Special Events Insurance Plan

Underwritten by:
Blue Cross and Blue Shield of Texas (BCBSTX)
Please read the brochure to understand your coverage.

ACCOUNT NUMBER: 101570
www.ahpcare.com/UTSystem/special-events

Endorsed by:
The University of Texas System

Blue Cross and Blue Shield of Texas is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.
### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>1</td>
</tr>
<tr>
<td>Effective and Termination Dates</td>
<td>1</td>
</tr>
<tr>
<td>Extension of Benefits</td>
<td>1</td>
</tr>
<tr>
<td>Accessing Emergency Care</td>
<td>1</td>
</tr>
<tr>
<td>Network Provider Information</td>
<td>2</td>
</tr>
<tr>
<td>Additional Covered Expenses</td>
<td>2</td>
</tr>
<tr>
<td>Outpatient Prescription Drug Benefit</td>
<td>2</td>
</tr>
<tr>
<td>Pre-Authorization Notification</td>
<td>2</td>
</tr>
<tr>
<td>Schedule of Medical Expense Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>5</td>
</tr>
<tr>
<td>Definitions</td>
<td>5</td>
</tr>
<tr>
<td>Pre-Existing Condition Limitation</td>
<td>8</td>
</tr>
<tr>
<td>Exclusions and Limitations</td>
<td>8</td>
</tr>
<tr>
<td>Academic Emergency Services</td>
<td>10</td>
</tr>
<tr>
<td>Claim Procedure</td>
<td>11</td>
</tr>
<tr>
<td>Important Notice</td>
<td>12</td>
</tr>
<tr>
<td>Privacy Disclosure</td>
<td>12</td>
</tr>
<tr>
<td>Affordable Care Act Notice</td>
<td>12</td>
</tr>
</tbody>
</table>

Please Note: We have capitalized certain terms that have specific, detailed meanings, which are important to help you understand your Policy. Please review the meaning of the capitalized terms in the Definitions section.
Eligibility

University of Texas System Institutions: All department-sponsored special events participants while they are: 1) participating in scheduled, supervised departmental or class-sponsored field trips or university sponsored activities including summer camps, special programs, and recreational sports trips; and 2) traveling to or from the scheduled, supervised events or practice sessions. To be eligible to enroll in the Student Health Special Events Insurance Plan, a participant must be a fee paying student at an institution of The University of Texas System taking credit hours, graduate student working on research/dissertation or thesis, post doctorate student, fellow or visiting scholar.

Each person who belongs to one of the “department-sponsored special events” as set forth in the paragraph above is eligible to be insured under this Policy. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, it only obligation is refund of premium.

Eligible person may be insured under this Policy subject to the following: 1) Payment of premium as set forth in the Policy; and 2) Enrollment/Invoice to the Company for such coverage.

Students must actively attend the department-sponsored special event for the dates of coverage purchased.

Effective and Termination Dates

Insurance under this Policy shall become effective on the later of the following dates:

1) The effective date of the Policy, August 01, 2012; or
2) The date premium is received by the administrator.

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

1) The last day of the period through which the premium is paid; or
2) The date the Policy terminates, July 31, 2013.

Extension of Benefits

The coverage provided under the Plan ceases on the termination date. However, if a Covered Person is hospital confined on the termination date for a covered Injury or Sickness for which benefits were incurred before the termination date, Covered Expenses for such covered Injury or Sickness will continue to be paid provided the condition continues, but not to exceed 90 days after termination date.

The total payments made in respect of the Covered Person 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.

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 Emergency Care to see if your situation would meet the criteria.

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

Network Providers allow the Insured to maximize the benefits offered under this Plan. You should seek treatment from the Blue Cross and Blue Shield of Texas (BCBSTX) BlueChoice® Participating Provider Option (PPO) Network, which consists of hospitals, doctors, ancillary, and other health care providers who have contracted with BCBSTX for the purpose of delivering covered health care services.

A list of network providers can be found online at [www.ahpcare.com/UTSystem/special-events](http://www.ahpcare.com/UTSystem/special-events) by selecting your campus and then clicking the “Find a Doctor or Hospital” link under Benefits or by calling (800) 521-2227.

Additional Covered Expenses

The Policy will always pay benefits in accordance with any applicable Federal and Texas State Insurance Law(s).

Outpatient Prescription Drug Benefit

**AT PHARMACIES PARTICIPATING IN THE PRIME THERAPEUTICS NETWORK ONLY:** Expenses are payable at 100% of the Allowable Amount after a $10 copay for each Generic and a $15 copay for each Brand Name prescription drug dispensed by a pharmacy participating in the Prime Therapeutics Network. After your prescription is filled, you will be required to pay for the prescription in full, and file your claim with Blue Cross and Blue Shield of Texas for reimbursement. You must go to a pharmacy participating in the Prime Therapeutics Network in order to access this program. Present your insurance ID Card to the pharmacy to identify yourself as a participant in this Plan. You can locate a participating pharmacy by calling (800) 423-1973 or online at [www.ahpcare.com/UTSystem/special-events](http://www.ahpcare.com/UTSystem/special-events) by selecting your campus and then clicking on the “Find a Pharmacy” link.

**ALL OTHER PHARMACIES:** Expenses are payable at 60% of the Allowable Amount after a $10 copay for each Generic and a $15 copay for each Brand Name prescription drug. After your prescription is filled, you will be required to pay for the prescription in full, and file your claim with Blue Cross and Blue Shield of Texas for reimbursement.

Covered Expenses for all prescription drugs are limited to a 30-day supply.

Pre-Authorization Notification

**IMPORTANT:** BCBSTX should be notified of all Hospital Confinements prior to admission in order to avoid a penalty for that care. Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, Pre-Authorization Notification is not a guarantee that benefits will be paid.

1. **Pre-Authorization Notification of Medical Non-Emergency Hospitalizations:** The patient, Doctor or Hospital should telephone (800) 441-9188 at least three (3) working days prior to the planned admission.

2. **Pre-Authorization Notification of Medical Emergency Hospitalizations:** The patient, patient’s representative, Doctor or Hospital should telephone (800) 441-9188 within three (3) working days of the admission or as soon as reasonably possible to provide the notification of any admission due to Medical Emergency.

BCBSTX is open for Pre-Authorization 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 (800) 441-9188.
Schedule of Medical Expense Benefits
Injury and Sickness

$100,000 Maximum Benefit, per Covered Person, per Policy year

$300 Deductible per Covered Person, per Policy year
If two or more covered family members are injured in the same accident, only one Deductible will apply.

Network Provider Individual Out-of-pocket Maximum: $3,000 per Policy Year
Out-of-Network Individual Out-of-pocket Maximum: $6,000 per Policy Year

The Network Provider for this plan is Blue Cross and Blue Shield of Texas (BCBSTX) BlueChoice® PPO Network.

After the Deductible is satisfied, benefits will be paid based on the selected Provider. Benefits will be paid at 80% of the Allowable Amount for services rendered by Network Providers in the Blue Cross and Blue Shield of Texas (BCBSTX) BlueChoice PPO Network, unless otherwise specified in the Policy. Services obtained from Out-of-Network providers (any provider outside the Blue Cross and Blue Shield of Texas (BCBSTX) BlueChoice PPO Network) will be paid at 60% of the Allowable Amount, unless otherwise specified in the Policy. Benefits will be paid up to the maximum for each service as specified below regardless of the provider selected, not to exceed the Maximum Benefit of $100,000.

Out-of-pocket Maximum means the maximum liability that may be incurred by a Covered Person in a benefit period for covered services under the terms of a Coverage Plan.

Once the Out-of-pocket limit has been satisfied, Covered Expenses will be payable at 100% for the remainder of the Policy Year, up to any maximum that may apply. The Out-of-pocket limit does not include Deductible, copays or any charges exceeding the Allowable Amount.

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Network Provider Plan Pays</th>
<th>Out-of-Network Provider Plan Pays</th>
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</thead>
<tbody>
<tr>
<td>Hospital Expense, daily semi-private room rate; intensive care; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses such as the cost of the operating room, Laboratory tests, X-ray examinations, Pre-admission testing, anesthesia, drugs (excluding take home drugs) or medicines, Physical Therapy, 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.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Surgical Expense, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure. The surgical procedure with the highest allowable should be priced at 100% of allowance and the remaining eligible procedures should be priced at 50% of the allowable.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Assistant Surgeon, payable only when required by the Hospital</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Doctor’s Visits</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Mental &amp; Nervous Disorder / Alcoholism &amp; Drug Abuse</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Network Provider Plan Pays</td>
<td>Out-of-Network Provider Plan Pays</td>
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</tr>
<tr>
<td><strong>Surgical Expense</strong>, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure. The surgical procedure with the highest allowable should be priced at 100% of allowance and the remaining eligible procedures should be priced at 50% of the allowable.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Day Surgery Miscellaneous</strong>, related to scheduled surgery performed in a Hospital, including the cost of the operating room, laboratory tests, x-ray examinations, including professional fees, anesthesia, drugs or medicines and supplies.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
<td>No Benefit</td>
<td>No Benefit</td>
</tr>
<tr>
<td><strong>Anesthetist</strong></td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Doctor’s Visits</strong></td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong>, benefits are limited to one visit per day.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Radiation Therapy and Chemotherapy</strong>, includes dialysis and respiratory therapy.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Emergency Room Expenses, $75 Copay per visit in lieu of the plan deductible, benefits are payable for the use of the Emergency Room &amp; Supplies.</strong></td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<tr>
<td><strong>Diagnostic X-rays &amp; Laboratory Procedures</strong></td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<tr>
<td><strong>Injections</strong>, when administered in the Doctor’s office and charged on the Doctor’s statement. (Plan Deductible does not apply.)</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Tests &amp; Procedures</strong>, diagnostic services and medical procedures performed by a Doctor, other than Doctor’s Visits, Physical Therapy and X-rays and Lab procedures. (Includes quantiferone gold (TB Blood Test))</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong>, all prescriptions are limited to 30 day supply. Allergy medications and birth control are covered and included. (See Outpatient Prescription Drug Section on page 2 for more details.)</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Mental &amp; Nervous Disorder / Alcoholism &amp; Drug Abuse</strong>, includes all related or ancillary charges incurred as a result of a Mental &amp; Nervous Disorder. Benefits are limited to one visit per day.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Other</th>
<th>Network Provider Plan Pays</th>
<th>Out-of-Network Provider Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Service</strong></td>
<td>80% of Allowable Amount</td>
<td>80% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong>, when prescribed by a Doctor and a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Dental</strong>, made necessary by Injury to sound, natural teeth only.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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<tr>
<td><strong>Maternity/Complications of Pregnancy</strong></td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td><strong>Needle Stick</strong>, only for students doing course work or hospital training.</td>
<td>100% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
</tr>
<tr>
<td>Other</td>
<td>Network Provider Plan Pays</td>
<td>Out-of-Network Provider Plan Pays</td>
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</tr>
<tr>
<td>Routine Well-Baby Care, limited to 3 days Hospital Confinement.</td>
<td>80% of Allowable Amount</td>
<td>60% of Allowable Amount</td>
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</table>
| Preventive Care Services, includes immunizations, routine sexually transmitted disease testing, flu shots, human papillovirus and cervical cancer screening.  
   a. 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 (“USPSTF”);  
   b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”);  
   c. Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, child(ren), and adolescents; and  
   d. With respect to women, such additional preventive care and screenings, not described in item “a” above, as provided for in comprehensive guidelines supported by the HRSA. | 100% of Allowable Amount | 60% of Allowable Amount |

Preventive Care services as mandated by State and Federal law. Please refer to the Policy or call Blue Cross and Blue Shield of Texas for more information at (800) 521-2227.

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**Coordination of Benefits**

Under a COB provision, the plan that pays first is called the Primary Plan. The Secondary Plan typically makes up the difference between the Primary Plan’s benefit and the covered expenses. When one plan does not have a COB provision, that plan is always considered Primary, and always pays first. You may still be responsible for applicable deductible amounts, copayments and coinsurance.

**Definitions**

*Allowable Amount* means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply or procedure.

For Hospitals, Doctors and other providers contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan — The Allowable Amount is based on the terms of the Network Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

For Hospitals, Doctors and other providers not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount) — The Allowable Amount will be the lesser of: (i) the provider’s billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare participating reimbursements adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for home health care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by home health discipline type adjusted for duration and adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall be updated on a periodic basis.
Definitions Continued

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting providers will represent an average contract rate in aggregate for network providers adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall be updated not less than every two years.

We will utilize the same claim processing rules and/or edits that it utilizes in processing Network Provider claims for processing claims submitted by non-contracted providers which may also alter the Allowable Amount for a particular service. In the event we do not have any claim edits or rules, we may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims.

The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by us within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the provider’s billed charges and Covered Persons services from a non-contracted provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted provider’s billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Covered Persons may call customer service at the number on the back of the BCBSTX identification card.

For multiple surgeries - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

For Prescription Drugs as applied to Network Provider and Out-of-Network Provider Pharmacies - The Allowable Amount for pharmacies that are Network Providers will be based on the provisions of the contract between BCBSTX and the pharmacy in effect on the date of service. The Allowable Amount for pharmacies that are not Network Providers will be based on the Average Wholesale Price.

Company means Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company (also referred to herein as “BCBSTX”).

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

Covered Person means any eligible student or an eligible Dependent who applies for coverage, and for whom the required premium is paid to the Company.

Deductible means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a Policy Term basis before benefits are payable under the Policy.

Doctor means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate. It will not include a Covered Person or a member of the Covered Person’s Immediate Family or household.
Definitions Continued

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person’s condition, Sickness, or Injury is of such a nature that failure to get immediate care could result in:

- placing the patient’s health in serious jeopardy;
- serious impairment of bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Medical Emergency Expenses: only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness, if possible.

Injury means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, and are considered a single Injury.

Insured means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

Interscholastic Activities means playing, participating and/or traveling to or from an interscholastic, intercollegiate, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

Medically Necessary means those services or supplies covered under the Plan which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participants condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of BCBSTX shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.
Definitions Continued

Network Provider means a Hospital, Doctor or other provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider.

Out-of-Network Provider means a Hospital, Doctor or other provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care provider.

Sickness means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

Pre-Existing Condition Limitation

The Policy does not provide coverage for a Pre-existing Condition until the Covered Person’s coverage has been in force for a period of not less than 12 months.

The Pre-existing Conditions Limitation will not apply if: the Covered Person did not receive any treatment, take any prescription medications, receive any advice or consult a Doctor for the pre-existing condition for a period of 12 consecutive months ending after the effective date of coverage; or the Insured was insured under the UT Student Health Insurance Plan or a Prior Qualifying Coverage for a period of at least 12 months; such coverage was continuous to a date not more than 63 days prior to the effective date of coverage under this Policy; and the Covered Person previously met the pre-existing conditions limitation of such coverage.

Pre-existing Condition means any condition, Injury or Sickness for which the Covered Person incurred expenses, received medical treatment, consulted a health care professional or took prescription drugs within the 12 months immediately preceding the effective date of coverage.

Exclusions and Limitations

Except as specified in this Policy, coverage is not provided for loss or charges incurred by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Allowable Amount;
2. Services that are provided, normally without charge, by the Student Health Center, infirmary or Hospital, or by any person employed by the University;
3. Acne;
4. Acupuncture procedures;
5. Biofeedback;
6. Breast augmentation or reduction;
7. Circumcision;
8. Testing or treatment for sleep disorders;
9. Any charges for surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are experimental or investigational;
10. Expenses incurred for Injury or Sickness, regardless if benefits are, or could be paid or payable under any Worker’s Compensation or Occupational Disease Law or Act, or similar legislation;
11. Treatment, services or supplies in a Veteran’s Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment;
Exclusions and Limitations Continued

12. Expenses in connection with services and prescriptions for eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems;

13. Sinus or other nasal surgery, including correction of a deviated septum by submucous resection and/or other surgical correction, except for a covered Injury;

14. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:
   - a covered Injury that occurred while the Covered Person was insured;
   - an infection or other diseases of the involved part; or
   - a covered child’s congenital defect or anomaly;

15. Injuries arising from Interscholastic Activities;

16. Riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;

17. Injury resulting from sky diving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping;

18. War, or any act of war, whether declared or undeclared or while in service in the active or reserve Armed Forces of any country or international authority;

19. Elective abortion;

20. Any expenses incurred in connection with sterilization reversal, vasectomy or vasectomy reversal and sexual reassignment;

21. Reproductive/Infertility procedures and fertility tests, including but not limited to: family planning, fertility tests, infertility (male or female), including any supplies rendered for the purpose or with the intention of achieving conception; premarital examinations. Examples of fertilization procedures are: ovulation induction; in vitro fertilization; embryo transplant; or similar procedures that augment or enhance the Covered Person’s reproductive ability;

22. Organ transplants. Neither donor or recipient expenses will be covered;

23. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury;

24. Foot care including: flat foot conditions, supportive devices for the foot, sublaxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care;

25. Hearing examinations; or other treatment for hearing defects or problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

26. Hirsutism; alopecia;
Exclusions and Limitations Continued

27. Weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind; surgery for the removal of excess skin or fat;

28. Prescription drug coverage is not provided for:
   - refills in excess of the number specified or dispensed after one (1) year from the date of the prescription;
   - drugs labeled “Caution - limited by federal law to investigational use” or experimental drugs;
   - immunizing agents, biological sera, blood or blood products administered on an outpatient basis;
   - any devices, appliances, support garments, hypodermic needles except as used in the administration of insulin, or non-medical substances regardless of their intended use;
   - drugs used for cosmetic purposes, including but not limited to Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control, etc;
   - fertility agents or sexual enhancement drugs, medications or supplies for the treatment of impotence and/or sexual dysfunction, including but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra;
   - lost or stolen prescriptions.

Academic Emergency Services

Students enrolled in the Student Health Insurance Plan can call the multilingual call center 24 hours a day, 365 days a year to confirm coverage and access available services. Services are available to students traveling more than 100 miles from their home or outside of their home country.

In addition to the insurance protection provided by your insurance plan, Academic HealthPlans has arranged to provide you with a $10,000 Accidental Death and Dismemberment benefit and access to travel assistance services anywhere in the world. These services include:

- **Medical Assistance** including referral to a doctor or medical specialist, medical monitoring when you are hospitalized, emergency medical evacuation to an adequate facility, medically necessary repatriation, and return of mortal remains.

- **Personal Assistance** including pre-trip medical referral information and while you are on a trip: emergency medication, embassy and consular information, lost document assistance, emergency message transmission, emergency cash advance, emergency referral to a lawyer, translator or interpreter access, medical benefits verification and medical claims assistance.

- **Travel Assistance** including emergency travel arrangements and arrangements for the return of your traveling companion or dependents.

- **Security Assistance** including access to a secure, web-based system for tracking global threats and health or location based risk intelligence, and at an additional cost, a crisis hotline and on the ground security assistance to help address safety concerns or to secure immediate assistance while traveling outside of the country.

In the event of a medical emergency call Academic Emergency Services immediately.
1-800-625-8833 toll free in the USA or Canada
1-240-330-1470 collect outside of the USA

This information provides you with a brief outline of the services available to you. Accident insurance is underwritten by ACE American Insurance Company on Form # AH-10324. Reimbursement for any service expenses is limited to the terms and conditions of the accident policy under which you are insured. You may be required to pay for services not covered under the policy. (*Academic Emergency Services, Inc. is not affiliated with BCBSTX.*)
Claim Procedure

In the event of Injury or Sickness, the student should:

1) Report to the Student Health Center for treatment or when not in school, to your Doctor or Hospital. Insureds should go to a participating Doctor or Hospital for treatment if possible.

   **IN AN EMERGENCY, REPORT DIRECTLY TO THE NEAREST EMERGENCY ROOM FOR TREATMENT.**

2) Mail to the address below all prescription drug receipts for providers outside of the Student Health Center and Prime Therapeutics, medical and hospital bills along with patient’s name and Insured student’s name, address, identification number or social security number and name of the University under which the student is Insured.

3) File claims 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.

Submit all Claims or Inquiries to:
Academic HealthPlans
P.O. Box 1605
Colleyville, TX 76034-1605

BCBSTX Customer Service: (800) 521-2227
Medical Providers Call: (800) 451-0287
All Other Calls: (855) AHP-CARE or (855) 247-2273

Academic Emergency Services:
(Toll Free Inside US or Canada): (800) 625-8833
(Outside US): (240) 330-1470

For more information about this Plan please visit:
www.ahpcare.com/UTSystem/special-events
**Important Notice**

This information provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in the state in which the policy was delivered. Complete details may be found in the policy on file at your school’s office. The policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

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**Privacy Disclosure**

Under HIPAA’s Privacy Rule, we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You will receive a copy of the BCBSTX HIPAA Privacy Notice upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605 or call (817) 479-2100. You may also view and download a copy from the website at: [www.ahpcare.com/UTSystem/special-events](http://www.ahpcare.com/UTSystem/special-events).

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**Affordable Care Act Notice**

The student health insurance coverage outlined in this brochure, offered by Blue Cross and Blue Shield of Texas, may not meet the minimum standards required by the health care reform law for the 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 for 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. This student health insurance coverage puts an annual limit of $100,000 on covered benefits. If a Covered Person has any questions or concerns about this notice, they can contact Blue Cross and Blue Shield of Texas Customer Service at (800) 521-2227. Be advised that a Covered Person 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 the Covered Person is under the age of 26. Students can 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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12