BROCHURE OF COVERAGE

Blanket Student
Accident & Sickness Plan
a Non-Renewable Term Policy

For Students Attending

FARMINGDALE
STATE
COLLEGE

2015 - 2016
Policy Form No. 302-005-3113

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

Administered by:
www.sas-mn.com
333 N. Main St, Suite 300 • P.O. Box 196
Stillwater, MN 55082-0196

A-28NY
INTRODUCTION
The College is making available a plan of blanket accident and sickness insurance (hereinafter called “plan” or “Plan”) underwritten by Nationwide Life Insurance Company and administered by Student Assurance Services, Inc. This brochure provides a general summary of the insurance coverage; the Schedule of Benefits is not all inclusive of eligible benefits payable under this plan. Keep this brochure as no individual policy will be issued. This summary is not a contract; the Master Policy is issued to the College and available upon request. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

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

SUMMARY OF PLAN BENEFITS
• The policy maximum benefit is unlimited.
• Benefits are subject to a deductible, in-network $50 or out-of-network $300, per person, per condition.
• The out-of-pocket maximum is $6,350 per person and $12,700 family.
• A 24-hour nurse line program providing phone-based health information is included.
• To maximize savings and reduce out-of-pocket expenses, select a PHCS by Multiplan, Inc. in-network participating provider. These providers have agreed to provide services at discounted rates.

For assistance and questions about insurance benefits, ID cards, claim status, or claim processing contact the Plan Administrator:
Student Assurance Services, Inc. (SAS)
Post Office Box 196
Stillwater, MN 55082-0196
www.sas-mn.com
Phone: (800) 328-2739

OTHER CONTACT INFORMATION:

Servicing Agent:
Niagara National Inc.
5001 Genesee Street
Buffalo, NY 14225
(800) 444-5530

Participating Provider Directory or Questions
PHCS by MultiPlan
Website: www.multiplan.com

SAS Plan Number:
31-61-0028-029-602-5
STUDENT ELIGIBILITY

All registered students are eligible to enroll in the accident and sickness insurance plan.

Full-time and part-time commuter students and dependents may enroll for annual coverage no later than the enrollment period deadline date 09-13-2015. New students registering with the College for Spring/Summer term, must enroll no later than 02-15-2016.

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

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

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

COVERAGE FOR DEPENDENTS

Students who enroll in the insurance plan may also enroll their eligible dependents by the enrollment period deadline dates 09-13-2015 or for Spring/Summer term by 02-15-2016. Enrollment forms and premium payments received after this date will only be accepted for dependents who qualify for late enrollment. Dependents must enroll when the student first enrolls in the insurance plan.

ENROLLMENT

All full-time resident students are automatically enrolled in the insurance plan. The premium for student only coverage will be added to the College tuition and fees, unless the student shows evidence of comparable insurance coverage by completing a waiver form and returning it to the Student Account Office by 09-13-2015. A completed waiver form is required at each semester. It is the student’s responsibility to notify the Student Health & Wellness Center in the event existing insurance coverage is terminated and the student requires coverage under the insurance plan.

All full-time and part-time commuter students may enroll in the plan on a voluntary basis by completing a form to request the Student Account Office to add the premium to the College tuition and fees.

To enroll for dependent coverage complete the enrollment form located on the website www.sas-mn.com and return it with the required premium payment to:
Student Assurance Services, Inc.
P.O. Box 196, Stillwater, MN 55082

All Late Enrollment: Students and dependents may enroll after the enrollment period deadline date 09-13-2015 or for Spring/Summer 02-15-2016, only when there is a qualifying event. Refer to page 5-6 for late enrollment requirements. All late enrollment inquiries must be sent to Student Assurance Services, Inc. www.sas-mn.com or call 1-800-328-2739.

ID CARDS

An ID card will be mailed to the student’s address on file approximately 2 weeks after the enrollment form and premium payment are received. Students do not need an ID card to be eligible to receive benefits under the Policy. For lost ID cards, request an ID card from the website www.sas-mn.com.
PERIODS OF COVERAGE AND ENROLLMENT/WAIVER PERIOD DEADLINE DATES

<table>
<thead>
<tr>
<th>TERM</th>
<th>DATE COVERAGE BEGINS</th>
<th>DATE COVERAGE ENDS</th>
<th>ENROLLMENT/ WAIVER PERIOD DEADLINE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANNUAL</td>
<td>08-16-2015</td>
<td>08-15-2016</td>
<td>09-13-2015</td>
</tr>
<tr>
<td>SPRING/SUMMER TERM</td>
<td>01-26-2016</td>
<td>08-15-2016</td>
<td>02-15-2016</td>
</tr>
</tbody>
</table>

IMPORTANT: Enrollment requests and premium payments received after the enrollment/waiver period deadline date are not accepted, except for late enrollment.

2015-2016 PREMIUM SCHEDULE

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Spring/Summer Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$1,717.00</td>
<td>$ 941.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$1,717.00</td>
<td>$ 941.00</td>
</tr>
<tr>
<td>Each Child</td>
<td>$1,717.00</td>
<td>$ 941.00</td>
</tr>
</tbody>
</table>

Premium includes an administrative fee charged by the College and an agent service fee.
PREMIUM

Payment of Premium/Due Date: All premium, charges or fees must be paid to Plan Administrator prior to the start of the term for which coverage is selected, or to the College collecting premium payments as agreed upon by the College. In no event will coverage become effective prior to the date of enrollment and before required premium is received.

Returned or Dishonored Payment: If a check or credit card payment for the premium is dishonored for insufficient funds, a reasonable service charge may be charged to the insured which will not exceed the maximum specified under state law. A dishonored check or credit card payment shall be considered a failure to pay premium and coverage shall not take effect.

Premium Refund Policy: A prorated refund, less any claims paid, will be issued only for the following situations below. Any refund provided may be subject to a $25 administration fee.

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

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

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

CHILDREN COVERED UNDER THIS PLAN

Children covered under the plan include the student’s natural children, legally adopted children, step children, and children for whom the student is the proposed adoptive parent without regard to financial dependence, residency with insured, student status or employment. A proposed adopted child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child’s adoption. Coverage under the plan lasts until the child turns 26 years of age and while the student’s insurance remains in force. Coverage also includes children for whom student is a permanent legal guardian if the children are chiefly dependent upon student for support and the student has been appointed the legal guardian by a court order. Foster children and grandchildren are not covered.

Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the child’s coverage would otherwise terminate and who is chiefly dependent upon student for support and maintenance, will remain covered while student’s insurance remains in force and the child remains in such condition. The student has 31 days from the date of the child’s attainment of the termination age to submit an application to request that the child be included in the coverage and proof of the child’s incapacity. The Plan Administrator has the right to check whether a child is and continues to qualify under this section.

The Plan Administrator has the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered student and all other prospective or covered members in relation to eligibility for coverage under this plan at any time.

WHEN COVERAGE BEGINS

Coverage under this Policy will begin as follows:

1. If the student elects coverage before becoming eligible, or within 31 days of becoming eligible for other than a special enrollment period, coverage begins on the date the student becomes eligible, or on the date determined by Farmingdale State College.

2. If the Student, marry while covered, and Plan Administrator receives notice of such marriage within 31 days thereafter, coverage for the spouse starts on the first day of the month following such marriage. If the Plan Administrator does not receive notice within 31 days of the marriage, the student must wait until the school’s next open enrollment period to add the spouse.

3. If the Student, have a newborn or adopted newborn child and the Plan Administrator receive notice of such birth within 31 days thereafter, coverage for the newborn starts at the moment of birth; otherwise, coverage begins on the date on which the Plan Administrator receives notice. Your adopted newborn child will be covered from the
moment of birth if the student takes physical custody of the infant as soon as the infant is released from the hospital after birth and the student files a petition pursuant to Section 115-c of the New York Domestic Relations Law within 31 days of the infant’s birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, the Plan Administrator will not provide hospital benefits for the adopted newborn’s initial hospital stay if one of the infant’s natural parents has coverage for the newborn’s initial hospital stay. If the student or spouse has other insurance coverage, the student must also notify the Plan Administrator of his or her desire to switch to parent and child/children or family coverage and pay any additional premium within 31 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which the Plan Administrator receives notice, provided that the student pays any additional premium when due.

SPECIAL ENROLLMENT PERIODS

The student, their spouse or the child can also enroll for coverage within 30 days of the involuntary loss of coverage in another health plan if coverage was terminated because student and/or dependent are no longer eligible for coverage under the other health plan due to:

1. Termination of employment;
2. Termination of the other health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated; or
7. A child no longer qualifies for coverage as a child under another health plan.

The Plan Administrator must receive notice and premium payment within 30 days of the loss of coverage. The effective date of coverage will depend on when the Plan Administrator receives the application. If the application is received between the first and fifteenth day of the month, coverage will begin on the first day of the following month. If the application is received between the sixteenth day and the last day of the month, coverage will begin on the first day of the second month.

In addition, the student, spouse or child can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. Loss of eligibility for Medicaid or a state child health plan.
2. Becomes eligible for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of one of these events. The effective date of coverage will depend on when the Plan Administrator receives the application. If the application is received between the first and fifteenth day of the month, coverage will begin on the first day of the following month. If the application is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month.

DOMESTIC PARTNER COVERAGE

This plan covers domestic partners of students as spouses. If the student selected family coverage, children covered under this plan also include the children of your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last [six (6)] months, where such registry exists; or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership. A
   A. The affidavit must be notarized and must contain the following:
      • The partners are both 18 years of age or older and are mentally competent to consent to contract;
      • The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
      • The partners have been living together on a continuous basis prior to the date of the application;
      • Neither individual has been registered as a member of another domestic partnership within the last [six (6)] months; and
   B. Proof of cohabitation (e.g., a driver’s license, tax return or other sufficient proof); and
   C. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
- A joint bank account;
- A joint credit card or charge card;
- Joint obligation on a loan;
- Status as an authorized signatory on the partner’s bank account, credit card or charge card;
- Joint ownership of holdings or investments;
- Joint ownership of residence;
- Joint ownership of real estate other than residence;
- Listing of both partners as tenants on the lease of the shared residence;
- Shared rental payments of residence (need not be shared 50/50);
- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- Shared household budget for purposes of receiving government benefits;
- Status of one (1) as representative payee for the other’s government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other’s life insurance policy;
- Designation as beneficiary under the other’s retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners’ financial interdependence;
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.
TERMINATION OF COVERAGE
Coverage under this plan will automatically be terminated on the first of the following to apply:
1. Premiums are to be paid by the student to Plan Administrator or school on each premium due date. While each premium is due by the due date, there is a grace period for each premium payment. If the premium payment is not received by the end of the grace period, coverage will terminate as follows:
   a. If the student fails to pay the required premium within a 30 day grace period, coverage will terminate retroactively.
2. The date on which the student ceases to meet the eligibility requirements as defined by the School. Written notice will be provided to the student at least thirty (30) days prior to when the coverage will cease.
3. Upon the student's death, coverage will terminate unless the student has coverage for dependents. If the student has coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.
4. For spouses in cases of divorce, the date of the divorce.
5. For children, until the end of the month in which the child turns twenty-six (26) years of age.
6. For all other dependents, the end of the month in which the dependent ceases to be eligible.
7. The end of the month during which the student provides written notice to Plan Administrator requesting termination of coverage, or on such later date requested for such termination by the notice.
8. If a student has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Plan Administrator to the Student.
9. The date that the School’s Policy is terminated.

EXTENSION OF BENEFITS
When the insured's coverage under this plan ends, benefits stop. If the insured is totally disabled on the date coverage under this plan terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability. If insured is pregnant on the date coverage under this plan terminates, continued benefits may be available for insured's maternity care.
For purposes of this section, "total disability" means insured is prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When the Insured May Continue Benefit.
1. If the insured is totally disabled on the date coverage under this plan terminates, Plan Administrator will continue to pay for insured’s care under this plan during an uninterrupted period of total disability until the first of the following:
   • The date insured is no longer totally disabled; or
   • 90 days from the date extended benefits began (if insured’s benefits are extended based on termination of student status)
2. If the insured is pregnant on the date coverage under this plan terminates, the Plan Administrator will continue to pay for insured’s maternity care under this plan through delivery and any post-partum services directly related to the delivery.

B. Limits on Extended Benefits.
The plan will not pay extended benefits:
• For any member who is not totally disabled or pregnant on the date coverage under this plan ends; or
• Beyond the extent to which the plan would have paid benefits if coverage had not ended.
**SCHEDULE OF BENEFITS**

<table>
<thead>
<tr>
<th>COVERED SERVICES FOR ESSENTIAL BENEFITS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Year Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Deductible - per person, per condition</td>
<td>$50</td>
<td>$300</td>
</tr>
<tr>
<td>additional deductibles and copays may apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured Percent - plan pays</td>
<td>80% of Preferred Allowance (PA)</td>
<td>60% of Reasonable &amp; Customary (R&amp;C)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum - per policy year, applies to in-network only; deductibles, copays (including Rx) and coinsurance paid by insured contribute toward the out-of-pocket maximum; once this maximum is met, the plan pays in-network eligible expenses at 100% of PA</td>
<td>$6,350 per person</td>
<td>None</td>
</tr>
</tbody>
</table>

**INPATIENT**

- **Room & Board** (paid at the daily semi-private room rate) - $500 copay per confinement

- **Intensive Care**

- **Hospital Miscellaneous** includes meals and prescribed diets, diagnostic imaging, laboratory, pharmaceuticals administered while an inpatient, use of operating room, anesthesia, therapeutic services, supplies, dressings, blood and blood plasma, oxygen, radiation therapy, chemotherapy, miscellaneous items used in association with a surgical or non-surgical event, preadmission testing and inpatient rehabilitation

- **Physician Visits** - 1 visit per day; physician visit not paid same day as surgery

- **Consulting Physician** - 1 visit per day

- **Skilled Nursing and Sub-Acute Care Facilities**

- **Inpatient Rehabilitation Facility** (includes physical therapy and chiropractic care) - limited to 60 visits per condition, per lifetime

**SURGERY BENEFITS (INPATIENT AND OUTPATIENT)**

- **Surgeon's Fees**

- **Assistant Surgeon**

- **Anesthesia Services**

- **Outpatient Surgical Miscellaneous** (includes facility fee, supplies, drugs, diagnostic imaging, x-rays, laboratory and other miscellaneous items used with surgical event) - $500 copay per surgical event

- **General Anesthesia for Dental Services**

- **Reconstructive Surgery**

- **Organ Transplant Surgery**

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

When multiple surgeries are performed through one or more incisions at the same operative session, the plan pays an amount not to exceed the benefit for the most expensive procedure being performed. The benefit for the primary or most expensive procedure or less expensive procedure is 50% of the benefit otherwise payable for each subsequent procedure.
<table>
<thead>
<tr>
<th>SCHEDULE OF BENEFITS Continued</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellness/Preventive &amp; Immunizations (only services listed on page X; includes STD screenings) - in-network deductible and copay are waived</td>
<td>100% of PA</td>
<td>No Benefit</td>
</tr>
<tr>
<td>Physician Office Visits (includes specialist/consultants) - 1 visit per day, not paid same day as surgery, <strong>$25 copay per visit</strong></td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diagnostic Imaging and X-ray Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>PET Scan, CT Scan, and MRI - <strong>$500 copay per procedure</strong></td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Infusion or Injections (performed in health care facility or physician office)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Medical Emergency Room (includes treatment provided outside the United States; visit to the emergency room for treatment of an emergency condition) – <strong>$150 copay per visit</strong>, waived if admitted; in-network deductible applies</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Urgent Care Facility (non-emergency services) - <strong>$150 copay per visit</strong>, waived if admitted</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Emergency Medical Transportation Services</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td><strong>OTHER SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>80% of R&amp;C after:</td>
<td>80% of R&amp;C after:</td>
</tr>
<tr>
<td>insured will need to file a claim for reimbursement; 30-day supply per prescription; copays do not apply to generic contraceptives; one copay per 30-day supply</td>
<td>$25 copay per generic drug</td>
<td>$25 copay per generic drug</td>
</tr>
<tr>
<td></td>
<td>$50 copay per preferred brand drug</td>
<td>$50 copay per preferred brand drug</td>
</tr>
<tr>
<td></td>
<td>$50 copay per non-preferred brand drug</td>
<td>$50 copay per non-preferred brand drug</td>
</tr>
<tr>
<td>Allergy Testing &amp; Treatment (includes testing/injections/treatment)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Diabetes Treatment and Education</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment/Prosthetic Appliances- <strong>$100 copay per prescription</strong></td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Rehabilitative and Habilitative Care (includes physical, and occupational therapies) – <strong>limited to 60 visits each, per condition, per lifetime</strong></td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Rehabilitative and Habilitative Care (includes speech therapy)</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Chiropractic Care – 1 visit per day</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Hospice</td>
<td>80% of PA</td>
<td>60% of R&amp;C</td>
</tr>
<tr>
<td>Club and Intramural Sports Injuries</td>
<td>Paid as any other Injury</td>
<td>Paid as any other Injury</td>
</tr>
<tr>
<td>Intercollegiate Sports Injuries</td>
<td>Paid as any other Injury</td>
<td>Paid as any other Injury</td>
</tr>
<tr>
<td>Maternity Services (including but not limited to: pre and post natal care, hospital services, diagnostic services at physician office and routine newborn care and inpatient newborn care)</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
</tbody>
</table>
Pediatric Dental (coverage for insureds up to age 19) - includes coverage for preventive & diagnostic, basic restorative, major, and medically necessary orthodontia services. Waiting periods and other limitations may apply. Pre-authorization may be required for major and orthodontic care. Benefits are subject to the medical deductible and out-of-pocket maximum. Please see policy for details on coverage. Medically Necessary Orthodontics means the patient must have a severe and handicapping malocclusion. This means the child’s condition must be severe enough to impact their ability to function such as having trouble eating and/or speaking.

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

MENTAL HEALTH AND ALCOHOLISM OR DRUG ABUSE

| Inpatient for Mental Conditions | Paid as any other Sickness |
| Outpatient for Mental Conditions | Paid as any other Sickness |
| Inpatient for Alcoholism/Drug Abuse | Paid as any other Sickness |
| Outpatient for Alcoholism/Drug Abuse | Paid as any other Sickness |

ELECTIVE AND NON-ESSENTIAL HEALTH BENEFITS

| Dental Injury (treatment due to injury to sound, natural teeth; does not include damage from biting or chewing) – limited to $150 per dental injury | 80% of PA | 80% of R&C |
| Private Duty Nurse | 80% of PA | 60% of R&C |
| Treatment Outside the United States (non-emergency) - maximum benefit $20,000 per policy year | 60% of Actual Charge |
OTHER SCHEDULED BENEFITS

BENEFITS MANDATED BY THE STATE OF NEW YORK
The Policy pays benefits in accordance with any applicable New York law. State-mandated benefits are listed below. Description of the mandates can be found in the Master Policy on the website www.sas-mn.com. Benefits may be subject to deductibles, coinsurance, limitations, or exclusions.

- Autism
- Biologically Based Mental Illness
- Breast Cancer Treatment
- Breast Reconstruction Surgery
- Cervical Cancer Screening
- Chemical Dependency and Substance Abuse
- Chiropractic Care
- Diabetes Treatment
- Eating Disorders
- End of Life Care
- Enteral Formula Treatment
- Experimental/Investigational Treatment
- Home Care
- Mammography Screening
- Minimum Pregnancy Stays
- Orally Administered Anticancer Drug
- Osteoporosis Treatment
- Off-Label Drug Treatment for Cancer
- Post-Mastectomy Reconstruction
- Prostate Cancer Screening
- Prehospital Emergency Ambulance Services
- Preadmission Tests
- Second Medical Opinion

ACCIDENTAL DEATH AND DISMEMBERMENT
Occurring within 90 days from date of accident, pays in addition one of the following (the largest applicable amount):

Accidental Death.................................................................................................................. $1,000
Single Dismemberment/Loss of Eye.................................................................................. $ 500
Double Dismemberment/Loss of Both Eyes................................................................. $1,000

ADDITIONAL PROGRAMS

ASK MAYO CLINIC (Nurse Line) ................................................................. see details on page 17

Note: This additional program is not underwritten by Nationwide Life Insurance Company, but provided by an independent vendor and is included if students participate in the insurance plan.
EXPLANATION OF BENEFITS

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

COST-SHARING EXPENSES AND ALLOWED AMOUNT

Balance Billing: When a non-participating provider bills the insured for the difference between the non-participating provider’s charge and the allowed amount. A participating provider may not balance bill for covered services.

Deductible: The amount the insured must pay for covered in-network and out-of-network services during each plan year, per condition, before this plan provides coverage. The deductible applies before any copayments or coinsurance are applied. The deductible may not apply to all covered services. The individual deductible applies to each person covered under this plan. The plan has a separate deductible for services provided by participating providers and a separate deductible for non-participating providers. Cost-sharing for out-of-network services does not apply toward the in-network deductible. Any charges of a non-participating provider that are in excess of the allowed amount do not apply toward the deductible.

Coinsurance: The insured’s share of the costs of a covered service, calculated as a percent of the allowed amount for the service that the insured is required to pay to a provider. The amount can vary by the type of covered service.

The plan will pay the insured percent of the allowed amount as the in-network or out-of-network benefit as shown in the Schedule of Benefits. The insured must also pay any charges of a non-participating provider that are in excess of the allowed amount.

Copayments: After the insured has satisfied the deductible, the insured must pay the copayments, or fixed amounts, for covered in-network and out-of-network services. However, when the allowed amount for a service is less than the copayment, the insured is responsible for the lesser amount.

Cost-Sharing: Amounts the insured must pay for covered services, expressed as copayments, deductibles and/or coinsurance.

In-Network Out-of-Pocket Limit: When a person within a family meets the individual in-network out-of-pocket limit or when persons in the same family have collectively met the family in-network out-of-pocket limit for payment of in-network copayments, deductibles and coinsurance for a plan year, the plan will provide coverage for 100% of the allowed amount for the rest of that plan year. Cost-sharing for out-of-network services, except for emergency services, does not apply toward the in-network out-of-pocket limit. This limit also never includes premium, balance billing charges or the cost of non-covered health care services.

Allowed Amount: means the maximum amount the plan will pay for the covered services or supplies, before any applicable copayment, deductible and coinsurance amounts are subtracted. The allowed amount is determined as follows:
- for participating preferred providers, will be the amount the plan has negotiated with the participating provider’s charge.
- for non-participating providers will be the lesser of: 1) the Fair Health rate at the 80% percentile; 2) the facility’s or provider’s fees charged; 3) a rate based on information provided by a third party vendor, which may reflect one or more of the following factors - the complexity or severity of treatment, level of skill and experience required for the treatment, or comparable providers’ fees and costs to deliver care. The non-participating provider’s actual charge may exceed the plan’s allowed amount. The insured must pay the difference between the allowed amount and the non-participating provider’s charge. Contact Plan Administrator at the number on the ID card or visit our website for information on the financial responsibility for services from a non-participating provider.
MEDICAL NECESSITY

This plan covers benefits described in this brochure as long as the health care service, procedure, treatment, test, device, prescription drug or supply (collectively, "service") is medically necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the service does not make it medically necessary or mean that the plan has to cover it.

The plan may base its decision on a review of:

- Insured's medical records;
- The plans medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the insured’s illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- The insured’s condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to the insured in a lower cost setting will not be medically necessary if they are performed in a higher cost setting. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

PREVENTIVE CARE

The plan cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to cost-sharing (copayments, deductibles or coinsurance) when performed by a participating provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”). However, Cost-sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply. The insured may contact the Plan Administrator at the number on the ID card or visit the website www.sas-mn.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an “A” or “B” rating from USPSTF, and immunizations recommended by ACIP.
GENERAL EXCLUSIONS AND LIMITATIONS

No coverage is available under this plan for the following:

A. Aviation.
This plan does not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
This plan does not cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary.

C. Cosmetic Services.
This plan does not cover cosmetic services, prescription drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. The plan also covers services in connection with reconstructive surgery following a mastectomy. Cosmetic surgery does not include surgery determined to be medically necessary.

D. Dental Services.
This plan does not cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Schedule of Benefits in this plan.

E. Experimental or Investigational Treatment.
This plan does not cover any health care service, procedure, treatment, device or prescription drug that is experimental or investigational. However, the plan will cover experimental or investigational treatments, including treatment for insured’s rare disease or patient costs for insured’s participation in a clinical trial as described in master policy or when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, the plan will not cover the costs of any investigational drugs or devices, non-health services required for insured to receive the treatment, the costs of managing the research, or costs that would not be covered under this plan for non-investigational treatments.

F. Felony Participation.
This plan does not cover any illness, treatment or medical condition due to insured’s participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of insured’s medical condition (including both physical and mental health conditions).

G. Foot Care.
This plan does not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, the plan will cover foot care when insured has a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in insured’s legs or feet.

H. Medically Necessary.
In general, this plan will not cover any health care service, procedure, treatment, test, device or prescription drug that the plan determines is not medically necessary. If an external appeal agent certified by the State overturns the denial, however, this plan will cover the service, procedure, treatment, test, device or prescription drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or prescription drug is otherwise covered under the terms of this plan.

I. Military Service.
This plan does not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.
J. **No-Fault Automobile Insurance.**
This plan does not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if the insured does not make a proper or timely claim for the benefits available to insured under a mandatory no-fault policy.

K. **Services Not Listed.**
This plan does not cover services that are not listed in the Schedule of Benefits as being covered.

L. **Services Provided by a Family Member.**
This plan does not cover services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister or brother of insured or the insured’s spouse.

M. **Services Separately Billed by Hospital Employees.**
This plan does not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.

N. **Services With No Charge.**
This plan does not cover services for which no charge is normally made.

O. **Vision Services.**
This plan does not cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Schedule of Benefits of this plan.

P. **War.**
This plan does not cover an illness, treatment or medical condition due to war, declared or undeclared.

Q. **Workers’ Compensation.**
This plan does not cover services if benefits for such services are provided under any state or federal Workers’ Compensation, employers’ liability or occupational disease law
PARTICIPATING PROVIDER NETWORK
Persons insured under the plan may choose to be treated within, or out of, the PHCS by Multiplan provider network. The PHCS by Multiplan provider network consists of hospitals, doctors, and other health care providers, that are organized into a network for the purpose of delivering quality health care at a negotiated fee. If medical treatment is obtained from a PHCS by Multiplan provider, a higher reimbursement will be received toward the insured’s covered medical expenses.

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

Note: A non-participating provider doesn’t have a contract with the plan to provide services to an insured. The insured will pay more to see a non-participating provider.

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

A complete listing of PHCS by Multiplan providers is available on the website: www.multiplan.com. The participation of individual providers is subject to change without notice. It is the insured’s responsibility to confirm a provider’s participation in the PHCS by Multiplan network when calling for an appointment or at time of visit.

*ASK MAYO CLINIC
Students who enroll and maintain medical coverage in this insurance plan have access to a 24-hour nurse line administered by Ask Mayo Clinic. This program provides:
• Phone-based, reliable health information in response to health concerns and questions; and
• Assistance in decisions on the appropriate level of care for an injury or sickness. Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

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

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

Appeal: A request for Plan Administrator to review a utilization review decision or a grievance again.

Cover, Covered or Covered Services: The medically necessary services paid for, arranged, or authorized for the insured under the terms and conditions of this plan.

Durable Medical Equipment ("DME"): Durable Medical Equipment is equipment which is:
- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency services the insured gets in a hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency condition; and within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient. “To stabilize” is to provide such medical treatment of an emergency condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility, or to deliver a newborn child (including the placenta).

Facility: A hospital; ambulatory surgical center; birthing center; dialysis center; rehabilitation facility; skilled nursing facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public Health Law; a comprehensive care center for eating disorders pursuant to Article 27-J of the New York Public Health Law; and a facility defined in New York Mental Hygiene Law Sections 1.03(10) and (33), certified by the New York State Office of Alcoholism and Substance Abuse Services, or certified under Article 28 of the New York Public Health Law (or, in other states, a similarly licensed or certified Facility). If insured receives treatment for substance use disorder outside of New York State, a facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for covered services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.
DEFINITIONS cont.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the New York Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general hospital, which:
- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care. Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a hospital that usually doesn’t require an overnight stay.

Member: The student or a covered dependent for whom required premiums have been paid. Whenever a member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, “member” also means the member’s designee.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Policy, during which the Policy is in effect.

Premium: The amount that must be paid for insured’s health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration (“FDA”) and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on the plan’s formulary. A prescription drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Provider: A physician, health care professional or facility licensed, registered, certified or accredited as required by state law. A provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.
DEFINITIONS cont.

Specialist: A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Student or Insured: The covered person who is enrolled and meets the eligibility requirements of the plan or school.

Student Health Services: Any organization, facility, or clinic, operated, maintained, or supported by the school which provides health care services to a Student.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency department care. Urgent care may be rendered in a participating physician’s office or urgent care center.

Urgent Care Center: A licensed facility (other than a hospital) that provides urgent care.
EXCESS COVERAGE
When there is a basis for a claim under the Policy and other medical coverage, benefits must be paid by other medical coverage first before benefits are paid under the Policy. When submitting a claim for payment, include the other medical coverage’s explanation of payment with any itemized bills to the Plan Administrator.

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

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

PRESCRIPTION DRUG CLAIM PROCEDURE
To obtain reimbursement for a prescription drug, the insured will need to pay for the prescription drug at the pharmacy and submit a copy of the drug label with a claim form to the address below.

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

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

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

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

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

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

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

Grievances may be sent to:
Student Assurance Services Inc.
P.O. Box 196 • Stillwater, MN 55082
(800) 328-2739
PROTECTION FROM SURPRISE BILLS
A surprise bill is a bill the insured receives for covered services provided on and after April 1, 2015 in the following circumstances:
1. For services performed by a non-participating physician at a participating hospital or ambulatory surgical center, when:
   • A participating physician is unavailable at the time the health care services are performed;
   • A non-participating physician performs services without the insured’s knowledge; or
   • Unforeseen medical issues or services arise at the time the health care services are performed.
A surprise bill does not include a bill for health care services when a participating physician is available and the insured elected to receive services from a non-participating physician.
2. The insured was referred by a participating physician to a non-participating provider without the insured’s explicit written consent acknowledging that the referral is to a non-participating provider and it may result in costs not covered by the plan.
The insured will be held harmless for any non-participating physician charges for the surprise bill that exceed the In-Network copayment, coinsurance or deductible if the insured assigns benefits to the non-participating physician in writing. In such cases, the non-participating physician may only bill for the In-Network copayment, coinsurance or deductible.

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