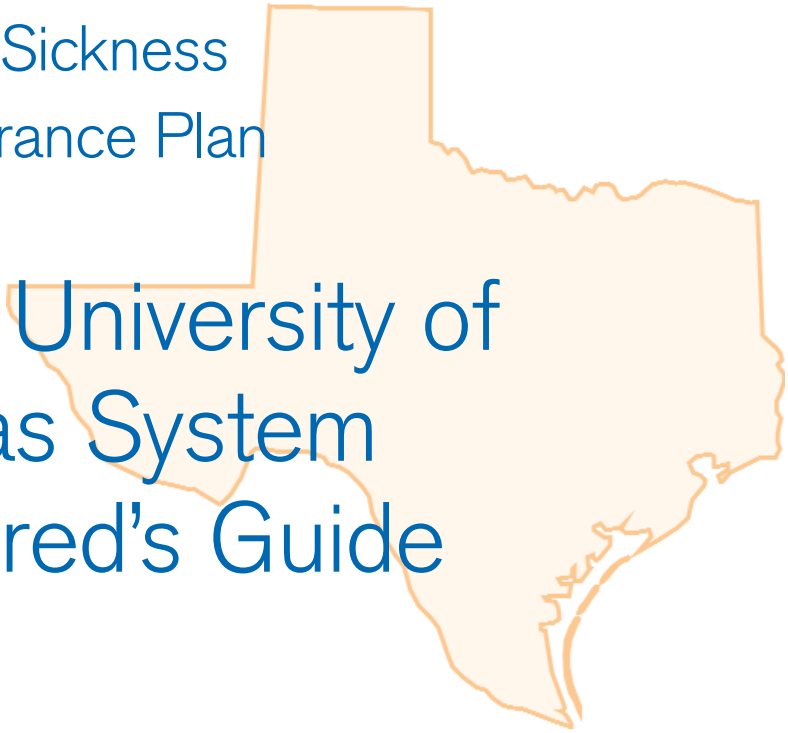
Endorsed by
The University of Texas System

2010-2011

Student Injury and Sickness Insurance Plan



The University of Texas System Insured's Guide

UnitedHealthcare®
A UnitedHealth Group Company

06-BR-TX-PPO (Rev 09) 42-50-1

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-888-344-6105 or by visiting us at www.uhcsr.com/UTSystem.

Eligibility

Maintaining Your Eligibility

All international students holding non-immigrant visas are eligible and are required to purchase this insurance plan in order to complete registration except for those students who certify in writing that comparable coverage is in effect under another plan as approved by the UT System Board of Regents. All medical students at Health Components are automatically enrolled in this insurance plan at registration. All other students taking credit hours, graduates students working on research/dissertation or thesis, post doctorate students, scholars, fellows and visiting scholars are eligible to enroll in this insurance plan.

Students - You are eligible to purchase coverage under this Policy if you are a registered fee paying student at a component institution of The University of Texas System. You must actively attend classes through the 12th class day after the date for which coverage is purchased.

The Company may investigate your student status to verify that the Policy Eligibility requirements are met. If the Company discovers that the Policy Eligibility requirements have not been met, its only obligation is refund of premiums.

Refund of premiums is allowed only if it is determined that the individual was either not eligible to enroll in the Plan or became ineligible because of failure to maintain student status or upon entry into the armed forces.

If You Want to Add Dependents

Eligible students who enroll in this Plan may also insure their Dependents. Eligible Dependents are the Insured student's spouse and unmarried children under 25 years of age, who are not self-supporting. **Any eligible Dependent who is a fee-paying student at The University of Texas may be Insured as a student or as a family member, but not as both.**

Newborn Infants (any child born of an Insured while that person is insured under this Policy) will be covered under this Policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent. To continue coverage for a newborn, the Insured must, within the 31 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage for that child will terminate at the end of the first 31 days after the child's birth.

Dependent Eligibility expires concurrently with that of the Insured student. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Note: Non-student Dependents are not eligible for services provided at a Student Health Center.

Enrollment Periods and Procedures (Effective and Termination Dates)

Enrollment periods and premiums are specified on the enrollment form for each individual campus. Your coverage becomes effective on the first day of the period on which premium is paid or the date the enrollment form and full premium are received by the Company or its authorized representative, whichever is later. Your coverage terminates on the Termination Date of this Policy or the ending date of the period for which you have paid premium, whichever is earlier.

If paying premiums for any payment period other than annual, Eligibility requirements specified on page one must be met to continue insurance coverage. To avoid a lapse in coverage, premium must be received by the Company or its authorized representative within 30 days after the coverage Expiration Date. This is a Non-Renewable One Year Term Policy.

Hard Waiver Health and Accident Insurance for Health Component Students

All Health Science Center and medical students are required to be enrolled in the insurance plan at registration unless proof of comparable coverage is furnished.

Texas Education Code Section 51.961 as added by Senate Bill 505, 77th Texas Legislature, authorizes a governing board to require health insurance of students enrolled in health institutions. The UT System Board of Regents voted November 8, 2001 to include this requirement beginning with the 2002-2003 Academic Year.

Mandatory Health and Accident Insurance for International Students

The Board of Regents of The University of Texas System requires all international students holding non-immigrant visas and living in the United States to maintain approved health insurance while enrolled at component institutions of The University of Texas. The Board of Regents has authorized the assessment of a health insurance fee to each such international student who cannot provide evidence of continuing coverage under another approved plan. This fee will be the amount of the premium approved for the UT System Student Health Insurance (SHI) Plan. Required SHI coverage for international students includes Repatriation and Medical Evacuation benefits.

UnitedHealthcare StudentResources - Website

UnitedHealthcare **Student**Resources Insurance wants to make it as simple as possible for you to get all the information you need about your health insurance policy. The URL is www.uhcsr.com/UTSystem. You may also obtain an Identification Card on-line through the UnitedHealthcare **Student**Resources website at www.uhcsr.com/UTSystem, as long as your correct premium payment has been posted to the UnitedHealthcare **Student**Resources database.

How To Enroll
(Your Personal Insurance Account)

Create your Account today!

Access information at your convenience, 24/7/365!

Through **www.uhcsr.com/UTSystem**, those students who have purchased our Student Health Insurance can access their insurance information any time day or night.

Our secure site provides online access to coverage information, print-friendly replacement ID cards and claims status including associated correspondence.

Creating an Online Account is as Easy as 1-2-3!

Visit **www.uhcsr.com/UTSystem** and:

1. Click the College Students link from our Home page
2. Click the 'Create an Account' link in the Already Have Insurance? area
3. Follow the onscreen prompts

After creating your account, you may log into our My Account area and begin to manage your insurance policies online, at your own convenience. Create your account today and access our online service suite to:

* Print an ID card -- to utilize Medical and Prescription benefit services
* Check Claim Status
* Update Personal Information
* Contact us with a question or comment
* Look up a Network Provider
* Review Plan Coverage
* Review effective dates and cost

Visit **www.uhcsr.com/UTSystem** today!

Extension of Benefits After Termination Date

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

Coverage will not apply if the coverage is replaced with a succeeding carrier providing substantially equivalent or greater benefits than those provided by this Policy. For purposes of this section, the terms “total disability” and “totally disabled” mean: 1) with respect to the Insured, the complete inability of the Insured to perform all of the substantial and material duties and functions of his or her occupation and any other gainful occupation in which such person earns substantially the same compensation earned prior to disability, and 2) with respect to the Insured’s covered Dependents, confinement as a bed patient in a Hospital.

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. After this “Extension of Benefits” provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Renewal Notices

It is your responsibility to make timely renewal payments to avoid a lapse in coverage.

Please refer to your enrollment form now to review the payment options you selected as a reminder of the enrollment periods and Effective Dates for your campus. **Mark your calendar now to avoid any lapse in coverage.**

All subscribers who enroll for periods less than one year will be mailed a renewal notice to submit their next premium payment; however, it is the Insured's responsibility to make timely renewal payment.

PLEASE NOTE: **Renewal notices will not be mailed from one policy year to the next. If you maintain your student status, you will be eligible to enroll in the following year's policy. If you do not maintain your student status, you may be eligible for the continuation plan. Contact your student insurance office before the policy termination date for information.**

Accessing Emergency Care

When a true Medical Emergency occurs, you may seek emergency care at any Hospital or emergency facility. **Please refer to the definition of Medical Emergency found on page 26 to see if your situation would meet these criteria.**

If Hospital Confinement should result from a covered Medical Emergency, benefits will be paid at 80% of the Preferred Allowance for Covered Medical Expenses in a Preferred Provider Hospital. If confined in an Out-of-Network Hospital, benefits will be paid at 80% of Allowable Charges until it is medically possible to be transferred to a Preferred Provider Hospital. If the transfer is not made when medically possible, the benefit will revert to Out-of-Network non-emergency allowance. At that time benefits will be paid at 60% of Allowable Charges for Covered Medical Expenses incurred.

Pre-Admission Notification

UMR Care Management should be notified of all Hospital Confinements prior to admission.

1. **PRE-ADMISSION NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **PRE-ADMISSION NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission or as soon as reasonably possible to provide the notification of any admission due to Medical Emergency.

UMR Care Management is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

Schedule of Basic Medical Expense Benefits

Up To $100,000 Maximum Benefit

Paid as Specified Below (For each Injury or Sickness)

$300 Deductible (Per Insured Person) (Per Policy Year)

If two or more covered family members are injured in the same accident, only one Deductible will apply. Each Insured Person will be eligible for the Maximum Benefit.

The Preferred Provider for this plan is **UnitedHealthcare Choice Plus**.

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 on Out-of-Network provider is used.

Preferred Provider Services: After the Deductible has been satisfied, Covered Medical Expenses incurred at a Preferred Provider will be paid at 80% of Preferred Allowance up to $10,000. After the Company has paid $10,000, additional Covered Medical Expenses will be paid at 100% of Preferred Allowance up to the $100,000 Maximum Benefit.

Out-of-Network Services: After the Deductible has been satisfied, Covered Medical Expenses incurred at Out-of-Network providers will be paid at 60% of Allowable Charges up to $10,000. After the Company has paid $10,000, additional Covered Medical Expenses will be paid at 100% of Allowable Charges up to the $100,000 Maximum Benefit.

Pre-existing Conditions are excluded 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 previous creditable coverage if the creditable coverage was continuous to a date not more than sixty-three (63) days prior to the Insured's Effective Date under this Policy.

NOTE: If the Component has a Student Health Center, the Deductible and Pre-existing Condition exclusion will be waived and benefits paid for 100% of Covered Medical Expenses incurred at the Student Health Center.

UTMB Galveston - Medical Group and Hospital: Outpatient Lab, X-ray and Prescription Drugs to be paid as the Student Health Center, which is 100% of PPO Allowance and waive the Deductible.

UT Physicians: 100% of PPO allowance waiving any Deductibles or copays.

Benefits are provided for:

1. the necessary treatment resulting from accidental needle sticks;
2. allergy testing and treatment after a $25 copay per allergy test;
3. routine sexually transmitted disease testing up to a $500 maximum Per Policy Year except as mandated, after a $25 copay per visit; and
4. allergy medicines and Prescription Drugs required for the treatment of a covered STD are subject to the $1,300 maximum under the Prescription Drug Benefit.

Benefits will be paid up to the Maximum Benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network, unless noted below.

Covered Medical Expenses include:

PA = Preferred Allowance AC = Allowable Charges		
INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Room & Board Expense, daily semi-private room rate; and general nursing care provided by the Hospital.	80% of PA	60% of AC
Intensive Care	80% of PA	60% of AC
Hospital Miscellaneous Expense, 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.	80% of PA	60% of AC
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth. *(See Benefits for Maternity and Post-Delivery Care)*	Paid as any other Sickness	
Physiotherapy	80% of PA	60% of AC
Surgeon's Fees, in accordance with data provided by Ingenix. 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.	80% of PA	60% of AC
Assistant Surgeon, payable only when required by the Hospital.	80% of PA	60% of AC
Anesthetist, professional services in connection with inpatient surgery.	80% of PA	60% of AC
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of AC
Physician's Visits, benefits are limited to one visit per day and do not apply when related to surgery.	80% of PA	60% of AC
Pre-admission Testing, the Deductible will be waived and benefits will be paid at 100% of Covered Medical Expenses incurred for Pre-admission Testing, provided the resulting Hospital Confinement begins within 10 days.	80% of PA	60% of AC
Psychotherapy, benefits are limited to one visit per day. *(30 days maximum)*	80% of PA	60% of AC

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Surgeon's Fees, in accordance with data provided by Ingenix. 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.	80% of PA	60% of AC
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of AC
Assistant Surgeon	No Benefits	
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of AC
Physician's Visits, benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	80% of PA	60% of AC
Medical Emergency Expenses, *$1,000 maximum, ($75 co-pay per visit in lieu of the Deductible)* Use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	80% of PA	80% of AC
Physiotherapy, benefits are limited to one visit per day. See exclusion number 20 for additional limitations.	80% of PA	60% of AC
Diagnostic X-ray & Laboratory Services, *(Includes one pap smear, up to $75 maximum Per Policy Year except as provided in the Benefits for Detection of Human Papillomavirus and Cervical Cancer.)*	80% of PA	60% of AC
Injections, when administered in the Physician's office and charged on the Physician's statement. *(Includes flu shot, $20 maximum Per Policy Year)* *(Plan Deductible does not apply)*	80% of PA	60% of AC
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. *(Includes quantiferone gold (TB blood test))*	80% of PA	60% of AC
Radiation Therapy & Chemotherapy	80% of PA	60% of AC

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Prescription Drugs: $1,300 maximum Per Policy Year for prescriptions filled at the SHC or a UnitedHealthcare Network Pharmacy (UHPS). *(Prescriptions filled at the SHC are: $10 copay for Generic / $15 copay for Name Brand drugs. Allergy medications are covered and included in the $1,300 maximum up to a 31 day supply per prescription.)*	UnitedHealthcare Network Pharmacy (UHPS) / $10 copay for Tier 1 / $15 copay for Tier 2 / up to a 31 day supply per prescription	No Benefits
Psychotherapy, benefits are limited to one visit per day. Including all related or ancillary charges incurred as a result of Mental & Nervous Disorder. *(Psychotherapy prescriptions are covered under the Prescription Drug benefit and not subject to the Psychotherapy limits.)* *Individual Therapy: $65 per day/Group Therapy: $20 per day (Combined Individual & Group Therapy maximum of 20 visits)*	80% of PA	60% of AC
OTHER		
Ambulance Services, *($300 maximum)*	80% of PA	80% of AC
Durable Medical Equipment	No Benefits	
Consultant Physician Fees, when requested and approved by the attending Physician.	80% of PA	60% of AC
Dental Treatment, made necessary by Injury to Sound, Natural Teeth.	80% of PA	60% of AC
Maternity, *(Benefits paid for Newborn Care while Hospital Confined. See Benefits for Maternity and Post-Delivery Care.)*	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Alcoholism / Drug Abuse	Paid under Psychotherapy	
Wellness Benefit/Routine Preventive Care, *(Includes immunizations. $500 maximum Per Policy Year.)*	100% of PA	60% U&C

UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable copayments. Your copayment is determined by the tier to which the Prescription Drug is assigned on the PDL. Tier status may change periodically and without notice to you. Please access www.uhcsr.com/UTSystem or call 1-877-417-7345 for the most up-to-date tier status.

$10 copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply

$15 copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply

Your maximum allowed benefit is $1,300 Per Policy Year.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost of the prescription.

If you do not present the card, you will need to pay for the prescription and then submit a prescription reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com/UTSystem or call 1-877-417-7345.

Definitions

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service at 1-877-417-7345.

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 2.
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

Preferred Providers Information

"**Preferred Providers**" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. The Preferred Provider in your local school area is:

UnitedHealthcare Choice Plus

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 us at 1-888-344-6105, by checking the website at **www.uhcsr.com/UTSystem** and/or by asking the provider when you make an appointment for services.

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

"**Allowable Charges**" means the Company's allowance for a specified Covered Medical Expense or the provider's charge for the service, whichever is less.

"**Out of Network**" providers have not agreed to any prearranged fee schedules. Insureds 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 the coinsurance specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call 1-888-344-6105 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 UnitedHealthcare Choice Plus will be paid at the coinsurance specified in the Schedule of Benefits, 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.

Medical Emergency Treatment

In the event of Medical Emergency and the Insured cannot reasonably reach a Preferred Provider, the Company shall provide reimbursement for the following Medical Emergency services at the Preferred Provider level of benefits until the Insured can reasonably be expected to transfer to a Preferred Provider: 1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital , including a freestanding emergency medical care facility, that is necessary to determine whether a Medical Emergency condition exists; 2) necessary Medical Emergency care services, including the treatment and stabilization of a Medical Emergency condition; and 3) services originating in a Hospital emergency facility, including a freestanding emergency medical care facility, following treatment or stabilization of a Medical Emergency condition.

Complaint Resolution

Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 1-888-344-6105. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

Continuity Of Care: Termination Of Provider Contracts

The Insured has the right to continuity of care while covered under this policy for a covered Injury or Sickness in the event of termination of a Preferred Provider's participation in the plan under the following circumstances: 1) the Insured is being treated for a Life Threatening Condition; or 2) the Insured is being treated under Special Circumstances.

"Life Threatening Condition" means a Sickness or Injury for which the likelihood of death is probably unless the course of the Injury or Sickness is interrupted. "Special Circumstances" means a condition regarding which the treating Physician or health care provider reasonably believes that discontinuing care by the treating Physician or health care provider could cause harm to the Insured. Examples of a Insured who has a special circumstance include a Insured with a disability, acute condition, or Life Threatening Condition or a Insured who is past the 24th week of pregnancy.

Preferred Provider Information Continued

Benefits will continue to be paid at the negotiated Preferred Provider level of benefits if a Insured whom the Physician or provider is currently treating has Special Circumstances in accordance with the dictates of medical prudence. The Physician or provider shall identify the Special Circumstances and shall: 1) request that the Insured be permitted to continue treatment under the Physician's or providers care; and 2) agree not to seek payment from the Insured of any amount for which the Insured would not be responsible if the Physician or provider were still a Preferred Provider.

All obligations on behalf of the Company for reimbursement at the Preferred Provider level of benefits for the ongoing treatment shall terminate after: 1) the 90th day after the effective date of the termination; or 2) if the Insured has been diagnosed as having a terminal Sickness at the time of termination, the expiration of a nine-month period after the effective date of the termination. If the Insured is past the 24th week of pregnancy at the time of termination, the Company shall continue the Preferred Provider benefits through the delivery of the child, immediate postpartum care and the follow-up checkup within the six-week period after deliver.

NOTICE: Although services may be or have been provided to an Insured at a health care facility that is a member of the Preferred Provider network, other professional services may be or have been provided at or through the facility by Physicians and other health care practitioners who are not members of the Preferred Provider network. The Insured may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by this policy.

Optional Major Medical Benefit

$400,000 Maximum Benefit (For each Injury or Sickness)

This optional benefit is subject to payment of an additional premium. Optional benefits may only be purchased at the time of initial enrollment in the Plan and may not be added later.

The Optional Major Medical Benefit begins payment after the Basic Maximum Benefit of $100,000 has been paid by the Company.

The Company will pay 100% for additional, Covered Medical Expenses incurred up to the Major Medical Maximum of $400,000.

The total benefit payable under Major Medical is $500,000 minus the Basic Benefits already paid.

No benefits will be paid under Major Medical for:

1. Room & Board Expenses which exceed 80% of Preferred Allowance for Preferred Provider and 60% of Allowable Charges for Out-of-Network;
2. Hospital Miscellaneous Expenses which exceed 80% of Preferred Allowance for Preferred Provider and 60% of Allowable Charges for Out-of-Network;
3. Intensive care expenses which exceed 80% of Preferred Allowance for Preferred Provider and 60% of Allowable Charges for Out-of-Network;
4. Psychotherapy; and
5. Pre-existing Conditions except for individuals who have been continuously insured under Optional Major Medical coverage for at least 12 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy.

Maternity Testing

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered if all other policy provisions have been met: Initial screening at first visit – Pregnancy test: Urine human chorionic gonatropin (HCG), Asymptomatic bacteriuria: Urine culture, Blood type and Rh antibody, Rubella, Pregnancy-associated plasma protein-A (PAPPA) (first trimester only), Free beta human chorionic gonadotrophin (hCG) (first trimester only), Hepatitis B: HBsAg, Pap smear, Gonorrhea: Gc culture, Chlamydia: chlamydia culture, Syphilis: RPR, and HIV: HIV-ab; Each visit – Urine analysis; Once every trimester – Hematocrit and Hemoglobin; Once during first trimester – Ultrasound; Once during second trimester – Ultrasound (anatomy scan); Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a; Once during second trimester if age 35 or over - Amniocentesis or Chorionic villus sampling (CVS); Once during second or third trimester – 50g Glucola (blood glucose 1 hour postprandial); and Once during third trimester - Group B Strep Culture. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of:

Life	$20,000
Both Hands, Both Feet, or Sight of Both Eyes	$20,000
One Hand and One Foot	$10,000
Either One Hand or One Foot and Sight of One Eye	$10,000
One Hand or One Foot or Sight of One Eye	$ 7,500
Entire Thumb and Index Finger of Either Hand	$ 2,000

Loss shall mean with regard to hands and feet, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

Coordination of Benefits

Benefits will be coordinated with any other medical, surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 6 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than six months under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

Application must be made and premium must be paid directly to UnitedHealthcare StudentResources and be received within 30 days after the expiration date of your student coverage. For further information on the Continuation privilege, please contact UnitedHealthcare **Student**Resources.

Mandated Benefits

Benefits for Colorectal Cancer Screening

Benefits will be paid the same as any other Sickness for a medically recognized screening examination for the detection of colorectal cancer for an Insured age 50 years of age or older and at normal risk for developing colon cancer. Benefits include the Insured's choice of:

1) a fecal occult blood test, including stool DNA test, performed annually and a flexible sigmoidoscopy performed every five years,
2) a colonoscopy, including a computer tomography colonography, performed every 10 years, or
3) one double contrast barium enema every five years.

For an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

An individual is at high risk for colorectal cancer if the individual has a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; A prior occurrence of a chronic digestive disease conditions such as inflammatory bowel disease, Crohn's disease or ulcerative colitis; or other predisposing factors.

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

Benefits Following a Brain Injury

Benefits will be paid the same as any other Injury for Medically Necessary services as a result of and related to a brain injury to facilitate the recovery and progressive rehabilitation of survivors of acquired brain injuries to the extent possible to their pre-injury condition. Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

The therapies listed and defined below must be provided for the coverage of an Acquired Brain Injury.

1. Cognitive rehabilitation therapy- Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the Insured's brain-behavioral deficits.
2. Cognitive communication therapy- Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
3. Neurocognitive therapy- Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
4. Neurocognitive rehabilitation- Services designed to assist cognitively impaired Insureds to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
5. Neurobehavioral testing- An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the Insured, family, or others.
6. Neurobehavioral treatment- Interventions that focus on behavior and the variables that control behavior.
7. Neurophysiological testing- An evaluation of the functions of the nervous system.

8. Neurophysiological treatment- Interventions that focus on the functions of the nervous system.
9. Neuropsychological testing- The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship normal and abnormal central nervous system functioning.
10. Neuropsychological treatment- Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
11. Outpatient day treatment services- Structured services provided to address functional deficits in behavior and/or cognition delivered in settings that include transitional residential, community integration, or non-residential services.
12. Psychophysiological testing- An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
13. Psychophysiological treatment- Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
14. Neurofeedback therapy- Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
15. Remediation- The process(es) of restoring or improving a specific function.
16. Post-acute transition services- Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
17. Community reintegration services, including day treatment services- Services that facilitate the continuum of care as an affected individual transitions into the community.
18. Post-acute care treatment services.

Benefits for post-acute care treatment services shall not be included in any policy maximum lifetime limit on the number of days of acute care treatment but shall be limited to 30 days of post-acute care treatment per policy year. Benefits for post-acute care treatment include reasonable expenses related to the periodic reevaluation of the care of the Insured who:

1. has incurred an Acquired Brain Injury;
2. has been unresponsive to treatment; and
3. becomes responsive to treatment at a later date.

A determination of whether expenses are reasonable for the periodic reevaluation may include consideration of factors including:

1. cost;
2. the time that has expired since the previous evaluation;
3. any difference in the expertise of the Physician performing the evaluation;
4. changes in technology; and
5. advances in medicine.

Treatment for an Acquired Brain Injury may be provided at a facility at which appropriate services may be provided, including:

1. a Hospital, including an acute and a post-acute rehabilitation hospital; and
2. an assisted living facility.

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

Benefits for Screening for Hearing Loss

Benefits will be paid the same as any other Sickness for a screening test for hearing loss for Dependent children from birth to the date the child is 30 days old and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

These benefits will not be subject to the Deductible but will be subject to any coinsurance, copayment, or any other provisions of the policy.

Benefits for the Treatment of Craniofacial Abnormalities

Benefits will be payable for Usual and Customary Charges for an Insured who is younger than 18 years of age for reconstructive surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. Benefits are subject to the policy Deductible, and any coinsurance or copayment requirements of the policy.

Benefits for Mastectomy

Benefits will be paid the same as any other Sickness for a mastectomy including a minimum of 48 hours of inpatient care following a covered mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer.

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

Benefits for Mammography

Benefits will be paid the same as any other Sickness for an annual screening mammography for Insureds 35 years and older or more often if recommended by the Physician. Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Reconstructive Surgery Following Mastectomy

Benefits will be paid as specified below for the reconstruction of the breast on which the mastectomy has been performed. Benefits will also be paid for surgery and reconstruction of the other breast to achieve a symmetrical appearance. Benefits will include prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy, in consultation with the attending Physician and the patient. Benefits shall be subject to the same Deductible, copayment, coinsurance and other provisions of the policy as for any other Sickness but shall not be subject to other dollar limitations of the policy except for any policy Maximum Benefit or policy Maximum Lifetime Benefit.

Benefits for Phenylketonuria or Other Heritable Disease

If Benefits are provided for Prescription Drugs under this policy, then benefits will be provided under the Prescription Drug Benefit for the formulas necessary for the treatment of Phenylketonuria or a Heritable Disease prescribed by or under the direction of a Physician.

“Phenylketonuria” means an inherited condition that, if not treated, may cause severe mental retardation. “Heritable disease” means an inherited disease that may result in mental or physical retardation or death.

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

Benefits for Childhood Immunizations

Benefits will be provided for childhood immunizations, following the American Pediatric Association recommendations, for Dependent children from birth through the sixth birthday. Immunizations against diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunizations that are required by law for the child shall be covered.

These benefits will not be subject to any coinsurance, Deductible or copayment provisions of the policy, but will be subject to other provisions of the policy.

Benefits for Temporomandibular and Craniomandibular Joint Dysfunction

Benefits will be paid the same as any other Sickness or Injury for medically necessary diagnostic and/or surgical treatment of skeletal joints, including comparable benefits for the medically necessary diagnostic and/or surgical treatment of conditions affecting the temporomandibular joint, including the jaw or the craniomandibular joint, as a result of an accident, trauma, congenital defect, developmental defect or a pathology.

No benefits will be paid for other dental services that are not otherwise shown in the Schedule of Benefits.

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

Benefits for Diabetes Treatment

Benefits will be paid the same as any other Sickness for medication, Equipment, Supplies, appliances and Self-management Training that are medically necessary for the treatment of Type I, Type II and gestational diabetes.

"Diabetes equipment" means:

1) blood glucose monitors, including noninvasive monitors, and monitors designed to be used by blind individuals;
2) insulin pumps, both external and implantable, and associated appurtenances;
3) insulin infusion devices; and
4) podiatric appliances for the prevention of complications associated with diabetes.
5) Biohazard disposal containers;

"Diabetes supplies" means:

1) test strips for blood glucose monitors;
2) visual reading and urine test strips;
3) lancets and lancet devices;
4) insulin and insulin analogs;
5) injection aids;
6) syringes;
7) prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
8) glucagon emergency kits;
9) batteries;
10) skin preparation items;
11) adhesive supplies;
12) infusion sets;
13) insulin cartridges;
14) durable and disposable devices to assist in the injection of insulin; and

15) other required disposable supplies;

16) tablets for glucose tests, ketones and protein.

Diabetes self-management training must be provided by a Physician. Self-management training includes:

1) training provided to a qualified Insured after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;

2) additional training authorized on the diagnosis of a Physician of a significant change in the qualified Insured's symptoms or condition that requires changes in the qualified Insured's self-management regime; and

3) periodic or episodic continuing education training when prescribed by a Physician as warranted by the development of new techniques and treatments for diabetes.

If the diabetes self-management training is provided on the written order of a Physician, the training must also include:

1) a diabetes self-management training program recognized by the American Diabetes Association;

2) diabetes self-management training provided by a multidisciplinary team:

A) the nonphysician members of which are coordinated by: (i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or (ii) an individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;

B) that consists of at least a licensed dietitian and a Registered Nurse and may include a pharmacist and a social worker; and

C) each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

3) diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or

4) diabetes self-management training that provides one or more of the following components:

A) a nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;

B) a pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

C) a component provided by a Physician assistant or registered nurse, for which the Physician assistant or registered nurse shall be paid, except that the Physician assistant or Registered Nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or

D) a component provided by a Physician.

An individual may not provide a component of diabetes self-management training specified above unless: the subject matter of the component is within the scope of the individual's practice; and, the individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health.

All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the Physician or practitioner who issues the written order for the supplies or equipment.

Diabetes supplies includes repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

In addition to the above benefits, on the approval of the United States Food and Drug Administration of new or improved diabetes equipment or diabetes supplies, including improved insulin or other Prescription Drugs, benefits will be provided for such new or improved equipment, supplies and medicine if medically necessary and appropriate as determined by a Physician.

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

Benefits for the Detection of Human Papillomavirus and Cervical Cancer

Benefits will be paid the same as any other Sickness for the early detection of cervical cancer for women 18 years of age or older. Coverage includes a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Screening tests required under this section must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists, or another similar national organization of medical professionals recognized by the commissioner.

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

Benefits for Maternity and Post Delivery Care

Benefits will be paid the same as any other Sickness for the Insured Mother and Newborn Infant for Maternity and Post Delivery Care. Benefits will be provided for inpatient stay following birth for a minimum of:

1) 48 hours following an uncomplicated vaginal delivery; and

2) 96 hours following an uncomplicated delivery by caesarean section.

Benefits will be provided for timely post delivery care. That care may be provided to the Insured and Newborn Infant by a Physician, Registered Nurse, or other appropriate licensed health care provider and may be provided at:

1) the Insured's home, a health care provider's office, or a health care facility; or

2) another location determined to be appropriate under rules adopted by the commissioner.

The benefits must allow the Insured the option to have the care provided in the Insured's home.

"Postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

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

Benefits for Complications of Pregnancy

Benefits will be paid the same as any other Sickness for Complications of Pregnancy.

"Complications of Pregnancy" means: 1) conditions, requiring Hospital Confinement (when pregnancy is not terminated), whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

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

Benefits for Osteoporosis

Benefits will be paid the same as any other Sickness for a "Qualified Enrollee" for medically accepted bone mass measurement to detect low bone mass and to determine the Insured's risk of osteoporosis and fractures associated with osteoporosis.

"Qualified enrollee" means an Insured who is:

1) a postmenopausal woman who is not receiving estrogen replacement therapy;

2) an individual with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures, or

3) an individual who is receiving long-term glucocorticoid therapy, or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

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

Benefits for Prescription Contraceptive Drugs or Devices

If benefits are provided for Prescription Drugs under this policy, benefits will be provided for: 1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration; and 2) an Outpatient Contraceptive Service. Outpatient Contraceptive Service means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

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

Benefits for Detection of Prostate Cancer

Benefits will be paid the same as any other Sickness for an annual diagnostic examination for the detection of prostate cancer, including:

1) a physical examination for the detection of prostate cancer; and

2) a prostate-specific antigen test used for the detection of prostate cancer for each Insured who is a) at least 50 years of age and asymptomatic; or b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

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

Benefits for Off-Label Drug Use

If benefits are provided for Prescription Drugs under this policy, then benefits will be provided under the Prescription Drug Benefit for any drug prescribed to treat an Insured for a covered chronic, disabling, or life-threatening Sickness if the drug: (1) has been approved by the Food and Drug Administration for at least one indication; and (2) is recognized for treatment of the indication for which the drug is prescribed in: (A) a prescription drug reference compendium approved by the commissioner for the purpose of this article; or (B) substantially accepted peer-reviewed medical literature.

Benefits shall include coverage of medically necessary services associated with the administration of the drug. A drug use that is covered under this section may not be denied based on a "Medical Necessity" requirement except for reasons that are unrelated to the legal status of the drug use. This section does not require coverage for: (1) experimental drugs not otherwise approved for any indication by the Food and Drug Administration; or (2) any disease or condition that is excluded from coverage under the plan. Benefits are not provided for a drug the Food and Drug Administration has determined to be contraindicated for treatment of the current indication.

"Contraindication" means the potential for, or the occurrence of, an undesirable alteration of the therapeutic effect of a prescribed drug prescription because of the presence, in the patient for whom it is prescribed, of a disease condition, or the potential for, or the occurrence of, a clinically significant adverse effect of the drug on the patient's disease condition.

"Indication" means any symptom, cause, or occurrence in a Sickness that points out the cause, diagnosis, course of treatment, or prognosis of the Sickness.

"Peer-reviewed medical literature" means published scientific studies in any peer-reviewed national professional journal.

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

Benefits for Telemedicine / Telehealth Services

Benefits will be paid for services provided through telemedicine and telehealth on the same basis as services provided through a face-to-face consultation. "Telemedicine" means a health care service initiated by a Physician or provided by a health professional acting under Physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunication technology, other than by telephone or facsimile, including: (a) compressed digital interactive video, audio, or data transmission; (b) clinical data transmission using computer imaging by way of still image capture and store and forward; and (c) other technology that facilitates access to health care services or medical specialty expertise. “Telehealth” means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional’s license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including: Compressed digital interactive video, audio or data transmission, clinical data transmission using computer imaging by way of still-image capture and store and forward, and other technology that facilitates access to health care services or medical specialty expertise.

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

Benefits for Prosthetic Devices and Services

Benefits will be paid based on the Medicare allowance for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices as specified below:

- Benefits will equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. sections 1395K, 1395L, 1395M and CFR 410.100, 414.202, 414.210, and 414.228 as applicable.
- Benefits will include repair and replacement of a prosthetic or orthotic device unless the repair or replacement is necessitated by misuse or loss by the Insured.
- Benefits are limited to the most appropriate model of device that adequately meets the medical needs of the Insured as determined by the treating Physician or podiatrist and prosthetist or orthotist.

"Prosthetic Device" means an artificial device designed to replace, wholly or partly, an arm or leg.

"Orthotic Device" means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Benefits shall be subject to all Deductible, copayment, coinsurance, but shall not be subject to any policy dollar limits but shall be subject to any other provisions of the policy.

Benefits for Amino Acid-Based Formulas

If benefits are provided for Prescription Drugs under this policy, then benefits will be paid under the Prescription Drug benefit for amino acid-based elemental formula for the treatment of an Insured who is diagnosed with any of the following diseases or disorders:

(1) immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins

(2) severe food protein-induced enterocolitis syndrome

(3) eosinophilic disorder, as evidenced by results from a biopsy; or

(4) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

Benefits will include coverage of any medically necessary services associated with the administration of the formula.

The treating Physician must issue a written order stating the amino acid-based elemental formula is medically necessary for the treatment of an Insured diagnosed with any of the diseases or disorders mentioned above.

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

Benefits for Routine Patient Care Costs for Clinical Trials

Benefits will be paid the same as any other Sickness for Routine Patient Care Costs to an Insured in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening Sickness and is approved by:

(1) the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;

(2) the National Institutes of Health;

(3) the United States Food and Drug Administration;

(4) the United States Department of Defense;

(5) the United States Department of Veterans Affairs; or

(6) an institutional review board of an institution in Texas which has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

"Routine Patient Care Costs" means the costs of any medically necessary health care service for which benefits are provided without regard to whether the Insured is participating in a clinical trial. Routine Patient Care Costs does not include:

(1) the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;

(2) the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;

(3) the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

(4) a cost associated with managing a clinical trial; or

(5) the cost of a health care service that is specifically excluded from coverage under the plan.

Benefits will not be paid for the cost of routine patient care provided through the research institution conducting the clinical trial for the cost unless the research institution, and each health care professional providing the routine patient care through the research institution, agrees to accept reimbursement at the rates established under the plan.

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

Definitions

ADOPTED CHILD means the adopted child placed with an Insured while that person is covered under this policy. Such child will be covered from the moment of placement for the first 31 days. The Pre-existing Conditions limitation will not apply to an adoptive child. The Insured must notify the Company of the adopted child not more than 31 days after placement or adoption. In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

COMPLICATIONS OF PREGNANCY means: 1) conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

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 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 or Sickness) as specified in the Schedule of Benefits.

DEPENDENT means the spouse (husband or wife) of the Named Insured, and their dependent, unmarried children, including any adopted child; any child in placement for adoption; any child for which suit is filed for adoption; any child for which the Named Insured is under court order to provide medical coverage; any natural born or adopted child of the spouse of the Named Insured; and, any dependent grandchild of the Named Insured. Children shall cease to be dependent on the first to occur of:

1) The end of the month in which they marry; or,

2) The end of the month in which the child attains the age of twenty-five (25) years;

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and,

2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age. If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

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 a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

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. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. 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 bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1) Placement of the Insured's health in serious jeopardy;

2) Serious impairment of bodily functions;

3) Serious dysfunction of any body organ or part;

4) Serious disfigurement; 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 Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

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 Sickness or Injury;

2) Provided for the diagnosis, or the direct care and treatment of the Sickness or 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.

MENTAL AND NERVOUS DISORDER means a Sickness that is a mental, emotional or behavioral disorder. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the (International Classification of Diseases) are considered one Sickness.

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.

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

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

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: 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 is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under the policy.

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.

PSYCHOTHERAPY means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

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

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

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.

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.

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. Acne; acupuncture;
2. Nicotine addiction;
3. Learning disabilities;
4. Biofeedback;
5. Durable Medical Equipment;
6. Circumcision;
7. Congenital conditions, except as specifically provided in the Benefits for Temporomandibular and Craniomandibular Joint Dysfunction, Benefits for Treatment of Craniofacial Abnormalities, and for Newborn or adopted Infants;
8. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery or Elective Treatment;
11. Elective abortion;
12. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, except when due to a disease process;
13. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process, except as specifically provided in the Benefit for the Screening of Hearing Loss;
14. Foot care including: care of corns, bunions (except capsular or bone surgery), calluses;
15. Hirsutism; alopecia;
16. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
17. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
18. Injury sustained while (a) participating in any interscholastic, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
19. Organ transplants; including organ donation;
20. 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;

21. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting as an active participant;
22. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months; The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy;
23. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
24. Routine Newborn Care, well-baby nursery and related Physician charges, except as specifically provided in the Benefits for Maternity and Post Delivery Care;
25. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
26. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
27. 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;
28. Sleep disorders;
29. Supplies, except as specifically provided in the policy;
30. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
31. Nasal and sinus surgery;
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
33. 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); and
34. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

Collegiate Assistance Program

Insured Students have access to nurse advice and health information 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID card. The Collegiate Assistance Program is staffed by Registered Nurses who can help students determine if they need to seek medical care, understand their medications, medical procedures, or learn ways to stay healthy.

Scholastic Emergency Services: Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you and your insured spouse and minor child(ren) are eligible for Scholastic Emergency Services (SES). The requirements to receive these services are as follows:

International Students, insured spouse and insured minor child(ren): You are eligible to receive SES worldwide, except in your home country.

Domestic Students, insured spouse and insured minor child(ren): You are eligible for SES when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

SES includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, Inc.; any services not arranged by SES, Inc. will not be considered for payment.

Key Services include:

* Medical Consultation, Evaluation and Referrals
* Foreign Hospital Admission Guarantee
* Emergency Medical Evacuation
* Medically Supervised Repatriation
* Emergency Counseling Services
* Lost Luggage or Document Assistance
* Care for Minor Children Left Unattended Due to a Medical Incident
* Prescription Assistance
* Critical Care Monitoring
* Return of Mortal Remains
* Transportation to Join Patient
* Interpreter and Legal Referrals

Please visit your school's insurance coverage page at www.uhcsr.com/UTSystem for the SES Global Emergency Assistance Services brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States
(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

When calling the SES Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at www.uhcsr.com/UTSystem for additional information, including limitations and exclusions pertaining to the SES program.

How To File A Claim

In the event of Injury or Sickness, students should:

1) Report to the Student Health Service or Infirmary for treatment or assistance, or to their Physician or Hospital.
2) Mail to the address below all medical and hospital bills including diagnosis along with the patient's name and Insured student's name, address, social security number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.
4) Submit all claims or inquiries to: UnitedHealthcare **Student**Resources, P.O. Box 809025, Dallas, Texas 75380-9025, Phone 1- 469-229-6700 or 1-888-344-6105.

If you receive medical care on campus from your respective component's Student Health Center, Health Service or Infirmary, your claim is filed for you. Note: UTD does not file claims for students.

Claims Appeals Process

If you believe that your claim was denied in error, or wish to request that additional consideration be given to the circumstances surrounding your claim, you may send UnitedHealthcare **Student**Resources a letter of appeal.

Send the appeal for reconsideration, with any additional pertinent information to:

UnitedHealthcare **Student**Resources

Claims Appeals

P. O. Box 809025

Dallas, TX 75380-9025

Your response will be addressed and a determination will be mailed to you. If your appeal is denied and you still believe that additional review is is needed, forward your appeal letter to the attention of Regulatory and Consumer Affairs at the above address.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

2301 West Plano Parkway, Suite 300

Plano, Texas 75075

(469) 229-6700

(888) 344-6105

Monday - Friday

7:00 a.m. - 4:00 p.m. Central Standard Time

Closed on Weekends

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

This Brochure is based on Policy #2010-50-1 v4