

# UnitedHealthcare® Student Resources

## HEALTH PLAN NOTICES OF PRIVACY PRACTICES

Notice for Medical Information: Pages 6-8.

Notice for Financial Information: Page 9.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### Language Assistance Services

**ATTENTION:** If you speak (English), we<sup>1</sup> provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans, or call the toll-free member phone number listed on your health plan ID card. We are available Monday through Friday, 8 a.m. to 8 p.m. E.T. TTY users may dial 711.

**ATENCIÓN:** Si habla español (Spanish), ofrecemos<sup>1</sup> servicios gratuitos en otros idiomas para ayudarle a que se comunique con nosotros. Ofrecemos intérpretes, cartas en otros idiomas y cartas en otros formatos como en letra grande. Para recibir ayuda, llame al **1-866-260-2723** para planes médicos, al **1-800-638-3120** para planes de la vista, al **1-877-816-3596** para planes dentales o llame al número de teléfono gratuito para miembros que aparece en su tarjeta de ID del plan de salud. Estamos disponibles de lunes a viernes, de 8 a.m. a 8 p.m., hora del Este. Los usuarios de TTY pueden marcar 711.

**注意:** 如果您說中文 (Chinese), 我們<sup>1</sup> 提供免費語言服務以協助您與我們溝通。我們提供口譯員、其他語言版本的信函、和其他格式的信函, 如大字體版。如需協助, 有關醫療計劃請撥打 **1-866-260-2723**, 有關視力計劃請撥打 **1-800-638-3120**, 有關牙科計劃請撥打 **1-877-816-3596**, 或撥打您的健保計劃會員卡上所列的免付費會員電話。我們的服務時間是週一至週五, 美東時間上午 8 點至晚上 8 點, 聽力語言殘障服務專線 (TTY) 使用者可撥打 711。

**LƯU Ý:** Nếu quý vị nói tiếng Việt (Vietnamese), chúng tôi<sup>1</sup> cung cấp dịch vụ ngôn ngữ miễn phí để giúp quý vị giao tiếp với chúng tôi. Chúng tôi cung cấp thông dịch viên, thư bằng các ngôn ngữ khác và thư ở các định dạng khác như chữ in lớn. Để được trợ giúp, vui lòng gọi số **1-866-260-2723** để biết các Chương trình Y tế, **1-800-638-3120** để biết các Chương trình Nhân khoa, **1-877-816-3596** để biết các Chương trình Nha khoa, hoặc gọi số điện thoại hội viên miễn phí được ghi trong thẻ ID chương trình bảo hiểm y tế của quý vị. Chúng tôi làm việc từ Thứ Hai đến Thứ Sáu, 8 giờ sáng đến 8 giờ tối, giờ chuẩn miền Đông, người dùng TTY có thể quay số 711.

**주의:** 귀하가 한국어 (Korean)를 구사하시면, 귀하와의 의사소통을 돕기 위해 저희<sup>1</sup>가 무료 언어 서비스를 제공합니다. 저희는 통역사, 다른 언어로 번역된 서신, 큰 활자체와 같은 다른 양식의 서신을 제공합니다. 도움을 받으시려면, 의료 보험은 **1-866-260-2723**, 안과 보험은 **1-800-638-3120**, 치과 보험은 **1-877-816-3596** 으로 전화하시거나, 귀하의 건강보험 ID 카드에 기재된 무료 회원용 전화번호로 전화하십시오. 월요일 ~ 금요일, 오전 8 시 ~ 오후 8 시(동부 표준시)까지 이용하실 수 있습니다. TTY 사용자들은 711 로 전화하실 수 있습니다.

PAALALA: Kung nagsasalita ka sa Tagalog (Tagalog), nagbibigay kami<sup>1</sup> ng libreng serbisyo sa wika upang matulungan kang makipag-ugnayan sa amin. Nag-aalok kami ng mga interpreter, liham sa iba pang wika, at liham sa iba pang format gaya ng malaking print. Upang humingi ng tulong, mangyaring tumawag sa **1-866-260-2723** para sa Mga Planong Medikal, **1-800-638-3120** para sa Mga Plano para sa Paningin, **1-877-816-3596** para sa Mga Plano para sa Ngipin, o tawagan ang toll-free na numero ng telepono ng miyembro na nakalista sa iyong ID card ng planong pangkalusugan. Available kami mula Lunes hanggang Biyernes, 8 a.m. hanggang 8 p.m. sa E.T. Maaaring mag-dial sa 711 ang mga user ng TTY.

ВНИМАНИЕ: Если вы говорите на русском языке (Russian), то мы<sup>1</sup> предоставим бесплатные переводческие услуги, которые помогут вам в общении с нами. Мы предлагаем услуги устных переводчиков, письма на других языках и письма в других форматах, например, крупным шрифтом. Чтобы получить помощь, звоните **1-866-260-2723** по поводу планов медицинского обслуживания, **1-800-638-3120** по поводу планов офтальмологического обслуживания, **1-877-816-3596** по поводу планов стоматологического обслуживания или звоните по бесплатному номеру телефона для участников, указанному в вашей идентификационной карте участника плана медицинского страхования. Мы работаем с понедельника по пятницу, с 8 утра до 8 вечера по Восточному времени. Пользователи линии TTY могут звонить по номеру 711.

ATANSYON: Si w pale Kreyòl Ayisyen (Haitian Creole), nou<sup>1</sup> bay sèvis lang gratis pou ede w kominike avèk nou. Nou ofri entèprèt, lèt ki ekri nan lòt lang, ak lèt ki ekri nan lòt fòm tankou gwo karaktè. Pou jwenn èd, tanpri rele **1-866-260-2723** pou Plan Medikal yo, **1-800-638-3120** pou Plan Vizyon yo, **1-877-816-3596** pou Plan Dantè yo, oswa rele nimewo telefòn gratis pou manm ki endike sou kat ID plan sante ou an. Nou disponib lendi jiska vandredi, ant 8 a.m. ak 8 p.m. E.T. Itilizatè TTY yo ka rele 711.

ATTENTION : Si vous parlez français (French), nous<sup>1</sup> offrons des services linguistiques gratuits pour vous aider à communiquer avec nous. Nous proposons des interprètes, des lettres dans d'autres langues et des lettres dans d'autres formats, tels que les gros caractères. Pour obtenir de l'aide, veuillez appeler le **1-866-260-2723** pour les plans médicaux, le **1-800-638-3120** pour les plans de vision, le **1-877-816-3596** pour les plans dentaires, ou appelez le numéro de téléphone gratuit des membres indiqué sur votre carte d'identification du plan d'assurance maladie. Nous sommes disponibles du lundi au vendredi de 8 h du matin à 8 h du soir Heure de l'Est. Les utilisateurs de télécopieur peuvent composer le 711.

UWAGA: Jeśli mówisz po polsku (Polish), możesz skorzystać z bezpłatnej pomocy językowej, aby się z nami skontaktować<sup>1</sup>. Oferujemy pomoc tłumacza oraz przygotowywanie listów w innych językach lub w innych formatach, np. dużym drukiem. Aby uzyskać pomoc, zadzwoń pod numer **1-866-260-2723** – plany medyczne, **1-800-638-3120** – plany okulistyczne, **1-877-816-3596** – plany stomatologiczne. Możesz też zadzwonić pod bezpłatny numer telefonu umieszczony na Twojej karcie identyfikacyjnej planu medycznego. Czynne w godzinach 8:00 a.m. — 8:00 p.m. od poniedziałku do piątku. Użytkownicy E.T. TTY mogą zadzwonić pod numer 711.

ATENÇÃO: Se você fala português (Portuguese), nós<sup>1</sup> disponibilizamos serviços de tradução gratuitos para ajudá-lo a se comunicar conosco. Disponibilizamos intérpretes e preparação de cartas em idiomas estrangeiros ou em formatos especiais, como ampliações. Se precisar de ajuda, ligue para **1-866-260-2723** para planos de saúde, **1-800-638-3120** para planos oftalmológicos, **1-877-816-3596** para planos odontológicos ou ligue para o número de chamada gratuita listado no cartão de identificação de seu convênio médico. Estamos disponíveis de segunda a sexta-feira, das 8 da manhã às 8 da noite, ET. Usuários de dispositivo de telecomunicação para surdos (TTY) devem discar 711.

ATTENZIONE: se parli italiano (Italian), mettiamo<sup>1</sup> a disposizione servizi linguistici gratuiti per comunicare con noi. Offriamo interpreti, lettere in altre lingue e lettere in altri formati, come stampe di dimensioni maggiori. Per ottenere assistenza, chiama il numero **1-866-260-2723** per i piani medici, **1-800-638-3120** per i piani oculistici, **1-877-816-3596** per i piani odontoiatrici o chiama il numero verde per membri indicato sulla tua tessera identificativa del piano sanitario. Siamo disponibili da lunedì a venerdì, dalle 8 a.m. alle 8 p.m. ora della Costa orientale degli Stati Uniti. Gli utenti TTY possono contattare il 711.





BAA' ÁKONÍNÍZIN: Diné bizaad (Navajo) bee yániití'go, níhí kwe'é hazhó'ó ahxít hodiilnih biniyé níhí<sup>1</sup> saad bee áka'e'eyeedígíí t'áá jíík'eh níhee hóló. T'áá haishíí at'a' halne'í, náána' la' saad bee naaltsos hadadilyaaígíí, dóó naaltsos nitsaago bik'ih da'ashch'íígo bee hadadilyaaígíí níhee hóló. Shíka'e'doowoł nínízingo, Ats'íís Nídanél'ííh bee Naaltsos bee Hada'dít'éhígíí biniyégo kohjí' **1-866-260-2723** hodiilnih, Anáá Nídanél'ííh Naaltsos bee Hada'dít'éhígíí biniyégo kohjí' **1-800-638-3120**, Awoo' Nídanél'ííh bee Naaltsos bee Hada'dít'éhígíí biniyégo kohjí' **1-877-816-3596** hodiilnih, doodago nits'íís nánél'ííh naaltsos bee náha'dít'éhígíí bíl ninaaltsos nit'ízi bee nééhozinígíí bine'déé' t'áá jíík'eh béésh bee hane'í biká'ígíí bee hodiilnih. Níhí éí Damóo Biiskání dóó niléí Nída'íiníshjí', abínígo 8 a.m. dóó niléí hxiilch'ííhjí' 8 p.m. oolkiljí' nahísiitáh. E.T. TTY doo hazhó'ó níjaa' bee adiníts'ágóogo díí 711 bíl adadidíilch'íígo bee hodiilnih.

FIIRO GAAR AH: Maku hadashaa Soomaali (Somali), waxaanu<sup>1</sup> bixinaa adeegyo luuqad ah oo bilaash ah si aanu kaaga caawino inaad nala xidhiidho. Waxaanu bixinaa turjumaan, waraaqo luuqado kale ah, iyo waraaqo qaabab kale oo far waawayn ku daabacan ah. Si aad caawimo u hesho, fadlan lasoo hadal **1-866-260-2723** wixii Caymisyada Caafimaadka ah, **1-800-638-3120** wixii Caymisyada Caafimaadka Indhaha ah, **1-877-816-3596** wixii Caymiska Daryeelka Iskaha ag. ama lambarka taleefanka bilaash ah ee xubinta ee ku yaal kaadhka aqoonsigaaga caymiska caafimaadka. Waxaa nala helayaa Isniinta ilaa Jimcaha, 8-da subaxnimo illaa 8-da fiidnimo. Isticmaalayaasha Saacada Bariga. TTY waxay garaaci karaan 711.

ΥΠΟΨΗ: Εάν μιλάτε ελληνικά (Greek), παρέχουμε<sup>1</sup> δωρεάν υπηρεσίες γλωσσικής υποστήριξης για να σας βοηθήσουμε να επικοινωνήσετε μαζί μας. Προσφέρουμε διερμηνείς, γράμματα σε άλλες γλώσσες και γράμματα σε άλλες μορφές όπως σε μεγάλο μέγεθος γραμματοσειρά. Για να λάβετε βοήθεια, καλέστε στο **1-866-260-2723** για Ιατρικά Προγράμματα, στο **1-800-638-3120** για Προγράμματα Όρασης, στο **1-877-816-3596** για Οδοντιατρικά Προγράμματα ή καλέστε χωρίς χρέωση στον τηλεφωνικό αριθμό μελών που βρίσκεται στην κάρτα μέλους του προγράμματος υγείας σας. Είμαστε διαθέσιμοι από Δευτέρα έως Παρασκευή, από τις 8 π.μ. έως τις 8 μ.μ. ώρα Ανατολικής Ακτής ΗΠΑ. TTY μπορούν να καλέσουν στο 711.

ધુવાન આપો: જો તમે ગુજરાતી (Gujarati) બોલો છો, અમે<sup>1</sup> તમને અમારી સાથે વાતચીત કરવામાં સહાય માટે મફત ભાષા સેવાઓ પૂરઠાન કરશું. અમેઢુભાષાવિાઓ, અનુભાષાઓમાંઅકુષરો અનેઅનુયસુવરૂપોમાંઅકુષરોજેમકેમોટીપૂરનિટપૂરઠાનકરશું. મદદમેળવવામાટે, કૃપાકરીનેતબલિ યોજનાઓ માટે**1-866-260-2723**, દૂરવૂટિ યોજનાઓ માટે**1-800-638-3120**, દંત ચકિતિસા યોજનાઓ માટે **1-877-816-3596** પરકોલ કરો. અથવાતમારાઆરોગ્યયોજનાઆઇડીકાર્ડપરસુચિબિલ્લુવટોલ-ફૂરીમિમૂબરફોનનંબરપરકોલકરો. અમેસોમવારથીશુક્રવાર 8 એ.એમ. થી 8 પી.એમ. સુધીઉપલબ્ધછીએ. ઇ.ટી. TTY વપરાશકરૂનાઓ 711 ડાયલકરીશકિછે.

# Notice of Non-Discrimination

We<sup>1</sup> do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
UHC\_Civil\_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to ask us to appeal.

If you need help with your complaint, please call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans or the toll-free member phone number listed on your health plan ID card. We are available Monday through Friday, 8 a.m. to 8 p.m. E.T. TTY/RTT users may dial 711.

You can also file a complaint with the U.S. Dept. of Health and Human services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free **1-800-368-1019, 1-800-537-7697 (TDD)**

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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<sup>1</sup>For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "We" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.



# Medical Information Privacy Notice

Effective January 1, 2023

We<sup>2</sup> are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as [www.uhcsr.com](http://www.uhcsr.com). We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees’ information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

## How We Collect, Use, and Disclose Information

**We must** collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

**We have the right to** collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may **collect, use, and disclose** your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (**when permitted by applicable law**) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may **collect information from, or disclose information to,** your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. **We may also de-identify health information in accordance with applicable laws.** After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Underwriting Purposes.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

**We may** collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual’s care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

## What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents **to request certain restrictions. Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website, such as [www.uhcsr.com](http://www.uhcsr.com).
- **You have the right to make a written request that we correct or amend your personal information.** Depending on your state of domicile, you may have the right to request deletion of your personal information. If we are unable to honor your request, we will notify you of our decision.

If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

## Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please **call the toll-free member phone number on your health plan ID card** or you may contact **UnitedHealthcare Student Resources:**  
For Medical Plans at **1-888-889-3822 (TTY/RTT 711)**.  
For Vision Plans at **1-800-638-3120 (TTY/RTT 711)**.  
For Dental Plans at **1-877-816-3596 (TTY/RTT 711)**.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at one of the following addresses:  
**For Medical Plans:**  
**UnitedHealthcare Student Resources**  
Privacy Office  
PO Box 809025  
Dallas, TX 75380-9025  
**For Vision Plans:**  
**UnitedHealthcare Student Resources**  
Vision HIPAA Privacy Unit  
PO Box 30978  
Salt Lake City, UT 84130  
**For Dental Plans:**  
**UnitedHealthcare Student Resources**  
Dental HIPAA Privacy Unit  
PO Box 30978  
Salt Lake City, UT 84130
- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at one of the addresses listed above.

**You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

<sup>2</sup>This Health Information Notice of Privacy Practices applies to the following health plans affiliated with UnitedHealth Group: UnitedHealthcare Insurance Company; and UnitedHealthcare Insurance Company of New York.



# Financial Information Privacy Notice

## THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

### Effective January 1, 2023

We<sup>3</sup> are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

### Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

### Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;

- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

### Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

### Questions About This Notice

- If you have any questions about this notice or want information about exercising your rights, **please call the toll-free member phone number on your health plan ID card** or you may contact **UnitedHealthcare Student Resources**:  
For Medical Plans at **1-888-889-3822 (TTY/RTT 711)**.  
For Vision Plans at **1-800-638-3120 (TTY/RTT 711)**.  
For Dental Plans at **1-877-816-3596 (TTY/RTT 711)**.

<sup>3</sup> For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 2, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Dental Benefit Providers, Inc.; OptumHealth Holdings, LLC; Spectera, Inc.; UMR, Inc.; United Behavioral Health, and United Behavioral Health of New York, I.P.A., Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to any other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

# How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

## For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to \$500,000 for health benefit plans, with some exceptions.
  - Up to \$300,000 for disability income benefits.
  - Up to \$300,000 for long-term care insurance benefits.
  - Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to \$100,000 in net cash surrender or withdrawal value.
  - Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

<p>To learn more about the Association and your protections, contact:</p> <p><b>Texas Life and Health Insurance Guaranty Association</b> 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or <a href="http://www.txlifega.org">www.txlifega.org</a></p>	<p>For questions about insurance, contact:</p> <p><b>Texas Department of Insurance</b> P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or <a href="http://www.tdi.texas.gov">www.tdi.texas.gov</a></p>
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**Note:** You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

## Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

### UnitedHealthcare Insurance Company

To get information or file a complaint with your insurance company or HMO:

**Call: Customer Service at 1-800-767-0700**

**Toll-free: 1-800-767-0700**

Email: [www.customerservice@uhcsr.com](mailto:www.customerservice@uhcsr.com)

Mail: UnitedHealthcare Student Resources, P.O. Box 809025, Dallas, Texas 75380-9025

### The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

## ¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

### UnitedHealthcare Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: Customer Service al 1-800-767-0700**

**Teléfono gratuito: 1-800-767-0700**

Correo electrónico: [insert email address]

Dirección postal: UnitedHealthcare Student Resources, P.O. Box 809025, Dallas, Texas 75380-9025

### El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030



## NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your coverage with UnitedHealthcare Insurance Company.

### **Mastectomy or Lymph Node Dissection**

**Minimum Inpatient Stay:** If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- (a) 48 hours following a mastectomy, and
- (b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

**Prohibitions:** We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

### **Coverage and/or Benefits for Reconstructive Surgery After Mastectomy**

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- (a) all stages of the reconstruction of the breast on which mastectomy has been performed;
- (b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- (c) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

This coverage will be subject to the deductible, coinsurance and/or copay as any other sickness or injury.

**Prohibitions:** We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

### **Examinations for Detection of Prostate Cancer**

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- (a) a physical examination for the detection of prostate cancer; and
- (b) a prostate-specific antigen test for each covered male who is
  - (1) at least 50 years of age; or
  - (2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

## **Inpatient Stay following Birth of a Child**

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- (a) 48 hours following an uncomplicated vaginal delivery, and
- (b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

**Prohibitions.** We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

## **Coverage for Tests for Detection of Colorectal Cancer**

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

- (a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
- (b) a colonoscopy performed every 10 years.

## **Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer and Cervical Cancer**

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

## **NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY**

Your health benefit plan coverage for an acquired brain injury includes the following services when they are medically necessary:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment
- Neurofeedback therapy and remediation

- Postacute transition services and community reintegration services, including outpatient day treatment services or other post-acute-care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute-care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute-care treatment or services may be obtained in any facility where those services may legally be provided, including acute or postacute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare **Student**Resources at 800-767-0700, or write us at UnitedHealthcare **Student**Resources, P.O. Box 809025, Dallas, TX 75380-9025.



**UNITEDHEALTHCARE INSURANCE COMPANY**  
**Administrative Office Address: P.O. Box 809025, Dallas, TX 75380-9025**

<b>POLICYHOLDER</b>	Texas Woman's University	<b>POLICY NUMBER</b>	2023-239-48
<b>ADDRESS</b>	304 Administration Drive Denton, TX 76204	<b>Effective Date</b> <b>Termination Date</b>	08-01-2023 at 12:01 a.m. 08-16-2024 at 11:59 p.m.

**PREMIUM FOR EACH INSURED PERSON**

SEE APPLICATION ATTACHED

THIS IS NOT A POLICY OF WORKERS COMPENSATION INSURANCE. THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYHOLDER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS COMPENSATION LAWS. THE POLICYHOLDER MUST COMPLY WITH THE WORKERS COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

**THIS POLICY CONTAINS PREFERRED PROVIDER BENEFITS**

**LIST OF ENDORSEMENTS ATTACHED TO AND FORMING A PART OF THIS POLICY**

**COL-06 END (5C)**

UnitedHealthcare Insurance Company

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this policy to pay the benefits provided by this policy for loss resulting from a cause covered by this policy. This policy is issued in consideration of the application and payment of the premiums. Premiums as specified above are payable for each Insured Person.

Non-Renewable One Year Term Insurance -- This Policy Will Not Be Renewed



**President**

**PREMIUMS AND PREMIUM PAYMENT**

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1) two years after the termination of this policy and 2) the date of final adjustment and settlement of all claims under this policy.

# Policyholder Application

## UnitedHealthcare Student Resources

UnitedHealthcare Insurance Company P.O. Box 809025 Dallas, TX 75380-9025

<b>Policyholder</b>	Texas Woman's University	<b>Date</b>	07/06/2023
<b>Mailing Address</b>	604 Administrative Drive, Suite 120 Denton, TX 76204	<b>Policy Number</b>	2023-239-48
<b>Telephone Number</b>	817-809-4722	<b>Effective</b>	2023/2024 Academic Year Student Plan

### Class of Persons to be Insured

All Intercollegiate Athletes engaged in the play or practice of an intercollegiate sport who are covered under 2022-239-4 are eligible to enroll in this plan on a voluntary basis, additional premium is required.

### Rates


#### Basic

IC Sports Policy	Annual	1st Special
	<b>Premium</b>	<b>Premium</b>
Student	360.00	16.00

### Effective/Expiration Dates

#### Basic

IC Sports Policy	
Annual	08/17/2023 through 08/16/2024
1st Special	08/01/2023 through 08/16/2023

Signature of School Official	<u>Matt Moustakas</u>	<b>Risk Mgt</b>	Date <u>7/13/23</u>
Please Print Name of above Official	<u>Matt Moustakas</u>		
Signature of Agent	<u></u>		Date <u>07/20/23</u>
Signature of Company Representative	<u>Jaclyn Maxwell</u>	Title <u>Account Manager</u>	Date <u>07/20/23</u>

**Policyholder Application (Continued)**  
**UnitedHealthcare Student Resources**  
**UnitedHealthcare Insurance Company**

**Texas Mandatory Offers of Coverage**

I hereby \_\_\_\_\_ elect \_\_\_\_\_ decline the Benefits for In-Vitro Fertilization Procedures offered to us as a group Policyholder as required by Texas Statute Ins s 1366.003.

I hereby \_\_\_\_\_ elect \_\_\_\_\_ decline the Benefits for Treatment of Speech and Hearing Disorders offered to us as a group Policyholder as required by Texas Statute Ins s 1365.003.

I hereby \_\_\_\_\_ elect \_\_\_\_\_ decline the Benefits for Treatment of Developmental Delays offered to us as a group Policyholder as required by Texas Statute Article 21.53F.

Signature of School Official \_\_\_\_\_  
Title \_\_\_\_\_  
Date \_\_\_\_\_



## TABLE OF CONTENTS

Eligibility and Termination Provisions	2
General Provisions	2
Definitions	4
Schedule of Benefits	8
Benefit Provisions	9
Mandated Benefits	11
Exclusions and Limitations	13

**PART I  
ELIGIBILITY AND TERMINATION PROVISIONS**

**Eligibility:** Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the Named Insured actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

Eligible persons may be insured under this policy subject to the following:

1. Payment of premium as set forth on the policy application; and,
2. Application to the Company for such coverage.

**Effective Date:** Insurance under this policy shall become effective on the later of the following dates:

1. The Effective Date of the policy; or
2. The date premium is received by the Administrator.

**Termination Date:** The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1. The last day of the period through which the premium is paid; or
2. The date the policy terminates.

**PART II  
GENERAL PROVISIONS**

**ENTIRE CONTRACT CHANGES:** This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

**PAYMENT OF PREMIUM:** All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

**NOTICE OF CLAIM:** Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

**CLAIM FORMS:** Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

**PROOF OF LOSS:** Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

## GENERAL PROVISIONS (Continued)

**TIME OF PAYMENT OF CLAIM:** Indemnities payable under this policy for any loss will be paid no later than the 60th day after receipt of due written proof of such loss provided the Company has received all items, statements and forms reasonably requested and required to secure final proof of loss.

**PAYMENT OF CLAIMS:** All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

**PAYMENT TO STATE:** Benefits will be payable to the Texas Department of Human Services for Covered Medical Expenses under this policy for an Insured Person when the Texas Department of Human Services pays for such expenses and notification is given to the Company with the claim. Benefits payable on behalf of a child under this policy will be paid to the Texas Department of Human Services after the Company receives written notice that:

1. the parent who purchased the coverage is: (a) a possessory conservator of the child under an order issued by a court in this state or is not entitled to possession of or access to the child; and (b) is required by court order or court-approved agreement to pay child support;
2. the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or Chapter 32, Human Resources Code; and
3. the Company is notified through an attachment to the claim for insurance benefits when the claim is first submitted to the Company that benefits must be paid directly to the Texas Department of Human Services.

**BENEFIT PAYMENTS TO PARENT OF A MINOR:** Benefits will be payable to a managing conservator who is not a student of the Policyholder provided such managing conservator is responsible for a minor child who is a dependent of a person who is a student of the Policyholder and which child is duly enrolled as an insured dependent, and the managing conservator has paid all or any portion of a medical bill that would be covered under the terms of the policy. The managing conservator of the child must provide a certified copy of a court order establishing the person as managing conservator or other evidence designated by the State Board of Insurance before the benefits can be paid to the managing conservator. The managing conservator must also submit valid receipts and invoices for such medical payments on behalf of the child.

**PHYSICAL EXAMINATION:** As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

**LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

**SUBROGATION:** The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

**RIGHT OF RECOVERY:** Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury as their liability may appear.

## GENERAL PROVISIONS (Continued)

**MORE THAN ONE POLICY:** Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

**MISSTATEMENT OF AGE:** If the age of an Insured has been misstated, the Insured shall be responsible for payment of any additional premium due had coverage been purchased at the correct issue age. The Company shall furnish notice to the Insured of such additional premium due. Additional premium that is not paid within 31 days from the date of notice of additional premium due may, at the election of the Company, be deducted from any claim payment then due and payable.

**REPRESENTATION:** In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured may not be used in any contest under the policy, unless a copy of the written instrument containing the statement is or has been provided to 1) the person making the statement, or 2) if the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

### PART III DEFINITIONS

**COVERED MEDICAL EXPENSES** means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

**DEDUCTIBLE** means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury) as specified in the Schedule of Benefits.

**ELECTIVE SURGERY OR ELECTIVE TREATMENT** means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

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

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

**INJURY** means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

**INSURED PERSON** means the Named Insured. The term "Insured" also means Insured Person.

## **DEFINITIONS (Continued)**

**INTENSIVE CARE** means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1. Progressive care;
2. Sub-acute intensive care;
3. Intermediate care units;
4. Private monitored rooms;
5. Observation units; or
6. Other facilities which do not meet the standards for intensive care.

**MEDICAL EMERGENCY** means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placement of the Insured's health in serious jeopardy;
2. Serious impairment of bodily functions;
3. Serious dysfunction of any body organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries.

**MEDICAL NECESSITY** means those services or supplies provided or prescribed by a Hospital or Physician which are:

1. Essential for the symptoms and diagnosis or treatment of the Injury;
2. Provided for the diagnosis, or the direct care and treatment of the Injury;
3. In accordance with the standards of good medical practice;
4. Not primarily for the convenience of the Insured, or the Insured's Physician; and,
5. The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

**NAMED INSURED** means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

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

**PHYSICIAN** means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family. The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

**PHYSIOTHERAPY** means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

**POSITIVE X-RAY** means an X-ray that shows the presence of a fracture; pathology; or disease.



**DEFINITIONS** *(Continued)*

**PRESCRIPTION DRUGS** means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

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

**SOUND, NATURAL TEETH** means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

**USUAL AND CUSTOMARY CHARGES** means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

**PART IV**  
**EXTENSION OF BENEFITS AFTER TERMINATION**

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

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

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

**PART V**  
**SCHEDULE OF BENEFITS**  
**MEDICAL EXPENSE BENEFITS-INJURY**  
**TEXAS WOMAN'S UNIVERSITY - STUDENT PLAN**  
**2023-239-48**  
**INJURY ONLY BENEFITS**

<b>Maximum Benefit</b>	<b>\$5,000 (For each Injury)</b>
<b>Deductible Preferred Provider</b>	<b>\$500 (Per Insured Person) (Per Policy Year)</b>
<b>Deductible Out of Network Provider</b>	<b>\$1,000 (Per Insured Person) (Per Policy Year)</b>
<b>Coinsurance Preferred Provider</b>	<b>80% except as noted below</b>
<b>Coinsurance Out of Network Provider</b>	<b>50% except as noted below</b>

The Preferred Provider for this plan is Multiplan.

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.

This policy provides benefits for Injury sustained by an Insured Person while: 1) actually engaged, as an official representative of the Policyholder, in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed coach or trainer of the Policyholder; or 2) actually being transported as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the play or practice of a scheduled intercollegiate sport.

All benefit 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.

<b>Inpatient</b>	<b>Preferred Provider Benefits</b>	<b>Out-of-Network Provider Benefits</b>
<b>Room and Board Expense:</b>	Preferred Allowance	Usual and Customary Charges
<b>Intensive Care:</b>	Preferred Allowance	Usual and Customary Charges
<b>Hospital Miscellaneous:</b>	Preferred Allowance	Usual and Customary Charges
<b>Physiotherapy:</b>	Preferred Allowance	Usual and Customary Charges
<b>Surgery:</b>	Preferred Allowance	Usual and Customary Charges
<i>(Specified Surgery based on data provided by FAIR Health, Inc.)</i>		
<b>Assistant Surgeon:</b>	Preferred Allowance	Usual and Customary Charges
<b>Anesthetist:</b>	Preferred Allowance	Usual and Customary Charges
<b>Registered Nurse:</b>	Preferred Allowance	Usual and Customary Charges
<b>Physician's Visits:</b>	Preferred Allowance	Usual and Customary Charges
<b>Pre-admission Testing:</b>	Preferred Allowance	Usual and Customary Charges
<b>Outpatient</b>	<b>Preferred Provider Benefits</b>	<b>Out-of-Network Provider Benefits</b>
<b>Surgery:</b>	Preferred Allowance	Usual and Customary Charges
<i>(Specified Surgery based on data provided by FAIR Health, Inc.)</i>		
<b>Day Surgery Miscellaneous:</b>	Preferred Allowance	Usual and Customary Charges
<b>Assistant Surgeon:</b>	Preferred Allowance	Usual and Customary Charges
<b>Anesthetist:</b>	Preferred Allowance	Usual and Customary Charges
<b>Physician's Visits:</b>	Preferred Allowance	Usual and Customary Charges
<b>Physiotherapy:</b>	Preferred Allowance	Usual and Customary Charges
<i>(Review of Medical Necessity will be performed after 12 visits per Injury)</i>		
<b>Medical Emergency:</b>	Preferred Allowance \$250 copay per visit	80% of Usual and Customary Charges \$250 Deductible per visit
<b>X-rays:</b>	Preferred Allowance	Usual and Customary Charges
<b>Laboratory:</b>	Preferred Allowance	Usual and Customary Charges
<b>Tests and Procedures</b>	Preferred Allowance	Usual and Customary Charges
<b>Injections:</b>	Preferred Allowance	Usual and Customary Charges
<b>Prescription Drugs:</b>	No Benefits	No Benefits

<b>Other</b>	<b>Preferred Provider Benefits</b>	<b>Out-of-Network Provider Benefits</b>
<b>Ambulance:</b>	Preferred Allowance	80% of Usual and Customary Charges
<b>Durable Medical Equipment:</b>	Preferred Allowance	Usual and Customary Charges
<b>Consultant:</b>	Preferred Allowance	Usual and Customary Charges
<b>Dental:</b>	Preferred Allowance	80% of Usual and Customary Charges

*(Benefits paid on Injury to Sound, Natural Teeth only.)*

**MAJOR MEDICAL**

**Maximum Benefit** **No Benefits**

**CATASTROPHIC MEDICAL**

**Maximum Benefit** **No Benefits**

**SHC Referral Required:** Yes ( ) No (X)

**Conversion Permitted:** Yes ( ) No (X)

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

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

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

\*If benefit is designated, see endorsement attached.

**SCHEDULE OF BENEFITS (Continued)**  
**INJURY ONLY BENEFITS**

**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:

Multiplan

The availability of specific providers is subject to change without notice. Insured should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-799-7716 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.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

**Inpatient Hospital Expenses**

**PREFERRED HOSPITALS** - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call (888) 799-7716 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 Multiplan will be paid at 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.



**SCHEDULE OF BENEFITS (Continued)**  
**INJURY ONLY BENEFITS**

**PREFERRED PROVIDER INFORMATION (Continued)**

**COMPLAINT RESOLUTION**

Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 1-888-799-7716. 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 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 Injury for which the likelihood of death is probable unless the course of the Injury 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.

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

All obligations on behalf of the Company for reimbursement at the Preferred Provider level of benefits for the ongoing treatment shall terminate after the 90th day after the effective date of the termination

**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.**

**PART VI**  
**MEDICAL EXPENSE BENEFITS - INJURY**

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Intensive Care:** If provided in the Schedule of Benefits.
2. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
3. **Physiotherapy (Inpatient):** See Schedule of Benefits.
4. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
5. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.
6. **Anesthetist Services:** professional services administered in connection with inpatient surgery.
7. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
8. **Physician's Visits:** when Hospital Confined. Benefits do not apply when related to surgery.
9. **Pre-Admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 7 working days prior to admission.
10. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
11. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.
12. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.
13. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.
14. **Physician's Visits (Outpatient):** Benefits do not apply when related to surgery or Physiotherapy.
15. **Physiotherapy (Outpatient):** See Schedule of Benefits.
16. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury.

**MEDICAL EXPENSE BENEFITS - INJURY ONLY (Continued)**

17. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.
18. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
19. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.
20. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.
21. **Prescription Drugs (Outpatient):** See Schedule of Benefits.
22. **Ambulance Services:** See Schedule of Benefits.
23. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of purchase price.
24. **Consultant Physician Fees:** when requested and approved by the attending Physician.
25. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

**PART VII  
MANDATED BENEFITS**

**BENEFITS FOR TELEMEDICINE / TELEHEALTH SERVICES**

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

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

**BENEFITS FOLLOWING A BRAIN INJURY**

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

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

1. Cognitive rehabilitation therapy - Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the Insured's brain-behavioral deficits.
2. Cognitive communication therapy - Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
3. Neurocognitive therapy - Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
4. Neurocognitive rehabilitation - Services designed to assist cognitively impaired Insureds to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
5. Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the Insured, family, or others.
6. Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior.
7. Neurophysiological testing - An evaluation of the functions of the nervous system.
8. Neurophysiological treatment - Interventions that focus on the functions of the nervous system.
9. Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship normal and abnormal central nervous system functioning.
10. Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
11. Outpatient day treatment services - Structured services provided to address functional deficits in behavior and/or cognition delivered in settings that include transitional residential, community integration, or non-residential services.
12. Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
13. Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
14. Neurofeedback therapy - Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
15. Remediation - The process(es) of restoring or improving a specific function.
16. Post-acute transition services - Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
17. Community reintegration services, including day treatment services - Services that facilitate the continuum of care as an affected individual transitions into the community.
18. Post-acute care treatment services.

### **MANDATED BENEFITS (Continued)**

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 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.



**PART VIII  
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. Biofeedback;
3. Chronic pain disorders;
4. Circumcision;
5. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy removal of warts, non-malignant moles and lesions;
6. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;
7. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
8. Elective Surgery or Elective Treatment;
9. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems;
10. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
11. Health spa or similar facilities; strengthening programs;
12. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
13. Hirsutism; alopecia;
14. Hypnosis;
15. Preventive medicines or vaccines, except where required for treatment of a covered Injury;
16. Injury caused by, contributed to, or resulting from the alcohol addiction to or use of 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;
17. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
18. Injury outside the United States and its possessions, Canada or Mexico , except for a Medical Emergency when traveling for academic study abroad programs business or pleasure;
19. Injury sustained while (a) participating in any interscholastic, high school, intramural, club, 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;
20. Injury sustained while (a) participating in any contest or competition of intramural football, etc. or intercollegiate football, etc.; (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;
21. Investigational services;
22. Organ transplants, including organ donation;

23. Participation in a riot or civil disorder; commission of or attempt to commit a felony; fighting as an active participant;
24. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:
  - 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 Benefits for Diabetes;
  - Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
  - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
  - anabolic steroids used for body building;
  - Growth hormones; or
  - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
25. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;
26. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury;
27. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
28. Sickness or disease in any form; over-exertion; fainting; or hernia, regardless of how caused;
29. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; Nasal and sinus surgery;
30. 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;
31. Sleep disorders;
32. Speech therapy; naturopathic services;
33. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
34. Supplies, except as specifically provided in the policy;
35. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; or snowmobile skiing scuba diving, surfing, roller skating, riding in a rodeo;
36. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and
37. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);.

# POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

## COORDINATION OF BENEFITS PROVISION

### Definitions

1. **Allowable Expenses:** Any necessary, reasonable, and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person. An Allowable Expense to a Secondary Plan includes the value or amount of any Deductible Amount or Coinsurance Percentage or amount of otherwise Allowable Expenses which was not paid by the Primary or first paying Plan.
2. **Plan:** A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services. Such group coverages include: (a) group or blanket insurance coverage, or any other group type contract or provision thereof; this will not include school accident coverage for which the parent pays the entire premium; (b) service plan contracts, group practice and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) coverage under governmental programs, including Medicare, and any coverage required or provided by statute.
3. **Primary:** The Plan which pays regular benefits.
4. **Secondary:** The Plan which pays a reduced amount of benefits which, when added to the Primary Plan's benefits will not be more than the Allowable Expenses.
5. **We, Us or Our:** The Company named in the policy to which this endorsement is attached.

**Effect on Benefits** - If an Insured Person has medical and/or drug coverage under any other Plan, all of the benefits provided are subject to coordination of benefits. During any policy year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Plan may not be more than the Allowable Expenses.

During any policy year or benefit period, We may reduce the amount We will pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made.

However, if: (1) the other Plan contains a section which provides for determining its benefits after Our benefits have been determined; and (2) the order of benefit determination stated herein would require Us to determine benefits before the other Plan, then the benefits of such other Plan will be ignored in determining the benefits We will pay.

This Plan determines its order of benefits using the first of the following rules which applies:

1. If the Insured's other Plan does not have Coordination of Benefits, that Plan pays first.
2. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.
3. Dependent Child/Parents Not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
  - a. the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year; but
  - b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
  - c. However, if the other Plan does not have the rule described in a. above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
4. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - a. first, the Plan of the parent with custody of the child;
  - b. then, the Plan of the spouse of the parent with the custody of the child; and
  - c. finally, the Plan of the parent not having custody of the child.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

**Right to Recovery and Release of Necessary Information** - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

**Facility of Payment and Recovery** - Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

**This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.**

## NON-DISCRIMINATION NOTICE

UnitedHealthcare **Student**Resources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator  
United HealthCare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.



