

**PART VI
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
UNIV. OF TEXAS - SYSTEM SPECIAL EVENTS
2011-550-7
INJURY AND SICKNESS BENEFITS**

Maximum Benefit	\$100,000 (For Each Injury or Sickness)
Deductible	\$200 (Per Insured Person) (Per Policy Year)
Coinsurance Preferred Providers	100% except as noted below
Coinsurance Out of Network	100% except as noted below

The Preferred Providers for this plan is UnitedHealthcare Options PPO.

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

After the Deductible of \$200 has been satisfied, benefits will be paid for 80% of Covered Medical Expenses incurred (70% of Covered Medical Expenses for Out-of-Network Room & Board, Intensive Care and Hospital Miscellaneous; 90% of Preferred Allowance for designated Preferred Provider Room & Board, Intensive Care and Hospital Miscellaneous) up to \$10,000. After the Company has paid \$10,000, payment will be made for 100% of additional Covered Medical Expenses incurred (70% of Covered Medical Expenses for Out-of-Network Room & Board, Intensive Care and Hospital Miscellaneous; 90% of Preferred Allowance for designated Preferred Provider Room & Board, Intensive Care and Hospital Miscellaneous) not to exceed \$100,000 maximum.

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

All benefits maximums are combined Preferred Provider and Out-of-Network, unless noted below. The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

Inpatient	Preferred Provider	Out-of-Network Provider
Room & Board:	90% of Preferred Allowance	70% of Usual and Customary Charges \$275 per day
Intensive Care:	90% of Preferred Allowance	70% of Usual and Customary Charges
Hospital Miscellaneous:	90% of Preferred Allowance	70% of Usual and Customary Charges
Routine Newborn Care: <i>(See Benefits for Maternity and Post Delivery Care)</i>	Paid as any other Sickness	Paid as any other Sickness
Physiotherapy:	Paid under Hospital Miscellaneous	Paid under Hospital Miscellaneous
Surgery: <i>(Specified surgery based on data provided by FAIR Health, Inc.)</i>	Usual and Customary Charges	Usual and Customary Charges
Assistant Surgeon: <i>(When required by the hospital.)</i>	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance	25% of Surgery Allowance
Registered Nurse's Services:	Usual and Customary Charges	Usual and Customary Charges
Physician's Visits:	Usual and Customary Charges	Usual and Customary Charges
Pre-admission Testing: <i>(The Deductible will be waived and benefits will be paid for 100% of Covered Medical Expenses incurred for Pre-Admission Testing provided the resulting Hospital Confinement begins within 10 days.)</i>	Usual and Customary Charges	Usual and Customary Charges
Psychotherapy: <i>(30 days maximum)</i>	Paid as any other Sickness	Paid as any other Sickness

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Outpatient	Preferred Provider	Out-of-Network Provider
Surgery: <i>(Specified surgery based on data provided by FAIR Health, Inc.)</i>	Usual and Customary Charges	Usual and Customary Charges
Day Surgery Miscellaneous: <i>(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)</i>	Usual and Customary Charges	Usual and Customary Charges
Assistant Surgeon:	No Benefits	No Benefits
Anesthetist:	25% of Surgery Allowance	25% of Surgery Allowance
Outpatient Miscellaneous Benefit:	No Benefits	No Benefits
Physician's Visits:	Usual and Customary Charges	Usual and Customary Charges
Physiotherapy: <i>(Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation.) (Review of Medical Necessity will be performed after 12 visits Per Injury or Sickness.)</i>	Usual and Customary Charges	Usual and Customary Charges
Medical Emergency: <i>(\$1,000 maximum, \$75 copay per visit in lieu of the Deductible.)</i>	Usual and Customary Charges	Usual and Customary Charges
X-rays: <i>(This benefit includes one Pap Smear when rendered at the Student Health Center.)</i>	Usual and Customary Charges	Usual and Customary Charges
Radiation Therapy & Chemotherapy:	Usual and Customary Charges	Usual and Customary Charges
Laboratory: <i>(This benefit includes one Pap Smear when rendered at the Student Health Center.)</i>	Usual and Customary Charges	Usual and Customary Charges
Tests & Procedures:	Usual and Customary Charges	Usual and Customary Charges
Injections:	Usual and Customary Charges	Usual and Customary Charges
Prescription Drugs: <i>(\$300 maximum Per Policy Year) (Student Health Center: \$2.00 co-pay for Generic Drugs and \$5.00 co-pay for Named Brand Drugs; Birth Control Pills are paid up to \$3.00. All Other: \$200.00 maximum. Co-pays are \$5.00 for Generic Drugs and \$10.00 for Named Brand Drugs.)</i>	Note Below	Note Below
Psychotherapy: <i>(\$975 maximum) (Individual Therapy: \$65 per day / Group Therapy: \$20 per day)</i>	Preferred Allowance	Allowable Charges
Other	Preferred Provider	Out-of-Network Provider
Ambulance: <i>(\$300 maximum)</i>	Usual and Customary Charges	Usual and Customary Charges
Durable Medical Equipment:	No Benefits	No Benefits
Consultant:	Usual and Customary Charges	Usual and Customary Charges
Dental: <i>(Injury to Sound, Natural Teeth only.)</i>	Paid as any other Injury	Paid as any other Injury
Alcoholism/Drug Abuse:	Paid under Psychotherapy	Paid under Psychotherapy
Maternity: <i>(See Benefits for Maternity and Post Delivery Care) (Benefits paid for Newborn Baby Care while Hospital Confined.)</i>	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion:	No Benefits	No Benefits
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Repatriation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
Medical Evacuation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
Supplemental Injury Benefits:	No Benefits	No Benefits
AD&D:	No Benefits	No Benefits
Intercollegiate Sports:	No Benefits	No Benefits

SCHEDULE OF BENEFITS (Continued)

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MAJOR MEDICAL

Maximum Benefit

No Benefits

CATASTROPHIC MEDICAL

Maximum Benefit

No Benefits

SHC Referral Required: Yes () No (X)

Conversion Permitted: Yes () No (X)

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

() 52 Week Benefit Period

(X) Extension of Benefits

Other Insurance: (X)*Coordination of Benefits () Excess Motor Vehicle () Primary Insurance

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

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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 Options PPO

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 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

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

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

The Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified in the Schedule of Benefits. Call (800) 767-0700 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Options PPO will be paid at the coinsurance percentages 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.

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INJURY AND SICKNESS BENEFITS

PREFERRED PROVIDER INFORMATION (Continued)

COMPLAINT RESOLUTION

Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 1-800-767-0700. 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 or In-Network Provider's participation in the plan under the following circumstances: 1) the Insured is being treated for a Life Threatening Condition; or 2) the Insured is being treated under Special Circumstances.

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

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

All obligations on behalf of the Company for reimbursement at the Preferred Provider or In-Network 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 or In-Network Provider benefits through the delivery of the child, immediate postpartum care and the follow-up checkup within the six-week period after deliver.

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