Fringe Benefit Group
11910 ANDERSON MILL RD
AUSTIN, TX 78726-1135

[DR-]

FORWARDING SERVICE REQUESTED

J040 1

JANE DOE
11910 ANDERSON MILL RD
AUSTIN TX 78726

This booklet includes a brief summary of your coverage. Please retain a copy of this book for your records as it contains important plan information. You can request a complete Certificate of Coverage by calling our Member Services team at 855-495-1190. Please review the information below and contact Member Services if you have any questions.

Employee Name: JANE DOE
Effective Date: 07/01/2020
Member No.: F00988422
Group Name: BAYADA Home Health Care-Benefits Plan
Group Number: FV1238

Coverage Summary*:
JANE (DOB-1/1/1980) - Medical MEC Plan
JANE (DOB-1/1/1980) - Medical MEC Plan

*For specific benefit information and to determine whether you or your dependents are covered under your employer's benefit plan(s), please refer to your Certificate of Coverage or your Summary Plan Description. The plan documents shall control in the event of any discrepancy between this coverage summary and the plan documents.

CARRIER INFORMATION
MEC Plan - Self Funded
Medical - Nationwide
Fringe Benefit Group
PO Box 21854
Eagan, MN 55121
Smart Data Solutions (SDS) EDI Payer ID#45289
For Benefit/Claims questions, call (855) 495-1190
For EOBs, Eligibility or Benefits visit
www.theamericanworker.com

PPO - First Health
To locate a provider, visit www.FirstHealthLBP.com
For claim questions, call (855) 495-1190

Discount Drug Card - CerPassRX
Rx Group Number: 78726
RX BIN: 022096
PCN: FBG
Member Services: (844) 636-7506
www.cerpassrx.com

Telemedicine - Teladoc
Customer Service: 1-800-Teladoc (800-835-2362)
Registration: Online at www.teladoc.com, with mobile app, or over the phone
Telephone medical consult with licensed physicians available 24 hours a day, 365 days a week.

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CerpassRx is excited to partner with The American Worker to provide you with a Prescription Discount program. In order to access discounts on your prescriptions with ease, we have included your prescription discount processing information on your new member ID card that is enclosed within this packet. You may begin using your ID card at the pharmacy today.

You will also gain access to our free CerpassRx member portal and mobile app. To learn more about the CerpassRx member portal and mobile app, please refer to the back of this page. If you have any further questions about your prescription discount, please contact our Member Services at 844-636-7506.

We look forward to *surpassing* your expectations on prescription discounts!

Start using your new prescription discount card today!
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1. Detach & save your new ID card that is enclosed within this packet.
2. Present your ID card anytime you are filling a prescription at your local pharmacy.
3. Save up to 85% on your prescriptions!

Have questions? Please call CerpassRX Member Services 844-636-7506 or email info@cerpassrx.com

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CERPASSRX®

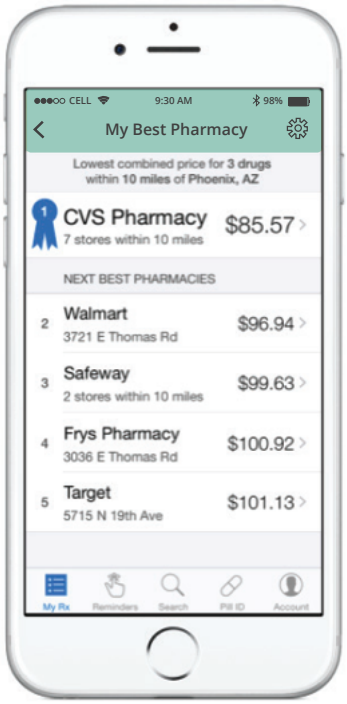
MEMBER

ACCESS YOUR PRIVATE, SECURE MEMBER PORTAL TODAY
VISIT CERPASSRX.COM OR DOWNLOAD OUR MOBILE APP

MEMBER PORTAL & MOBILE APP

This private, secure website is designed just for you. Your pharmacy plan information is available and kept up-to-date in real time. You can access your member portal by visiting www.CERPASSRX.com OR by downloading our mobile app.

The mobile app provides easy, on-the-go access to your personalized health information. Once you have your member ID number, download the app to take advantage of the benefits your pharmacy plan offers.



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- Learn about medication side effects and interactions.
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- Track individual and family spend.

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CERPASSRX

CREATE YOUR MEMBER PORTAL ACCOUNT:

Visit cerpassrx.com and click on the member portal button. Click "activate your account" and enter your member ID shown on your ID card. From there, proceed with completing your personal information to activate your member portal account.

Have questions? For more information, call or click today at 844-636-7506
www.cerpassrx.com // 5904 Stone Creek Dr, Ste. 120 The Colony, TX 75056

CERPASSRX

MINIMUM ESSENTIAL COVERAGE

Minimum Essential Coverage is a self-insured program that provides affordable coverage that meets the requirements under the Affordable Care Act. The plan provides 100% coverage for the required services included as Standard Preventive Care, **when utilizing a First Health Network provider**.

Minimum Essential Coverage	
Plan Pays 100% of the Required Preventive Services, When Utilizing a First Health Network Provider	Including: Services for Adults Services for Women Services for Children

First Health Network

IMPORTANT: This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. You **must use a First Health provider in order to receive benefits under this plan**. No benefits will be paid for out-of-network claims.

- Over 490,000 provider locations across the country
- Network providers submit claims for you to simplify the claim process
- To locate a provider online, visit www.FirstHealthLBP.com

Below is a partial list of services covered by the Minimum Essential Coverage plan.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. You can view the full list of covered services at: https://www.healthcare.gov/preventive-care-benefits/

If you are unable to access this information online or have questions, please call (855) 495-1190.

Covered Services for Adults

- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Type 2 Diabetes screening for adults with high blood pressure
- Colorectal Cancer screening for adults over 50
- Aspirin use for men and women of certain ages
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Obesity screening and counseling for all adults
- Diet counseling for adults at higher risk for chronic disease
- Depression screening for adults
- Alcohol Misuse screening and counseling
- Immunization vaccines for adults - doses, recommended ages, and recommended populations vary: Hepatitis, Hepatitis B, Herpes, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Well-woman visits to obtain recommended preventive services
- Contraception coverage for women: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs

Covered Services for Children

- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages; Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Depression screening for adolescents
- Immunization vaccines for children from birth to age 18 - doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella
- Obesity screening and counseling
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Vision screening for all children
- Medical History for all children throughout development; Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years.
- Oral Health risk assessment for young children; Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- Developmental screening for children under age 3, and surveillance throughout childhood
- Height, Weight and Body Mass Index measurements for children: Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Hearing screening for all newborns
- Hematocrit or Hemoglobin screening for children

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SCHEDULE OF BENEFITS

Policy Holder: BAYADA Home Health Care
Policy Number: FV1238
Effective Date: 7/1/2018
Policy Anniversary: 7/1/2021
Program Manager: Fringe Benefit Group, Inc.

This product is (a) not a substitute for minimum essential health coverage under the Affordable Care Act (ACA); and (b) does not qualify as minimum essential coverage under the ACA.

Who Pays For the Coverage

- The coverage under this policy is contributory. This means you make contributions towards its cost.

We will provide the benefits shown. Any change in amount is subject to the Change in Amounts of Benefits provision.

DAILY IN-HOSPITAL AND SKILLED NURSING FACILITY INDEMNITY BENEFIT

Daily In-Hospital Benefit:	Daily Benefit $100. Up to a Lifetime Maximum of 500 days of confinement (except for Substance Abuse, Mental Illness Disorder, and In-patient Skilled Nursing Facility).
Intensive Care Unit:	Double the Daily In-Hospital Benefit above, up to a maximum of 30 days per Calendar Year.
Mental Illness Disorder:	50% of the Daily In-Hospital Benefit above will be paid, up to a maximum of 30 days per Calendar Year. Lifetime Maximum $30,000.
Substance Abuse:	50% of the Daily In-Hospital Benefit above will be paid, up to a maximum of 30 days per Calendar Year. Lifetime Maximum $30,000.
In-patient Skilled Nursing Facility:	50% of the Daily In-Hospital Benefit above, Maximum Benefit per Covered Person per period of confinement: 60 days. The confinement is covered only if it follows a covered Hospital stay of at least 3 days.

EMERGENCY ROOM INDEMNITY BENEFIT FOR ILLNESS ONLY

- Maximum per Covered Person per day: $75, limited to 1 day per ER visit
- Maximum days per Covered Person per Calendar Year: 4
- Visit day must commence within 72 hours of when illness first manifests itself

DOCTOR'S OFFICE INDEMNITY BENEFIT due to Illness, Accident or Medical Emergency

- Maximum per Covered Person per day: $75
- Maximum days per Covered Person per Calendar Year: 6 days

Routine exams, medical treatment, immunizations, and injections are not covered under this benefit.

OUTPATIENT DIAGNOSTIC X-RAY AND LAB INDEMNITY BENEFIT

Maximum per Covered Person per testing day when Hospital Confinement is not required:

Diagnostic X-Ray Benefit

- Per Covered Person per testing day: $75
- Maximum testing days per Covered Person per Calendar Year: 3 days

Lab Indemnity Benefit

- Per Covered Person per testing day: $75
- Maximum testing days per Covered Person per Calendar Year: 3 days

Routine exams are not covered under this Benefit.

INPATIENT, OUTPATIENT, OR OUTPATIENT MINOR SURGICAL INDEMNITY BENEFIT

Daily Inpatient Surgical Indemnity Benefit:
$500 per Covered person to a maximum of 1 day per Calendar Year.

Daily Outpatient Surgical Indemnity Benefit:
$250 per Covered Person.

Daily Outpatient Minor Surgical Indemnity Benefit:
$50 per Covered Person.

The amount payable for the Outpatient Benefit is limited to a maximum of 1 day per Covered Person per Calendar Year.

ANESTHESIA INDEMNITY BENEFIT

30% of the amount paid for a covered surgical procedure.

VISION CARE BENEFIT

Percentage Payable: 80%
Maximum Amount of Vision Expense Benefits per
Covered Person per Calendar Year: $300

CHANGE IN AMOUNTS OF BENEFITS

Any change in the amount of benefits due to a change in Your Eligible Class will be effective on the Policy Anniversary Date provided:

- You are actively at work, and
- You make any required payment for the change to be effective.

If You are not actively at work, such change will be effective on the first day on which You return to work. If You or Your Policyholder do not make the required payment within 31 days of the change, any increased benefits will not be effective until You give Proof of Good Health satisfactory to Us. Such increased benefits will be effective on a date set by Us.

Changes in benefits due to an Amendment to the Policy will take effect:

- **For You:**
  - On the Amendment date, if You are actively at work performing all the normal duties of Your job for a full work day:
    - While physically present at Your normal place of employment; or
    - At some other place of business that the Policyholder requires You to go; or
    - On the day You return to work, if You are not actively at work on the Amendment date.
- **For Your Dependent** (if applicable):
  - On the Amendment date, if the Dependent is not confined to a Hospital; or
  - On the day after the Dependent is released from a Hospital, if Hospital confined on the Amendment date.

Payment will be based on the benefits in effect at the time of death, loss, or the service is rendered.

Any reduction in the amount of benefits due to Your reaching an Age specified in the Schedule of Benefits will be made if You are actively at work or not.

GENERAL EXCLUSIONS AND LIMITATIONS

Benefits are not provided for Loss, Injury or Illness which results directly or indirectly, wholly or partly from:

1. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression,
2. Declared or undeclared war or acts thereof.
3. Accidental Bodily Injury occurring while serving on full-time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by Us pro-rata for any period of active-full time duty).
4. Any Injury or Illness arising out of or in the course of work for wage or profit.
5. Any Injury or Illness covered by any Workers' Compensation Act, Occupational Disease law or similar law.
6. Except in regard to Limited Medical Benefits, Accidental Bodily Injuries received while the Covered Person was operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
7. Charges for which:
   - there is no legal obligation to pay, or
   - no charge is made, or
   - in the absence of Coverage, no charge would be made.
8. Charges incurred after Termination of Coverage, except as provided under the Extension Due to Total Disability provision.
9. Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law.
10. Charges which are not Medically Necessary (as defined) for treatment of Illness or Injury.
11. Charges for services which are not related to and consistent with the treatment of any Injury or Illness of the Covered Person.
12. Charges for medical care, services, or supplies which are not furnished or prescribed by a Doctor (as defined).
13. Charges for Experimental or Investigational treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices.
14. Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an Injury or Illness by any of the following:
    - The American Medical Association;
    - The U.S. Surgeon General;
    - The U.S. Department of Public Health;
    - The National Institutes of Health; or
15. Charges related to cosmetic surgery or dental care done to beautify a person without medical or dental indication of Injury or Illness.
16. Unless specifically provided in the Policy:
    - charges for dental treatment.
    - charges for oral surgery.
    - charges for treatment of Mental Illness Disorders.
    - charges for treatment of Substance Abuse Disorders.
    - charges for routine physicals or general health exams, unless they are necessary for the diagnosis and treatment of an Illness.
    - charges for refractions, eyeglasses or hearing aids or their fitting.
    - charges in connection with obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology.
    - charges for treatment or services for temporomandibular joint dysfunction or TMJ pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope.
    - charges for routine immunizations and vaccinations, including but not limited to polio, mumps, measles, small pox, DPT, Influenza or tine tests.
    - Birth control medication in any form.
    - Prescription medication recommended or dispensed by; a physician, surgeon, nurse or other Doctor.
17. Charges for reversal procedures in connection with previous male or female sterilization.
18. Charges for services in the nature of educational or vocational testing or training.
19. Any charges for elective abortions.
20. Any charges for outpatient food, food supplements or vitamins.

21. Radial keratotomies.
22. Charges for treatment of male or female infertility; in vitro and in vivo fertilization of an ovum; or artificial insemination including but not limited to:
    - Drugs and medicines;
    - Diagnostic and surgical procedures including but not limited to:
        - Aspiration of ovarian cysts;
        - Harvesting or obtaining eggs;
        - Other surgical treatment of infertility;
        - Diagnostic laboratory and pathology procedures; and
        - Diagnostic radiology, nuclear medicine and ultra sound procedures.
23. Charges for stand-by Doctors to include but not limited to surgeons, pediatricians, anesthesiologists, anesthetists, or other Doctor as defined by the Policy; or stand-by supplies, equipment, rooms, or any other service, supply or treatment not actually used in the care or treatment of an Illness or Injury.
24. Charges for Custodial Care.
25. Charges for durable medical equipment.
26. Charges related to smoking cessation.
27. Charges for the treatment of the following:
    - Codependency;
    - Social, occupational, or religious maladjustments;
    - Compulsive gambling;
    - Chronic marital or family problems when not related to the primary focus of treatment which must be a diagnosable Mental Illness Disorder.

CONTINUATION OF COVERAGE

[DR-]

THIS PROVISION IS SUBJECT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) AND ALL SUBSEQUENT LAWS EFFECTING THIS ACT.

This provision applies to an Employer with twenty (20) or more Employees on a typical business day during the preceding Calendar Year if group health Coverage was provided to Employees. Due to COBRA's complexity, this provision only includes information that would allow a qualified beneficiary to make a general determination of his rights under the law.

This provision is not a detailed account of the law and does not contain the full text of the law or regulations. Therefore, it
is imperative that legal counsel or other appropriate counsel be sought for additional needed information.

Generally, all group health plans with over twenty (20) Employees are directly affected under COBRA or, under a federal law that COBRA may have amended. The only plans that may be exempt are church plans, state and local government group health plans and plans maintained by the Government of the District of Columbia or any territory or possession of the United States. Your Employer or plan administrator may be contacted for the plan's exempt or nonexempt status.

An individual may be eligible for Coverage if on the day before a qualifying event he was covered under his Employer's group health plan. If Coverage was lost due to a qualifying event, continuation of Coverage may be available for a certain period of time. Non-resident aliens who do not receive any United States income are not qualified ~~B~~beneficiaries and cannot continue under COBRA.

The term "qualified beneficiary" means, with respect to a covered Employee any other individual who, on the day before the qualifying event for that Employee, is a beneficiary under the plan as:
a. The spouse of the covered Employee;
b. The Dependent child of the covered Employee;
c. The surviving Spouse of the covered Employee; or
d. A child born to or adopted by a covered Employee during a period of COBRA Coverage.

The term "qualifying event" means, with respect to any covered Employee, any of the following events which would result in the loss of Coverage of a qualified beneficiary.

QUALIFYING EVENTS AND MAXIMUM CONTINUATION PERIODS:

1. 18 Months:
   - Termination of covered Employee's employment (except for gross misconduct)
   - The covered Employee's reduction of work hours.
2. 36 Months:
   - The death of the covered Employee.
   - The covered Employee's legal separation or divorce from the Employee's spouse.
   - The covered Employee's entitlement to Medicare.
   - The Dependent child ceasing to be a Dependent child under the terms of the Plan.
3. 29 Months:
   - Only applies if the qualifying event was a termination of employment (except for gross misconduct) or a reduction in work hours that allowed an eighteen (18) month period of continuation.

In order to qualify for the additional eleven (11) months of coverage, the Social Security Administration must make a determination that the qualified beneficiary was disabled at the time of a termination or reduction in hours of employment or that covered Employee or qualified beneficiary became disabled at any time during the first sixty (60) days of COBRA continuation coverage. If the covered Employee or qualified beneficiary entitled to the additional eleven (11) months of coverage has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the additional eleven (11) months of coverage. If the covered Employee or qualified beneficiary is determined to be disabled, the covered Employee or qualified beneficiary must give notice to the plan administrator within sixty (60) days of the Social Security determination and before the end of the original eighteen (18) month continuation period. The plan administrator may charge an additional amount for this Coverage.

Coverage will terminate if a covered Employee or qualified beneficiary recovers from the disability during the eleven (11) month period. The covered Employee or qualified beneficiary is responsible for notifying the plan administrator within thirty (30) days of the date the Social Security Administration no longer finds the disability to exist. Coverage can terminate in the month that begins more than thirty (30) days after the determination date of the Social Security
Administration.

4. Certain Bankruptcy Proceeding Under Title 11, United States Code: Under this special proceeding, loss of Coverage means a substantial elimination of Coverage within one (1) year before or after the Employer has entered into a bankruptcy proceeding.

For the purpose of this special proceeding, a qualified beneficiary may be a covered Employee who retired on or before the date of the loss of coverage and any other individual who on the date before the event was:
a. The Spouse of the covered Employee;
b. The Dependent child of the covered Employee;
c. The surviving Spouse of the covered Employee; or
d. A child born to or adopted by a covered Employee during a period of COBRA coverage.

It appears that Coverage may continue until the death of the covered Employee or qualified beneficiary, or up to thirty-six (36) months for the surviving Spouse or Dependent child(ren) of the covered Employee after the date of the death of the covered Employee.

As Bankruptcy Laws and COBRA are two (2) very distinct and unique laws, legal counsel should be consulted before determinations and actions commence under this qualifying event. For notification and election termination, reduction of hours, death, bankruptcy, the Plan Participant must notify the plan administrator within thirty (30) days of the qualifying event. The plan administrator will then provide written notice to the covered Employee or qualified beneficiary within fourteen (14) days. The covered Employee or qualified beneficiary must then elect COBRA coverage within sixty (60) days.

The election period will end sixty (60) days after the date of the qualifying event or sixty (60) days after the date the written notice was received, whichever is later. In addition, the required Premium must be paid within forty (45) days of the date of election.

For divorce, legal separation or ineligibility of a Dependent under the plan each covered Employee or qualified beneficiary must notify the Employer or plan administrator within sixty (60) days of the event. If the notice is not sent to the Employer or plan administrator within sixty (60) days, the group health plan does not have to offer the qualified beneficiary an opportunity to elect continuation Coverage.

Once the plan administrator is notified of the event, the plan administrator will provide written notice to the qualified-beneficiary. The qualified beneficiary must then elect COBRA coverage within sixty (60) days. The election period will end sixty (60) days after the date of the qualifying event or sixty (60) days after the date the written notice was received, whichever is later. In addition, the required Premium must be paid within forty-five (45) days of the date of election.
Notification to an individual who is qualified as the Spouse of the covered Employee, will be treated as notification to all other qualified beneficiaries residing with the Spouse at the time of the notification.

Each qualified beneficiary has the opportunity to make an independent election. However, if a qualified beneficiary who is the Spouse of a covered Employee makes an election to provide any other qualified beneficiary with COBRA coverage, the election will be binding on that qualified beneficiary.

Waiver:
If a covered Employee or qualified beneficiary waives the right to continue under COBRA and later revokes the waiver, he must do so within the election period. Coverage will not be provided during the period of time when coverage was waived. Waivers and revocations are considered made on the date they are sent to the Employer or plan administrator.

CONTINUATION OF COVERAGE

[DR-]

Other Reasons Why Cobra Coverage May Terminate:
COBRA continuation coverage can end prior to the maximum continuation period due to any of the following events:
A. The first day on which timely Premium payment is not made.
B. The date upon which the Employer ceases to maintain any group health plan.
C. The date upon which the covered Employee or qualified beneficiary is covered under any other group health plan whether or not such new plan contains limitation periods with respect to any pre-existing condition as long as the limitation period does not apply to the covered Employee or qualified beneficiary.
D. The date the covered Employee or qualified beneficiary is entitled to Medicare. However, this event by itself may not end coverage for a covered Employee or qualified beneficiary who has End Stage Renal Disease. "Entitled" means - having made application and qualified for Medicare.
E. The date on which Coverage would terminate for similarly situated active Employees to whom a qualifying event had not occurred.

Any alternative continuation coverage will not extend the maximum COBRA coverage period and will run concurrent with COBRA continuation.

When a covered Employee or qualified beneficiary's coverage ends under COBRA, and if the policy provides the right to convert to a health plan, the covered Employee or qualified beneficiary will be entitled to the conversion privilege.
The plan administrator may be contacted for additional information on COBRA. If further information is needed the U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, N.W. - Room N-5658, Washington, DC 20210 may be contacted.

CONTINUANCE OF COVERAGE
Benefits for the Plan Participant and his Dependents may continue past the day they would otherwise cease as provided under Termination of Coverage upon payment of the required premium.
The Plan Participant's coverage will continue:
A. For up to two (2) months after he ceases full-time work due to temporary layoff or leave of absence; or
B. For up to six (6) months after he ceases full-time work due to Illness or Injury; or
C. Until the first day of the Plan month following any month in which the number of hours worked falls below the required minimum. Dependent coverage will continue if A. or B. above apply to the Plan Participant.

This coverage will not continue if the Plan Participant begins work for pay or profit with another employer.

The Plan Sponsor must follow a plan which prevents individual selection. If benefits are to be continued under this provision, written notice must be provided to Us by the Plan Sponsor if a Plan Participant is pensioned, retired or absent from work for any other reason. State law may provide a special continuance of coverage when You terminate. See your Plan Sponsor for details.

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NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

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

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

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

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

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

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

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

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

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care.

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

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

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

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

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

OTHER PRIVACY LAWS AND REGULATIONS

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

RIGHTS THAT YOU HAVE

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

Amendments to Your PHI. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such

notification is necessary. A request form can be obtained by writing to your designated contact at the address provided in the "Contact Information" section. [DR-]

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

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

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

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

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

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the "Contact Information" section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-800-635-6585, or mail your request to:

Fringe Benefit Group, Inc.
Attn: Carol Adams, Privacy Officer
11910 Anderson Mill Road
Austin, TX 78726

EFFECTIVE DATE

This Notice is effective 9/15/2015

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