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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.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury for which benefits are payable before the Termination Date, Covered Medical Expenses for such Injury will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

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: Claim forms are not required.

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.

PRESCRIPTION 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 where service is rendered. 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 V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS-INJURY
FLORIDA GULF COAST UNIVERSITY - STUDENT PLAN-INJURY ONLY
2020-2161-8
INJURY ONLY BENEFITS

Student Maximum Benefit	\$2,000 (For Each Injury)
Student Deductible	\$100 (For Each Injury)
Coinsurance	90% except as noted below

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

Room & Board:	Usual and Customary Charges
Intensive Care:	Usual and Customary Charges
Hospital Miscellaneous:	Usual and Customary Charges
Physiotherapy:	Usual and Customary Charges
Surgery:	Usual and Customary Charges
<i>(Specified Surgery based on data provided by FAIR Health, Inc.)</i>	
Assistant Surgeon:	Usual and Customary Charges
Anesthetist:	Usual and Customary Charges
Registered Nurse's Services:	Usual and Customary Charges
Physician's Visits:	Usual and Customary Charges
Pre-admission Testing:	Usual and Customary Charges

Outpatient

Surgery:	Usual and Customary Charges
<i>(Specified Surgery based on data provided by FAIR Health, Inc.)</i>	
Day Surgery Miscellaneous:	Usual and Customary Charges
	\$100 Deductible per visit
Assistant Surgeon:	20% of Surgery Allowance
Anesthetist:	Usual and Customary Charges
Physician's Visits:	Usual and Customary Charges
	\$30 Deductible per visit
Physiotherapy:	Usual and Customary Charges
<i>(15 visits maximum for each Injury)</i>	
Medical Emergency:	Usual and Customary Charges
	\$100 Deductible per visit
<i>(The Deductible will be waived if admitted to the Hospital.)</i>	
X-rays:	Usual and Customary Charges
	\$30 Deductible per visit
Laboratory:	Usual and Customary Charges
	\$30 Deductible per visit
Tests & Procedures:	Usual and Customary Charges
Injections:	Usual and Customary Charges
Prescription Drugs:	Usual and Customary Charges
	\$15 Deductible per prescription for generic drugs
	\$30 Deductible per prescription for brand name
	up to a 31-day supply per prescription

SCHEDULE OF BENEFITS (CONTINUED)
MEDICAL EXPENSE BENEFITS-INJURY
FLORIDA GULF COAST UNIVERSITY - STUDENT PLAN-INJURY ONLY
2020-2161-8
INJURY ONLY BENEFITS

Other

Ambulance:	Usual and Customary Charges
Durable Medical Equipment:	Usual and Customary Charges
Consultant:	100% of Usual and Customary Charges
	\$45 Deductible per visit
Dental:	80% of Usual and Customary Charges
	\$500 maximum (For each Injury)
<i>(Benefits paid on Injury to Sound, Natural Teeth only.)</i>	
Skilled Nursing Facility:	Usual and Customary Charges
	60 visits maximum (Per Policy Year)
Hospice Care:	Usual and Customary Charges
Urgent Care Center:	Usual and Customary Charges
	\$50 Deductible per visit

SHC Referral Required: Yes () No (X)

Conversion Permitted: Yes () No (X)

() 52 Week Benefit Period or (X) Extension of Benefits

Pre Admission Notification: Yes () No (X)

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

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

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):** See Schedule of Benefits
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. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;
2. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
3. 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;
4. 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;
5. Health spa or similar facilities; strengthening programs;
6. Hearing examinations or hearing aids;
7. Hypnosis;
8. Preventive medicines or vaccines, except where required for treatment of a covered Injury;
9. Injury for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
10. 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;
11. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting, except in self-defense;
12. Prescription Drugs, services or supplies as follows:
 - a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use;
 - b. Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - d. Products used for cosmetic purposes;
 - e. Anabolic steroids used for body building;
 - f. Growth hormones; or
 - g. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
13. Screening exams or testing in the absence of Injury;
14. Sickness or disease in any form;
15. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
16. Speech therapy;
17. Supplies, except as specifically provided in the policy;
18. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and
19. 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 StudentResources 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 <http://www.hhs.gov/ocr/office/file/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.

