition or quality of medical care; (d) is delivered at the most appropriate level of care and not primarily for the sake of convenience; and (e) is not considered experimental unless coverage for experimental services or supplies is required by law.

Mountaineering means the sport, hobby or profession of walking, hiking and climbing up mountains either: 1) utilizing harnesses, ropes, crampons, or ice axes; or 2) ascending 4,500 meters or above.

Other Insurance means any one of the following types of policies or plans that provides benefits for Hospital confinement medical expenses for you at the time of Loss on Your Effective Date of coverage, and such policy or plan requires You to pay any applicable Deductible and/or portion of coinsurance: individual, group or blanket insurance plans; HMO's, PPO's, POS's, EPO's, employer organization plans, employee benefit organizational plans, or other arrangements of benefits for persons of a group. Insurance does not include Medicare or Medicaid.

Parachuting means an activity involving the breaking of a free fall from an airplane using a parachute.

Physician means a licensed practitioner of medical, surgical or dental services acting within the scope of his/her license. The treating Physician may not be You, a Traveling Companion or a Family Member.

Policy means the Group Master Policy including the application and any endorsements, riders or amendments that will attach during the period of coverage.

Pre-Existing Condition means an illness, disease, or other condition during the six (6) month period immediately prior to the Effective Date for which You, a Traveling Companion, a Family Member booked to travel with You: 1) exhibited symptoms that would have caused one to seek care or treatment; or 2) received or received a recommendation for a test, examination, or medical treatment; or 3) took or received a prescription for drugs or medicine. Item (3) of this definition does not apply to a condition that is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the six (6) month period before the Effective Date.

Quarantine means Your strict isolation imposed by a Government authority or Physician to prevent the spread of disease. An embargo preventing You from entering a country is not a Quarantine.

Reasonable and Customary Charges means charges commonly used by Physicians in the locality in which care is furnished.

Scheduled Departure Date means the date on which You are originally scheduled to leave on the Trip.

Scheduled Return Date means the date on which You are originally scheduled to return to the point of origin or to a different final destination.

Sickness means an illness or disease of the body that: 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. An illness or disease of the body that begins prior to the Effective Date of coverage is not a Sickness as defined herein and is not covered by this certificate unless it suddenly worsens or becomes acute after the Effective Date.

Sound Natural Teeth means teeth that are whole or properly restored and are without impairment, periodontal or other conditions and are not in need of the treatment provided for any reason other than an Accidental Injury. For purposes of this Certificate, teeth previously restored with a crown, inlay, onlay, or porcelain restoration or treated by endodontics, except amalgam or composite resin fillings, are not considered Sound Natural Teeth.

Strike means any unannounced labor disagreement that interferes with the normal departure and arrival of a Common Carrier.

Travel Arrangements means: (a) transportation; (b) accommodations; and (c) other specified services arranged by the Travel Supplier for the Trip.

Travel Supplier means tour operator, Participating Organization, Cruise line, airline, hotel, travel agency, etc. who has made the land, air and/or sea arrangements.

Trip means a trip or class of trips outside Your Home Country as described on the Confirmation of Coverage.

Unforeseen means not anticipated or expected and occurring after the Effective Date of Your coverage.

You or Your refers to the Insured.

GENERAL PROVISIONS

The following provisions apply to all coverages:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

CONTROLLING LAW - Any part of this Certificate that conflicts with the state law where the Certificate is issued is changed to meet the minimum requirements of that law.

GOVERNING JURISDICTION – The insurance regulatory agency and courts of the jurisdiction in which You are located shall have jurisdiction over the individual or group insurance coverage as if such coverage or plan were issued directly to You.

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

SUBROGATION - To the extent the Company pays for a Loss suffered by You, the Company will take over the rights and remedies You had relating to the Loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the Loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company.

ASSIGNMENT - This Certificate is not assignable, whether by operation of law or otherwise, but benefits may be assigned.

WHEN YOUR COVERAGE BEGINS - Provided:
(a) coverage has been elected; and
(b) the required premium has been paid.

All coverage will begin on the later of the Effective Date, or upon Your departure from Your Home Country.

WHEN YOUR COVERAGE ENDS - Your coverage will end at 11:59 P.M. local time on the date that is the earliest of the following:
(a) the date the Policy is terminated;
(b) the Scheduled Return Date as stated on the travel tickets;
(c) the date You return to Your origination point if prior to the Scheduled Return Date;
(d) upon Your return to Your Home Country;
(e) one hundred eighty (180) days after the Effective Date.

EXCESS INSURANCE LIMITATION - The insurance provided by this Certificate shall be in excess of all other valid and collectible insurance or indemnity. If at the time of the occurrence of any Loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of Loss, over the amount of such Other Insurance or indemnity, and applicable Deductible.

The following provisions apply to all benefits except Baggage/Personal Effects and Baggage Delay:

PAYMENT OF CLAIMS - The Company, or its designated representative, will pay a claim after receipt of acceptable Proof of Loss.

Benefits provided by this Certificate may, at the option of the Company, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to You.

Any payment made in good faith will discharge the Company's liability to the extent of the claim.

The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid by Other Insurance policies. In no event will the Company reimburse You for an amount greater than the amount paid by You.

NOTICE OF CLAIM - Written notice of claim must be given by the claimant (either You or someone acting for You) to the Company or its designated representative within twenty (20) days after a covered Loss first begins or as soon as reasonably possible. Notice should include Your name, the Travel Supplier's name and the Plan number. Notice should be sent to the Company's administrative office, or to the Company's designated representative.

PROOF OF LOSS - The claimant must send the Company, or its designated representative, Proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS - Benefits payable under this Certificate for any Loss other than Loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written Proof of such Loss. Subject to due written Proof of Loss, all accrued indemnities for Loss for which this Certificate provides periodic payment will be paid

monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within thirty (30) days following receipt by the Company of due Proof of Loss. Failure to pay within such period shall entitle the claimant to interest at the rate of six (6) percent per annum from the thirtieth (30th) day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You or Your assignee shall be notified by the Company or designated representative of any known failure to provide sufficient documentation for a due Proof of Loss within thirty (30) days after receipt of the claim. Any required interest payments shall be made within thirty (30) days after the payment.

The following provisions apply to Baggage/Personal Effects and Baggage Delay coverages:

NOTICE OF LOSS - If Your property covered under this Certificate is lost, stolen or damaged, You must:

(a) notify the Company, or its authorized representative as soon as possible;
(b) take immediate steps to protect, save and/or recover the covered property:
(c) give immediate notice to the carrier or bailee who is or may be liable for the Loss or damage;
(d) notify the police or other authority in the case of robbery or theft within twenty-four (24) hours.

PROOF OF LOSS - You must furnish the Company, or its designated representative, with Proof of Loss. This must be a detailed sworn statement. It must be filed with the Company, or its designated representative, within ninety (90) days from the date of Loss. Failure to comply with these conditions shall invalidate any claims under this Certificate.

SETTLEMENT OF LOSS - Claims for damage and/or destruction shall be paid after acceptable proof of the damage and/or destruction is presented to the Company and the Company has determined the claim is covered. Claims for lost property will be paid after the lapse of a reasonable time if the property has not been recovered. You must present acceptable Proof of Loss and the value involved to the Company.

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, either You or the Company can make a written demand for an appraisal. After the demand, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

BENEFIT TO BAILEE - This insurance will in no way inure directly or indirectly to the benefit of any carrier or other bailee.

BAGGAGE DELAY (Outward Journey Only)

The Company will reimburse You for the expense of necessary personal effects, up to the Maximum Benefit shown on the Confirmation of Coverage, if Your Checked Baggage is delayed or misdirected by a Common Carrier for more than twenty-four (24) hours, while on a Trip.

You must be a ticketed passenger on a Common Carrier.

Additionally, all claims must be verified by the Common Carrier who must certify the delay or misdirection and receipts for the purchases must accompany any claim.

BAGGAGE/PERSONAL EFFECTS

The Company will reimburse You up to the Maximum Benefit shown on the Confirmation of Coverage, if You sustain Loss, theft or damage to baggage and personal effects during the Trip, provided You have taken all reasonable measures to protect, save and/or recover the property at all times. The baggage and personal effects must be owned by and accompany You during the Trip. The police or other authority must be notified within twenty-four (24) hours in the event of theft.

This coverage is subject to any coverage provided by a Common Carrier and all other valid and collectible insurance indemnity and shall apply only when such other benefits are exhausted.

There will be a per article limit shown on the Confirmation of Coverage.

There will be a combined Maximum Benefit limit shown on the Confirmation of Coverage for the following:

jewelry; watches; articles consisting in whole or in part of silver, gold or platinum; furs; articles trimmed with or made mostly of fur; personal computers; cameras and their accessories and related equipment.

The Company will pay the lesser of the following:

(a) Actual Cash Value at time of Loss, theft or damage to baggage and personal effects; or
(b) the cost of repair or replacement in like kind and quality.

EXTENSION OF COVERAGE
If You have checked Your property with a Common Carrier and delivery is delayed, coverage for Baggage/Personal Effects will be extended until the Common Carrier delivers the property.

EMERGENCY EVACUATION

The Company will pay benefits for Covered Expenses incurred, up to the Maximum Benefit shown on the Confirmation of Coverage, if an Accidental Injury or Sickness commencing during the course of the Trip results in Your necessary Emergency Evacuation. An Emergency Evacuation must be ordered by a Physician who certifies that the severity of Your Accidental Injury or Sickness warrants Your Emergency Evacuation.

Emergency Evacuation means:

(a) Your medical condition warrants immediate transportation from the hospital where You are first taken when injured or sick to the nearest Hospital where appropriate medical treatment can be obtained;
(b) after being treated at a local Hospital, Your medical condition warrants transportation to the United States where You reside, to obtain further medical treatment or to recover; or
(c) both (a) and (b), above.

Covered Expenses are reasonable and customary expenses for necessary Transportation, related medical services and medical supplies incurred in connection with Your Emergency Evacuation. All Transportation arrangements made for evacuating You must be by the most direct and economical route possible. Expenses for Transportation must be:

(a) recommended by the attending Physician;
(b) required by the standard regulations of the conveyance transporting You; and
(c) authorized in advance by the Company or its authorized representative.

Transportation to Join You: If You are traveling alone and are in a Hospital alone for more than seven (7) consecutive days or if the attending Physician certifies that due to Your Accidental Injury or Sickness, You will be required to stay in the Hospital for more than seven (7) consecutive days, upon request the Company will bring a person, chosen by You, for a single visit to and from Your bedside.

Transportation services are provided if authorized in advance by the assistance provider and are limited to necessary Economy Fares less the value of applied credit from unused travel tickets, if applicable.

Transportation means any Common Carrier, or other land, water or air conveyance, required for an Emergency Evacuation and includes air ambulances, land ambulances and private motor vehicles.

The Company will not cover any expenses provided by another party at no cost to You or already included within the cost of the Trip.

NON-MEDICAL EMERGENCY EVACUATION

The Company will reimburse You, up to the Maximum Benefit shown on the Confirmation of Coverage, for all reasonable expenses incurred for Your transportation to the nearest place of safety, or to Your primary place of residence, if You must leave Your Trip for a Covered Reason, as defined below.

Evacuation must occur within ten (10) days of any covered event. Arrangements will be by the most appropriate and economical means available and consistent with Your health and safety. Benefits are only payable for arrangements made by the assistance provider.

Covered Reasons: The Company will pay for the Non-Medical Emergency Evacuation Benefits listed above if, while on Your Trip, a formal recommendation from the appropriate local authorities, or the U.S. State Department, is issued for You to leave a country You are visiting on Your Trip due to:

1) a natural disaster;
2) civil, military or political unrest; or
3) You being expelled or declared a persona non-grata by a country You are visiting on Your Trip.

These benefits will not duplicate any other benefits payable under this Certificate or any coverage(s) attached to this Certificate.

REPATRIATION OF REMAINS

The Company will pay the reasonable Covered Expenses incurred to return Your body to Your primary residence if You die during the Trip. This will not exceed the Maximum Benefit shown on the Confirmation of Coverage. This benefit is provided if authorized in advance by the assistance provider.

Covered Expenses include, but are not limited to, expenses for embalming, cremation, casket for transport and transportation.

TRIP DELAY

The Company will reimburse You for Covered Expenses, up to the Maximum Benefit shown on the Confirmation of Coverage, if You are delayed, while coverage is in effect, en route to or from the Trip for twelve (12) or more hours due to a defined Hazard.

Covered Expenses:
(a) Any additional expenses incurred;
(b) An economy fare from the point where You ended Your Trip to a destination where You can catch up to the Trip; or
(c) A one-way Economy Fare to return You to Your originally scheduled return destination.

You must provide the following documentation when presenting a claim for these benefits:
  a) Written confirmation of the reasons for delay from the Common Carrier whose delay resulted in the Loss, including but not limited to, scheduled departure and return times and actual departure and return times.

TRIP INTERRUPTION

The Company will reimburse You, up to the Maximum Benefit shown on the Confirmation of Coverage, if You join Your Trip after departure or are unable to continue on the Trip due to any of the following reasons that are Unforeseen and takes place after departure:

Your Sickness, Accidental Injury or death, that results in medically imposed restrictions as certified by a Physician at the time of Loss preventing Your continued participation in the Trip. A Physician must advise to cancel the Trip on or before the Scheduled Return Date;

Sickness, Accidental Injury or death of a Family Member or Traveling Companion booked to travel with You that results in medically imposed restrictions as certified by a Physician preventing that person's continued participation in the Trip;

Sickness, Accidental Injury or death of a non-traveling Family Member;

You or a Traveling Companion being hijacked, Quarantined, required to serve on a jury, subpoenaed, the victim of felonious assault during the Trip; having Your principal place of residence made Uninhabitable by fire, flood, volcano, earthquake, hurricane or other natural disaster; or burglary of Your principal place of residence during the Trip.

The Company will reimburse You for the following:
a) the airfare paid less the value of applied credit from an unused travel ticket, to return home, join or rejoin the original Land/Sea Arrangements limited to the cost of one-way economy airfare (or similar quality as originally issued ticket) by scheduled carrier, from the point of destination to the point of origin shown on the original travel tickets.

In no event shall the amount reimbursed exceed the amount You prepaid for the Trip.

LIMITATIONS AND EXCLUSIONS

The following exclusions apply to Trip Interruption, Trip Delay, Emergency Evacuation, Repatriation of Remains:

Loss caused by or resulting from:
1. Pre-Existing Conditions, as defined in the Definitions section (except Emergency Evacuation and Repatriation of Remains);
2. suicide, attempted suicide or any intentionally self-inflicted injury while sane or insane (unless results in the death of a non-traveling Family Member);
3. intentionally self-inflicted injuries;
4. war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not), civil war;

5. participation in any military maneuver or training exercise;
6. piloting or learning to pilot or acting as a member of the crew of any aircraft;
7. participation as a professional in athletics;
8. being under the influence of drugs or intoxicants, unless prescribed and used in accordance with the instructions provided by a Physician;
9. commission or the attempt to commit a dishonest, fraudulent or criminal act;
10. participating in Bodily Contact Sports (football, wrestling, ice hockey, rugby, lacrosse, boxing, full contact karate, hurling and rodeo); skydiving; hang-gliding; Parachuting; Mountaineering; any race; bungee cord jumping; speed contest (speed contest shall not include any of the regatta races); scuba diving unless accompanied by a dive master or if the depth exceeds fifty (50) feet; deep sea diving; spelunking or caving; heliskiing; extreme skiing; Extreme Sports.
11. dental treatment except as a result of an injury to Sound Natural Teeth within twelve (12) months of the injury;
12. pregnancy and childbirth (except for complications of pregnancy); except if Hospitalized;
13. curtailment or delayed return for other than covered reasons;
14. traveling for the purpose of securing medical treatment;
15. services not shown as covered;
16. directly or indirectly, the actual, alleged or threatened discharge, dispersal, seepage, migration, escape, release or exposure to any hazardous biological, chemical, nuclear radioactive material, gas, matter or contamination;
17. care or treatment that is not Medically Necessary;
18. care or treatment for which compensation is payable under Worker's Compensation Law, any Occupational Disease law; the 4800 Time Benefit plan or similar legislation;
19. care or treatment that is payable under any Other Insurance policy;
20. Accidental Injury or Sickness when traveling against the advice of a Physician;
21. cosmetic surgery except for: reconstructive surgery incidental to or following surgery for trauma, or infection or other covered disease of the part of the body reconstructed, or to treat a congenital malformation of a child.
22. canyoning or canyoneering (traveling in canyons using a variety of techniques that may include walking, scrambling, climbing, jumping, abseiling and/or swimming);
23. any expenses incurred in the Home Country.

The following exclusions apply to Baggage/Personal Effects and Baggage Delay:

The Company will not provide benefits for any Loss or damage to:

1. animals;
2. automobiles and automobile equipment;
3. boats or other vehicles or conveyances;
4. trailers;
5. motors;
6. motorcycles;
7. aircraft;
8. bicycles (except when checked as baggage with a Common Carrier);
9. household effects and furnishing;
10. antiques and collector's items;
11. eye glasses, sunglasses or contact lenses;
12. artificial teeth and dental bridges;
13. hearing aids;
14. artificial limbs and other prosthetic devices;
15. prescribed medications;
16. keys, cash, stamps, securities and documents;
17. tickets;
18. credit cards;
19. professional or occupational equipment or property, whether or not electronic business equipment;
20. cell phones, computer hardware or software;
21. sporting equipment if loss or damage results from the use thereof;
22. musical instruments;
23. retainers and orthodontic devices.

Any Loss caused by or resulting from the following is excluded:

1. breakage of brittle or fragile articles;
2. wear and tear or gradual deterioration;
3. insects or vermin;
4. inherent vice or damage while the article is actually being worked upon or processed;
5. confiscation or expropriation by order of any government;

6. war or any act of war whether declared or not;
7. theft or pilferage while left unattended in any vehicle;
8. mysterious disappearance;
9. property illegally acquired, kept, stored or transported;
10. insurrection or rebellion;
11. imprudent action or omission;
12. property shipped as freight or shipped prior to the Scheduled Departure Date.

The following exclusions apply to Non-Medical Emergency Evacuation:
The Company does not cover:

1) Loss or expense recoverable under any Other Insurance or through an employer;
2) Loss or expense arising from or attributable to:
    (a) fraudulent or criminal acts committed or attempted by You;
    (b) alleged violation of the laws of the country You are visiting, unless the Company determines such allegations to be fraudulent, or
    (c) failure to maintain required documents or visas;
3) Loss or expense arising from or attributable to:
    (a) debt, insolvency, business or commercial failure;
    (b) the repossession of any property; or
    (c) Your non-compliance with a contract, license or permit;
4) Loss or expense arising from or due to liability assumed by You under any contract.

STATE MANDATED LANGUAGE
GROUP CERTIFICATE NSHTC 2500 A&H P&C SPLIT

Massachusetts

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, upon mutual agreement, either You or the Company can make a written request for an appraisal. After the request, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be non-binding. Such appraisal will be voluntary, will be by mutual consent by all parties, and will be non-binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

NSHTC 2200 MA PC

Oklahoma – A&H

The following **FRAUD STATEMENT** and **UNDERWRITING** notices are added:

FRAUD STATEMENT
Warning: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for proceeds of an insurance certificate containing any false, incomplete or misleading information is guilty of felony.

UNDERWRITTEN BY
This certificate is underwritten by:
Nationwide Mutual Insurance Company
1 Nationwide Plaza
Columbus, OH 43215-2220

The following is added to the **TEN-DAY FREE LOOK** provision:

If We do not return any premiums or money's paid within thirty (30) days from the date of cancellation, We will pay interest on the proceeds.

On page 1, the second full paragraph is deleted in its entirety and replaced with the following:

This Certificate of Insurance is issued in consideration of the enrollment form and payment of any premium due. All statements in the enrollment forms are representations and not warranties. Only statements contained in a written enrollment form will be used to render this Certificate voidable, reduce benefits or defend a claim.

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Family Member** is deleted in its entirety and replaced with the following:

Family Member means Your legal or common law spouse, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child from the moment of placement with You, step-child, children-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, aunt, uncle, niece, nephew or Domestic Partner who reside in the United States, Canada or Mexico.

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Pre-Existing Condition** is deleted in its entirety and replaced with the following:

Pre-Existing Condition means any injury, sickness or condition of You, an Insured's Traveling Companion or an Insured's Family Member booked to travel with him or her for which within the six (6) month period prior to the effective date under the Group Policy (a) first manifested itself or exhibited symptoms which would have caused one to seek diagnosis, care or treatment; (b) required taking prescribed drugs or medicine, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or (c) required medical treatment or treatment was recommended by a Physician.

Such an Injury or Sickness will continue to be a Pre-Existing Condition until the expiration of 12 consecutive months, beginning with the effective date of coverage.

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS**, the **CONTROLLING LAW** provision is deleted in its entirety and replaced with the following:

CONTROLLING LAW - Any part of this certificate that conflicts with the state law of Oklahoma is changed to meet the minimum requirements of that law. Where the policy and certificate differ, the certificate will govern.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be voidable if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

Under the section entitled **GENERAL PROVISIONS**, the **WHEN YOUR COVERAGE ENDS** provisions are revised as follows:

The references to 11:59 pm are amended to read 12:01 am.

Under the section entitled **GENERAL PROVISIONS**, the **EXCESS INSURANCE LIMITATION** provision does not apply to medical or dental benefits. The reference to "Excess Insurance" does not apply to Accident Medical Expense or Sickness Medical Expense.

Under the section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provision is deleted in its entirety and replaced with the following:

PROOF OF LOSS - The claimant must send the Company, or its designated representative, Proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusion 4 is deleted in its entirety and replaced with the following:

4. war or any act of war, whether war is declared or not while serving in military service or any auxiliary thereto;

In the section entitled **COORDINATION OF BENEFITS**, the definition of **Plan** is deleted in its entirety and replaced with the following:

Plan means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

(a) group, blanket or franchise insurance coverage,
(b) service plan contracts, group practice, individual practice and other prepayment coverage,
(c) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and
(d) any coverage under governmental programs, and any coverage required or provided by any statute.
(e) all group or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts include individual policy forms that are utilized and whether or not the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.

(f) both group and individual automobile "no fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.

Plan does not include:

(a) Individual or family policies, or individual or family subscriber contracts, except as provided in items (v) and (vi) above.

(b) Individually underwritten and issued contracts which provide a contractual right to renewal regardless of membership in or connection with any particular organization or group shall not be considered group type contracts, irrespective of the mode or channel of premium payment and regardless of any reduction in premium the covered person may receive by virtue of such method of premium collection.

(c) group or group-type hospital indemnity benefits (written on a non-expense incurred basis) of $30 per day or less unless they are characterized as reimbursement type benefits but are designed to administer so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at the time of claim. In any event, the amount of group and group-type hospital indemnity benefits which exceed $30 per day may be construed as being included under the definition of Plan.

(d) School accident type coverages, written on either an individual, blanket, group or franchise basis should not be taken in to consideration in coordination of benefits. In this context, school accident type coverages are defined to mean coverage covering grammar school, middle school, and high school students for accidents only, including athletic injuries, either on a 24 hour basis or "to and from school" for which the parent pays the entire premium.

In the section entitled **COORDINATION OF BENEFITS**, the **Right of Recovery** provision is deleted in its entirety and replaced with the following:

Whenever payments which should have been made under this Plan in accordance with this section have been made under any other Plans, the insurer shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the insurer shall be fully discharged from liability under this Plan.

NSHTC 2200 OK AH

Oklahoma – P&C

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS,** the **CONTROLLING LAW** provision is deleted in its entirety and replaced with the following:

CONTROLLING LAW - Any part of this Certificate that conflicts with the state law of Oklahoma is changed to meet the minimum requirements of that law.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be voidable if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, or makes any claim for proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Under the section entitled **GENERAL PROVISIONS,** the WHEN **YOUR COVERAGE ENDS** provision is revised as follows:

All references to 11:59 PM are amended to read 12:01 AM.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusion 4 is deleted in its entirety and replaced with the following:

4. War or any act of war, whether war is declared or not while serving in military service or any auxiliary thereto:

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusions 7, 10, 16 and 20 are deleted in their entirety.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, subsections which read, **"The following exclusions apply to Baggage/Personal Effects and Baggage Delay"** the exclusions related to war are deleted in their entirety and replaced with the following:

War or any act of war, whether war is declared or not while serving in military service or any auxiliary thereto:

NSHTC 2200 OK PC

Tennessee

The following is added to page 1 of the Certificate:

This Certificate is underwritten by:
Nationwide Mutual Insurance Company
1 Nationwide Plaza
Columbus, OH 43215
(614) 854-3375

The Certificate includes an **EXCESS INSURANCE LIMITATION**. The benefits in this Certificate are secondary to any valid and collectible insurance.

The Free-Look provision on page 1 is deleted in its entirety and replaced with the following:

All premium is non-refundable after a ten (10) day review period from the date of purchase in the event You have not incurred any claims during that time. In the event the premium paid for coverage is less than the required premium for coverage, benefits will be paid in direct proportion of the actual amount paid to the required premium due.

Under the Section entitled **GENERAL DEFINITIONS**, the definition of **Accident** is deleted in its entirety and replaced with the following:

Accident means an unexpected and unintended event, which occurs at an identifiable time and place, but shall also include exposure resulting from a mishap to a conveyance in which You are traveling.

Under the Section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the Section entitled **GENERAL PROVISIONS**, the following is added to the **NOTICE OF CLAIM** provision:

A claim form will be sent to You within 15 days of Our receipt of Your Notice of Claim. If such form is not furnished within fifteen (15) days after the giving of such notice, You shall be deemed to have complied with the requirements of this Certificate as to Proof of Loss upon submitting, within the time fixed in the Certificate for filing Proofs of Loss, written proof covering the occurrence, the character and the extent of the Loss for which claim is made.

The fully completed claim form must be returned to the claims administrator with:
1. Written Proof of Loss.
2. Any other documentation that the Company may reasonably request.

All these required items, including the claim form, must be postmarked within 90 days or as soon as reasonably possible after the date of Loss. Otherwise, the claim may be denied.

Under the Section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provisions are deleted in their entirety and replaced with the following:

You must send the Company or the claims administrator, Proof of Loss within 180 days or as soon as reasonably possible after a covered Loss occurs. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

NSHTC 2200 TN

Texas – A&H

Under the section entitled **GENERAL DEFINITIONS**, the definition of **HOSPITAL** is deleted in its entirety and replaced with the following:

Hospital means a facility that:
(a) is licensed as a hospital and operated pursuant to law; and
(b) is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians), medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
(c) provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (RN); and
(d) is an institution which maintains and operates a minimum of five beds; and
(e) has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
(f) maintains permanent medical history records.

Hospital does not include:
(a) the federal government or any agency thereof for the treatment of members or ex-members of the armed forces; or
(b) convalescent homes, convalescent facilities, rest facilities, or nursing facilities; or
(c) home or facilities primarily for the aged, drug addicts, alcoholics, those primarily affording custodial care, educational care or those primarily affording care for mental and nervous disorders.

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Pre-Existing Condition** is deleted in its entirety and replaced with the following:

Pre-Existing Condition means an illness, disease, or other condition during the six (6) month period immediately prior to the Effective Date for which You, a Traveling Companion or a Family Member booked to travel with You: 1) received medical advice or treatment for a disease or physical condition; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition that is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the six (6) month period before the Effective Date.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance in writing within the two-year period after the Effective Date of coverage concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.
You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

Under the section entitled **GENERAL PROVISIONS**, the following is added to the **WHEN YOUR COVERAGE ENDS** provision:

Coverage will not end solely because a person becomes an elected official in Texas.

Under the section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provision is deleted in its entirety and replaced with the following:

PROOF OF LOSS - You have 91 days from the date of your loss to submit your claim to us, except as otherwise provided by law.

Within 15 business days after we receive of notice of a claim we will:

- acknowledge receipt of the claim (If acknowledgement of the claim is not made, in writing, we will make a record of the date, means, and content of the acknowledgement.)
- commence any investigation of the claim; and
- request from you all items, statements, and forms that We reasonably believe, at that time, will be required from you. Additional requests may be made if during the investigation of the claim such additional requests are necessary.

We will notify you in writing of the acceptance or rejection of a claim no later than 15 business days after we receive all Proof of Loss required by us. If we reject the claim, we will tell you the reasons for the rejection. If we are unable to accept or reject the claim within 15 business days after we receive all Proof of Loss required, we will notify you within the 15 business-day period and tell you why we need additional time to investigate the claim. If we require additional time to investigate your claim, we will notify you if we accept or reject the claim no later than 45 business days after we request additional time to investigate the claim.

Except as otherwise provided, if we delay payment of a claim for more than 60 business days following receipt of all required Proof of Loss, we will pay the amount of the claim plus 18 percent interest per year along with reasonable attorney fees. If a lawsuit is filed, such attorney fees shall be taxed as part of the costs in the case.

Under the section entitled **GENERAL PROVISIONS**, the following **ENTIRE CONTRACT** provision is added:

ENTIRE CONTRACT - This certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this certificate is not valid until the change is approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the certificate. An agent does not have authority to change this certificate or to waive any of its provisions.

Under the section entitled **COORDINATION OF BENEFITS**, the provision entitled **Rules** is amended to read:

Rules
The general order of benefits is as follows:
The Primary Plan must pay or provide its benefits as if the Secondary Plan or plans did not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan into account when it determines its benefits. There is one exception. A contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided.

A Secondary Plan may take the benefits of another plan into account only when, under this subchapter, it is secondary to that other plan.

In determining the order of benefit, We must use the first of the following rules which applies.

1. With respect to categories of non-dependent as related to dependent coverage, the benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent. There is one exception. If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.
2. With respect to a dependent child whose parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. As used in this paragraph, the word “birthday " refers only to month and day in a calendar year, not the year in which the person was born. If the plan does not have the rule based upon the parent's birthday, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon gender of the parent will determine the order of benefits.
3. With respect to a dependent child whose parents are separated or divorced, where two or more plans cover the child, benefits for the child are determined in this order:
   a) first, the plan of the parent with custody of the child;
   b) then, the plan of the spouse of the parent with the custody of the child; and
   c) finally, the plan of the parent not having custody of the child.
   d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those

terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

e) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph 2. above of this subsection.

4. With respect to active as related to inactive employees, the benefits shall be determined in the following order. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. With respect to continuation coverage, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
   a) first, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
   b) second, the benefits under the continuation coverage.
   c) If the other plan does not have the rule described in subparagraphs (A) and (B) of this paragraph, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. Where none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter term. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. The start of a new plan does not include:
   a) a change in the amount or scope of a plan's benefits;
   b) a change in the entity which pays, provides or administers the plan's benefits; or
   c) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

NSHTC 2200 TX AH

Texas – P&C

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Business Day** is added as follows:

Business Day means all days except Saturday, Sunday, or holidays recognized by Texas.

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than two (2) years from the date the cause of action first accrues.

Under the section entitled **GENERAL PROVISIONS**, the following is added to the **WHEN YOUR COVERAGE ENDS** provision:

Coverage will not end solely because a person becomes an elected official in Texas.

Under the section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provision is deleted in its entirety and replaced with the following:

PROOF OF LOSS - You have 91 days from the date of your Loss to submit your claim to us, except as otherwise provided by law.

Within 15 Business Days after we receive of notice of a claim we will:

- acknowledge receipt of the claim (If acknowledgement of the claim is not made, in writing, we will make a record of the date, means, and content of the acknowledgement.)
- commence any investigation of the claim; and
- request from you all items, statements, and forms that We reasonably believe, at that time, will be required from you. Additional requests may be made if during the investigation of the claim such additional requests are necessary.

We will notify you in writing of the acceptance or rejection of a claim no later than 15 business days after we receive all Proof of Loss required by us. If we reject the claim, we will tell you the reasons for the rejection. If we are unable to accept or reject the claim within 15 business days after we receive all Proof of Loss required, we will notify you within the 15 business-day period and tell you why we need additional time to investigate the claim. If we require additional time to investigate your claim, we will notify you if we accept or reject the claim no later than 45 business days after we request additional time to investigate the claim.

Except as otherwise provided, if we delay payment of a claim for more than 60 business days following receipt of all required Proof of Loss, we will pay the amount of the claim plus 18 percent interest per year along with reasonable attorney fees. If a lawsuit is filed, such attorney fees shall be taxed as part of the costs in the case.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, within thirty (30) days of the date of the disagreement either You or the Company can make a written demand for an appraisal. Within fifteen (15) days after the demand, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion within fifteen (15) days of their selection on the amount of the Loss. If they do not agree, they will select an arbitrator within fifteen (15) days from the date of their opinion. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

NSHTC 2200 TX PC

ON CALL INTERNATIONAL TRAVEL ASSISTANCE SERVICES

The Travel Assistance program feature provides a variety of travel related services. Services offered include: Pre-Trip Information Medical Monitoring Medical, Dental and Pharmacy Referrals Legal Referrals - Bail bond* Hospital Admission Guarantee Dispatch of Medicine Translation Service Lost Baggage Retrieval Inoculation Information Passport / Visa Information Emergency Message Forwarding Emergency Cash Advance* Prescription Drug / Eyeglass Replacement*

* Payment reimbursement is Your responsibility

FOR 24/7 TRAVEL ASSISTANCE SERVICES ONLY

CALL TOLL FREE:
855-464-8974 (within the United States and Canada)

OR CALL COLLECT
603-328-1361 (From all other locations)

Travel assistance services are provided by an independent organization and not by the Company. There may be times when circumstances beyond On Call's control hinder their endeavors to provide travel assistance services. They will, however, make all reasonable efforts to provide travel assistance services and help you resolve your emergency situation.

FOR FILING A CLAIM

Contact the Nationwide Plan Administrator at:
Customer Service: 888-352-3169
Direct Line: 727-725-7522
Mailing Address: Attention: Co-ordinated Benefit Plans, LLC
On Behalf of Nationwide Mutual Insurance Company and Affiliated Companies
P.O. Box 26222
Tampa, FL 33623
Or E-mail your information to: NWTravClaims@cbpinsure.com

IMPORTANT: To facilitate prompt claims settlement, You will be asked to provide proof of Your loss. Therefore, be sure to obtain the following as applicable: 1.) For medical claims - detailed medical statements from treating physicians where and when the accident or Sickness occurred as well as receipts for medical services and supplies; 2.) For baggage and baggage delay claims - reports from parties responsible (i.e. airline, cruiseline, etc.) for loss, theft, damage or delay. Some claims may also require a police report. Please obtain receipts for lost or damaged items; 3.) For trip delay claims - a statement from party causing delay and receipts for expenses; 4.) For cancellation/interruption claims - Your travel invoice, the cancellation or interruption date, original unused tickets/vouchers, the travel organizer's cancellation clause with regard to nonrefundable losses. You will also be asked to provide proof of payment.