

UnitedHealthcare® Student Resources
HEALTH PLAN 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.

Medical Information Privacy Notice

Effective January 1, 2024

We are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice that is currently in effect.

The terms “information” or “health information” in this notice include information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees’ information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to confirm we are meeting our privacy obligations.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we **may** collect, use, and disclose your health information:

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have.

- For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered. **For Treatment, including** to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- **For Health Care Operations**, as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Underwriting Purposes** however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders**, we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or certain activities related to preparing research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information.

- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

1. Alcohol and Substance Use Disorder
2. Biometric Information
3. Child or Adult Abuse or Neglect, including Sexual Assault
4. Communicable Diseases
5. Genetic Information
6. HIV/AIDS
7. Mental Health
8. Minors' Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

We will follow the more stringent and protective law, where it applies to us.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For information on how to revoke your authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Any request for restrictions must be made in writing. Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you to confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website.

In certain states, you may have the right to request that we delete your personal information. Depending on your state of residence, you may have the right to request deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, please **call the toll-free member phone number on your health plan ID card** or you may contact **UnitedHealthcare Student Resources**:
For Medical Plans at **1-888-889-3822 (TTY/RTT 711)**.
For Vision Plans at **1-800-638-3120 (TTY/RTT 711)**.
For Dental Plans at **1-877-816-3596 (TTY/RTT 711)**.
- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at one of the following addresses:
For Medical Plans:
UnitedHealthcare Student Resources
Privacy Office
PO Box 809025
Dallas, TX 75380-9025
For Vision Plans:
UnitedHealthcare Student Resources
Vision HIPAA Privacy Unit
PO Box 30978
Salt Lake City, UT 84130
For Dental Plans:
UnitedHealthcare Student Resources
Dental HIPAA Privacy Unit
PO Box 30978
Salt Lake City, UT 84130
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at one of the addresses listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

¹This Medical Information Notice of Privacy Practices applies to the following health plans affiliated with UnitedHealth Group: UnitedHealthcare Insurance Company; and UnitedHealthcare Insurance Company of New York.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

We² are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.

- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About This Notice

- If you have any questions about this notice or want information about exercising your rights, **please call the toll-free member phone number on your health plan ID card** or you may contact **UnitedHealthcare Student Resources**:

For Medical Plans at **1-888-889-3822 (TTY/RTT 711)**.

For Vision Plans at **1-800-638-3120 (TTY/RTT 711)**.

For Dental Plans at **1-877-816-3596 (TTY/RTT 711)**.

² For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Dental Benefit Providers, Inc.; OptumHealth Holdings, LLC; Spectera, Inc.; UMR, Inc.; United Behavioral Health, and United Behavioral Health of New York, I.P.A., Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to any other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

Language Assistance Services

ATTENTION: If you speak (English), we¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans, or call the toll-free member phone number listed on your health plan ID card. We are available Monday through Friday, 8 a.m. to 8 p.m. E.T. TTY users may dial 711.

ATENCIÓN: Si habla español (Spanish), ofrecemos¹ servicios gratuitos en otros idiomas para ayudarle a que se comunique con nosotros. Ofrecemos intérpretes, cartas en otros idiomas y cartas en otros formatos como en letra grande. Para recibir ayuda, llame al **1-866-260-2723** para planes médicos, al **1-800-638-3120** para planes de la vista, al **1-877-816-3596** para planes dentales o llame al número de teléfono gratuito para miembros que aparece en su tarjeta de ID del plan de salud. Estamos disponibles de lunes a viernes, de 8 a.m. a 8 p.m., hora del Este. Los usuarios de TTY pueden marcar 711.

注意：如果您說中文 (Chinese)，我們¹ 提供免費語言服務以協助您與我們溝通。我們提供口譯員、其他語言版本的信函、和其他格式的信函，如大字體版。如需協助，有關醫療計劃請撥打 **1-866-260-2723**，有關視力計劃請撥打 **1-800-638-3120**，有關牙科計劃請撥打 **1-877-816-3596**，或撥打您的健保計劃會員卡上所列的免付費會員電話。我們的服務時間是週一至週五，美東時間上午 8 點至晚上 8 點，聽力語言殘障服務專線 (TTY) 使用者可撥打 711。

LUU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), chúng tôi¹ cung cấp dịch vụ ngôn ngữ miễn phí để giúp quý vị giao tiếp với chúng tôi. Chúng tôi cung cấp thông dịch viên, thư bằng các ngôn ngữ khác và thư ở các định dạng khác như chữ in lớn. Để được trợ giúp, vui lòng gọi số **1-866-260-2723** để biết các Chương trình Y tế, **1-800-638-3120** để biết các Chương trình Nhân khoa, **1-877-816-3596** để biết các Chương trình Nha khoa, hoặc gọi số điện thoại hội viên miễn phí được ghi trong thẻ ID chương trình bảo hiểm y tế của quý vị. Chúng tôi làm việc từ Thứ Hai đến Thứ Sáu, 8 giờ sáng đến 8 giờ tối, giờ chuẩn miền Đông, người dùng TTY có thể quay số 711.

주의: 귀하가 한국어 (Korean)를 구사하시면, 귀하와의 의사소통을 돕기 위해 저희¹가 무료 언어 서비스를 제공합니다. 저희는 통역사, 다른 언어로 번역된 서신, 큰 활자체와 같은 다른 양식의 서신을 제공합니다. 도움을 받으시려면, 의료 보험은 **1-866-260-2723**, 안과 보험은 **1-800-638-3120**, 치과 보험은 **1-877-816-3596** 으로 전화하시거나, 귀하의 건강보험 ID 카드에 기재된 무료 회원용 전화번호로 전화주십시오. 월요일 ~ 금요일, 오전 8 시 ~ 오후 8 시(동부 표준시)까지 이용하실 수 있습니다. TTY 사용자들은 711 로 전화하실 수 있습니다.

PAALALA: Kung nagsasalita ka sa Tagalog (Tagalog), nagbibigay kami¹ ng libreng serbisyo sa wika upang matulungan kang makipag-ugnayan sa amin. Nag-aalok kami ng mga interpreter, liham sa iba pang wika, at liham sa iba pang format gaya ng malaking print. Upang humingi ng tulong, mangyaring tumawag sa **1-866-260-2723** para sa Mga Planong Medikal, **1-800-638-3120** para sa Mga Plano para sa Paningin, **1-877-816-3596** para sa Mga Plano para sa Ngipin, o tawagan ang toll-free na numero ng telepono ng miyembro na nakalista sa iyong ID card ng planong pangkalusugan. Available kami mula Lunes hanggang Biyernes, 8 a.m. hanggang 8 p.m. sa E.T. Maaaring mag-dial sa 711 ang mga user ng TTY.

ВНИМАНИЕ: Если вы говорите на русском языке (Russian), то мы¹ предоставим бесплатные переводческие услуги, которые помогут вам в общении с нами. Мы предлагаем услуги устных переводчиков, письма на других языках и письма в других форматах, например, крупным шрифтом. Чтобы получить помощь, звоните **1-866-260-2723** по поводу планов медицинского обслуживания, **1-800-638-3120** по поводу планов офтальмологического обслуживания, **1-877-816-3596** по поводу планов стоматологического обслуживания или звоните по бесплатному номеру телефона для участников, указанному в вашей идентификационной карте участника плана медицинского страхования. Мы работаем с понедельника по пятницу, с 8 утра до 8 вечера по Восточному времени. Пользователи линии TTY могут звонить по номеру 711.

ATANSYON: Si w pale Kreyòl Ayisyen (Haitian Creole), nou¹ bay sèvis lang gratis pou ede w kominike avèk nou. Nou ofri entèprèt, lèt ki ekri nan lòt lang, ak lèt ki ekri nan lòt fòm tankou gwo karaktè. Pou jwenn èd, tanpri rele **1-866-260-2723** pou Plan Medikal yo, **1-800-638-3120** pou Plan Vizyon yo, **1-877-816-3596** pou Plan Dantè yo, oswa rele nimewo telefòn gratis pou manm ki endike sou kat ID plan sante ou an. Nou disponib lendi jiska vandredi, ant 8 a.m. ak 8 p.m. E.T. Itilizatè TTY yo ka rele 711.

ATTENTION : Si vous parlez français (French), nous¹ offrons des services linguistiques gratuits pour vous aider à communiquer avec nous. Nous proposons des interprètes, des lettres dans d'autres langues et des lettres dans d'autres formats, tels que les gros caractères. Pour obtenir de l'aide, veuillez appeler le **1-866-260-2723** pour les plans médicaux, le **1-800-638-3120** pour les plans de vision, le **1-877-816-3596** pour les plans dentaires, ou appelez le numéro de téléphone gratuit des membres indiqué sur votre carte d'identification du plan d'assurance maladie. Nous sommes disponibles du lundi au vendredi de 8 h du matin à 8 h du soir Heure de l'Est. Les utilisateurs de télécriteur peuvent composer le 711.

UWAGA: Jeśli mówisz po polsku (Polish), możesz skorzystać z bezpłatnej pomocy językowej, aby się z nami skontaktować¹. Oferujemy pomoc tłumacza oraz przygotowywanie listów w innych językach lub w innych formatach, np. dużym drukiem. Aby uzyskać pomoc, zadzwoń pod numer **1-866-260-2723** – plany medyczne, **1-800-638-3120** – plany okulistyczne, **1-877-816-3596** – plany stomatologiczne. Możesz też zadzwonić pod bezpłatny numer telefonu umieszczony na Twojej karcie identyfikacyjnej planu medycznego. Czynne w godzinach 8:00 a.m. — 8:00 p.m. od poniedziałku do piątku. Użytkownicy E.T. TTY mogą zadzwonić pod numer 711.

ATENÇÃO: Se você fala português (Portuguese), nós¹ disponibilizamos serviços de tradução gratuitos para ajudá-lo a se comunicar conosco. Disponibilizamos intérpretes e preparação de cartas em idiomas estrangeiros ou em formatos especiais, como ampliações. Se precisar de ajuda, ligue para **1-866-260-2723** para planos de saúde, **1-800-638-3120** para planos oftalmológicos, **1-877-816-3596** para planos odontológicos ou ligue para o número de chamada gratuita listado no cartão de identificação de seu convênio médico. Estamos disponíveis de segunda a sexta-feira, das 8 da manhã às 8 da noite, ET. Usuários de dispositivo de telecomunicação para surdos (TTY) devem discar 711.

ATTENZIONE: se parli italiano (Italian), mettiamo¹ a disposizione servizi linguistici gratuiti per comunicare con noi. Offriamo interpreti, lettere in altre lingue e lettere in altri formati, come stampe di dimensioni maggiori. Per ottenere assistenza, chiama il numero **1-866-260-2723** per i piani medici, **1-800-638-3120** per i piani oculistici, **1-877-816-3596** per i piani odontoiatrici o chiama il numero verde per membri indicato sulla tua tessera identificativa del piano sanitario. Siamo disponibili da lunedì a venerdì, dalle 8 a.m. alle 8 p.m. ora della Costa orientale degli Stati Uniti. Gli utenti TTY possono contattare il 711.

HINWEIS: Wenn Sie Deutsch (German) sprechen, bieten wir¹ kostenlose Sprachdienstleistungen an, um Ihnen die Kommunikation mit uns zu erleichtern. Wir bieten Dolmetscher, Briefe in anderen Sprachen und Briefe in anderen Formaten wie Großdruck. Um Hilfe zu erhalten, erreichen Sie Medizinische Versorgungspläne telefonisch unter **1-866-260-2723**, Optische Versorgungspläne unter **1-800-638-3120**, Zahnärztliche Versorgungspläne unter **1-877-816-3596** oder über die gebührenfreie Telefonnummer auf Ihrem Gesundheitsplan-Ausweis. Wir sind montags bis freitags von 8 Uhr morgens bis 8 Uhr abends (ET) für Sie da. TTY-Benutzer können 711 wählen.

注記: 当社¹はお客様とのコミュニケーションを容易にするために、日本語(Japanese)によるサービスを無料で提供しております。通訳者、他言語版の書類、大活字版などの他のフォーマットの書類をご利用いただけます。お問い合わせ電話番号は、医療保険 **1-866-260-2723**、眼科保険 **1-800-638-3120**、歯科保険 **1-877-816-3596** です。もしくは、お客様の保険 ID カードに記載のフリーダイヤル番号までお問い合わせください。営業時間は月曜日～金曜日、午前 8 時～午後 8 時(米国東部標準時間)です。TTY をご利用の場合は、711 をダイヤルしてください。

توجه: اگر زبان شما فارسی (Farsi) است، ما¹ می‌توانیم خدمات زبانی را به طور رایگان به شما ارائه کنیم تا بتوانید با ما ارتباط برقرار کنید. ما می‌توانیم خدمات ترجمه همزمان، مکاتبه به زبان‌های دیگر و مکاتبه در قالب‌های دیگر مانند چاپ درشت را به شما ارائه کنیم. برای کسب اطلاعات بیشتر، با شماره **1-866-260-2723** برای برای پلان‌های بیمه پزشکی، **1-800-638-3120** برای پلان‌های بیمه چشم‌پزشکی، **1-877-816-3596** برای پلان‌های بیمه دندان‌پزشکی یا شماره رایگان ویژه اعضا که بر روی کارت شناسایی پلان بیمه درمانی درج شده است، تماس بگیرید. طی روزهای دوشنبه تا جمعه، از ساعت 8 صبح تا 8 ب.ظ E.T. آماده پاسخ‌گویی به شما هستیم. کاربران TTY می‌توانند با 711 تماس بگیرند.

ध्यान दें: यदि आप हिन्दी (Hindi) बोलते हैं, हम¹ निःशुल्क भाषा सेवाएं प्रदान करते हैं ताकि हमारे साथ बातचीत करने में आपकी मदद हो सके। हम दुभाषिये, अन्य भाषाओं में पत्र, और अन्य प्रारूपों में पत्र, जैसे बड़े प्रिंट में, प्रदान करते हैं। मदद लेने के लिए, मेडिकल प्लान्स के लिए कृपया **1-866-260-2723** पर कॉल करें, विज्ञान प्लान्स के लिए **1-800-638-3120** पर कॉल करें, डेंटल प्लान्स के लिए **1-877-816-3596** पर कॉल करें, अथवा अपने हेल्थ प्लान आईडी कार्ड पर दिए गए टोल-फ्री सदस्य फ़ोन नंबर पर कॉल करें। हम सोमवार से शुक्रवार, सुबह 8 बजे से शाम 8 बजे तक उपलब्ध हैं। ई.टी. TTY उपभोक्ता 711 डायल कर सकते हैं।

LUS TSHAJ TAWM: Yog tias koj hais lus Hmoob (Hmong), peb¹ muaj cov kev pab cuam txhais lus pub dawb los pab koj txuas lus nrog peb. Peb muaj cov neeg txhais lus, cov ntaub ntawv sau ua lwm yam lus, thiab cov ntaub ntawv sau ua lwm yam qauv ntawv xws li ntaub ntawv luam tawm ua tej daim loj. Txhawm rau thov kev pab, thov hu rau **1-866-260-2723** txog rau cov Pawg Kho Mob, **1-800-638-3120** txog rau cov Pawg Kho Qhov Muag, **1-877-816-3596** txog rau cov Pawg Kho Hniav, los sis hu rau tus nab npawb xov tooj tswv cuab hu-dawb uas teev muaj nyob rau ntawm koj daim npav ID qhia txog pawg kho mob rau fab kev noj qab haus huv. Peb qhib hnuv Monday txog rau Friday, sij hawm 8 a.m. txog 8 p.m. E.T. Cov neeg siv TTY hu tau rau 711.

យកចិត្តទុកដាក់: ប្រសិនបើលោកអ្នកនិយាយ ភាសាខ្មែរ (Khmer), យើង¹ ផ្តល់សេវាភាសាដោយឥតគិតថ្លៃដើម្បីជួយអ្នកទាក់ទងជាមួយយើង។ យើងផ្តល់ឱកាសឱ្យអ្នកបកប្រែភាសា លិខិតឯកសារផ្សេងៗទៀត និង លិខិតក្នុងទម្រង់ផ្សេងៗទៀតដូចជា កាតព្វកិច្ចក្នុង។ ដើម្បីទទួលបានលិខិត ឬសូមទាក់ទងលេខ **1-866-260-2723** សម្រាប់ផែនការវេជ្ជសាស្ត្រ, **1-800-638-3120** សម្រាប់ផែនការគិតប្រាក់, **1-877-816-3596** សម្រាប់ផែនការឆ្មារ, ឬសម្រាប់ទំនាក់ទំនងផ្សេងៗទៀតសម្រាប់អ្នកដែលមានការប្រឈមនឹងភាសាខ្មែរ។ យើងផ្តល់ឱកាស អីម៉ែលឬសូត្រលិខិតស្រុក ចាប់ពីម៉ោង 8 ព្រឹកដល់ម៉ោង 8 យប់។ អ្នកក្នុង TTY អាចហៅទូរស័ព្ទ 711។

ATENCIÓN: No ti pagsasaom ket Ilocano (Ilocano), adda¹ ipapaaymi a libre a serbisio iti lengguahe a tumulong kenka a makikomunikar kadakami. Ituktukonmi dagiti mangilawlawag, surat iti sabali a lengguahe, ken surat iti sabali pay a pormat kas iti dadakkel a letra. Tapno makaala iti tulong, pangngaasim ta awagam ti **1-866-260-2723** para kadagiti Medikal a Plano, **1-800-638-3120** para kadagiti Plano iti Panagkita, **1-877-816-3596** para kadagiti Plano iti Dental, wenno awagam a libre ti numero ti telepono iti miembro a nakalista iti ID kard ti planom iti salun-at. Addakami iti Lunes agingga't Biernes, 8 iti bigat agingga't 8 iti rabii. Dagiti agus-usar iti E.T. TTY ket mabalin nga i-dialda ti 711.

BAA' ÁKONÍNÍZIN: Diné bizaad (Navajo) bee yánilti'go, nihí kwe'é hazhó'ó ahxíł hodiilnih biniyé nihí¹ saad bee áka'e'eyeedígfí t'áá jíík'eh nihee hóló. T'áá haishíí at'a' halne'í, nááná ía' saad bee naaltsoos hadadilyaaígfí, dóó naaltsoos nitsaago bik'ih da'ashch'íígo bee hadadilyaaígfí nihee hóló. Shíka'e'doowoł nínízingo, Ats'íís Nídanél'ííh bee Naaltsoos bee Hada'dít'éhígfí biniyégo kohjí' **1-866-260-2723** hodiilnih, Anáá Nídanél'ííh Naaltsoos bee Hada'dít'éhígfí biniyégo kohjí' **1-800-638-3120**, Awoo' Nídanél'ííh bee Naaltsoos bee Hada'dít'éhígfí biniyégo kohjí' **1-877-816-3596** hodiilnih, doodago nits'íís nánél'ííh naaltsoos bee náha'dít'éhígfí bíł ninaaltsoos nítł'ízi bee nééhozinígfí bine'déé' t'áá jíík'eh béesh bee hane'í biká'ígfí bee hodiilnih. Nihí éí Damóo Biiskání dóó niléí Nida'iiniishjł', abínígo 8 a.m. dóó niléí hxiilch'ííhjí' 8 p.m. ookiljí' nahísíitáh. E.T. TTY doo hazhó'ó níjaa' bee adinits'ágóogo díí 711 bíł adadidíłch'íłgo bee hodiilnih.

FIIRO GAAR AH: Maku hadashaa Soomaali (Somali), waxaanu¹ bixinaa adeegyo luuqad ah oo bilaash ah si aanu kaaga caawino inaad nala xidhiidho. Waxaanu bixinaa turjumaan, waraaqo luuqado kale ah, iyo waraaqo qaabab kale oo far waawayn ku daabacan ah. Si aad caawimo u hesho, fadlan lasoo hadal **1-866-260-2723** wixii Caymisyada Caafimaadka ah, **1-800-638-3120** wixii Caymisyada Caafimaadka Indhaha ah, **1-877-816-3596** wixii Caymiska Daryeelka Ilkaha ag, ama lambarka taleefanka bilaash ah ee xubinta ee ku yaal kaadhka aqoonsigaaga caymiska caafimaadka. Waxaa nala helayaa Isniinta ilaa Jimcaha, 8-da subaxnimo illaa 8-da fiidnimo. Isticmaalayaasha Saacada Bariga. TTY waxay garaaci karaan 711.

ΥΠΟΨΗ: Εάν μιλάτε ελληνικά (Greek), παρέχουμε¹ δωρεάν υπηρεσίες γλωσσικής υποστήριξης για να σας βοηθήσουμε να επικοινωνήσετε μαζί μας. Προσφέρουμε διερμηνείς, γράμματα σε άλλες γλώσσες και γράμματα σε άλλες μορφές όπως σε μεγάλου μεγέθους γραμματοσειρά. Για να λάβετε βοήθεια, καλέστε στο **1-866-260-2723** για Ιατρικά Προγράμματα, στο **1-800-638-3120** για Προγράμματα Όρασης, στο **1-877-816-3596** για Οδοντιατρικά Προγράμματα ή καλέστε χωρίς χρέωση στον τηλεφωνικό αριθμό μελών που βρίσκεται στην κάρτα μέλους του προγράμματος υγείας σας. Είμαστε διαθέσιμοι από Δευτέρα έως Παρασκευή, από τις 8 π.μ. έως τις 8 μ.μ. ώρα Ανατολικής Ακτής ΗΠΑ. TTY μπορούν να καλέσουν στο 711.

ધૂયાન આપો: જો તમે ગુજરાતી (Gujarati) બોલો છો, અમે¹ તમને અમારી સાથે વાતચીત કરવામાં સહાય માટે મફત ભાષા સેવાઓ પૂરઠાન કરશું. અમેદુભાષિયાઓ, અનુભાષાઓમાંઅકષરો, અનેઅનુસૂવરૂપોમાંઅકષરોજેમકેમોટીપ્રતિપ્રદાનકરશું. મદદમેળવવામાટે, કૃપાકરીનેતબિંબી યોજનાઓ માટે**1-866-260-2723**, દ્રષ્ટિ યોજનાઓ માટે**1-800-638-3120**, દંત ચિકિત્સા યોજનાઓ માટે **1-877-816-3596** પરકોલ કરો. અથવાતમારાઆરોગ્યયોજનાઆઇડીકાર્ડપરસુચિબિધ્ધટોલ-ફ્રીમેમ્બરફોનનંબરપરકોલકરો. અમેસોમવારથીશુક્રવાર, 8 એ.એમ. થી 8 પી.એમ. સુધીઉપલબ્ધછીએ. ઈ.ટી. TTY વપરાશકર્તાઓ 711ડાયલકરીશકેછે.

UNITED HEALTHCARE INSURANCE COMPANY
Administrative Office Address: P.O. Box 809025, Dallas, TX 75380-9025

POLICYHOLDER	Barry University	POLICY NUMBER	2024-170-8
ADDRESS	11300 NE Second Avenue Miami, FL 33161	Effective Date	8-11-2024 at 12:01 a.m.
		Termination Date	8-10-2025 at 11:59 p.m.

PREMIUM FOR EACH INSURED PERSON

Student	Annual	\$0.00
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TOLL-FREE NUMBER FOR INQUIRIES: For inquiries and to obtain information about your coverage, or for assistance in resolving a complaint, please call (800) 767-0700.

LIST OF ENDORSEMENTS ATTACHED TO AND FORMING A PART OF THIS POLICY
COL-06-FL END (5C)

UNITED HEALTHCARE INSURANCE COMPANY

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this policy to pay the benefits provided by this policy for loss resulting from a cause covered by this policy. This policy is issued in consideration of the application and payment of the premiums. Premiums as specified above are payable for each Insured Person .

Non-Renewable One Year Term Insurance -- This Policy Will Not Be Renewed


President

Countersigned by _____ Licensed Resident Agent

PREMIUMS AND PREMIUM PAYMENT

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1) two years after the termination of this policy and 2) the date of final adjustment and settlement of all claims under this policy.

TABLE OF CONTENTS

Eligibility and Termination Provisions	2
General Provisions	3
Definitions	5
Schedule of Benefits.....	8
Benefit Provisions	9
Mandated Benefits	
Benefits for Outpatient Services.....	11
Benefits for Procedures Involving Bones or Joints of the Jaw and Facial Region.....	11
Exclusions and Limitations	12

PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the Named Insured actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

Eligible persons may be insured under this policy subject to the following:

- 1) Payment of premium as set forth on the policy application; and,
- 2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

- 1) The Effective Date of the policy; or
- 2) The date premium is received by the Administrator.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid; or
- 2) The date the policy terminates.

COVERED LOSS - TIME LIMITS

Covered Medical Expenses will be paid under the Schedule of Benefits for loss:

- 1) Due to Injury to an Insured Person provided that treatment by a Physician: a) begins within 90 days after the date of Injury; and, b) is received within 24 months after date of Injury

PART II GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the riders and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such rider or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

All statements and descriptions in the application, or in negotiations therefore, by or in behalf of the Insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy unless: 1) they are fraudulent; 2) they are material either to the acceptance of the risk or to the hazard assumed by the Company; or 3) the Company in good faith would either not have issued the policy, would not have issued it at the same premium rate, would not have issued the policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the Company as required either by the application for the policy or otherwise.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

NOTICE OF CLAIM: Written notice of claim must be given to the Company or to one of its authorized agents within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss, or as soon as reasonably possible. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid within 45 days after receipt of due written proof of such loss. If a claim or a portion of a claim is contested by the Company, the Insured shall be notified, in writing, within 45 days after receipt of the claim. The notice shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested, the Company shall pay or deny the contested claim or portion of the claim within 60 days. The Company shall pay or deny any claim no later than 120 days after receipt of the claim. To calculate the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of 10 percent (10%) per year.

Upon written notification by the Insured, the Company shall investigate any claim of improper billing by the Physician, Hospital or other health care provider. The Company shall determine if the Insured was properly billed for those procedures and services actually received. If determined by the Company that the Insured has been improperly billed, the Company will notify the Insured and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, the Company shall pay to the Insured 20 percent (20%) of the amount of the reduction up to a maximum of five hundred dollars (\$500 .00).

GENERAL PROVISIONS (Continued)

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Loss-of-life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or estate. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

CHANGE OF BENEFICIARY: The Insured can change the beneficiary any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the policy unless the designation of the beneficiary is irrevocable.

PHYSICAL EXAMINATION AND AUTOPSY: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined. Failure to comply with the requirements of this provision shall not reduce any claim if extenuating circumstances beyond the control of the Insured prevented the Insured from notifying the Company of his or her inability to present himself or herself for the scheduled examination.

COVERAGE FOR THE HANDICAPPED: The Company shall not refuse to provide or charge unfairly discriminatory rates for health insurance coverage for a person solely because the person is mentally or physically handicapped. Nothing in this provision shall be construed to require the Company to provide insurance coverage against a handicap which the Insured Person has already sustained.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of the applicable statute of limitations from the time written proofs of loss are required to be furnished.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury as their liability may appear. Any such right of subrogation or reimbursement provided to the Company under the policy shall not apply or shall be limited to the extent that the Florida Statutes or the courts of Florida eliminate or restrict such rights.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

PART III DEFINITIONS

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement or rider to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury) as specified in the Schedule of Benefits.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

HOSPITAL means an institution: 1) licensed as a hospital and operated pursuant to law; and 2) primarily and continuously engaged in providing or operating, either on its premises or in facilities controlled by the hospital, under the supervision of a staff of duly licensed Physicians, medical, diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an outpatient basis for which a charge is made; and 3) which provides 24 hour nursing services by or under the supervision of Registered Nurses (R.N.'s).

Hospital also means a licensed hospital which is accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities. No claim for payment shall be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability.

The term hospital shall also include licensed birth centers.

For medical care or treatment of a Dependent child, hospital also means a nonprofit, licensed hospital which provides diagnosis, treatment, or care for patients whose physical functions or movements are impaired by accident, disease or congenital deformity; which accepts patients for treatment without regard to race, color, national origin, sex, religion, or affiliation; which does not have facilities for major surgery; and which provides treatment and care primarily of a charitable nature.

The term hospital shall not be inclusive of: 1) any military or veteran's hospital or soldier's home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces; 2) convalescent homes, convalescent, rest, or nursing facilities; or 3) facilities for the aged, drug addicts or alcoholics and those primarily custodial, educational or rehabilitory care or those primarily affording care for Mental and Nervous Disorder.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury for which benefits are payable.

DEFINITIONS *(Continued)*

INJURY means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

INSURED PERSON means the Named Insured. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

- 1) Progressive care;
- 2) Sub-acute intensive care;
- 3) Intermediate care units;
- 4) Private monitored rooms;
- 5) Observation units; or
- 6) Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in:

- 1) Death;
- 2) Placement of the Insured's health in jeopardy;
- 3) Serious impairment of bodily functions;
- 4) Serious and permanent dysfunction of any body organ or part; or
- 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries.

MEDICAL NECESSITY means those services or supplies provided or prescribed by a Hospital or Physician which are:

- 1) Essential for the symptoms and diagnosis or treatment of the Injury;
- 2) Provided for the diagnosis, or the direct care and treatment of the Injury;
- 3) In accordance with the standards of good medical practice;
- 4) Not primarily for the convenience of the Insured, or the Insured's Physician; and
- 5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

DEFINITIONS *(Continued)*

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture; pathology; or disease.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following treatments: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POSITIVE X-RAY means an X-ray that shows the presence of a fracture; pathology; or disease.

PRE-EXISTING CONDITION means any condition which manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received within the 24 months immediately prior to the Insured's Effective Date under this policy. Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

TOTALLY DISABLED means a condition of a Named Insured which, because of Injury, renders the Insured unable to actively attend classes. A Totally Disabled Dependent is one who is unable to perform all activities usual for a person of that age.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

PART IV
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
BARRY UNIVERSITY INTERCOLLEGIATE SPORTS PLAN
2024-170-8
INJURY ONLY BENEFITS

Maximum Benefit	\$25,000 (For each Injury)
Deductible	\$0
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network	60% except as noted below

The Preferred Provider for this plan is Multiplan.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

This policy provides benefits for Injury sustained by an Insured Person while: 1) actually engaged, as an official representative of the Policyholder, in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed coach or trainer of the Policyholder; or 2) actually being transported as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the play or practice of a scheduled intercollegiate sport.

The benefits payable are as defined in and subject to all provisions of this policy and any riders or endorsements thereto. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

NOTE: No benefits will be paid for services designated as “No Benefits” in the Schedule.

Inpatient	Preferred Provider	Out-of-Network
Room & Board:	\$1,000 copay per Hospital Confinement	\$1,000 Deductible per Hospital Confinement
Intensive Care:	Preferred Allowance \$1,000 copay per Hospital Confinement	Usual and Customary Charges \$1,000 Deductible per Hospital Confinement
Hospital Miscellaneous:	Preferred Allowance	Usual and Customary Charges
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
Surgery:	Preferred Allowance	Usual and Customary Charges
<i>(Specified surgery based on data provided by FAIR Health, Inc.) (Except Dental Surgery. See Other)</i>		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Registered Nurse’s Services:	Preferred Allowance	Usual and Customary Charges
Physician’s Visits:	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing:	Preferred Allowance	Usual and Customary Charges
Outpatient	Preferred Provider	Out-of-Network
Surgery:	Preferred Allowance	Usual and Customary Charges
<i>(Specified surgery based on data provided by FAIR Health, Inc.) (Except Dental Surgery. See Other)</i>		
Day Surgery Miscellaneous:	Preferred Allowance	Usual and Customary Charges
<i>(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)</i>		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Physician’s Visits:	\$50 copay per visit Preferred Allowance	\$50 Deductible per visit Usual and Customary Charges
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
<i>(Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician’s release for rehabilitation.) (Review of Medical Necessity will be performed after 12 visits per Injury)</i>		
Medical Emergency:	\$500 copay per visit Preferred Allowance	\$500 Deductible per visit 80% of Usual and Customary Charges

(The Copay/per visit Deductible will be waived if admitted to the Hospital.)

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
BARRY UNIVERSITY INTERCOLLEGIATE SPORTS PLAN
2024-170-8
INJURY ONLY BENEFITS

Outpatient	Preferred Provider	Out-of-Network
X-rays:	Preferred Allowance	Usual and Customary Charges
Laboratory:	Preferred Allowance	Usual and Customary Charges
Tests and Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges
Prescription Drugs:	No Benefits	No Benefits
Other	Preferred Provider	Out-of-Network
Ambulance:	\$50 copay per trip Preferred Allowance	\$50 Deductible per trip 80% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
Consultant:	\$50 copay per visit Preferred Allowance	\$50 Deductible per visit Usual and Customary Charges
Dental: <i>(Benefits paid on Injury to Sound, Natural Teeth only)</i>	Preferred Allowance	Usual and Customary Charges

MAJOR MEDICAL

Maximum Benefit

No Benefits

CATASTROPHIC MEDICAL

Maximum Benefit

No Benefits

SHC Referral Required: Yes () No (X)

Conversion Permitted: Yes () No (X)

Pre-Admission Notification: Yes () No (X)

(X) **104 week Benefit Period** or () **Extension of Benefits**

Other Insurance : (X) ***Coordination of Benefits**

() **Primary Insurance**

*If benefit is designated, see rider or endorsement attached.

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
BARRY UNIVERSITY INTERCOLLEGIATE SPORTS PLAN
2024-170-8
INJURY ONLY BENEFITS

PREFERRED PROVIDER INFORMATION

“Preferred Providers” are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

Multiplan.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

“Out of Network” providers have not agreed to any prearranged fee schedules. Insured’s may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured’s responsibility.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at 80%, up to any limits specified in the Schedule of Benefits. Call (800) 767-0700 for information about Preferred Hospitals.

OUT-OF-NETWORK HOSPITALS - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by Multiplan will be paid at 80% of Preferred Allowance or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

PART V
MEDICAL EXPENSE BENEFITS - INJURY

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any rider or endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.
2. **Intensive Care:** If provided in the Schedule of Benefits.
3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
4. **Physiotherapy (Inpatient):** See Schedule of Benefits.
5. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
6. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.
7. **Anesthetist Services:** professional services administered in connection with inpatient surgery.
8. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
9. **Physician's Visits:** when Hospital Confined. Benefits do not apply when related to surgery.
10. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.
11. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
12. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.
13. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.
14. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

MEDICAL EXPENSE BENEFITS - INJURY (Continued)

15. **Physician's Visits (Outpatient):** Benefits do not apply when related to surgery or Physiotherapy.
16. **Physiotherapy (Outpatient):** benefits are limited to one visit per day.
17. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury.
18. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.
19. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
20. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.
21. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.
22. **Prescription Drugs (Outpatient):** See Schedule of Benefits.
23. **Ambulance Services:** See Schedule of Benefits.
24. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of purchase price.
25. **Consultant Physician Fees:** when requested and approved by the attending Physician.
26. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

PART VI
MANDATED BENEFITS

BENEFITS FOR OUTPATIENT SERVICES

Benefits will be provided for treatment performed outside a Hospital for any Injury as defined in the policy provided that such treatment would be covered on an inpatient basis and is provided by a health care provider whose services would be covered under the policy if the treatment were performed in a Hospital. Treatment of the Injury must be a Medical Necessity and must be provided as an alternative to inpatient treatment in a Hospital. Reimbursement is limited to amounts that are Usual and Customary for the treatment or services.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR PROCEDURES INVOLVING BONES OR JOINTS OF THE JAW AND FACIAL REGION

Benefits will be paid the same as any other Injury for diagnostic or surgical procedures involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is medically necessary to treat conditions caused by Injury.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

PART VII
EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Biofeedback;
2. Chronic pain disorders;
3. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;
4. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;
5. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
6. Elective Surgery or Elective Treatment, except cosmetic surgery made necessary as the result of a covered Injury or to correct a disorder of a normal bodily function;
7. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems;
8. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
9. Health spa or similar facilities; strengthening programs;
10. Hearing examinations or hearing aids;
11. Hypnosis;
12. Preventive medicines or vaccines, except where required for treatment of a covered Injury;
13. Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
14. Injury for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
15. Injury for which benefits are paid by the prior insurer to the extent of its accrued liability and extension of benefits or benefit period as required by F.S. 627.667;
16. Investigational services;
17. Nuclear, chemical or biological Contamination, whether direct or indirect. "Contamination" means the contamination or poisoning of people by nuclear and/or chemical and/or biological substances which cause Sickness and/or death;
18. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;
19. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting, except in self-defense;

EXCLUSIONS AND LIMITATIONS *(Continued)*

20. Pre-existing Conditions, will apply for the first 24 months, except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months. Credit will be given for the time the Insured was covered under a previous similar plan if the previous coverage was continuous to a date not more than 63 days prior to the Insured's Effective Date under this policy;
21. Prescription Drugs dispensed or purchased while not Hospital Confined; except as specifically provided under Benefits for Outpatient Services; or except when dispensed at the Student Health Center ;
22. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;
23. Screening exams or testing in the absence of Injury;
24. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
25. Sickness or disease in any form;
26. Nasal and sinus surgery, except for treatment of chronic purulent sinusitis;
27. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping;
28. Sleep disorders;
29. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
30. Supplies, except as specifically provided in the policy;
31. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and
32. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

POLICY ENDORSEMENT

It is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

COORDINATION OF BENEFITS PROVISION

Definitions

- (1) **Allowable Expenses:** Any necessary, reasonable, and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person.

An Allowable Expense to a Secondary Plan includes the value or amount of any Deductible Amount or Coinsurance Percentage or amount of otherwise Allowable Expenses which was not paid by the Primary or first paying Plan.

- (2) **Plan:** A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services. Such group coverages include: (a) group insurance coverage, or any other group type contract or provision thereof; this will not include school accident coverage for which the parent pays the entire premium; (b) service plan contracts, group practice and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) coverage under governmental programs, including Medicare, and any coverage required or provided by statute.
- (3) **Primary:** The Plan which pays regular benefits.
- (4) **Secondary:** The Plan which pays a reduced amount of benefits which, when added to the Primary Plan's benefits will not be more than the Allowable Expenses.
- (5) **We, Us or Our:** The Company named in the policy to which this rider is attached

Effect on Benefits - If an Insured Person has medical and/or drug coverage under any other Plan, all of the benefits provided are subject to coordination of benefits.

During any policy year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Plan may not be more than the Allowable Expenses.

During any policy year or benefit period, We may reduce the amount We will pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made.

However, if: (1) the other Plan contains a section which provides for determining its benefits after Our benefits have been determined; and (2) the order of benefit determination stated herein would require Us to determine benefits before the other Plan, then the benefits of such other Plan will be ignored in determining the benefits We will pay.

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

- (1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.

COORDINATION OF BENEFITS PROVISION *(Continued)*

- (2) Dependent Child/Parents Not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
- a. the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
 - c. However, if the other Plan does not have the rule described in a. above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- (3) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
1. first, the Plan of the parent with custody of the child;
 2. then, the Plan of the spouse of the parent with the custody of the child; and
 3. finally, the Plan of the parent not having custody of the child.
- (4) Laid off or Retired Employee. The benefits of a policy or plan which covers a person as an employee who is neither laid off nor retired, or as that employee's Dependent, are determined before those of a policy or plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph shall not apply.
- (5) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

This Coordination of Benefits provision shall not be applied against an indemnity-type policy, an excess insurance policy as defined in 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

Right to Recovery and Release of Necessary Information - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery - Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

