



University of Colorado  
Denver

STUDENT  
INJURY AND SICKNESS  
INSURANCE PLAN  
2013-2014



UnitedHealthcare®

**IMPORTANT:** Please see the Notice on the back of the front cover of this plan material concerning student health insurance coverage.

Policy Number: 2013-202513-1

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### Notice Regarding Your Student Health Insurance Coverage

**Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2012 and \$500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of \$500,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-767-0700. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.**

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Dear Student,

The University of Colorado Denver, Downtown Campus (DC) strongly encourages all students to have health insurance coverage. This will help insure success in the academic community even in the event of an unexpected medical expense. The University highly recommends that you consider this health program to help protect yourself against unexpected health emergencies which might arise. Without adequate medical protection your ability to maintain good health and meet education expenses could be seriously jeopardized. If you are not currently covered by other medical insurance at an adequate level, we urge you to take advantage of this opportunity to purchase medical protection at a very reasonable cost. The Student Injury and Sickness Insurance Plan is designed to coordinate with the Health Center at Auraria to assure the availability of quality health care at the lowest possible cost. The endorsed plan made available by the University of Colorado Denver, Downtown Campus Student Injury and Sickness Insurance Plan is described in this brochure. Be sure to read the Schedule of Benefits as well as the Exclusions and Limitations sections of this brochure. Coverage is voluntary and you must enroll in every coverage period that you want coverage (your coverage does not automatically renew after the semester in which you were enrolled). It is very important to know what the Policy does and does not cover. If you have any questions about this plan, please contact AmeriBen at 855-539-8678. We look forward to assisting you in maintaining good health while you achieve your educational goals.

Sincerely,  
Student Insurance Office  
Tivoli 127  
303-556-6273

## NON-DISCRIMINATION POLICY

The University of Colorado Denver, Downtown Campus does not discriminate on the basis of race, color, national origin, sex, age, disability, creed, religion, sexual orientation, or veteran status in admission and access to, and treatment and employment in, its educational programs and activities.

The University of Colorado Denver, Downtown Campus takes action to increase ethnic, cultural, and gender diversity, to employ qualified disabled individuals, and to provide equal opportunity to all students and employees.

The University of Colorado Denver, Downtown Campus complies with all local, state, and federal laws and regulations related to education, employment and contracting.

## STUDENT INJURY AND SICKNESS INSURANCE PLAN

This brochure is designed to acquaint students and other interested parties with the medical services available, cost of the plan and exclusions to the services offered. We ask that you read it carefully so that you will know the extent of medical services and insurance benefits you can expect.

The insurance plan is entirely supported by student premiums, no tuition or State appropriations are used to pay for these services.

The insurance becomes effective for a student as provided in the Master Policy and explained in this booklet.

## ELIGIBILITY

Domestic undergraduate students taking 6 or more credit hours and graduate students enrolled in a degree-seeking program are eligible to enroll in this plan on a voluntary basis. International students with a visa status other than an F-1 or J-1 who are engaged in educational activities through the University provided he or she: 1) possesses a current valid visa; and 2) is temporarily located outside his or her home country as a non-resident alien may participate on a voluntary basis.

International students engaged in Practical Training (OPT) through the University are eligible to enroll for up to one year (or the length of the OPT term, whichever is the lesser) beyond their regular course of study, provided they were enrolled in the separate University-sponsored International Student Health Insurance Plan in the

## ELIGIBILITY (CON'T)

immediately preceding semester are eligible to enroll in this plan on a voluntary basis.

An eligible student must actively attend classes for at least the first 31 days of the period for which he or she is enrolled. Students who withdraw after such 31 days must remain covered under the Policy and no refund will be made. Home study and correspondence courses do not fulfill the Eligibility requirements that the student actively attend classes. On-line students are eligible for coverage under this plan. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claim paid.

Eligible Dependents, including Domestic Partners of enrolled students may participate on a voluntary basis.

## COVERAGE DATES AND COSTS

The Master Policy becomes effective 12:01 a.m., August 19, 2013. Coverage becomes effective on the first day of the Coverage Period for which full premium is received by the enrollment deadline. The Master Policy terminates at 11:59 p.m. on August 17, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

### Dates and Rates:

	Fall	Spring	Spring/ Summer	Summer
Student	\$1,150	\$889	\$1,552	\$659
Spouse/Domestic Partner	\$2,636	\$2,019	\$3,555	\$1,531
Each Child	\$1,881	\$1,445	\$2,537	\$1,089

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

Coverage Period(s):	Beginning	Through	Enrollment Deadlines:
Fall	08-19-2013	01-20-2014	09-04-2013
Spring	01-21-2014	05-18-2014	02-07-2014
Spring/ Summer	01-21-2014	08-17-2014	02-07-2014
Summer	05-19-2014	08-17-2014	06-06-2014

## COVERAGE DATES AND COSTS (CON'T)

### REFUNDS

Refunds will be made upon the entry of any Insured Person into the armed forces of any country. Refund rates are pro-rated. A refund will be returned to such person upon written request, less any claims paid.

Students must actively attend classes the first 31 days of the semester for which the student purchased insurance coverage. If the student withdraws from school or drops below the required credit hours within the first 31 days they are not eligible for the Student Injury and Sickness Insurance Plan. Any student who withdraws from school or who drops below the required credit hours during the first 31 days of the Coverage Period for which he or she is enrolled will not be covered under the Policy and a full refund of premium will be made less any claims paid. Students who withdraw from school or drop below the required credit hours will not be entitled to any benefits during the days described above and no claims received will be honored. **No other refunds will be issued.**

If the Insured Person elects coverage and wants to terminate coverage at a later date due to any reason except for entrance into the Armed Forces, or if the Insured Person withdraws from school within 31 days of the semester in which he or she enrolled for insurance, he or she **cannot terminate coverage** under this Plan and get a refund after the Enrollment Deadline date.

## ENROLLMENT PROCESS

All fee-paying students attending credit courses at the University of Colorado Denver, Downtown Campus, including on-line students, enrolled in 6 credit hours or more as a domestic undergraduate, or a degree-seeking graduate student may enroll in the Plan. See the University of Colorado Denver, Downtown Campus website for enrollment information at [www.ucdenver.edu/studentlife/healthinsurance](http://www.ucdenver.edu/studentlife/healthinsurance).

A specified period of time will be allowed at the beginning of each semester for enrolling in the plan. See "Coverage Dates and Costs" on page 3 for the Enrollment Deadline dates.

**Coverage is voluntary and the Insured Person must enroll in every coverage period for which he or she wants coverage (coverage does not automatically renew).**

## DEPENDENT COVERAGE (Including Newborn Enrollment and Eligibility)

Eligible students who do enroll may also insure their eligible dependents on a voluntary basis. Eligible dependents are the spouse or Domestic Partner and dependent children under age 26. Dependent/Domestic Partner eligibility expires concurrently with that of the Insured Student unless the dependent is covered through the Extension of Benefits provision after termination of coverage.

### Newborn Children

In the event of the birth of a child to an Insured Person while the student's health plan is in force, that child automatically becomes a Insured Person from the moment of birth. Coverage will continue for 31 days. If the student wants continuing coverage for the newborn after 31 days, enrollment and payment of premium must be made within the first 31 days, or the coverage will terminate for that child at the end of the 31-day period. While covered under the Policy, coverage is subject to all Policy provisions, including the deductible. Benefits mandated by the state of Colorado that apply to newborn infants are payable under the Policy for the first 31 days.

## LATE ENROLLMENT

Students will not be allowed to enroll in the Plan after the applicable enrollment deadline period unless proof is furnished that the eligible student was dropped from coverage under another Creditable health plan during the 30 days\* immediately preceding the date of the request for late enrollment. In such cases, the cost of the period will be the same as it would have been at the beginning of that period but the effective date will be the date the student enrolls and makes the full payment. The premium for the period purchased will not be pro-rated unless the period purchased is 60 days or less. In such cases, a one month premium amount will apply to coverage periods of up to 30 days and a two month premium amount will apply to Coverage Periods of 31 to 60 days.

\*30 days means the enrollment form and full payment is due at the Student Insurance Office within that 30 day period.

## CONFIRMATION OF COVERAGE FOR PARTICULAR SERVICES

It is the student's responsibility to confirm whether or not a particular service is covered under the plan. This confirmation must be done with AmeriBen by calling them at 855-539-8678. Health Center staff, including medical providers, are not adequately trained to provide confirmation of coverage for any services.

Health Center at Auraria: **303-556-2525**

Find out the availability of daily access, appointments and hours of the Health Center.

### 100% Reimbursement With NO Deductible or Coinsurance

(This applies to eligible services; this option is not always available due to hours of operation and staffing)

Prescriptions at the Health Center at Auraria:

Are not subject to any copay up to a 30-day supply per prescription. Contraceptives are provided at the Health Center at Auraria for students only.

**SPECIAL HEALTH CENTER BENEFITS**

The deductible and pre-existing condition exclusion will be waived and benefits will be paid at 100% for Medical Expenses incurred when treatment is rendered at the Health Center at Auraria. This includes limited well care, supplies, in-house testing and procedures. No claim forms will be required. Health Center at Auraria benefits are not always available due to hours of operation and staffing.

## CONFIRMATION OF COVERAGE FOR PARTICULAR SERVICES (CON'T)

### Cofinity Participating Provider Network:

The University of Colorado Denver, Downtown Campus has a specially-designed Participating Network through Cofinity. The following Hospitals are in the network (Eligible Expenses are payable at the 80% of the Allowable Charge reimbursement level):

Denver	Denver Health Exempla St. Joseph National Jewish Health Porter Adventist Hospital PSL Medical Center Rose Medical Center
Aurora	Children's Hospital Medical Center of Aurora North Campus Medical Center of Aurora South Campus Spalding Rehabilitation Hospital University of Colorado Hospital
Boulder	Boulder Community Foothills Hospital Boulder Community Hospital
Englewood	Swedish Medical Center
Littleton	Littleton Adventist Hospital
Thornton	North Suburban Medical Center North Valley Hospital
Lone Tree	Sky Ridge Medical Center
Parker	Parker Adventist Hospital Parker Valley Hope
Wheat Ridge	Exempla Lutheran Medical Center

NOTE: This is not an all-inclusive list of Hospitals and may be subject to change. For a more complete list and verification of Hospitals, facilities and Doctors in the Participating Providers Network visit [www.cofinity.net](http://www.cofinity.net) or call 800-831-1166. For participating Providers outside the State of Colorado visit [www.myfirsthealth.com](http://www.myfirsthealth.com) or call First Health at 800-226-5116.

### Admission Notification:

For pretreatment pre-notification of emergency and non-emergency hospitalizations, call AmeriBen at 800-388-3193.

## SUMMARY OF BENEFITS

Benefits will be paid when a Insured Person incurs Covered Medical Expenses while under the Plan. The expense must be due to an Injury or Sickness, be Medically Necessary, and authorized by a Doctor. All benefits are subject to Reasonable and Customary guidelines, deductibles, copayments, coinsurance, plan maximums and limitations and exclusions. Reasonable and Customary allowances will be determined using the current survey of Fair Health Inc. with a 75th percentile reimbursement level.

## POLICY YEAR DEDUCTIBLES, Per Insured Person

Participating Providers	Non-Participating Providers
\$250	\$500

### **HEALTH CENTER AT AURARIA**

For services performed at the Health Center at Auraria, the Policy Year Deductible will be waived.

## OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum per Insured Person per Policy Year is:

- \$2,500 for services provided by a Participating Provider
- \$5,000 for services provided by a Non-Participating Provider

After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% up to the policy Maximum Benefit subject to any benefit maximums that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. The policy Deductible, Copays and per service Deductibles and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays and per service Deductibles.

## PRESCRIPTION DRUG PLAN

Benefits are provided through Express Scripts, a point-of-service provider. Please call 800-206-4005 for questions regarding benefits or participating pharmacies. If a Insured Person incurs Rx claims within the first 6 weeks of enrollment, the Insured Person must pay for the Rx and submit a claim to Express Scripts after the 6th week at:

Express Scripts, Inc.  
P.O. Box 66583  
St. Louis, MO 63166-6583  
Attn: STD Acnts  
Group # AM2A

After 6 weeks, the Insured Person may go to any participating pharmacy. A \$10 Copay will apply per generic prescription. A Copay of \$30 will apply per brand name prescription. A Copay of \$50 will apply per non-formulary prescription.

Copays are for allowable drugs, for up to a 31 day supply per prescription or refill. Mail Order is not available for prescriptions. Generic oral contraceptives are covered with no copay. Brand and non-formulary copays will apply unless there is medical necessity. If you have medical necessity for Brand and non-formulary contraceptive drugs your provider must fill out a Prior Authorization form and it must be approved by Express Scripts. All contraceptives at the Health Center at Auraria are covered with no copays.

When a generic drug is available and the Insured Person chooses to purchase a brand name drug, even when the Doctor writes "dispense as written" or "may not substitute," the Insured Person must pay the cost difference between the brand name prescription and the generic prescription, in addition to the Copay. For prescriptions filled at non-network participating pharmacies the Insured Person will be reimbursed the difference between the retail amount the Insured Person paid at the pharmacy and the network negotiated rate less the applicable Copay.

**Specialty Drug Program** – The Specialty Drug Program covers certain drugs commonly referred to as **high-cost specialty drugs**. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through a select group of pharmacies. These pharmacies comprise the Specialty Pharmacy Network (SPN). The SPN specializes in dispensing and delivering drugs that require special handling. Specialty Pharmacies provide additional helpful services, including free courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease

## PRESCRIPTION DRUG PLAN (CON'T)

for which the medication is dispensed. Common conditions that involve treatment with one of the specialty drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis.

With a new Specialty Pharmacy prescription, a Insured Person may contact Member Services or access the internet website address shown on the Insured Person's medical identification card to identify the drugs contained on the Specialty Pharmacy list. A Insured Person may also contact Member Services or access the internet website for assistance in locating the Specialty Pharmacy that can be used to obtain medication.

The Copay for Specialty drugs will mirror the Retail Network Pharmacy copays. Specialty Drugs can only be filled for 30 days. Members may fill a one-month supply at a local participating pharmacy before using the Specialty Pharmacy Network (SPN).

## PRESCRIPTION DRUG PLAN HEALTH CENTER AT AURARIA

Maintenance medications filled at the Health Center at Auraria may be filled up to a 90 day supply. No copays or deductibles apply at the Health Center at Auraria for prescription drugs.

For Maintenance medications filled near the end of the semester, only a 30 day supply can be filled 30 days or less to the end of the semester for which premium has been paid; and only a 60 day supply can be filled 60 to 30 days to the end of the semester for which premium has been paid. If it is over 60 days to the end of the semester for which premium has been paid a 90 day supply can be filled.

Contraceptives provided at the Health Center at Auraria are provided with no copay.

## PRE-EXISTING CONDITIONS

Covered Medical Expenses are subject to Exclusions and Limitations for Pre-Existing Conditions on page 31 and Creditable Coverage on page 32.

## RIGHT OF REIMBURSEMENT

The Company shall have a lien against any recovery received by an Insured Person as compensation for an Injury or Sickness to the extent that the Insured Person received benefits for such Injury or Sickness under the coverage of the Policy. The Company's lien will apply to

## RIGHT OF REIMBURSEMENT (CON'T)

such recovery made by the Insured Person from any person, or entity that was responsible for causing such Injury or Sickness or their insurers. The Insured Person will not be required to return to the Company more than the amount which was recovered for such Injury or Sickness.

The Insured Person (or a parent or a guardian if the Insured Person is not able to execute such papers) will execute and deliver such papers as may be required by the Company. Also, the Insured Person will do whatever else is needed to help the Company in its attempts to recover the benefits it paid under the Policy to the Insured Person or the Insured Person's assignee.

## MAXIMUM BENEFIT

The maximum benefit is \$500,000 per Insured Person per Policy Year.

## GENERAL PLAN PROVISIONS

Coverage will be in effect 24 hours a day for emergency treatment. An Insured Person will be insured at home, school or when traveling outside the United States while insurance is in force.

## COVERED MEDICAL EXPENSES

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness 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.

Covered Medical Expenses include:

### State Mandated Covered Medical Expenses

1. Treatment of **Autism Spectrum Disorders**: Benefits will be paid the same as any other Sickness for Covered Medical Expenses related to the assessment, diagnosis and treatment, including Applied Behavior Analysis, of Autism Spectrum Disorders. Treatment for Autism Spectrum Disorders must be prescribed or ordered by a licensed Physician or license psychologist.

"Applied behavior analysis" means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

## COVERED MEDICAL EXPENSES (CON'T)

"Autism Spectrum Disorders" include the following neurobiological disorders: autistic disorder, asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time of diagnosis.

"Treatment for Autism Spectrum Disorders" shall be for treatments that are Medically Necessary, appropriate, effective, or efficient. Treatment for Autism Spectrum Disorders shall include:

- a. Evaluation and assessment services;
- b. Behavior training and behavior management and applied behavior analysis, including but not limited to, consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers;
- c. Habilitative or rehabilitative care, including but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies;
- d. Psychiatric care;
- e. Psychological care, including family counseling;
- f. Therapeutic care; and
- g. Pharmacy care and medication if provided for in the policy.

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

2. **Biologically Based Mental Illness**: Benefits will be paid the same as any other Sickness for the treatment of Biologically Based Mental Illness and Mental Disorders as defined below. The benefit provided will not duplicate any other benefits provided in this policy.

"Biologically Based Mental Illness" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

"Mental Disorder" means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. Mental Disorder also includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient, day treatment, and in-patient basis, exclusive of residential treatment.

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

## COVERED MEDICAL EXPENSES (CON'T)

3. **Cervical Cancer Vaccines:** Benefits are payable for the cost of cervical cancer vaccinations for all female Insured Persons for whom a vaccination is recommended by the Advisory Committee on Immunization practices of the United States Department of Health and Human Services.
4. **Child Health Supervision Services:** Benefits will be paid for the Usual and Customary Charges for Child Health Supervision Services from birth up to the age of 13. Benefits are payable on a per visit basis to one health care provider per visit.

Child Health Supervision Services rendered during a periodic review are covered only to the extent such services are provided during the course of one visit by, or under the supervision of a single Physician, Physician's assistant or Registered Nurse.

Child Health Supervision Services means the periodic review of a child's physical and emotional status by a Physician or other provider as above. A review shall include but not be limited to a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, preventative services, and laboratory tests in keeping with prevailing medical standards.

Immunizations are based on the recommended childhood immunization schedule and the recommended immunization schedule for children who start late or who are more than 1 month behind published by the CDC. Recommended schedules are available from:

Advisory Committee on Immunization Practices,  
[www.cdc.gov/nip/acip](http://www.cdc.gov/nip/acip);

American Academy of Pediatrics, [www.aap.org](http://www.aap.org);

American Academy of Family Physicians,  
[www.aafp.org](http://www.aafp.org).

The policy Deductible and dollar limits will not be applied to this benefit.

Benefits shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the policy.

5. **Cleft Lip or Cleft Palate:** Benefits will be paid the same as any other Sickness for treatment of newborn children born with cleft lip or cleft palate or both. Benefits shall include the Medically Necessary care and treatment including oral and facial surgery; surgical management; the Medically Necessary care by a plastic or oral surgeon; prosthetic treatment such as obturators, speech appliances,

## COVERED MEDICAL EXPENSES (CON'T)

feeding appliances; Medically Necessary orthodontic and prosthodontic treatment; rehabilitative speech therapy, otolaryngology treatment; and audiological assessments and treatment.

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

6. Therapies for **Congenital Defects and Birth Abnormalities:** Benefits will be paid the same as any other Sickness for physical, occupational and speech therapy for congenital defects and birth abnormalities for covered Dependent children beginning after the first 31 days of life to five years of age.

Benefits will be paid for the greater of the number of such visits provided under the policy or twenty visits per year for each therapy. Benefits will be provided without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

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

7. **Diabetes:** Benefits will be paid for the Usual and Customary Charges for all medically appropriate and necessary equipment, supplies, and outpatient diabetes self-management training and educational services including nutritional therapy if prescribed by a Physician.

Diabetes outpatient self-management training and education shall be provided by a Physician with expertise in diabetes.

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

8. **Hearing Aids for Minor Children:** Benefits will be paid for Covered Medical Expenses for Hearing Aids for a Minor Child who has a hearing loss that has been verified by a licensed Physician and a licensed Audiologist. The Hearing Aid shall be medically appropriate to meet the needs of the Minor Child according to accepted professional standards.

Benefits shall include the purchase of the following:

- Initial Hearing Aids and replacement Hearing Aids not more frequently than every five years;
- A new Hearing Aid when alterations to the existing Hearing Aid cannot adequately meet the needs of the Minor Child; and

## COVERED MEDICAL EXPENSES (CON'T)

- c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to professional standards.

“Hearing Aid” means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. “Hearing Aid” shall include any parts or ear molds.

“Minor Child” means an Insured Person under the age of eighteen.

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

### 9. **Hospitalization and General Anesthesia for Dental Procedures for Dependent Children:**

Benefits will be paid the same as any other Sickness for general anesthesia, when rendered in a Hospital, outpatient surgical facility, or other facility licensed pursuant to Colorado Statute Section 25-3-101, and for associated Hospital or facility charges for dental care provided to a Dependent child. Such Dependent child shall, in the treating Physician’s opinion, meet one or more of the following criteria:

- a. The child has a physical, mental, or medically compromising condition;
- b. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;
- c. The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
- d. The child has sustained extensive orofacial and dental trauma.

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

### 10. **Medical Foods:** Benefits are payable for Medical Foods needed to treat inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as specified below.

If the policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Sickness for Medical Foods, to the extent Medically Necessary, for home use for which a Physician has issued a

## COVERED MEDICAL EXPENSES (CON'T)

written, oral or electronic prescription. Benefits will not be provided for alternative medicine.

Coverage includes but is not limited to the following diagnosed conditions: phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Benefits do not apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

There is no age limit on the benefits provided for inherited enzymatic disorders except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

Medical foods means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy that are specifically designed and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a Physician.

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

### 11. **Oral Anticancer Medication:** If the policy provides benefits for cancer chemotherapy treatment, then benefits will be provided for prescribed, orally administered anticancer medication that has been approved by the Federal Food and Drug Administration and is used to kill or slow the growth of cancerous cells.

The orally administered medication shall be provided at a cost to the Insured not to exceed the Coinsurance percentage or the Copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose.

The medication provided pursuant to this benefit shall:

- a. only be prescribed upon a finding that it is Medically Necessary by the treating Physician for

## COVERED MEDICAL EXPENSES (CON'T)

the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice;

- b. be clinically appropriate in terms of type, frequency, extent site, and duration; and
- c. not be primarily for the convenience of the Insured or Physician.

This benefit does not require the use of orally administered medications as a replacement for other cancer medications, nor does it prohibit the Company from applying an appropriate formulary or other clinical management to any medication described in this benefit.

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

12. **Preventive Health Care:** Benefits will be provided for the cost of the following Preventive Health Care services, in accordance with the A or B recommendations of the Task Force for the particular Preventive Health Care service:
- a. Alcohol misuse screening and behavioral counseling interventions for adults by their Physician;
  - b. Cervical Cancer Screening;
  - c. Breast Cancer Screening with Mammography:
    - 1) Benefits shall be determined on a Policy Year basis and shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy;
    - 2) If an Insured Person who is eligible for a preventive mammography screening has not utilized the benefit during the Policy Year, then the coverage shall apply to one diagnostic screening for that same Policy Year. Any other diagnostic screenings shall be subject to all applicable policy provisions;
    - 3) Benefits shall also be provided for an annual breast cancer screening with mammography for an Insured Person possessing at least one risk factor including, but not limited to, a family history of breast cancer, being forty years of age or older, or a genetic predisposition to breast cancer;
  - d. Cholesterol screening for lipid disorders;
  - e. Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps. Benefits shall also be provided to an Insured Person who is at a high risk for colorectal cancer, including an Insured Person

## COVERED MEDICAL EXPENSES (CON'T)

who has a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by a Physician;

- f. Childhood immunizations pursuant to the schedule established by the ACIP;
- g. Influenza vaccinations pursuant to the schedule established by the ACIP;
- h. Pneumococcal vaccinations pursuant to the schedule established by the ACIP; and
- i. Tobacco use screening of adults and tobacco cessation interventions by the Insured Person's Physician.

For the purposes of this mandate:

"ACIP" means the advisory committee on immunization practices to the centers for disease control and prevention in the federal Department of Health and Human Services, or any successor entity.

"A Recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit of the preventive health care service is substantial.

"B Recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

"Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal Department of Health and Human Services.

The policy Deductible and Coinsurance will not be applied to this benefit.

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

13. **Prostate Cancer Screening:** Benefits will be paid for actual charges incurred for an annual screening by a Physician for the early detection of prostate cancer. Benefits will be payable for one screening per year for any male Insured 50 years of age or older. One screening per year shall be covered for any male

## COVERED MEDICAL EXPENSES (CON'T)

Insured 40 to 50 years of age who is at risk of developing prostate cancer as determined by the Insured's Physician. The screening shall consist of the following tests:

- a. A prostate-specific antigen (PSA) blood test; and
- b. Digital rectal examination.

The policy Deductible will not be applied to this benefit and this benefit will not reduce any diagnostic benefits otherwise allowable under the policy.

Benefits shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the policy.

14. **Prosthetic Devices:** Benefits will be paid for the Usual and Customary Charges for the purchase of Prosthetic Devices.

Prosthetic device means an artificial device to replace, in whole or in part, an arm or leg. Benefits are limited to the most appropriate model that adequately meets the medical needs of the Insured as determined by a Physician. Repairs and replacements of Prosthetic Devices are also covered unless necessitated by misuse or loss.

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

15. **Telemedicine Services:** Benefits will be paid for Covered Medical Expenses on the same basis as services provided through a face-to-face consultation for services provided through Telemedicine for an Insured residing in a county with one hundred fifty thousand or fewer residents. "Telemedicine" means the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education. The term does not include services performed using a telephone or facsimile machine.

Nothing in this provision shall require the use of Telemedicine when in-person care by a participating provider is available to an Insured Person within the Company's network and within the Insured's geographic area.

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

## COVERED MEDICAL EXPENSES (CON'T)

### All Other Covered Medical Expenses

16. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits.
17. **Ambulance Services**
18. **Anesthetist Services (Inpatient):** professional services administered in connection with Inpatient surgery.
19. **Anesthetist Services (Outpatient):** professional services administered in connection with outpatient surgery.
20. **Assistant Surgeon Fees:** in connection with inpatient and outpatient surgery.
21. **Chemotherapy (Outpatient)**
22. **Complications of Pregnancy:** Same as any other Sickness.
23. **Consultant Physician Fees:** when requested and approved by the attending Physician.
24. **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.
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.
26. **Diabetes Services:** See Benefits for Diabetes.
27. **Diagnostic X-ray Services (Outpatient):** Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
28. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. 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 or Sickness. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price. See also Benefits for Prosthetic Devices on page 18.
29. **Hospital Miscellaneous Expenses:** 1) when confined as an Inpatient; or 2) as a precondition for being confined as an Inpatient. Benefits will be paid for services and supplies such as: the cost of the

## SCHEDULE OF BENEFITS

Maximum Benefit:	\$500,000 (per Insured Person per Policy Year)
Deductible:	\$250 PPO Network (per Insured Person per Policy Year) \$500 OON (per Insured Person per Policy Year)
Co-Insurance	80% PPO Providers (except as noted below) 60% OON (except as noted below)
Out-of-Pocket	\$2,500 PPO (excluding deductible, copay and non-covered expenses) and (per insured person per policy year) \$5,000 OON (excluding deductible, copay and non-covered expenses) and (per insured person per policy year)

The PPO Network is Cofinity (in the State of Colorado) and FIRST HEALTH (outside the State of Colorado). The Deductible and Pre-Existing Condition exclusion will be waived and benefits will be paid at 100% for Medical Expenses incurred when treatment is rendered at the Health Center at Auraria. Pregnancy is not subject to the pre-existing condition limitations of the Plan.

PA = Preferred Allowance for PPO providers. U&C = Usual & Customary of Fair Health Index for non-network (OON) providers. The Fair Health Index for this Plan is 75%.

BENEFIT DESCRIPTIONS	HEALTH CENTER AT AURARIA	PREFERRED PROVIDER	OUT-OF-NETWORK PROVIDER	ADDITIONAL LIMITATIONS AND EXPLANATIONS
<b>INPATIENT</b>				
<b>Anesthetist:</b>	N/A	80% of PA	60% of U&C	
<b>Assistant Surgeon:</b>	N/A	25% of surgery allowance	25% of surgery allowance	
<b>Hospital Miscellaneous:</b>	N/A	80% of PA	60% of U&C	
<b>Physician's Visits:</b>	N/A	80% of PA	60% of U&C	
<b>Physiotherapy:</b>	N/A	80% of PA	60% of U&C	
<b>Pre-admission Testing:</b>	N/A	80% of PA	60% of U&C	
<b>Registered Nurse's Services:</b>	N/A	80% of PA	60% of U&C	
<b>Room &amp; Board:</b>	N/A	80% of PA	60% of U&C	
<b>Routine Newborn Care:</b>	N/A	Paid as any other Sickness	Paid as any other Sickness	
<b>Surgery:</b>	N/A	80% of PA	60% of U&C	
<b>OUTPATIENT</b>				
<b>Anesthetist:</b>	100%	80% of PA	60% of U&C	
<b>Assistant Surgeon:</b>	100%	25% of surgery allowance	25% of surgery allowance	
<b>Chemotherapy:</b>	N/A	80% of PA	60% of U&C	
<b>Day Surgery Miscellaneous:</b>	100%	80% of PA	60% of U&C	
<b>Injections:</b>	100%	80% of PA	60% of U&C	
<b>Laboratory:</b>	100%	80% of PA	60% of U&C	
<b>Medical Emergency:</b>	100%	\$150 copay per visit 80% of PA	\$150 copay per visit, 80% of U&C	
<b>Physician's Visits:</b>	100%	\$20 copay per visit 100% of PA	60% of U&C	
<b>Physiotherapy:</b>	N/A	80% of PA	60% of U&C	
<b>Prescription Drugs:</b>	100%	<b>\$10</b> copay generic <b>\$30</b> copay brand <b>\$50</b> copay non-formulary Up to a 31-day supply per Rx.	No Benefits	Prescriptions filled at Express Scripts pharmacies. Coverage for Maintenance Drugs through Express Scripts for up to 90 days for 3x the copay and up to 60 days for 2x the copay.
<b>Radiation Therapy:</b>	N/A	80% of PA	60% of U&C	
<b>Surgery:</b>	100%	80% of PA	60% of U&C	

## SCHEDULE OF BENEFITS (CON'T)

BENEFIT DESCRIPTIONS	HEALTH CENTER AT AURARIA	PREFERRED PROVIDER	OUT-OF-NETWORK PROVIDER	ADDITIONAL LIMITATIONS AND EXPLANATIONS
<b>Tests &amp; Procedures:</b>	100%	80% of PA	60% of U&C	
<b>X-rays:</b>	100%	80% of PA	60% of U&C	
<b>OTHER</b>				
<b>Ambulance:</b>	N/A	80% of PA	80% of U&C	
<b>Complications of Pregnancy:</b>	N/A	Paid as any other Sickness	Paid as any other Sickness	
<b>Consultant:</b>	100%	\$20 copay per visit 100% of PA	60% of U&C	
<b>Dental:</b>		80% of PA	80% of U&C	\$5,000 maximum Per Policy Year Benefits paid on Injury to Sound, Natural Teeth only. Benefits are not subject to the \$500,000 Maximum Benefit.
<b>Diabetes Services:</b>	N/A	See Benefits for Diabetes	See Benefits for Diabetes	
<b>Durable Medical Equipment:</b>	100%	80% of PA	60% of U&C	Exception: See Benefits for Prosthetic Devices. \$5,000 maximum Per Policy Year. Durable Medical Equipment benefits payable under the \$5,000 maximum Per Policy Year are not included in the \$500,000 Maximum Benefit. Prosthetic Appliances/Orthotic Devices are not subject to the DME \$5,000 maximum Per Policy Year.
<b>Elective Abortion:</b>	N/A	No Benefits	No Benefits	
<b>Infertility Testing:</b>	N/A	80% of PA	60% of U&C	\$1,000 maximum Per Policy Year. Infertility testing benefits are not subject to the \$500,000 Maximum Benefit.
<b>Maternity:</b>	N/A	Paid as any other Sickness	Paid as any other Sickness	
<b>Medical Evacuation:</b>	N/A	Benefits provided by FrontierMEDEX	Benefits provided by FrontierMEDEX	
<b>Mental Illness Treatment :</b>	N/A	Paid as any other Sickness	Paid as any other Sickness	See also Benefits for Biologically Based Mental Illness on page 12.
<b>Nutrition Programs:</b>	N/A	80% of PA	60% of U&C	Benefits are not subject to the \$500,000 Maximum Benefit.
<b>Preventive Care Services:</b>	100%	100% of PA	No Benefits	No Deductible, copay or coinsurance will be applied to Preventive Care Services when the services are received from a Preferred Provider. Benefits include routine immunization titers. See also Benefits for Preventive Health Care on page 17.
<b>Reconstructive Breast Surgery Following Mastectomy:</b>	N/A	Paid as any other Sickness	Paid as any other Sickness	
<b>Repatriation:</b>	N/A	Benefits provided by FrontierMEDEX	Benefits provided by FrontierMEDEX	
<b>Substance Use Disorder:</b>	100%	Paid as any other Sickness	Paid as any other Sickness	See also Benefits for Biologically Based Mental Illness on page 12.

## COVERED MEDICAL EXPENSES (CON'T)

- 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.
30. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.
  31. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
  32. **Maternity:** Same as any other Sickness. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.
  33. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.
  34. **Medical Evacuation:** 1) when Hospital Confined for at least five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.
  35. **Mental Illness Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; and 2) on an outpatient basis including intensive outpatient treatment. See also Benefits for Biologically Based Mental Illness on page 12.
  36. **Physician's Visits (Inpatient):** non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the Inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.
  37. **Physician's Visits (Outpatient):** Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the Inpatient benefit for Physician's Visits, but not both on the same day.

## COVERED MEDICAL EXPENSES (CON'T)

- Physician's Visits for preventive care are provided as specified under Preventive Care Services.
38. **Physiotherapy (Inpatient):** See Schedule of Benefits.
  39. **Physiotherapy (Outpatient):** Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy, unless excluded in the policy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.
  40. **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 3 working days prior to admission.
  41. **Prescription Drugs (Outpatient)**
  42. **Preventive Care Services:** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. See also Benefits for Preventive Health Care on page 17.
  43. **Radiation Therapy (Outpatient)**
  44. **Reconstructive Breast Surgery Following Mastectomy:** same as any other Sickness and in connection with a covered mastectomy. Benefits include: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.
  45. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while an Inpatient; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

## COVERED MEDICAL EXPENSES (CON'T)

46. **Repatriation:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.
47. **Room and Board Expense:** 1) daily semi-private room rate when confined as an Inpatient; and 2) general nursing care provided and charged by the Hospital.
48. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.
49. **Substance Use Disorder Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; 2) on an outpatient basis including intensive outpatient treatment. See also Benefits for Biologically Based Mental Illness on page 12.
50. **Surgery (Inpatient):** Physician's fees for Inpatient surgery. 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.
51. **Surgery (Outpatient):** Physician's fees for outpatient surgery. 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.
52. **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. The following therapies will be paid under the Tests and Procedures (Outpatient) benefit: inhalation therapy; infusion therapy; pulmonary therapy; and respiratory therapy. Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

## EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. **Acupuncture;**
2. Nicotine **addiction**, except as specifically provided in the policy;
3. Milieu therapy, learning disabilities, **behavioral** problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation;
4. **Cosmetic procedures**, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
5. **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;
6. **Dental treatment**, except for accidental Injury to Sound, Natural Teeth
7. **Elective Surgery** or Elective Treatment;
8. **Elective** abortion;
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; except when due to a covered Injury or disease process;
10. **Health spa** or similar facilities; strengthening programs;
11. **Hearing examinations;** hearing aids, except as specifically provided in the policy; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
12. **Hirsutism;** alopecia;
13. **Hypnosis;**
14. **Immunizations**, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
15. **Injury** or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
16. **Injury** sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
17. **Injury** sustained while (a) participating in any intercollegiate, or professional sport, contest or

## EXCLUSIONS AND LIMITATIONS (CON'T)

- competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
18. **Investigational** services;
  19. **Lipectomy**;
  20. **Participation** in a riot or civil disorder; commission of or attempt to commit a felony;
  21. **Pre-existing Conditions** in excess of \$1,000 for a period of 6 months, except for individuals who have been continuously insured for at least 6 consecutive months under the school's student insurance policy; The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under prior Creditable Coverage if such Creditable Coverage was continuous to a date not more than 90 days prior to the Insured's Effective Date under this policy; This exclusion will not be applied to an Insured Person who is under age 19;
  22. **Prescription Drugs**, services or supplies as follows:
    - a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other nonmedical substances, regardless of intended use, except as specifically provided in the policy;
    - b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    - c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    - d) Products used for cosmetic purposes;
    - e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    - f) Anorectics - drugs used for the purpose of weight control;
    - g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    - h) Growth hormones; or
    - i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
  23. **Reproductive/Infertility** services including but not limited to: family planning; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;

## EXCLUSIONS AND LIMITATIONS (CON'T)

24. **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;
25. **Residential treatment** of eating disorders, such as anorexia or bulimia;
26. **Routine Newborn Infant Care**, well-baby nursery and related Physician charges except as specifically provided in the policy;
27. Preventive care services; **routine physical examinations** and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
28. **Services** provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
29. **Skeletal irregularities** of one or both jaws, including orthognathia and mandibular retrognathia; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
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. **Speech therapy**, except as specifically provided in the policy;
32. **Supplies**, except as specifically provided in the policy;
33. **Surgical breast reduction**, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
34. **Treatment** in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
35. **War or any act of war**, declared or undeclared; or while in the armed forces of any country other than the United States (a pro-rata premium will be refunded upon request for such period not covered); and
36. **Weight management**, service and supplies related to weight reduction programs, weight management programs, and treatment for obesity, (except surgery for morbid obesity), (treatment for Morbid Obesity is covered. Morbid Obesity is defined as follows: Morbid Obesity associated with serious and life threatening disorders such as diabetes mellitus and hypertension. Morbid Obesity means a body weight of two times the

## EXCLUSIONS AND LIMITATIONS (CON'T)

normal weight or greater, or 100 pounds in excess of normal body weight based on normal body weight using generally accepted height and weight tables for a person of the same age, sex, height and frame. Benefits will be provided only upon written request for treatment with a treatment plan written by a Physician, and services or treatment must meet the Company's medical criteria.) and surgery for removal of excess skin or fat.

## PRE-EXISTING CONDITIONS

Expenses Incurred by an Insured Person over \$1,000 as a result of a Pre-existing Condition will not be considered.

This limitation will not apply if, during the period immediately preceding the Insured Person's effective date of coverage under the current Policy, the Insured Person was covered under prior Creditable Coverage for 6 consecutive months. Prior Creditable Coverage of less than 6 months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Condition limitation will apply only if the Insured Person becomes eligible and enrolls for coverage within 90 days of termination of his or her prior coverage.

Pre-existing Conditions do not apply to:

- a. a newborn dependent child; or
- b. pregnancy or complications of pregnancy; or
- c. an Insured Person who is under age 19.

## IMPORTANT NOTICE

Federal regulations now permit the time you are on the University of Colorado Denver, Downtown Campus Student Injury and Sickness Insurance Plan to be counted as a credit toward satisfying pre-existing clauses in future health insurance plans you may participate in after you leave the University.

These regulations provide that, when your coverage under the University sponsored plan terminates (for example, your academic studies at University of Colorado Denver, Downtown Campus are completed or your eligibility under this Plan ends), you are eligible to receive a certificate showing the amount of time you were covered.

Please call AmeriBen at 855-539-8678 to obtain a certificate.

## CREDITABLE COVERAGE

An Insured Person whose coverage under prior Creditable Coverage ended no more than 90 days before the Insured Person's effective date under the current Plan will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Insured Person was covered under such coverage. If there is a break in Creditable Coverage of more than 90 days, the Company will credit only the days of such coverage under the break.

Creditable Coverage means benefits or coverage provided under: 1) Medicare or Medicaid; 2) An employee welfare benefit plan or group health insurance or health benefit plan; 3) An individual health benefit plan; 4) A state health benefits risk pool (including but not limited to CoverColorado); or 5) Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5(e) of the federal "Peace Corps Act"(U.S.C. sec. 2504(e)).

## EXTENSION OF BENEFITS

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date. The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

## CONTINUATION OF COVERAGE

All Insured Persons who have been continuously insured under the school's regular student policy for at least 3 consecutive months and who are no longer an Eligible Person under the Policy, he or she has the right to exercise the option to continue coverage up to 3 months beginning on the date coverage would otherwise terminate. When an Insured Person chooses to exercise this right, his or her written request and the appropriate premium must be received by the Company (or authorized representative) within 31 days following the date coverage under the Policy terminates. In no event will this option to continue coverage be extended beyond the number of months initially requested. Continuation of Coverage will be subject to the terms and conditions of the Policy in effect on the date the Insured Person becomes eligible under this option.

## COORDINATION OF BENEFITS

The purpose of this medical insurance policy is to assist in the payment of medical bills. It is not intended that an Insured Person receive benefits greater than his/her total allowable expenses. *This plan will coordinate benefits with any other valid and collectible insurance.*

Benefits paid by the Master Policy will not exceed: 1) any applicable Policy maximums; and, 2) 100% of the compensable expenses incurred when combined with benefits paid by any Other Valid and Collectible Insurance.

### Medicare or Medicaid

If an Insured Person is eligible for Medicare or Medicaid benefits, this plan may (or may not) be primary to Medicare or Medicaid. This is determined by Medicare or Medicaid regulations, as applicable. **NOTE: THE HEALTH CENTER AT AURARIA IS NOT A MEDICARE OR MEDICAID PROVIDER.**

## DEFINITIONS

**Coinsurance** means a provision of the insurance by which the Insured Person and the insurance carrier share in a specified ratio (e.g. 80% / 20%, 100% / 0%) for the payment of hospital or medical expenses resulting from a Sickness or Injury.

**Copayment** means a charge for Covered Medical Expense which must be paid by the Insured Person.

**Covered Medical Expenses** means reasonable charges which are: 1) not in excess of Usual and Customary charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of benefits; 4) made for services and supplies not excluded under the policy;

5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

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

**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 an amount otherwise payable as

## DEFINITIONS (CON'T)

Covered Medical Expenses before payment of any benefit is made. The Deductible will apply as specified in the Schedule of Benefits.

**Domestic Partner** means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare; and 4) is the same sex as the Named Insured. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

**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.

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

**Medical Emergency** means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe the condition would result in any of the following: 1) Death; 2) Placement of the Insured's health in jeopardy; 3) Serious impairment of bodily functions; 4) Serious dysfunction of any body organ or

## DEFINITIONS (CON'T)

part; or 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus. Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

**Medical Necessity** means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following: 1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury; 2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury; 3) In accordance with the standards of good medical practice; 4) Not primarily for the convenience of the Insured, or the Insured's Physician; and, 5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means that both: 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 Inpatient confinement.

**Mental Illness** means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. Mental Illness does not mean a Biologically Based Mental Illness or a Mental Disorder as defined in the Benefits for Biologically Based Mental Illness. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

**Policy Year** means a twelve (12) month period beginning each Fall semester and specifically defined by the University as the academic year.

**Pre-existing Condition** means any condition for which an Insured Person: 1) incurred charges; 2) received medical treatment; 3) consulted a health care professional; or 4) took Prescription Drugs within the 6 months immediately prior to the Insured's Effective Date under this policy. "Pre-existing Condition" does not include pregnancy.

**"Preferred Providers"** are the Physicians Hospitals and other health care providers who have contracted to

## DEFINITIONS (CON'T)

provide specific medical care at negotiated prices. Preferred Providers in your local school area are physicians and hospitals who are participating members of Cofinity.

The availability of specific providers is subject to change without notice. You should always confirm that a Preferred Provider is participating at the time services are required by calling Cofinity, for services in Colorado, at 800-831-1166 toll-free or by checking the network's website: [www.cofinity.net](http://www.cofinity.net) and/or by asking the provider when you make an appointment for services. For services outside the State of Colorado call First Health at 800-226-5116 toll-free or by checking the network's website: [www.myfirsthealth.com](http://www.myfirsthealth.com).

**"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. You may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are your responsibility. Regardless of the provider, you are responsible for the payment of your Deductible. You must satisfy your Deductible before benefits are paid. We will pay according to the benefit limits in the Schedule of Medical Expense Benefits.

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

**Usual and Customary Charges** means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

## CLAIM SUBMISSIONS REQUIREMENTS/PROOF OF LOSS DEADLINES

You have 90 days after the date of loss to furnish proof of loss to AmeriBen. If you do not furnish notice of proof within the time allotted, your claim will still be considered if you show that it was not reasonably possible to furnish the notice of proof and that the notice of proof was furnished as soon as reasonably possible. Except for absence of legal capacity, no claim for benefit will be accepted after one year from date treatment was completed. AmeriBen and University of Colorado Denver reserve the right and opportunity to examine the person whose Injury or Sickness is the basis of a claim as often as it may reasonably require during continuance of the claim. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed. Nor shall action be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the Policy. If any time limitation of the Policy with respect to giving notice, filing proof of loss or commencing an action at law or in equity is less than permitted by the law of the state in which you reside at the time the Policy is issued, the limitation is hereby extended to agree with the minimum period permitted by such law.

## NOTICE OF APPEAL RIGHTS

### Right to Internal Appeal

#### **Standard Internal Appeal**

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Designated Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination. In order to secure an Internal Review after the receipt of the notification of a benefit denied due to a contractual exclusion, the Insured Person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the policy exclusion does not apply to the denied benefit.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);

## NOTICE OF APPEAL RIGHTS (CON'T)

3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact AmeriBen at 1-855-539-8678 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: AmeriBen, PO Box 7887, Boise, ID 83707.

#### **Expedited Internal Appeal**

For Urgent Care Requests, an Insured Person or a Designated Representative may submit a request, either orally or in writing, for an Expedited Internal Appeal of an Adverse Determination:

1. involving Urgent Care Requests; and
2. related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received emergency services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or a Designated Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Designated Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Insured Person has been notified of the final determination.

At the same time an Insured Person or a Designated Representative files an EIR request, the Insured Person or the Designated Representative may file:

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating

## NOTICE OF APPEAL RIGHTS (CON'T)

Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

To request an Expedited Internal Appeal, please contact AmeriBen at 1-855-539-8678. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, AmeriBen, PO Box 7887, Boise, ID 83707.

### **Right to External Independent Review**

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

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

### **Standard External Review**

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

### **Expedited External Review**

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

1. The Insured Person or the Insured Person's Designated Representative has received an Adverse Determination, and
  - a. The Insured Person, or the Insured Person's Designated Representative, has submitted a request for an Expedited Internal Appeal; and
  - b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. The Insured Person or the Insured Person's Designated Representative has received a Final Adverse Determination, and
  - a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the

## NOTICE OF APPEAL RIGHTS (CON'T)

Insured Person's ability to regain maximum function; or

- b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

The Insured Person or Insured Person's Designated Representative's request for an Expedited External Review must include a Physician's Certification that the Insured Person's medical condition meets the above criteria.

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.

### **Where to Send External Review Requests**

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

Claims Appeals  
AmeriBen  
PO Box 7887  
Boise, ID 83707  
855-539-8678

### **Questions Regarding Appeal Rights**

Contact AmeriBen at 855-539-8678 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

## PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of UnitedHealthcare Insurance Company's privacy practices by calling them toll-free at 800-767-0700 or visiting them at [www.uhcsr.com](http://www.uhcsr.com).

## FRONTIERMEDEX: GLOBAL EMERGENCY SERVICES

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

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

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

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

### Key Services include:

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

Please visit [www.uhcsr.com/frontiermedex](http://www.uhcsr.com/frontiermedex) for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:  
(800) 527-0218 Toll-free within the United States  
(410) 453-6330 Collect outside the United States

## FRONTIERMEDEX: GLOBAL EMERGENCY SERVICES (CON'T)

Services are also accessible via e-mail at [operations@frontiermedex.com](mailto:operations@frontiermedex.com).

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

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

FrontierMEDEX is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in MyAccount at [www.uhcsr.com/frontiermedex](http://www.uhcsr.com/frontiermedex) for additional information, including limitations and exclusions.

## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

### Loss of Life, Limb or Sight

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

### For Loss Of:

Life	\$5,000
Two or More Members	\$5,000
One Member	\$2,500
Thumb or Index Finger	\$1,250

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

## CLAIMS PROCEDURES

Written notice of any event that may lead to a claim under the Policy must be given to the Company or its authorized administrator within 60 days after the event. Written proof of loss must be furnished to the Company within 90 days after the date of loss. Proper positive written notice and proof of loss must be given before the Company will be liable for any loss.

### **Send Medical claims to:**

AmeriBen  
PO Box 7887  
Boise, ID 83707  
Group #0812014

### **Send Prescription claims to:**

Express Scripts, Inc.  
P.O. Box 66583  
St. Louis, MO 63166-6583  
Attn: Claims Department  
800-206-4005

## CLAIMS, ELIGIBILITY AND BENEFIT QUESTIONS

### **AmeriBen**

855-539-8678

Website:

<http://ucdenver.ameriben.com>

E-Mail inquiries at:

[webinquiries@ameriben.com](mailto:webinquiries@ameriben.com)

## PARTICIPATING PROVIDER ORGANIZATIONS

### **COFINITY (Inside Colorado)**

Toll-Free Number for PPO Information 800-831-1166

[www.cofinity.net](http://www.cofinity.net)

### **FIRST HEALTH NETWORK (Outside Colorado)**

Toll-Free Number for PPO Information 800-226-5116

[www.myfirstthealth.com](http://www.myfirstthealth.com)

## HEALTH CARE MANAGEMENT PROGRAM

### **AmeriBen Compass Medical Management, Inc.**

For Pre-Admission Notification

800-388-3193

## INSURANCE COMPANY

### **UnitedHealthcare Insurance Company**

Form Number: 12-BR-CO

Policy Number: 2013-202513-1

