NATIONWIDE RETIREE HEALTH CARE PLAN

Summary Plan Description
January 2016
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The following is the Summary Plan Description (SPD) for the Nationwide Insurance Companies and Affiliates Retiree Health Care Plan, Nationwide Mutual Fire Insurance Company Retiree Health Care Plan and the Farmland Mutual Insurance Company Retiree Health Care Plan (individually or collectively, the “Plan”) as of January 1, 2016. The Plan is a welfare plan that provides medical benefits to Retired Associates and their Dependents.

Some options within the Plan are “self-insured” while others are “insured.” When a Coverage Option is self-insured, it means that Nationwide accepts the risk and is responsible for paying any eligible Expenses incurred by a Plan Participant. Non-Medicare eligible Retired Associates, Surviving Spouses, Household Members, and Dependents are eligible for self-insured coverage. Currently, the self-insured Coverage Options under the Plan include the Health Savings Choice 1 (HSC1), Health Savings Choice 2 (HSC2), and the Premium Preferred Provider Organization (PPO) options. These options also include prescription drug coverage.

When a Coverage Option is insured, it means an insurance company, through a contractual agreement with Nationwide, assumes the risk for funding all Benefits under the Plan. Medicare-eligible Retired Associates, Surviving Spouses, Household Members, and Dependents are eligible for insured coverage. Currently, the insured Coverage Options under the Plan include a Medicare Advantage PPO, two indemnity health plans that supplement Medicare parts A and B coverage, and two prescription drug plan options.

This SPD and Appendix B (attached for non-Medicare Participants) and Appendix C (attached for Medicare Participants) is a written statement to inform you about the coverage, and any limitations, exclusions, and requirements that apply within the Plan. Many words used in this SPD have special meanings. These words appear in capital letters and are either defined for you in this SPD, or are defined in the Plan document or applicable insurance certificates (also referred to as the “Evidence of Coverage” documents).

Each Plan’s formal legal Plan document rather than the descriptions in this SPD, govern administration of the Plan and all benefit payments. In case of a conflict or any error or omission, the actual legal Plan document prevails in every case. Copies of the Plan documents are available upon request or may be examined at the office of the Plan Administrator and a nominal charge may apply for copies. Plan documents for the insured benefits (Medicare eligible options) include the applicable insurance certificates, policies, and other associated documents. If you participate in any of these benefits, you should review these documents to determine your benefits. If you need a copy of these documents, please contact the Claims Administrator listed in the “Administrative Detail” section of this SPD.

This section addresses only your eligibility to elect coverage under the Plan. The rules regarding eligibility for cost-sharing are contained in the “Employer Contribution to Retiree Plan Coverage” section.

When you retire(d) from a Participating Company, you may have the option of continuing your coverage under an Active Health Care Plan pursuant to federal law (otherwise known as “COBRA” continuation coverage) if you meet the eligibility requirements in the Active Health Care Plan.

An “Active Health Care Plan” refers to the following Company-sponsored health plans:

- Nationwide Insurance Companies Employee Health Care Plan
- Farmland Mutual Insurance Company Employee Health Care Plan
In lieu of COBRA, as a Retired Associate you may instead elect coverage in this Plan for yourself and your Dependents if you meet the eligibility requirements described below.

**Eligibility Requirements for Retired Associates**

You will become eligible to participate in the Plan as a Retired Associate if:

- You are eligible as an Active Associate or Disabled Associate for health care benefits under the Active Health Care Plan, pursuant to its terms and conditions, on your Severance Date or on the date your Long-Term Disability benefits terminate ("LTD End Date"), as applicable
- Your Severance Date (or LTD End Date) occurs after reaching age 55 (or age 52 or older if you are involuntarily terminated as a result of job elimination as defined in the Nationwide Severance Pay Plan)
- You are credited with at least 120 Months of Retiree Medical & Life Eligibility Service; and
- You are eligible for, and elect to receive, benefits from the Nationwide Retirement Plan.

**Severance Date** means the date on which a Retired Associate’s employment ended as a result of retirement or the termination of the Retirement Plan with respect to any Participating Employer. With respect to a Surviving Spouse, Severance Date means the date on which the Active Associate or Retired Associate, as applicable, died.

Even if you meet the eligibility criteria above, you are not eligible to participate in the Plan if you are:

- Permanently residing outside of the United States of America
- Already covered under the Plan as a Retired Associate’s Dependent
- Covered as a Dependent under an Active Health Care Plan.

If you are covered as a Dependent under an Active Health Care Plan, and later lose that coverage, you can elect coverage under the Plan provided that you elect coverage within 60 days of the event. For more information, see the “Qualified Change in Status” section of this document.

If you meet the eligibility requirements listed above, and you do not elect coverage under the Plan at the time of retirement, to the extent otherwise eligible, you may enroll in the Plan during any Annual Enrollment or as a result of any permitted mid-year change, if you provide Evidence of Continuous Coverage for all individuals being enrolled and meet any other additional criteria as described in the “Enrollment During the Annual Enrollment Period” and “Mid-Year Enrollments and Changes” sections, as applicable.

Retired Associates (or Surviving Spouses) who enroll themselves and their Dependents or Household Members in a Coverage Option that is insured are also subject to the eligibility provisions described in the Evidence of Coverage document. To the extent that there is a difference, the eligibility provisions of the insured products will control.

Eligibility requirements have changed over time and Nationwide reserves the right to change them in the future. To be currently eligible, Retirees, Spouses, Dependents and all other individuals must have met the Plan’s eligibility requirements on the Severance Date or the LTD End date as well as the Plan’s current eligibility requirements. If you have questions about the Plan's eligibility requirements on your Severance Date or LTD End date, please contact the Associate Service Center.
Eligibility Requirements for Dependents

Dependents may include a Retired Associate’s Spouse, Domestic Partner, Child, and/or Disabled Child (each term is defined below in bold.)

A Dependent will be eligible to participate in the Plan if she is:

- Eligible for dependent medical coverage under the Active Health Care Plan on the Retired Associate’s Severance Date (or LTD End Date)
- Permanently Residing within the United States of America
- Not covered under the Active Health Care Plan; and
- Not already covered under the Plan.

**Spouse:**
A Spouse is an individual who is lawfully married to a Retired Associate under any state law. For purposes of this definition, the term “state” means any state of the United States, the District of Columbia, any territory or possession of the United States and any foreign jurisdiction having the legal authority to sanction marriages.

A Spouse must be married to the Retired Associate on the Retired Associate’s date of termination of employment.

A person who no longer qualifies as a Spouse as a result of divorce or dissolution of marriage will no longer qualify as a Dependent.

A **Surviving Spouse** is the Spouse of a former Active Associate or Retired Associate who satisfied the eligibility requirements to participate in this Plan on the date of the Retired Associate’s or Active Associate’s death. Coverage extended to a Surviving Spouse and any Dependents is described in the “Coverage for Dependents after Your Death” section of this document.

**Domestic Partner:**
A Domestic Partner is an individual who has entered into a domestic partnership with a Retired Associate and:

- The partner and the Retired Associate are over the age of 18
- The partner and the Retired Associate are not related by blood closer than permitted by applicable state law for marriage
- The partner and Retired Associate share a committed relationship or intend for the relationship to last indefinitely and provide evidence of same via an acceptable form of documentation as established by the Plan Administrator in its sole discretion
- The domestic relationship is exclusive and neither the partner nor the Retired Associate are legally married to or in a domestic partnership with anyone else
- The partner and Retired Associate share a common residence and have lived together for a minimum period of at least six months; and
- The partner and Retired Associate are jointly financially responsible for each other’s common welfare and financial obligations or the Domestic Partner is Financially Dependent upon the Retired Associate. For purposes of joint financial responsibility, common welfare and financial obligations include, but are not limited to, the following major household expenses:
A person who no longer qualifies as a Domestic Partner as a result of not satisfying one or more of the above eligibility requirements will no longer qualify as a Dependent or Household Member.

**Child:**

A child is a:

- Natural child of a Retired Associate or Spouse until the end of the calendar year in which the child turns age 26
- Natural child of a Domestic Partner who resides with the Retired Associate for more than half of the Plan Year of coverage until the end of the calendar year in which the child turns age 26
- Legally adopted child of a Retired Associate or Spouse upon the date of “placement for adoption,” as that term is defined in ERISA Section 609(c)(3)(B) until the end of the calendar year in which the child turns age 26
- Legally adopted child of a Domestic Partner upon the date of “placement for adoption,” as that term is defined in ERISA Section 609(c)(3)(B) who resides with the Retired Associate for more than half of the Plan Year of coverage until the end of the calendar year in which the child turns age 26
- Minor ward for whom a Retired Associate or Spouse has been named a legal guardian by a court order until the end of the month in which the minor ward turns age 18; or
- Grandchild of a Retired Associate or Spouse until the end of the calendar year in which the grandchild turns age 26 and:
  - Who resides with the Retired Associate or Surviving Spouse for more than half of the Plan Year of coverage; and
  - For whom the Retired Associate or Surviving Spouse will provide more than half of their support for the Plan Year of coverage.

**Disabled Child:**

A Disabled Child means a Child, over age 26, who is unable to engage in substantial gainful activity due to a physical or mental impairment as determined by the Plan Administrator in its sole discretion and the Disabled Child is Financially Dependent on the Participant.

A Retired Associate’s Disabled Child will be eligible to participate in the Plan if the following requirements are met:

- Prior to the end of the year in which the Child turned age 26, the Child was unable to engage in substantial gainful activity due to a physical or mental impairment as determined by the Plan Administrator in its sole discretion
- The Child was eligible for coverage under the Plan or Active Health Care Plan at the end of the calendar year in which the child turned age 26; and
- No later than 60 days after the end of the calendar year in which the Child turns age 26, the Retired Associate or Surviving Spouse notifies and submits acceptable proof to the
Plan Administrator or its delegate that the Child meets the definition of Disabled Child and satisfies all other eligibility requirements in the Plan.

A Disabled Child’s coverage will terminate unless within 60 days of receiving a request for documentation from the Plan Administrator or its delegate, the Retired Associate or Surviving Spouse submits proof acceptable to the Plan Administrator or its delegate that the Child continues to meet the definition of Disabled Child and all other eligibility requirements in the Plan. Contact the Associate Service Center for additional details or an application.

**Important Eligibility Information for Household Members, Domestic Partners, and Children of Domestic Partners**

Prior to August 1, 2014, Household Members were eligible to participate in the Plan and included Domestic Partners, Children of Domestic Partners, Qualifying Relatives, and Other Qualifying Individuals. Between August 1, 2014 and December 31, 2014, if an individual was not already enrolled in Household Member coverage, only Household Members who met the new definitions of Domestic Partner or Child of Domestic Partner could elect Household Member coverage. Effective January 1, 2016, Domestic Partners and Children of Domestic Partners will no longer be considered as Household Members with separate health care coverage options, but as Dependents under the Plan if they meet the eligibility requirements.

Household Members enrolled in this Plan (or an Active Health Care Plan) as of July 31, 2014, are “grandfathered” and may continue coverage as a Household Member of a Retired Associate until December 31, 2016, as long as they meet the definition of a Qualifying Relative or Qualifying Individual and all other Plan eligibility requirements.

If Household Member coverage terminates for any reason at any time after August 1, 2014, you cannot re-enroll the Household Member in coverage under the Plan at a future date. Household Members not currently enrolled cannot be added to the coverage.

**Breaks in Coverage**

Rehired Retired Associates retain the same eligibility and Cost-Sharing that they had at their previous Severance Date as long as they can provide Evidence of Continuous Coverage from the later of:

- The date you waived coverage under the Plan; or
- The date your coverage under the Plan was terminated.

A Dependent must be eligible as of your first Severance Date in order to be eligible upon your subsequent termination. Dependents added during the rehire period will not be eligible to participate in the Plan.
PRIOR ELIGIBILITY RULES, EXCEPTIONS, AND ACQUISITIONS

Nationwide Retirees Who Retired Before January 1, 1995

Nationwide retirees who retired before January 1, 1995 may cover any Dependents that they had as of January 1, 1995, whether or not they had those Dependents on their date of retirement.

Provident/Nationwide Life Insurance Company of America

If you were an Active Associate of Provident as of September 30, 2002, who has been credited with 120 Months of Retiree Medical & Life Eligibility Service, has attained age 55, and has been continuously employed by Nationwide, Nationwide Life Insurance Company of America (NLICA) or a Non-Participating Company from October 1, 2002, until your retirement, you may qualify as a “NLICA Retired Employee.” Please see the “Employer Contribution to Retiree Plan Coverage” section for eligibility for cost-sharing.

Please contact the Associate Service Center to confirm whether you are eligible to participate in the Plan as a NLICA Retired Employee.

Harleysville Associates

If you are not yet eligible for Medicare when you retire, access under the Plan is available to you and your Dependents if you leave the Company after you reach age 55 (age 52 if you leave due to job elimination) and have at least 120 Months of Retiree Medical & Life Eligibility Service. Your service time with Harleysville will be recognized for eligibility under the Plan.

Medicare-eligible retirees and their Medicare-eligible Spouses access health coverage through the individual commercial Medicare plan market. One Exchange is available to help you with decision making and the enrollment process.

Please see the “Employer Contribution to Retiree Plan Coverage” section for eligibility for cost-sharing.

Allied Insurance retirees who terminated before January 1, 2014, and Harleysville retirees who retired before January 1, 2013, may cover only the Spouse/Domestic Partner they had as of the date their employment with the company ended.
**ENROLLMENT AND COVERAGE EFFECTIVE DATE**

**Enrollment upon Commencement of Retirement Benefits**

As a newly Retired Associate who commences monthly benefits under the Nationwide Retirement Plan and meets the other eligibility requirements, in lieu of COBRA coverage in the Active Health Care Plan, you may:

- Elect coverage under this Plan for yourself and your Dependents; or
- Defer enrollment in this Plan until a later date (see the “Waiver of Retiree Medical Benefits” section for information regarding delaying your enrollment.)

If you defer commencing monthly benefits under the Nationwide Retirement Plan, you will also have to defer commencement of your coverage in this Plan.

Coverage under the Plan is not automatic upon your retirement; you must enroll to participate in the Plan. If you wish to enroll, the Associate Service Center must receive your completed enrollment materials within 60 days following your Severance Date (or LTD End Date). In general, coverage will be effective on the first day of the month following the calendar month in which your Severance Date (or LTD End Date) occurs and simultaneously with the commencement of benefits under the Nationwide Retirement Plan. If you elect coverage for your Dependents, coverage will begin on the date your coverage begins.

If you do not enroll within this time frame, coverage will be deemed to be waived. If you waive coverage, Evidence of Continuous Coverage is required to enroll you and your Dependents at a later date. You may only enroll you and your Dependents in the Plan later during a subsequent Annual Enrollment Period or as a result of a Qualified Change in Status. See the “Enrollment During the Annual Enrollment Period” and “Mid-Year Enrollments and Changes” sections of this document for more information.

**Enrollment of a Dependent by Two Retired Associates**

In the event two Retired Associates share the same Dependent, a Dependent may only be enrolled by one Retired Associate, and no dual coverage or enrollment under the Plan will be permitted. In the event a Dependent is enrolled by more than one Retired Associate, the Retired Associates will have 30 days to choose who is going to cover the Dependent. If the Retired Associates fail to notify the Plan Administrator within 30 days, claims will be paid as if the Child was only enrolled in the Coverage Option elected by the Retired Associate with the earliest birthday in the calendar year with no secondary coverage from any other Nationwide-sponsored health plan.

**Dependent Eligibility Verification**

The Plan Administrator will periodically require a Retired Associate or Surviving Spouse to provide specific documentation to prove those individuals she has elected coverage for as a Dependent or Household Member are eligible to participate in the Plan. The attached “Appendix A-Dependent Eligibility Requirements” document provides a listing of acceptable documentation. If the Retired Associate or Surviving Spouse fails to provide the requested documentation in the required time period, coverage for those individuals will be terminated.
Waiver of Retiree Medical Benefits

A Retired Associate or Surviving Spouse may elect to waive coverage for herself or a Dependent at any time. If you decide to waive your coverage in this Plan, you are not required to defer/waive benefits under the Nationwide Retirement Plan.

If coverage in this plan is waived, the Retired Associate, Surviving Spouse, or Dependents may enroll in the Plan during any Annual Enrollment Period or as a result of a Qualified Change in Status to the extent otherwise eligible for such coverage, but only if you can provide Evidence of Continuous Coverage from the later of:

- The date you waived coverage under the Plan; or
- The date coverage under this Plan was terminated for the individual(s) being enrolled.

Definition of Evidence of Continuous Coverage

“Evidence of Continuous Coverage” means evidence that the Retired Associate or Dependent for whom coverage is sought has had medical benefits coverage continuously in effect under a Spouse’s employer’s (including military) health care plan, a Spouse’s employer’s (including military) retiree health care plan, the individual’s former employer’s (including military) health care plan or retiree health care plan, COBRA continuation health care coverage, a group Medicare Advantage health care plan for those eligible for Medicare, an individual Medicare Advantage health care plan for those eligible for Medicare, or coverage as a Household Member under the Plan or the Nationwide Employee Health Care Plan(s).

Evidence of Continuous Coverage includes Federal or state Health Insurance Marketplace Silver, Gold, or Platinum coverage (but excludes the lowest level Bronze coverage) as defined by Healthcare.gov.

Enrollment During the Annual Enrollment Period

The Annual Enrollment Period is held annually for a specified period, generally during the last quarter of the Plan Year. You will be notified regarding the timing of the Annual Enrollment Period. During the Annual Enrollment Period, as a Retired Associate or Surviving Spouse, you may elect to continue, enroll for, stop, or change coverage under the Plan for yourself and/or your Dependents.

If you elect to continue coverage or to change the Coverage Option selected for yourself and any Dependents, and such individuals have been covered continuously under the Plan, there is no proof of insurability requirement. However, if you are enrolling yourself or a Dependent, and have not been continuously covered under the Plan, you will be required to provide Evidence of Continuous Coverage from the later of:

- Your Severance Date (or LTD End Date); or
- The date you or your Dependent lost coverage under the Plan until the date the newly elected coverage is effective.

Any change made during the Annual Enrollment Period will be effective on January 1 of the following Plan Year. If you’re currently enrolled in a Nationwide-offered health care Coverage Option and you don’t make any changes during the Annual Enrollment Period, you and your Dependents will automatically...
remain in your current Coverage Option. However, if your current Coverage Option is not offered during the subsequent Annual Enrollment Period, you must make a new election or your coverage will default to the Coverage Option described in the Annual Enrollment Period materials. Please note: You are required to re-enroll your eligible Household Members each year. If you fail to re-enroll an eligible Household Member during the Annual Enrollment Period coverage will be deemed "waived" for that individual.

**Important Enrollment Information for Household Members**

Household Members enrolled as of July 31, 2014, are “grandfathered” and may continue coverage as a Household Member until December 31, 2016, as long as they reside with you, continue to meet all Plan eligibility requirements, and you elect to continue their coverage during the Annual Enrollment Period. If Household Member coverage terminates for any reason at any time, you cannot re-enroll the Household Member in coverage under the Plan at a future date.

Household Members not currently enrolled in this Plan (or an Active Health Care Plan) cannot be added to the coverage.

**When Does Active Associate Coverage Terminate**

If you elect coverage under the Plan, your coverage in the Active Health Care Plan will continue through the last day of the calendar month in which your Severance Date (or LTD End Date) occurs.

If you do not elect coverage under the Plan, your Active Health Care Plan coverage will terminate on your Severance Date (or LTD End Date).

**Expatriate Coverage**

Retiree Medical Benefits offered by the Plan are not available as a supplement to any other country’s social insurance system. Therefore, Retired Associates, along with their Dependents, who are eligible for social insurance through any other country, would not obtain a Benefit under the Plan for services, treatment, or payments made by or provided through any other country’s social insurance system. Additionally, individuals who permanently reside outside the United States are not eligible to enroll in the Plan.

**MID-YEAR ENROLLMENTS AND CHANGES**

Coverage can be dropped at any point during the year. All other changes must be made during the Annual Enrollment Period or outside the Annual Enrollment Period if you or your Dependents:

- Experience a Qualified Change in Status; or
- Receive a Qualified Medical Child Support Order (QMCSO) for your Child.
Qualified Change in Status

Mid-year election changes are permissible for a Retired Associate, Surviving Spouse, or a Dependent upon a Qualified Change in Status. Mid-year elections are also permitted for a Medicare Retired Associate, Surviving Spouse, and Dependents if there is a Qualified Change in Status and Medicare rules and regulations permit the change (e.g., Medicare’s special enrollment period.)

A “Qualified Change in Status” means:

- A Change in Dependent Status
  - A change in a former Dependent’s condition whereby the Dependent regains eligibility to participate in the Plan; provided, that such individual satisfied the Plan’s eligibility requirements applicable to Dependents on the Severance Date (or LTD End Date) or, in the case of a newly-born Dependent, the Dependent was born to the Retired Associate within 10 months of the Severance Date (or LTD End Date); or
  - A change in the employment or a significant change in medical coverage of the Retired Associate’s Spouse
- A Loss of Coverage. A “Loss of Coverage” means the loss of other medical coverage that existed at the time coverage under this Plan for such individual was most recently waived, which loss occurred because of:
  - Exhaustion of the period of continuation coverage provided by another plan as a result of the provisions of COBRA
  - Loss of eligibility for coverage under the plan providing the other medical coverage, including a loss of eligibility as a result of divorce, legal separation, death, termination of employment, reduction in the hours of employment, or
  - The termination of employer contributions toward the cost of such other medical coverage
- Access to a new coverage option under the Plan; and
- A loss of Federal or State Health Insurance Marketplace coverage due to an event that is considered to be a qualifying event for purposes of Federal or state Marketplace coverage. This does not include a loss of Federal or state Marketplace coverage due to a voluntary termination of that coverage, including a termination or loss of Marketplace coverage due to failure to pay premiums on a timely basis.

If you have a Qualified Change in Status, you may be able to change your coverage elections. Any change must be appropriate for and consistent with the Qualified Change in Status. The Associate Service Center must receive your election changes within 60 days of your Qualified Change in Status.

A change in coverage is consistent with the Qualified Change in Status only if:

- The Qualified Change in Status results in you or your Dependent(s) losing benefit coverage or results in a significant change in cost of coverage; and
- The election changes to your coverages under the Plan is consistent with the loss of coverage.

You must submit evidence of the Qualified Change in Status. In addition, you must provide Evidence of Continuous Coverage for the individual being enrolled from the later of:

- The Severance Date (or LTD End Date); or
- The date that you or your Dependent first lost coverage under the Plan until the date the newly elected coverage is effective.
Effective Date of Coverage for a Qualified Change in Status

In general, changes to participation in the Plan, including change in coverage, upon a Qualified Change in Status will be effective the first day of the calendar month coincident with or next following the calendar month in which the event occurred if your completed election forms are received by the Associate Service Center within 60 days of the Qualified Change in Status. If you do not change your elections within this time frame, and you are not eligible for Medicare, you will have to wait until the next Annual Enrollment Period to change your elections.

If the Qualified Change in Status is the addition of a Dependent due to that Dependent satisfying the Plan’s eligibility requirements, the date the Dependent satisfies the Plan’s eligibility requirements is the effective date (assuming Evidence of Continuous Coverage has been provided.)

Note, in no event, will a Retired Associate or Surviving Spouse be able to add an individual to coverage under the Plan as a Dependent where that individual:

- Did not satisfy the Plan’s Dependent eligibility requirements on the Retired Associate’s Severance Date (or LTD End Date), or
- Was not born to the Retired Associate or Surviving Spouse within ten months from the Severance Date (or LTD End Date).

Newborn Dependent

A newborn Dependent, born within ten months from the Severance Date (or LTD End Date), will be covered from the Dependents’ date of birth provided the Retired Associate or Surviving Spouse:

- Is enrolled in the Plan; and
- Enrolls the Dependent within 60 days after the date of birth.

Qualified Medical Child Support Orders

There is an exception to the Qualified Change in Status requirements for election changes involving changes as a result of a Qualified Medical Child Support Order (QMCSO). Nationwide must add your Child to your coverage pursuant to a QMCSO. The Child, however, must meet the Plan’s eligibility requirements for Dependents, and you must be enrolled in coverage under the Plan. You may obtain a copy of the QMCSO procedures, free of charge, by making a request to the Plan Administrator.

Changing from Active Associate Status (or COBRA status) to Non-Medicare Retired Associate Status

If you are enrolled in the HSC1 Coverage Option under the Active Health Care Plan (including COBRA), and you enroll in the HSC1 Coverage Option in this Plan, you will be credited for any deductibles and out-of-pocket expenses you incurred during the Plan Year while enrolled in the Active Health Care Plan.
If you are enrolled in the HSC2 Coverage Option under the Active Health Care Plan (including COBRA), and you enroll in the HSC2 Coverage Option in this Plan, you will be credited for any deductibles and out-of-pocket expenses you incurred during the Plan Year while enrolled in the Active Health Care Plan.

**Transfer from Household Member Status to Retired Associate Status**

Retired Associates who transfer from Household Member status to Retired Associate status will have all past service and Plan participation considered as if it were service and participation under the Plan for purposes of, but not limited to, waiting periods, deductibles, coinsurance percentages, and maximum benefits limits for non-Medicare eligibles.

**Transfer from Household Member Status to Dependent**

Individuals who transfer from Household Member status to Dependent status will have all past service and participation under the Plan considered as if it were service and participation under the Plan currently, including but not limited to, waiting periods, deductibles, coinsurance percentages, and maximum benefit limits for non-Medicare eligibles, if otherwise permissible under the terms of the Plan.

In the case of an individual transferring from Household Member status to Dependent status, the individual must have been a Household Member at the time of your Severance Date (or LTD End Date).

**Changing the Type of Coverage During the Plan Year**

You cannot change your Coverage Option during the Plan Year unless you or a covered Dependent becomes eligible for Medicare.

**Transitioning to a Medicare option**

If you or a Dependent become Medicare-eligible due to age or disability, that individual is no longer eligible for coverage under the non-Medicare Coverage Options offered by Nationwide. Enrollment in Medicare Part A and Part B with payment of any required Part B premium is required and you or your Dependent may elect coverage under one of the Medicare Coverage Options at that time. If you are currently enrolled in retiree coverage and do not elect a Medicare Coverage Option when you become Medicare eligible, you will automatically be enrolled in the Medicare Advantage (PPO) Plan (as long as you are enrolled in Medicare Part B and have made the required Medicare Part B contributions.)

**COVERAGE OPTIONS FOR NON-MEDICARE ELIGIBLE PARTICIPANTS**

Non-Medicare eligible Retired Associates, Dependents and Household Members may enroll in one of the self-insured Coverage Options described in this section. If you or your Dependents or Household Members are eligible for Medicare, please see the “Coverage Options for Medicare Eligible Participants” section of this document for information about available coverage.
Coverage Options

Currently, the self-insured non-Medicare Coverage Options under the Plan are:

- Health Savings Choice 1 (HSC1)
- Health Savings Choice 2 (HSC2); and
- Premium Preferred Provider Organization (PPO).

All three Coverage Options listed above include prescription drug coverage.

The HSC1 and HSC2 Coverage Options are high deductible health plans. If you enroll in the HSC1 or HSC2 you may be eligible to contribute to a Health Savings Account (HSA). See IRS Publication 969 for additional details on HSA eligibility.

All options allow you or your covered Dependents the flexibility to use any doctor, hospital, or other medical provider you choose; however it’s important to remember that you will save money by using providers who are part of the network. By selecting a network provider, you will receive the provider’s Negotiated Fee and be eligible for the in-network level of benefits, which will likely lower your out-of-pocket expenses. A list of network providers is available on the Claim’s Administrator’s web site. Please note: Preventive Care services are not covered out-of-network.

If you choose to receive your treatment from a non-network provider, Plan Benefits will be based on the Negotiated Fee with network participating providers. The non-network provider may bill you for the difference between their charges and the Allowable Expense.

As a Retired Associate or Surviving Spouse, you may choose to enroll yourself and any non-Medicare eligible Dependents or Household Members in one of these Coverage Options. Please note that your Dependents who qualify for coverage under the Plan, and who are also not eligible for Medicare, must be enrolled in the same option that you choose.

Summary of Medical Benefits

The attached “Appendix B – 2016 Schedule of Benefits for Non-Medicare Eligible Participants”, section “SB 1.0” provides a detailed summary of the deductibles, out-of-pocket maximums, coinsurance, and copayments for each Coverage Option available under the Plan. Additional Covered Expenses are described in section “SB 1.1” of Appendix B and in the “General Benefit Provisions” and “Medical Benefit Exclusions and Limitations” sections of this document.

Summary of Prescription Benefits

When you enroll in one of the self-insured Coverage Options you will automatically have prescriptions drug coverage; you do not need to enroll for this coverage separately from your medical coverage. Coverage is provided through a network of retail pharmacies and a mail order program.

The attached “Appendix B – 2016 Schedule of Benefits for Non-Medicare Eligible Participants”, section “SB 1.2” provides information about the deductible, coinsurance, copayments, day supply limitations,
generic drug benefits, maintenance drug benefits, genetic testing, generic and specialty drug therapy, and contraceptive drug coverage. Section “SB 1.2” also provides a list of items that are excluded from coverage under the Plan.

**Limitations**

The attached “Appendix B – 2016 Schedule of Benefits for Non-Medicare Eligible Participants”, section “SB 1.3” provides information about Medical Necessity, Prior Authorization and pre-estimates.

**COVERAGE OPTIONS FOR MEDICARE ELIGIBLE PARTICIPANTS**

Medicare eligible Retired Associates, Dependents and Household Members may enroll in one of the insured Coverage Options described in this section. If you or your Dependents or Household Members are not eligible for Medicare, please see the “Coverage Options for Non-Medicare Eligible Participants” section of this document for information about available coverage.

**Coverage Options**

Currently, the insured medical Coverage Options under the Plan include a Medicare Advantage PPO and two health plans that supplement Medicare parts A and B coverage (Senior Supplement Standard Plan F and Senior Supplement Standard Plan K). As a Retired Associate or Surviving Spouse, you may choose to enroll yourself and any Medicare eligible Dependents or Household Members in one of these Coverage Options.

In addition to the medical Coverage Options, you may choose to enroll in one of the two insured prescription drug plan options. Both options qualify as creditable coverage. See the “Summary of Prescription Benefits” section below for more information.

Coverage is not automatic. You must enroll to receive benefits. You must be enrolled in Medicare Parts A and B to be eligible to enroll for coverage. Please note that your Dependents who qualify for coverage under the Plan, and who are also eligible for Medicare, must be enrolled in the same option that you choose.

If you or any of your Dependents are currently enrolled in a non-Medicare eligible Coverage Option and later become Medicare eligible, you or your Dependents will be automatically enrolled in the same Medicare Coverage Option as other Participants you are covering. If none of the Participants you are covering are enrolled in a Medicare Coverage Option, you will be automatically enrolled in the Medicare Advantage PPO option under the Plan unless you make a different election within the timeframe specified in this Plan.

**Summary of Medical Benefits**

The attached “Appendix C – 2016 Schedule of Benefits for Medicare Eligible Participants” section “SB 2.1”, “SB 2.2”, and “SB 2.21”, provides detailed summaries of the deductibles, out-of-pocket maximums, coinsurance, and copayments for the Medicare Advantage PPO, the Senior Supplement Standard Plan F, and the Senior Supplement Standard Plan K Coverage Options available under the Plan.
Additional benefits and exclusions are described in the “General Benefit Provisions” and “Medical Benefit Exclusions and Limitations” sections of this document. The insured Coverage Options are also subject to the benefits and coverage rules, including any applicable limitations and restrictions, described in the applicable Evidence of Coverage that you will receive once you are enrolled.

**Summary of Prescription Benefits**

When you enroll in one of the insured Medicare-eligible Coverage Options, you will also have the opportunity to enroll in a Nationwide-offered prescription drug plan. Coverage is not automatic; you will need to enroll separately from your medical coverage. If you waive Nationwide-offered medical coverage, you also waive the opportunity to elect Nationwide-offered prescription drug coverage.

Prescription drug coverage that is available to individuals who are eligible for Medicare is classified as either creditable or non-creditable. The creditable classification simply means that the prescription drug coverage is designed so that on average, it is expected to pay out as much as standard Medicare prescription drug coverage would pay. It’s important because if your coverage is considered non-creditable, you could pay more for your Medicare prescription drug coverage later.

Nationwide currently offers access to two prescription drug plans (PDP). Both options qualify as “creditable coverage”.

If you enroll in the Medicare Advantage (PPO) Plan, under Medicare’s rules you are only eligible for the Nationwide-offered drug plans. You will not be able to choose a non-Nationwide-offered prescription drug plan. Medicare does not allow you to have both a Medicare Advantage PPO plan and a separate Medicare Part D prescription drug plan. Therefore, if you select a non-Nationwide-offered prescription drug plan, Medicare will disenroll you from your Medicare Advantage PPO Plan and you may also lose your medical coverage.

If you choose to enroll in one of the Senior Supplement Plans, you have a choice — you may enroll in one of the two prescription drug plans through Nationwide, choose an alternate prescription drug plan, or choose not to participate in any plan at all.

Please note: To avoid late enrollment penalties, you must have continuous coverage through a Medicare Part D plan or other creditable prescription drug coverage from the time you first become eligible for Medicare Part D.

The attached “Appendix C – 2016 Schedule of Benefits for Medicare Eligible Participants”, section “SB 2.3” provides information about the deductible, coinsurance, copayments, day supply limitations, coverage gap, and catastrophic coverage.

**GENERAL BENEFIT PROVISIONS**

The following provisions apply to non-Medicare Participants. If you are a Medicare Participant, consult the Evidence of Coverage document for more information about these services. If you need a copy of this document, please contact the Claims Administrator listed in the “Administrative Detail” section of this SPD.
Hospital Stay for New Mothers and Newborn Child

The hospital stay of a new mother and her newborn child will not be limited to fewer than 48 hours in the event of a normal vaginal delivery or 96 hours in the event of a delivery by caesarean section, provided, however, that, in the event the mother’s Physician, in consultation with the mother, shall determine that a stay of such length is not necessary, the stay may be shortened.

Coverage for Reconstruction After Mastectomy

Coverage is provided for reconstructive breast surgery after a mastectomy. This includes surgery to reconstruct the unaffected breast to produce a symmetrical appearance. Prostheses and treatment for physical complication at all stages of a mastectomy is covered, including lymphodemas.

How to Receive Benefits

Medical
In most cases, your doctor or treating provider will bill the Plan directly. If your doctor or treating provider does not bill the Plan directly, you should submit the bills to the Claims Administrator. Please make sure that you include all pertinent information, such as name, ID number, and Social Security number, when filing your claim. All of the information needed to file your claim can be found on your health care card, if you have been provided one.

Prescription Drug Retail
To use your prescription drug Benefit at a retailer, you may need to present your Retail Rx ID card to any participating pharmacy. The pharmacist will fill the prescription and only charge you the co-payment amount per prescription. There are no claim forms for you to file.

If a pharmacist cannot determine your eligibility or has any questions regarding your prescription, they will call or contact the Pharmacy Benefits Manager (PBM) for authorization.

Prescription Drug Mail Order
Initially, to have a prescription filled by mail order service, you must send your original prescription along with a form to the PBM. If you do not have the mail service order form, you can request one from the Associate Service Center. Subsequent prescriptions can be refilled by calling the PBM. Oral specialty medications must be purchased through the PBM specialist pharmacy instead of through the retail or mail order program. Contact CVS/Caremark at www.cvscaremarkspecialtyrx.com for specialty pharmacy information.

MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to non-Medicare Participants. If you are a Medicare Participant, consult the Evidence of Coverage document for information about exclusions and limitations.

The Plan will not pay Benefits for Expenses Incurred or losses sustained:

- While committing or attempting to commit a felony
• While engaging in an illegal occupation
• While on active duty with the armed forces of any sovereign power, including but not limited to the United States or any state territory or foreign government
• As a result of treatment in connection with a Pregnancy or childbirth as a surrogate mother
• As a result of donating organs for transplant unless donated to or on behalf of a member of the Participant’s immediate family
• For treatment, services, or supplies which are otherwise provided at no cost to a Participant, and which are provided by the United States government, the government of any other nation, any of their agencies, a state, province, or other political unit of any such governments
• For treatment, services, or supplies furnished by or for the United States Government or any of its agencies, except that Benefits covered by this Plan will be paid for:
  o Care for a non-service related condition by a Veteran's Administration Hospital on or after April 7, 1986
  o Care by a military Hospital to the Participant, if the Participant is an armed services retiree, rendered on or after October 1, 1986
• To the extent that Covered Expenses are in excess of the Allowable Expense
• For treatment which has not been approved by a Physician
• To the extent that Benefits payable under more than one provision of this Plan would be more than the actual Expense Incurred or the Allowable Expense
• For which the Participant is not legally required to pay
• Which do not meet the criteria set forth in Code Section 213
• Which are otherwise covered under this Plan to the extent such benefits would exceed any annual or lifetime maximums
• Any state mandated benefit not otherwise provided under the terms of the Plan
• Any charges which exceed the cost of the most medically appropriate and cost-effective course of treatment or durable equipment, as determined by the Plan Administrator or Claims Administrator, as applicable
• For the administration of drugs, unless included in the Benefits described in the Plan
• Over-the-counter nutritional and electrolyte supplements, including those used for enteral feedings unless included in the Benefits described in this Article or unless administered in a Hospital
• Over-the-counter infant formula
• For a private Hospital room, unless a semi-private room is unavailable
• For non-prescription contraceptive supplies
• Due to Cosmetic Treatment
• For medical examinations or treatments which are not Medically Necessary for the treatment of an Injury or Sickness, or which are not Preventive Care
• For Experimental Treatment, including Experimental Treatment for which the cost is provided in whole or in part by any local, state, or federal government or private agency. The fact that an Experimental or investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or investigational or unproven in the treatment of that
particular condition. This exclusion does not apply to Eligible Expenses provided during a Clinical Trial for which Benefits are provided as described herein

- For Custodial Care
- For marriage counseling
- For non-covered items, including, but not limited to, treadmills, exercise equipment, health club memberships, van lifts, chairlift, stair-lift, air conditioners, humidifiers, dehumidifiers, and vaporizers
- By a Participant donating organs for transplant
- Habilitative Treatment for Participants over age 19
- Day treatment, unless recommended by the Claims Administrator in lieu of Inpatient Confinement
- For eye examinations, refractions, eyeglasses, contact lenses, hearing aids or the fitting of any of these, unless part of Wellness Benefits
- For Friday and/or Saturday room and board charge when admission to a Hospital is made on a Friday or a Saturday. This exclusion is waived in an Emergency, if surgery or tests that are not possible on an Outpatient basis are performed on the day of admission or the following day, or if there is an underlying medical condition necessary for such admission, or otherwise in accordance with the Claims Administrator’s standard guidelines
- For room and board charges when an Outpatient Surgery is performed on an Inpatient basis provided; however, that this exclusion will be waived if documentation satisfactory to the Plan Administrator is furnished that the hospitalization was necessary
- For bereavement, financial, legal counseling or other services which are not related to the care of the hospice patient
- For family planning procedures such as in vitro fertilization, embryo transfer, artificial insemination, and all procedures included, and including any similar types of procedures
- For supplies or equipment given, for a charge, to a Participant to take home without Prior Authorization of the need for such supplies or equipment
- For nutrition counseling services, unless otherwise described in this Plan or provided for in accordance with the Claims Administrator’s standard guidelines
- For personal convenience or comfort items, including those provided while confined to a Hospital
- For computerized communications devices
- For vocational therapy
- For childbirth classes
- Routine foot care, such as treatment and care of calluses, flat feet, fallen arches, chronic foot strain, corns, bunions (except capsular or bone surgery), toenails (except for surgery for ingrown nails). This exclusion does not apply to pre- and post-operative diagnostic procedures related to open cutting procedure by a podiatrist
- For hypnosis, biofeedback, treatment of stress, therapy through behavior modification techniques and psychoanalysis
- For sex therapy
- For intelligence quotient and similar testing, unless such testing is neuropsychiatric testing when used as part of a neurological evaluation to diagnose Injury or Illness
- For treatment rendered as a pre-condition to court ordered parole, probation custody or visitation evaluation
- For care required to obtain or continue employment or for insurance, marriage or adoption (tests, examinations, immunizations, etc.)
- For orthoptic therapy, visual training or radial keratotomy, Lasik or other surgical procedures intended to eliminate or reduce the need for corrective lenses
- For massage therapy, including aquatic therapy
- Inpatient physical medicine rehabilitation
- Private duty nursing service where assigned solely to provide one-on-one service
- Acupuncture
- Temporomandibular joint dysfunction (TMJ), except as determined under the Claims Administrator’s standard medical guidelines. This exclusion will apply to intra-oral devices or any other non-surgical method to alter the occlusion and/or vertical dimension of teeth and jaw in connection with TMJ
- Hearing exams and hearing aids, except in the following situations:
  - When diagnosing and treating hearing loss which occurs directly from diseases including, but not limited to, Meniere’s disease, acoustic neuroma, otosclerosis, and cholesteatoma
  - When monitoring for complications or side effects directly resulting from treatment of a specific disease, including but not limited to brain tumor, acoustic neuroma, otosclerosis, cholesteatoma, or ototoxic pharmaceuticals; or
  - When conducting a comprehensive audiometric examination for a child age 12 or younger
- Coverage of bariatric surgery will be limited to Participants who meet generally accepted medical criteria applied in such situations, including but not limited to, a review by medical staff, and conformance to the Claims Administrator’s standard medical guidelines.

EMPLOYER CONTRIBUTION TO RETIREE PLAN COVERAGE

As a Retired Associate, you are responsible for paying all costs associated with the Coverage Option you elect, but you may be eligible for “cost-sharing.” Cost-sharing is a term that describes Nationwide’s method of providing company financial support for retiree health care coverage and it means that Nationwide pays a portion of the cost of the health care coverage during retirement.

Eligibility for Cost-Sharing for Those Hired Before June 1, 2000

You are eligible for Employer cost-sharing if:
- You were hired before June 1, 2000
- You remain continuously employed or receiving LTD benefits after June 1, 2000 until your Severance Date (or LTD End Date)
- Your Severance Date (or LTD End Date) occurs after reaching age 55 (or age 52 or older if you are involuntarily terminated as a result of job elimination as defined in the Nationwide Severance Pay Plan); and You are credited with at least 180 Months of Retiree Medical & Life Eligibility Service.
A Surviving Spouse of an Active Associate who did not meet the eligibility requirements for cost-sharing on the date of death is not eligible for cost-sharing.

A Surviving Spouse of an Active Associate who did meet the eligibility requirements for cost-sharing on the date of death is eligible for cost-sharing on the same basis as the Retired Associate.

**Eligibility for Cost-Sharing for Those Hired On or After June 1, 2000**

If you were hired or rehired on or after June 1, 2000, you are not eligible for Employer cost-sharing, unless:

- You were eligible for coverage as a Retired Associate upon your initial Severance Date (or LTD End Date) and you can provide Evidence of Continuous Coverage for the period beginning the first of the month following the date of your initial Severance Date (or LTD End Date) to the date of the most recent rehire; or
- Your termination of employment occurred after January 1, 2005, your termination was due to an involuntary termination as a result of job elimination as defined in the Nationwide Severance Pay Plan, and you are rehired within 90 days of your termination date.

**Company Financial Support**

The amount, if any, that Nationwide will contribute toward a Retired Associate’s coverage is based on the Retired Associate’s:

- Date of hire
- Severance Date (or LTD End Date)
- Medicare eligibility; and
- Number of Months of Retiree Medical Cost-Sharing Service completed, which is capped at the lesser of:
  - 25 years; or
  - The amount of cost-sharing service that was credited as of December 31, 2009.

The Employer contribution amount will also be based on whom the Retired Associate elects to cover, the Medicare eligibility of those covered, and whether any “grandfather” provisions apply. For example, separate contribution schedules have been maintained for former Provident and Allied associates. This Employer contribution is subject to a maximum dollar amount that the Company will contribute each month toward the cost of your medical coverage. See the “Maximum Employer Contribution” section of this document for more information.

The Retired Associate pays all costs that are in excess of the Employer contribution. The Employer contribution is not affected by the Coverage Option that the Retired Associate elects. Information about Coverage Option cost and the Employer contribution, if applicable, will be communicated at the time the Retired Associate commences coverage and during each subsequent Annual Enrollment Period. Any such contributions shall be made on a basis which does not discriminate in favor of Highly Compensated Individuals, as that term is used in Internal Revenue Code Sections 105 and 125, or Key Employees, at that term is used in Internal Revenue Code Section 125(b)(2).
**Maximum Employer Contribution**

The amount, if any, that Nationwide will contribute toward a Retired Associate’s medical and prescription coverage under the Plan is subject to a maximum amount. This maximum amount is referred to as the "Maximum Employer Contribution." This fixed monthly amount, as reflected in the Schedule of Retiree Medical Cost-Sharing will not be increased. However, the Employer contribution that you receive will change if you change your coverage election or if you or a Dependent becomes Medicare-eligible. Separate maximum employer contribution schedules have been maintained for former Provident and Allied acquisition associates.

Once you retire, you will be notified each year during the Annual Enrollment Period of your contribution, the Employer contribution, and the Employer maximum contribution as they apply to you.

These cost-sharing provisions, like the rest of the Plan provisions, may be altered or amended from time to time or the Plan may be terminated at any time.

**Pension Deduction and Direct Billing**

Contributions for the cost of coverage under the Plan may be made by way of withholding from your pension benefit or direct billing. A Retired Associate or Surviving Spouse, as applicable, must elect to reduce her pension benefits under the Retirement Plan for the amount of contributions required to pay for the Coverage Option elected at the time such coverage is elected. If the amount of contributions required to pay for the Coverage Option is greater than her pension benefit under the Retirement Plan, she will be direct billed instead.

The cost of prescription drug coverage for Medicare-eligible Participants cannot be deducted from your pension, and therefore you will be direct billed by the Claims Administrator. You will be billed for the amount in excess of the company contribution, if any.

**Health Reimbursement Account**

If you are eligible for cost-sharing, are Medicare-eligible, and you enroll in one of the Senior Supplement Coverage Options offered under the Plan, but waive prescription drug plan coverage, the Company will contribute $35 per month to your Health Reimbursement Account (HRA) for each Medicare-eligible individual who is enrolled and waives prescription coverage.

If you are eligible for cost-sharing, are Medicare-eligible, but waive coverage under the Plan, the Company will contribute $70 per month to your HRA for each Medicare-eligible individual who enrolls in an individual Medicare Advantage medical plan outside of the Plan.

HRA funds can be used to pay for any eligible health care expense and Medicare Part B and D premiums. Prescription drugs are not an eligible health care expense.

Contact the Associate Service Center for details and refer to the Nationwide Retiree Health Reimbursement Account Plan Summary Plan Description for further information.

Harleysville Associates, please see information regarding your company financial support in the “Special Provisions for Acquisition Associates” section below.
Retiree Health Care Credit Program

Retired Associates who participated in the Retiree Health Care Company Credit Program as an Active Associate may receive a monthly deposit to an HRA when eligible for Medicare for any credits earned. For information about this program, please refer to the Retiree Health Care Company Credit Program Summary Plan Description. A copy of this document can be obtained by contacting the Associate Service Center.

Special Provisions for Acquisition Associates

Allied

As an “Allied Retiree”, you are subject to the Allied cost share schedules and rates. Dependents, other than your Spouse, are not eligible for coverage.

You are considered an “Allied Retiree” if you meet the following conditions and elect the Allied retiree benefits/cost structure:

- You were an Allied associate on or before December 27, 1998 and severed employment prior to January 1, 2014
- You remained continuously employed by Allied/Nationwide since the acquisition until your Severance Date (or LTD End Date)
- Your Severance Date (or LTD End Date) occurred after reaching age 55 (or age 52 or older if you are involuntarily terminated as a result of job elimination as defined in the Nationwide Severance Pay Plan); and
- Your combined Allied and Nationwide Months of Retiree Medical & Life Eligibility Service is equal to or greater than 60 months but less than 120 months when you retire. (If you were employed by Allied prior to December 28, 1998, you will be credited with up to 60 Months of Retiree Medical & Life Eligibility Service.)

If you are credited with 120 or more Months of Retiree Medical & Life Eligibility Service, you will be considered a Retired Associate and not an Allied Retiree.

Please contact the Associate Service Center to confirm whether you are eligible for Medical Benefits as an Allied Retiree.

CalFarm

You are eligible for Employer cost-sharing if:

- You remain continuously employed since the acquisition until your Severance Date (or LTD End Date)
- Your Severance Date (or LTD End Date) occurs after reaching age 55 (or age 52 or older if you are involuntarily terminated as a result of job elimination as defined in the Nationwide Severance Pay Plan); and
- You are credited with at least 180 Months of Retiree Medical & Life Eligibility Service.
CalFarm acquisition associates who meet the criteria outlined above will receive credit for their combined pre-acquisition CalFarm service and nationwide service when calculation cost-sharing.

**Provident**

You are eligible for Employer cost-sharing if:

- You remain continuously employed since the acquisition until your Severance Date (or LTD End Date)
- Your Severance Date (or LTD End Date) occurs after reaching age 55 (or age 52 or older if you are involuntarily terminated as a result of job elimination as defined in the Nationwide Severance Pay Plan); and
- You are credited with at least 120 Months of Retiree Medical & Life Eligibility Service.

A “Provident Retiree” is eligible for special Provident cost-sharing. The Number of Months of Retiree Medical Cost-Sharing Service completed is capped at 30 years.

**Harleysville**

For the majority of Harleysville Associates, Company financial support is only available through the Nationwide Retiree Health Care Credit program. See the “Retiree Health Care Company Credit Program Summary Plan Description” for more information.

Company financial support may be available at age 65 if you were hired by Harleysville prior to January 1, 1993 and have at least 20 years of Harleysville service as of December 31, 2012. The Company will make a contribution to a Health Reimbursement Account (HRA) based on your years of service with Harleysville as of December 31, 2012. No additional cost-sharing service will accrue after 2012.

<table>
<thead>
<tr>
<th>Annual Company Contribution (age 65 &amp; Over)</th>
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<tr>
<td><strong>Years of Service</strong></td>
<td><strong>Amount</strong></td>
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<td>25 - 29</td>
<td>$587</td>
</tr>
<tr>
<td>Under 25</td>
<td>$528</td>
</tr>
</tbody>
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The Company financial support will be credited to an HRA, beginning the later of the month in which your employment ends or the month in which you reach age 65.
TERMINATION OF COVERAGE

Termination of a Retired Associate’s or Surviving Spouse’s Coverage

As a Retired Associate or Surviving Spouse, your coverage under this Plan will end on the earliest of the following:

- The last day of the Pay Period (or if direct billed, the last day of the period of the bill) for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due
- The earlier of:
  - The last day of the Pay Period (or last day of the period of bill), or
  - The last day of the Plan Year
  in which you voluntarily cancel coverage
- The date the Plan terminates, either in whole or for your group; or
- The date you are incarcerated.

If enrolled in a Medicare Coverage Option, coverage under this Plan will end the later of:

- The terms described above; or
- As permitted by CMS rules.

Termination of a Dependent’s Coverage

Coverage under the Plan for Dependents will end on the earliest of the following:

- The date the Retired Associate’s or Surviving Spouse’s coverage ends if it ends for a reason other than the individual’s death (see “Coverage for Dependents after Your Death” section)
- The last day of the Pay Period (or if direct billed, the last day of the period of the bill) for which the last contribution is made, if the Retired Associate or Surviving Spouse fails to make any required contribution towards the cost of coverage for her Dependents when due
- The date the Plan is amended to eliminate all Dependent coverage
- The earlier of:
  - The last day of the Pay Period (or last day of the period of bill), or
  - The last day of the Plan Year
  in which the Retired Associate or Surviving Spouse voluntarily cancels her Dependent coverage; or
- The day on which the Dependent no longer meets the definition of a Dependent or satisfies the Plan’s eligibility requirements; provided, however, that coverage for a Dependent who becomes an Active Associate will not end until such individual is eligible for coverage as an Active Associate.
Payment of Benefits after Termination of Coverage

No Benefit will be paid after coverage terminates except for Expenses Incurred for service rendered before the termination of coverage.

Extension of Medical Coverage for Hospital Confined Persons

For non-Medicare Coverage Options or as required under Medicare, if a Participant is confined in a Hospital at the time of termination and incurring expenses before the day coverage under the Plan ends, coverage for the Sickness or Injury causing the Confinement will be extended until the individual is discharged from the Hospital.

Coverage for Dependents after Your Death

If a Retired Associate dies and is survived by Dependents covered under the Plan on her date of death, the Company will continue coverage of those Dependents through the last day of the calendar month in which the death occurs. Such Dependents may elect COBRA, or in lieu of COBRA, may continue coverage under the Plan.

If a Retired Associate dies and is survived by Dependents not covered under the Plan on her date of death, such Dependents may elect coverage under the Plan per this provision provided the Dependents elects coverage within 60 days from such date of death and can provide Evidence of Continuous Coverage.

If an Active Associate who was eligible to retire on her date of death dies and is survived by Dependents not covered under the Plan on her date of death, such Dependents may elect coverage under the Plan per this provision provided the Dependents elects coverage within 60 days from such date of death and can provide Evidence of Continuous Coverage. The Dependents will be eligible to enroll in one of the retiree Coverage Options.

Surviving Dependents may not elect coverage once coverage has been waived or the 60 day election period has passed, except as otherwise provided by the Plan’s terms.

Surviving Dependents can continue coverage until the earliest of the following dates:

- Failure to pay any applicable contribution within 30 days of its due date
- The date the Plan is amended to eliminate all Dependent coverage or the date on which coverage for the Surviving Spouse’s or Retired Associate’s class is eliminated, as applicable
- The end of the month in which the Surviving Spouse or Dependent Child tells the Plan Administrator to cancel coverage if it is voluntarily canceled.
- With respect to the Surviving Spouse, the date she becomes covered by other health coverage, other than Medicare; or
- With respect to a surviving Dependent Child
  - The date she is no longer a Dependent; or
  - The end of the month in which the Surviving Spouse dies or is no longer covered under the Plan.
If You Are Rehired

If you are rehired as an Active Associate while covered under this Plan, your coverage under this Plan will terminate on the last day of the calendar month that you became eligible for active coverage. You may enroll in the Employee Health Care Plan (“Active Plan”) in the manner and form permitted under the Active Plan (see the Employee Health Plan for Active Associates and LTD Recipients Summary Plan Description for specific details).

CONTINUATION OF COVERAGE

In General

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires Nationwide to provide a Qualified Beneficiary under the Plan the right to elect to continue coverage if the Qualified Beneficiary loses coverage under the Plan due to certain Qualifying Events. This continuation of coverage is referred to as “COBRA Coverage.”

The maximum period of COBRA Coverage is 36 months, but it may be terminated early for the reasons stated in the Plan. If you lose coverage for any reason other than a Qualifying Event, COBRA Coverage will not be extended to you or your covered Dependents under this Plan.

The terms “Qualified Beneficiary” and “Qualifying Events” have very specific meanings, which are described in more detail below.

Qualified Beneficiary

Only Qualified Beneficiaries have the right to elect COBRA continuation coverage on their own behalf. To be considered a “Qualified Beneficiary,” a Dependent must be covered under the Plan on the day before the Qualifying Event. In addition, your newborn or newly adopted child will be considered a Qualified Beneficiary if he or she is enrolled within 60 days of their birth or adoption. Any other Dependent who was not covered immediately prior to the Qualifying Event will not be treated as a Qualified Beneficiary, even if he or she is enrolled for coverage under the Plan at a later time.

You and your covered Dependents will be considered a Qualified Beneficiary only with respect to the coverages that are in effect on the date of the Qualifying Event.

Qualifying Events

The following events, referred to as “Qualifying Events,” trigger the entitlement to COBRA Coverage if the occurrence of the event causes a loss of group coverage under the Plan:

- You get a divorce from your Spouse or your Domestic Partner is no longer eligible*;
- You die; or
- Your Dependent Child reaches the limiting age under the Plan (i.e., last day of the calendar year in which your child turns age 26).*
You or the Dependent must notify the Plan Administrator within 60 days from the later of the Qualifying Event or the date when coverage is lost in order to receive a COBRA election form. This should be done by contacting the Associate Service Center at 877-766-7231.

**Coverages Available**

Your COBRA Coverage will be the same coverage option in which you were enrolled at the time of the Qualifying Event. You cannot change your coverage election until the next Annual Enrollment Period, except in the event of a Qualified Change in Status.

**Notice of COBRA Continuation Coverage and Electing COBRA Continuation Coverage**

Once Nationwide receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries.

If coverage for your Dependents ends because you get a divorce or legal separation from your Spouse or your Dependent Child reaches the limiting age under the Plan (i.e., last day of the calendar year in which your child turns age 26), you, your Spouse, or your Dependent, as applicable, must notify Nationwide within 60 days of the Qualifying Event or the date coverage is lost, which ever is later, in order to receive a COBRA election form. This can be done by contacting the Associate Service Center. If you or your Dependent do not contact Nationwide within the 60-day period, the effected Dependent will no longer be considered a Qualified Beneficiary and will not be allowed to elect COBRA coverage.

A Qualified Beneficiary must elect COBRA continuation coverage in writing within 60 days after the date your group coverage ends or the date on the COBRA election notice you receive, whichever is later. For each Qualified Beneficiary who elects COBRA continuation coverage, coverage will begin on the date of the qualifying event or the date the Plan coverage would otherwise have been lost, whichever is later.

**Required Contributions**

The required contribution for continuation coverage is 102% of the total cost of the health care coverage. The first month of coverage (if it is a partial month) will be prorated. The Surviving Spouse or Dependent must pay the appropriate cost of such coverage.

**Maximum Period of COBRA Continuation Coverage**

COBRA continuation coverage is a temporary continuation of coverage. The maximum period of continuation coverage is 36 months.

**When COBRA Continuation Coverage Ends**

Continuation coverage will end on the earliest of the following:
- The date the Dependent obtains other group coverage
- The date the Dependent becomes entitled to Medicare benefits after electing COBRA
• The date the Dependent cancels coverage or fails to make the required contribution
• The date the Plan terminates and the coverage is not replaced by similar coverage; or
• The date that is 36 months after you begin COBRA coverage.

HOW TO FILE AN INITIAL CLAIM FOR BENEFITS

If you are a Participant in one of the insured Coverage Options available to Medicare eligible participants, your claims will be decided by the Claim Administrator in accordance with the Claims Administrator’s internal procedures.

For non-Medicare Coverage Options, a Claim for Benefits is a written request to the Claims Administrator for a Plan benefit. In most cases, your service provider will submit a Claim for Benefits on your behalf.

Claims for Benefits under the Plan are divided into four types:

1. Post-service Claims
2. Pre-service Claims
3. Urgent Care Claims; and
4. Concurrent Care Decisions.

The date by which a Claim for Benefits must be submitted to the Claims Administrator and the timeframe for making a decision on your claim is dependent on the type of claim.

Post-Service Claims

Post-Service Claims are those claims that are filed for payment after medical care has been received. In addition, a claim for prescription drug benefits and any claims for Medical Benefits occurring before the treatment or service is received, but is not otherwise considered under the Plan’s terms to be a Pre-Service Claim or Urgent Care Claim, will be considered a Post-Service Claim. In general, you should file Post-Service Claims with the Claims Administrator within one (1) year of the date the expense is incurred unless it is a claim for prescription drug benefits, in which case you will have 90 days from the date the expense is incurred. The Plan Administrator may make an exception if the current or former Participant provides adequate proof, within a reasonable period of time following the expiration of the one (1) year limitation, setting forth the specific reasons why the requirement could not be met.

If the Claims Administrator denies your Post-Service claim, you will receive a written or electronic notice from the Claims Administrator within 30 days of receipt of the claim, as long as you provided all of the information necessary to process the claim. If the Claims Administrator needs additional information to process your claim, they will notify you within this 30-day period. You then have 45 days from your receipt of the notice to provide the required information. If the Claims Administrator receives all of the needed information within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after receipt of the requested information. If you do not provide the needed information to the Claims Administrator within the 45-day period, the Claims Administrator will deny your Claim for Benefits.

If it is beyond the control of the Claims Administrator to make a decision within the original 30-day period, the Claims Administrator may extend the 30-day period by a period not longer than 15 days. You will be notified of the extension before the original 30-day period ends. The notice will include the reason for the extension and the date by which the Claims Administrator expects to make a decision.
In general, a denial notice will explain:

- The reason for the Adverse Benefit Determination
- Refer to the part of the Plan or other documents governing the Plan on which the determination is based
- Provide a description of additional material or information needed to perfect the claim and an explanation of why this information is necessary
- Include a description of the Claims Administrator's review procedures; and
- Provide claim appeal procedures.

If you have prescription drug coverage and are asked to pay the full cost of a Prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Plan, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures to the Plan Administrator. Also, if you pay a co-payment and believe that the amount of the co-payment is incorrect, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures to the Plan Administrator. When you file a claim, your claim will be processed under the same procedures for Post-service group health plan claims as described in this Section.

**Pre-Service Claims**

Pre-Service Claims are claims for Medical Benefits that require approval before obtaining medical care. You should file your Pre-Service Claim with the Claims Administrator. If you file an incomplete Pre-Service Claim, the Claims Administrator will notify you of the deficiency and inform you of any additional information necessary within five days after the Claims Administrator receives the claim.

If you properly submit your Pre-Service Claim with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of claim. If the Claims Administrator needs additional information to process your claim, they will notify you of the information needed within this 15-day period. You then have 45 days to provide the required information. If the Claims Administrator receives all of the needed information within the 45-day time frame, the Claims Administrator will notify you of its claim determination within 15 days after receipt of the requested information. If you do not provide the needed information within the 45-day period, the Claims Administrator will deny your Claim for Benefits.

If it is beyond the control of the Claims Administrator to make a decision within the original 15-day period, the Claims Administrator may extend the 15-day period by a period of not longer than 15 days. You will be notified of the extension before the original 15-day period ends. The notice will include the reason for the extension and the date by which the Claims Administrator expects to make a decision.

In general, a denial notice will explain:

- The reason for the Adverse Benefit Determination
- Refer to the part of the Plan or other documents governing the Plan on which the determination is based
- Provide a description of additional material or information needed to perfect the claim and an explanation of why this information is necessary
- Include a description of the Claims Administrator's review procedures; and
- Provide claim appeal procedures.
**Urgent Care Claims**

Urgent Care Claims are those claims that require notification or a benefit determination before receiving medical care and either:

- A delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function; or
- In the opinion of a Physician with knowledge of your medical condition, could cause severe pain that cannot be adequately managed without the care or treatment that is subject of the claim.

You should file your Urgent Care Claims with the Claims Administrator. You may submit the claim via facsimile or call the number listed on your health care card. If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the deficiency and inform you of any additional information necessary within 24 hours after the Claims Administrator receives the claim.

If you properly submit your Urgent Care Claim, you will receive written notice of the claim decision from the Claims Administrator within 72 hours of receipt of the claim, unless the Claims Administrator needs additional information to process your claim. If additional information is required, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. If the Claims Administrator receives all of the needed information within the 48-hour time frame, the Claims Administrator will notify you of the determination within 48 hours after receipt of the requested information. If you do not provide the needed information within the 48-hour period, the Claims Administrator will deny your Claim for Benefits.

In addition, if it is beyond the control of the Claims Administrator to make a decision within the 72-hours period, the Claims Administrator may extend the 72-hour period by a period of not longer than 48 hours. You will be notified of the extension before the original 72-hour period ends. The notice will include the reason for the extension and the date by which the Claims Administrator expects to make a decision.

A notice of denial may be oral with a written or electronic confirmation to follow within three days. In general, a denial notice will explain:

- The reason for the Adverse Benefit Determination
- Refer to the part of the Plan or other documents governing the Plan on which the determination is based
- Provide a description of additional material or information needed to perfect the claim and an explanation of why this information is necessary
- Include a description of the Claims Administrator’s expedited review procedures; and
- Provide claim appeal procedures.

**Concurrent Care Decisions**

Concurrent Care is an ongoing course of treatment to be provided over an approved period of time or for an approved number of treatments. Any reduction or termination by the Plan or Claims Administrator of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an Adverse Benefit Determination. The Claims Administrator will notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the approved treatment is reduced or terminated.
If your request to extend the course of treatment is an Urgent Care Claim, as defined above, the Claims Administrator will notify you of their decision within 24 hours after receipt of your request, provided your request is made at least 24 hours before the end of the prescribed period of time or number of treatments. If your request to extend an approved treatment is an Urgent Care Claim but it is not made at least 24 hours before the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above for Urgent Care Claims.

If you request to extend an Approved Treatment in a non-urgent circumstance, the Claims Administrator will consider your request to be a new claim and process the claim in accordance with the Post-Service Claim or Pre-Service Claim timeframes, whichever applies.

**HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION**

If you are a Participant in one of the insured Coverage Options available to Medicare eligible participants, your appeal of an Adverse Benefit Determination (a “denied claim”) will be decided by the Claim Administrator in accordance with the Claims Administrator's internal procedures for such appeals.

The information in this section applies to appeals of denied claims for non-Medicare eligible Participants. The Claims Administrator will decide all levels of appeals for denied claims, except for those involving Plan enrollment and eligibility appeals, which will be determined by the Plan Administrator.

**Claim Denial**

If your initial Claim for Benefits is denied in whole or part, you may submit a written request for reconsideration of that decision (an “appeal”). Your appeal must be submitted, in writing, within 180 days after you receive notice of the claim denial. The review of your appeal will take into account all written comments, documents, records, and any other information that you submit to the Claims Administrator, without regard to whether such information was submitted or considered during the initial benefit determination. Your appeal should be submitted as follows:

- Appeals for enrollment or eligibility matters should be filed with the Plan Administrator.
- Appeals for Medical Benefits or prescription drug benefits should be filed with the Claims Administrator.

**Appeal Process**

Except for enrollment and eligibility matters and Urgent Care Claims, the Plan provides two levels of internal appeal. For all appeals, whether first or second level, the Claims Administrator will appoint a qualified individual(s), who was not involved in deciding the initial claim nor is the subordinate of such individual, to decide the appeal. The Claims Administrator may consult with or seek the participation of medical or other experts as part of the appeal resolution process. By submitting an appeal, you consent to this referral and the sharing of pertinent medical claims information. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination nor is the subordinate of such individual. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your Claim for Benefit.
**Appeal Determinations — First Level Appeal**

The Claims Administrator will provide you with a written notification, which may be via electronic means, of their decision of your appeal as follows:

- For appeals of Pre-Service Claims, the review will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of Post-Service Claims, the appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.
- For appeals of Urgent Care Claims, see the “Urgent Care Claim Appeals that Require Immediate Action” section below.

Please note that the appeal decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure.

**Appeal Determinations — Second Level Appeal**

If you are not satisfied with the decision following your first appeal, you have the right to request a second level of appeal from the Claims Administrator within a reasonable period of time. You have the same rights as you do under the first level of appeal, including the right to reasonable access to and copies of all documents, records, and other information relevant to your Claim for Benefits. The determination of the second level of appeal will be completed in the same form and manner as under the first level so that a decision will be rendered and you will be notified within 15 days for Pre-Service Claims and within 30 days for Post-Service Claims. Notification following the second level of appeal will be in writing and in the same form as the notification provided at the first level, and will include the reason for denial, if applicable, and reference to the specific Plan provision relied upon in making the determination.

**Urgent Care Claim Appeals that Require Immediate Action**

Your appeal may require immediate action if:

- A delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function; or
- In the opinion of a Physician with knowledge of your medical condition, could cause severe pain that cannot be adequately managed without the care or treatment that is subject of the claim.

In these urgent situations, an expedited appeal of a claim denial may be submitted orally or in writing. You or your physician may call the Claims Administrator or submit a claim via facsimile to make a Claim for Benefits.

The Claims Administrator will provide you with a written determination, which may be by electronic means, within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

**Enrollment and Eligibility Appeals**

Appeals of Adverse Benefit Determinations involving enrollment and eligibility claims will be determined by the Plan Administrator. The Plan provides one level of appeal for enrollment and eligibility claims. The
Plan Administrator will provide you with a written notification, which may be via electronic means, of its decision of your appeal within 60 days from receipt of a request for appeal of a denied claim.

**FUNDING**

Some Coverage Options within the Plan are self-funded and, therefore, are not subject to state insurance laws. All other Coverage Options are insured. The Participating Employers fund the trust and insurance policies that are used to pay the premiums and most of the administrative costs of the plan for both the self-funded and the insured Coverage Options.

**GENERAL PROVISIONS**

*Reservation of Right to Amend or Terminate Plans*

Nationwide reserves the right to change or discontinue any of the philosophies, policies, procedures, and Benefits at any time.

*Coordination of Benefits*

Coordination of benefits rules apply to all options under the Plan that pays benefits for Expenses Incurred, except for prescription drug benefits. If insured, see the coordination of benefits rules contained in the insurance policy. All other self-insured plans that cover a Retired Associate and/or his or her Dependents will be taken into account for this provision, even plans that do not have maintenance of benefits provisions.

The Plan’s determination of which plan is primary follows the “birthday rule.” This means the plan that covers the individual may reduce benefits if another plan covers that claimant as an employee or member. The benefits of a plan that covers the individual as a Dependent Child of a person whose date of birth, excluding the year of birth, occurs earlier in the calendar year, shall be determined before the benefits of a plan that covers such person as a Dependent of a person whose date of birth, excluding the year of birth, occurs later in the calendar year.

However, if the Dependent Child has separated or divorced parents, benefits for the child are determined in this order:

a) First, the Other Plans of the parent with custody of the Dependent Child
b) Then the Other Plans of the Spouse of the parent with custody of the Dependent Child
c) Finally, the Other Plans of the parent not having custody of the Dependent Child.

If there is a court decree which gives financial responsibility to a particular parent for health care expenses of the Dependent Child, then (a), (b), and (c) above do not apply. In this case, any Other Plans which covers the Child as a Dependent may reduce benefits before the Other Plans that covers the Child as a Dependent of the parent with financial responsibility.

Coordination of benefits does not apply to health plans that are flexible spending arrangements or accounts under Internal Revenue Code Section 125.
To carry out this provision:

- You must furnish to the Claims Administrator any necessary information;
- The Claims Administrator may, without asking for consent, obtain necessary information from any source; and
- The Claims Administrator may release information to other plans.

If another plan pays an amount that the Plan should have paid, the Plan Administrator has the right to pay the benefit to that plan. This ends the Plan Administrator’s duty for payment of such claim.

**Maintenance of Benefits**

The amount paid by the self-insured Coverage Options for non-Medicare Participants under the Plan, when combined with amounts paid under any other coverage that is determined to be primary, will not exceed what the Plan would have paid if it provided the primary coverage. You should file claims as early as possible with all insurance companies under which you or your Dependent have health coverage. This will help the Plan Administrator provide the maximum amount due as soon as possible.

Where this Plan is not determined to be primary, no benefits will be paid under this Plan, except an amount equal to the excess, if any, of b. minus a., where:

(a) The amount paid by the primary plan (the other plan),

(b) The amount that would be paid under this Plan in the absence of the other plan.

**Right of Recovery**

The Plan Administrator has a right to recover any money paid by a third party against whom you and/or your Dependents or survivors assert any claim for recovery. The Plan’s right of recovery includes, but is not limited to, payments from a third party, any liability or other insurance covering a third party, you or your Dependents’ own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault insurance or school insurance coverages that are paid or payable. The right of recovery will be, in first priority, to the extent of any and all benefits paid, and will apply even if you and your Dependents have not been made whole for the loss.

The Plan Administrator may require you to sign and deliver all necessary papers to protect the rights of the Plan to recovery, and to avoid actions which would prejudice the Plan Administrator’s right of recovery. The Plan Administrator may independently pursue and recover paid benefits from any party who was paid such benefits. The Plan Administrator may require you to provide a statement setting forth such right of recovery.

The Plan has a right to recover from the Participant any money the Participant receives from a third-party against whom the Participant asserts any claim for recovery due to the negligence or intentional acts of the third-party. The Plan’s right to recover is limited to the benefits paid. The Plan may request that the Participant give a document setting forth the right to recovery.

No participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan’s rights hereunder; specifically, no court costs, attorney’s fees or other representatives’ fees may be deducted from the Plan’s recovery without the prior express written consent of the Plan Administrator. This right shall not be defeated by the so called “Fund Doctrine,” “Common Fund Doctrine,” “Attorneys’ Fund Doctrine” or any similar theory in which an individual recovers a common fund for the benefit of persons other than himself or a client and then claims to be entitled to a reasonable fee from the fund as a whole for this service.
The Plan Administrator has the discretion to recover reasonable attorney fees that are incurred by the Plan to enforce the Plan’s right to reimbursement from the Participant.

**Plan Interpretation**

The Benefits Administrative Committee (BAC) and the Claims Administrator, as applicable, have the authority and discretion to interpret the Plan. Their interpretation is final and binding.

**Limitations Period to Commence Legal Action**

All current and former Plan Participants shall have one year from the date an expense is incurred to commence legal action related to this expense under the terms of the Plan. The Plan Administrator, at its sole discretion, may waive this requirement if the current or former Plan Participant provides adequate proof, within a reasonable period of time following expiration of the one-year limitation, setting forth the specific reasons why the requirement could not be met.

**ADMINISTRATIVE DETAIL**

You should know some administrative details about the Plan. Although you will not need this information every day, it is a good idea to keep it in an easily accessible location.

**Plan Names and Plan Numbers**

- Nationwide Insurance Companies and Affiliates Retiree Health Care Plan (523)
- Nationwide Mutual Fire Insurance Company Retiree Health Care Plan (524); and
- Farmland Mutual Insurance Company Retiree Health Care Plan (525).

**Plan Type**

The Plan consists of both self-funded and fully insured options and is a welfare benefit plan subject to ERISA.

**Plan Sponsor**

The Plan Sponsor is Nationwide Mutual Insurance Company, with principal home office located at One Nationwide Plaza, Columbus, OH 43215-2220.

**Employer Identification Number (EIN)**

31-4177100

**Plan Year**

Each annual period beginning on January 1 and ending on December 31.
Plan Administrator
The Benefits Administrative Committee is the Plan Administrator for the purposes of ERISA:

Benefits Administrative Committee
One Nationwide Plaza (1-01-103)
P.O. Box 182171
Columbus, OH 43218 – 2171
Telephone: 877-768-7231
Fax: 614-249-1191

Agent for Service of Legal Process
The Agent for Service of Legal Process is:

Nationwide Mutual Insurance Company
Associate Vice President - Litigation-Discovery Unit
Attn: Service of Process Team
One Nationwide Plaza (1-30-403)
Columbus, OH 43215

Telephone: 1-877-764-0418

Service of legal process may also be made upon the Plan Administrator.

Claims Administrator

<table>
<thead>
<tr>
<th>Medical Claims</th>
<th>Non-Medicare Coverage Options</th>
<th>Medicare Coverage Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare</td>
<td>P.O. Box 30432</td>
<td>Salt Lake City, UT 84131-1362</td>
</tr>
<tr>
<td>Salt Lake City, UT 84130-0432</td>
<td>Phone: 800-201-1336</td>
<td>Phone Numbers:</td>
</tr>
<tr>
<td>Phone: 800-201-1336</td>
<td>Fax: 801-938-2100</td>
<td>877-711-5893 (pre-enrollment)</td>
</tr>
<tr>
<td>Medical Appeals</td>
<td>UnitedHealthcare</td>
<td>UnitedHealthcare Appeals and Grievance Department</td>
</tr>
<tr>
<td>Springfield Service Center</td>
<td>P.O Box 6106</td>
<td>PO Box 6106</td>
</tr>
<tr>
<td>PO Box 740800</td>
<td>MS CA124-0157</td>
<td>MS CA124-0157</td>
</tr>
<tr>
<td>Atlanta, GA 30374-0800</td>
<td>Phone: 800-201-1336</td>
<td>Phone Numbers:</td>
</tr>
<tr>
<td>Phone: 800-201-1336</td>
<td>Phone: 801-938-2100</td>
<td>877-711-5893 (pre-enrollment)</td>
</tr>
</tbody>
</table>

Prescription Drugs Claims
CVS/Caremark
PO Box 52196
Phoenix, AZ 85072-2196
Telephone: 800-776-1355

Prescription Drugs Appeals
Caremark Appeals Department
MC 109
PO. Box 52084
Phoenix, AZ 85072-2084
Telephone: 866-818-6898
Fax: 866-443-1172
STATEMENT OF ERISA RIGHTS

As a Participant in the Nationwide Insurance Companies and Affiliates Retiree Health Care Plan, the Nationwide Mutual Fire Insurance Company Retiree Health Care Plan, or the Farmland Mutual Insurance Company Retiree Health Care Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights.

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

- If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, which is listed in your telephone directory.

You may also contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-275-7922. You may also visit EBSA’s website on the Internet at http://www.dol.gov/ebsa/.
## Appendix A – Dependent Eligibility Requirements

<table>
<thead>
<tr>
<th>Spouse/Civil Union Partner:</th>
<th>Required Documents</th>
</tr>
</thead>
</table>
| Spouse (includes common law spouses in states where recognized) | - Marriage certificate; or  
- Affidavit signed by both spouses; or  
- Federal tax return filed within last 2 years; or  
- Monthly mortgage statement issued within last 6 months showing joint ownership; or  
- Annual mortgage statement issued within last 12 months showing joint ownership. |
| Same-sex civil union partner (Spouse or Household Member) | - Government-issued civil union license /certificate plus proof of joint ownership\(^1\) within last 6 months; or  
- Government-issued civil union license /certificate plus Federal tax return filed within last 2 years listing the partner as a dependent |

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<tr>
<th>Dependent Children</th>
<th>Required Documents</th>
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| Biological | - Government-issued birth certificate in long-form (Plan Administrator may permit short-form or form with only one parent if usually provided by the State); or  
- Qualified Medical Child Support Order (QMSCO). |
| Step-Child | - Same requirements as Biological Child plus same requirements as Spouse (in order to show that the associate’s, retiree’s or LTD recipient’s spouse is the Step-child’s biological parent). |
| Grandchild | - Same requirements as Biological Child plus government-issued birth certificate showing Grandchild’s parent as child of associate, retiree, or LTD recipient plus Federal tax return filed within last 2 years listing the Grandchild as a dependent. |
| Legal Ward | - Same requirements as Biological Child plus court order documenting legal guardianship plus Federal tax return filed within last 2 years listing the Legal Ward as a dependent. |
| Adopted Child | - Adoption placement agreement and petition for adoption; or  
- Adoption certificate. |
| Handicapped Child | - Same requirements as Biological Child, Step-child, Grandchild, Adopted Child, or Legal Ward, as applicable, plus Federal tax return filed within last 2 years listing the Handicapped Child as a dependent plus medical certification of handicap. |
| Foster Child | - Foster care letter of placement. |

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<th>Household Members</th>
<th>Required Documents</th>
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| Adult | - Federal tax return filed within last 2 years listing the Household Member as a dependent; or  
- Proof of joint ownership within last 6 months. |
| Child | - Federal tax return filed within last 2 years listing the Household Member as a dependent; or  
- Proof of residency\(^2\) within last 12 months. |

\(^1\) Proof of joint ownership may include: a mortgage statement, credit card statement, bank statement, and residential leasing agreement listing both individuals’ names as co-owners. Plan Administrator may determine other forms of acceptable proof of joint ownership.

\(^2\) Proof of residency may include: unexpired state issued ID, driver’s license, document from child’s school, school report card, printed school enrollment or registration, 1098 tuition statement, or SSN stub, any of which also show associate’s, retiree’s, or LTD recipient’s address.
Analysts from the Associate Service Center can answer your questions about enrollment. Call the Associate Service Center at 877-768-7231 or email source1@nationwide.com.