2013-2014

**PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS**

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of the Health Science Center at Fort Worth Campus

UNT™

UNIVERSITY OF NORTH TEXAS SYSTEM

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.

UnitedHealthcare®
A UnitedHealth Group Company

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $500,000 for each Injury or Sickness that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-866-429-4868. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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Student Insurance Plan

The rising costs of medical care have made the UNT System increasingly aware of the importance of adequate insurance to provide care when Injuries and Sicknesses require treatment.

The UnitedHealthcare Insurance Company Plan is specifically designed for the University of North Texas students. The Policy covers students who require hospitalization treatment for Injuries or Sicknesses.

All international students, who are required to carry adequate health care protection, and other students who are not protected under a family health insurance plan will benefit from a careful examination of this officially sponsored student insurance plan. The University is fortunate in being able to offer these benefits at a reasonable cost.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic 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 nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 866-429-4868 or by visiting us at www.uhcsr.com/unt.

Eligibility

All students taking credit hours at the University of North Texas Health Science Center at Fort Worth and any students participating in a distance learning program are required to purchase this Insurance plan, unless proof of comparable coverage is furnished. All registered international students, scholars or other persons with a current passport and student visa engaged in educational activities at the university are automatically enrolled in this insurance plan at registration and the premium for coverage is added to their tuition billing, unless proof of comparable coverage is furnished. This includes International students engaged in curricular practical training, Optional Practical Training, Internship, Practicum, Academic Training, Study Abroad, or other credit or non-credit activity as a bona fide UNT student.

Online courses do fulfill the Eligibility requirements that the student attend classes. Students admitted into online-only programs who do not reside in the state of Texas are not eligible for coverage in the plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy's Eligibility requirements have been met. Student status will be verified by the Registrar's Office. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse (husband or wife) and dependent children under 26 years of age.

Dependent Eligibility expires concurrently with that of the Insured student.

Medical Evacuation/Repatriation coverage is available for purchase by eligible students and Dependents when the person's other comparable insurance policy does not provide this benefit.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., July 19, 2013. The individual student's coverage becomes effective on the first day of the period for 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. The Master Policy terminates at 11:59 p.m., August 13, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Refunds of premiums are allowed only upon entry into the armed forces.

The Policy is a Non-Renewable One Year Term Policy.

Extension of Benefits After Termination

The coverage provided under the Policy ceases on the Termination Date. However, if the 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 under the Basic Plan 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.

Schedule of Medical Expense Benefits

Injury and Sickness

Maximum Benefit: $500,000 Paid As Specified Below
(For Each Injury or Sickness)

Deductible Preferred Provider: $300 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network: $600 (Per Insured Person, Per Policy Year)
(The Deductible applies to students and Dependents.)

Coinsurance Preferred Provider: 80% except as noted below
Coinsurance Out-of-Network: 60% except as noted below

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 a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $500,000 for each Injury or Sickness.

The Deductible will be waived and benefits will be paid for 100% of Covered Medical Expenses incurred at the Student Health and Wellness Center. Students paying the student medical service fee are allowed access to providers for medical treatment, but will incur charges for services and visits rendered. The Pre-Existing Condition exclusion and limitation is waived when students are treated at the Student Health and Wellness Center.

The following are covered at the Student Health & Wellness Center: 1) under the Health Center's annual Pap coverage except as mandated: Chlamydia (STD), Thin Prep, Gonorrhea, RPR (Syphilis), H/H (anemia), HIV testing, urinalysis (chem), and CMP (blood chemistry); 2) an annual physical will cover the examination and lab work, including CMP, urinalysis, STD testing and H/H; 3) acne treatment (acne medications will be covered under the Prescription Drug benefits); 4) All CDC recommended immunizations, including HPV and Bacterial Meningitis are covered (If not a PPACA mandated benefit, a $25 copay is applicable); 5) Immune Titers and 6) Screening for Tb by administering the T-spot test. If the test result is positive, a 1 view chest x-ray to determine if contagious.

Needle stick / Face splash as a result of course work in a clinical setting will be paid as any other Injury or Sickness.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. 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 otherwise specifically stated. Covered Medical Expenses include:

PA = Preferred Allowance	U&C = Usual & Customary Charges	
INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Room and Board Expense, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	80% of PA	60% of U&C
Intensive Care	80% of PA	60% of U&C
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 U&C
Routine Newborn Care, see Benefits for Maternity and Post Delivery Care.	Paid as any other Sickness	
Physiotherapy	Paid under Hospital Miscellaneous Expense	
Surgeon's Fees, 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 U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Surgeon's Fees, 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 U&C
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 U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	80% of PA	60% of U&C
Physiotherapy, physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of PA	60% of U&C
Medical Emergency Expenses, facility charge for 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	60% of U&C
Diagnostic X-ray Services	80% of PA	60% of U&C
Radiation Therapy	80% of PA	60% of U&C
Chemotherapy	80% of PA	60% of U&C
Laboratory Services	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement. (Bacterial Meningitis vaccines are covered after a $25 copay / Deductible per injection except as provided under the Preventive Care Services benefit.)	80% of PA	60% of U&C
Prescription Drugs **Students:** A $10 Deductible for Generic / $35 Deductible for Brand Name is payable for all prescriptions filled at the Student Health and Wellness Center.	UnitedHealthcare Pharmacy (UHCP) $10 Copay per prescription for Tier 1 $25 Copay per prescription for Tier 2 $40 Copay per prescription for Tier 3 up to a 31-day supply per prescription	No Benefits Prescriptions are only covered if filled at a UHCP Pharmacy
OTHER		
Ambulance Services	80% of PA	60% of U&C
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. Durable medical equipment includes prosthetic devices as provided for in the Benefits for Prosthetic Devices and Services. *($2,500 maximum per Policy Year) (Durable Medical Equipment benefits payable under the $2,500 maximum are not included in the $500,000 Maximum Benefit.)*	80% of PA	60% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	80% of PA	60% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *(Benefits are not subject to the $500,000 Maximum Benefit.)*	80% of U&C	80% of U&C

OTHER	Preferred Providers	Out-of-Network Providers
Mental Illness Treatment, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	
Maternity, see Benefits for Maternity and Post Delivery Care.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	No Benefits	
Preventive Care Services, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.	100% of PA	No Benefits
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy.	See Benefits for Reconstructive Surgery Following Mastectomy	
Diabetes Services, in connection with the treatment of diabetes. See Benefits for Diabetes Treatment.	Paid as any other Sickness	
Urgent Care Center, facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.	80% of PA	60% of U&C

Preferred Provider Information

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

UnitedHealthcare Choice Plus

The availability of specific providers is subject to change without notice. Insured's should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-866-429-4868 and/or by asking the provider when making an appointment for services.

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

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

"Network Area" means the 50 mile radius around the local school campus the Named Insured is attending.

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 Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call (866) 429-4868 for information about Preferred Hospitals.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient 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 percentages 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, Preferred, Out-of-Network Providers or their representatives with questions or complaints may call the Customer Service Department at 1-866-429-4868. 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 an Insured who has a special circumstance include an Insured with a disability, acute condition, or Life Threatening Condition or an Insured who is past the 24th week of pregnancy.

Benefits will continue to be paid at the negotiated Preferred Provider level of benefits if an 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 delivery.

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.

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare 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 Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com/unt or call 855-828-7716 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

$25 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply

$40 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply

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 for the prescription.

If you do not present the card, you will need to pay for the prescription and then submit a 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/unt and log in to your online account or call 855-828-7716.

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-3).
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.

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/unt or call Customer Service at 1-855-828-7716.

Maternity Testing

This policy does not cover all routine, preventive, or screening examinations or testing. The following maternity tests and screening exams will be considered for payment according to the policy benefits 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
- HIV: HIV-ab
- Coombs test

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)

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 1-866-429-4868.

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	$10,000
Two or More Members	$10,000
One Member	$ 5,000
Thumb or Index Finger	$ 1,000

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, 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 Provision

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

Mandated Benefits

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.

"Post delivery 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 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.

Exclusions provided in the policy do not include limitations or exclusions of therapies listed and defined below. The following therapies 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 outpatient day treatment services- Services that facilitate the continuum of care as an affected individual transitions into the community.
18. Post-acute care treatment services – Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

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 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 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 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, Ccopayment, Coinsurance, limitations, or any other provisions 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 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.

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.

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 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 or upon written order of a Physician as specified below. 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.

Additional Benefits

Additional mandated benefits are provided for the following as required by the Texas Department of Insurance. A detail of these benefits may be found in the Master Policy on file at the University: Benefits for Telemedicine/Telehealth Services, Benefits for Temporomandibular and Craniomandibular Joint Dysfunction, Benefits for Mammography, Benefits for Off-Label Drug Use, Benefits for Childhood Immunizations, Benefits for The Treatment of Craniofacial Abnormalities, Benefits for Screening for Hearing Loss, Benefits for Osteoporosis, Benefits for Complications of Pregnancy, Benefits for Phenylketornuria or Other Heritable Disease, Benefits for Prescription Contraceptive Drugs or Devices, Benefits for Amino Acid-Based Formulas, and Benefits for Orally Administered Anticancer Medications.

Definitions

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) 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.

INJURY means bodily injury which is all of the following:

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.
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.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital by reason of an Injury or Sickness for which benefits are payable under this policy.

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.

PRE-EXISTING CONDITION means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 12 months immediately prior to the Insured's Effective Date under the policy.

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or 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. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. 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 any of the following:

1. Acupuncture;
2. Nicotine addiction, except as specifically provided in the policy;
3. Learning disabilities; except as specifically provided in the policy;
4. Biofeedback;
5. Circumcision;
6. 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;
7. 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;
8. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
9. Elective Surgery or Elective Treatment;
10. Elective abortion;
11. Eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses; except when due to a covered Injury or disease process;
12. Hearing examinations; hearing aids; or cochlear implants; or other treatment for hearing defects and problems, except as a result of an infection or trauma; or except as specifically provided in the Benefits for the Screening of Hearing Loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
13. Hirsutism;
14. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury, or as specifically provided in the policy;
15. Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
17. Injury sustained while (a) participating in any 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;
18. Organ transplants, including organ donation;
19. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting as an active participant;
20. 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; provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;

21. 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, except as specifically provided in the policy and in the Benefits for Diabetes;
    b) Immunization agents, except as specifically provided in the policy; 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) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
22. 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; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
23. Routine Newborn Infant Care, well-baby nursery and related Physician charges; except as specifically provided in the Benefits for Maternity and Post Delivery Care;
24. Preventive Care Services; 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;
25. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
26. 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;
27. Sleep disorders;
28. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
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. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
32. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
33. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 866-429-4868 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Appeal.

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact Claims Appeals at 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

After exhausting the Company's Internal Appeal process, the Insured Person, or the Insured Person's Authorized Representative, has the right to request an External Independent Review when the service or treatment in question:

1. Is a Covered Medical Expense under the Policy; and
2. Is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level or care, or effectiveness.

Standard External Review

A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited External Review

An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
   a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
   b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and
   a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
   b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

Standard Experimental or Investigational External Review

An Insured Person, or an Insured Person's Authorized Representative, may submit a request for an Experimental or Investigational External Review when the denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational.

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational External Review

An Insured Person, or an Insured Person's Authorized Representative, may submit an oral request for an Expedited Experimental or Investigational External Review when:

1. The Insured Person or the Insured Person's Authorized Representative has received an Adverse Determination, and
   a. The Insured Person, or the Insured Person's Authorized Representative, has submitted a request for an Expedited Internal Appeal; and
   b. Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective is not initiated promptly; or
2. The Insured Person or the Insured Person's Authorized Representative has received a Final Adverse Determination, and
   a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
   b. The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly

Where to Send External Review Requests

All types of External Review requests shall be submitted to Claims Appeals at the following address:

Claims Appeals
UnitedHealthcare **Student**Resources
PO Box 809025
Dallas, TX 75380-9025
888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service at 866-429-4868 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state department of insurance may be able to assist you at:

Texas Consumer Health Assistance Program
Texas Department of Insurance
Mail Code 111-1A
333 Guadalupe
P.O. Box 149091
Austin, TX 78714
(855) 839-2427 (855-TEX-CHAP)
www.texashealthoptions.com
chap@tdi.state.tx.us

FrontierMEDEX: Global Emergency Medical Services

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

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

Domestic Students, insured spouse and insured minor child(ren): You are eligible for FrontierMEDEX services 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.

FrontierMEDEX 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 services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment.

Key Services include:

*Transfer of Insurance Information to Medical Providers
*Transfer of Medical Records
*Worldwide Medical and Dental Referrals
*Emergency Medical Evacuation
*Transportation to Join a Hospitalized Participant
*Replacement of Corrective Lenses and Medical Devices
*Hotel Arrangements for Convalescence
*Return of Dependent Children
*Legal Referrals
*Message Transmittals
*Monitoring of Treatment
*Medication, Vaccine and Blood Transfers
*Dispatch of Doctors/Specialists
*Facilitation of Hospital Admission Payments
*Transportation After Stabilization
*Emergency Travel Arrangements
*Continuous Updates to Family and Home Physician
*Replacement of Lost or Stolen Travel Documents
*Repatriation of Mortal Remains
*Transfer of Funds
*Translation Services

Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(800) 527-0218 Toll-free within the United States

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

When calling the FrontierMEDEX 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 FrontierMEDEX ID Number as listed on your Medical ID Card;
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.

FrontierMEDEX 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 FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in MyAccount at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to ***My Account*** at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "create My Account Now" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare **Student**Resources' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account has been enhanced to include *Message Center* - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to ***My Account*** as described above and select *UnitedHealth Allies Plan* to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

ID Cards

One way we are becoming greener is to no longer automatically mail out ***ID Cards***. Instead, we will send an email notification when the digital ID card is available to be downloaded from ***My Account.*** An Insured student may also use ***My Account*** to request delivery of a permanent ID card through the mail. ID Cards may also be accessed via our mobile site at my.uhcsr.com.

Claim Procedure

In the event of Injury or Sickness:

1. University of North Texas Health Science Center students should visit the UNTHSC Student Health Clinic or report to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured'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.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, Texas 75380-9025
1-866-429-4868
Claims@uhcsr.com
Customerservice@uhcsr.com

Please keep this Brochures 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 payment of benefits.

This Brochure is based on Policy # 2013-598-3

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UNIVERSITY OF NORTH TEXAS SYSTEM

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2013-598-3

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC # 1 (7/18/13)
Added this paragraph to SOB header to match 2012 Brochure:

"Needle stick / Face splash as a result of course work in a clinical setting will be paid as any other Injury or Sickness."

NOC # 2 (7/23/13)
Added "5) Immune Titers" to SOB header SHC paragraph.