Student Accident and Sickness Health Plan
2009-2010
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Dear Student,

The University of Colorado Denver – Downtown Denver Campus (DDC) strongly encourages all students to have adequate 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 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 Accident and Sickness Health 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 benefits of the University of Colorado Denver – Downtown Denver Campus Student Accident and Sickness Health Plan are described in this brochure. Be sure to read the Schedule of Medical Benefits as well as the Exclusions and Limitations sections of this brochure. 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 800-626-5520 and refer to Group # 0190389. We look forward to assisting you in maintaining good health while you achieve your educational goals.

Sincerely,

Student Health Insurance Office
Diane Siewert, Coordinator
Diane.Siewert@ucdenver.edu
303-556-3399

NON-DISCRIMINATION POLICY

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

STUDENT ACCIDENT AND SICKNESS HEALTH 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.

The description in this brochure is generalized information. In all cases the contract with Great-West Life & Annuity Insurance Company is the document that will prevail, in accordance with the “Blanket” policy regulations of the State of Colorado. Claims should be submitted to Great-West Healthcare, NEIC #80705 at 1000 Great-West Drive, Kennett, MO 63857-3749. The Policy is a non-renewable one-year term policy. Correspondence concerning claims status, eligibility and benefits should be directed to AmeriBen by calling 800-626-5520, reference the School’s Group #0190389.

This brochure is only a summary of a master insurance policy (the Master Policy) issued to the Policyholder by the Company. The Master Policy contains language and provisions not contained in this brochure. In the event of a conflict between this brochure and the Master Policy, the Master Policy will govern. Any provision of the Master Policy in conflict with the laws of the jurisdiction in which the Policyholder is located is hereby automatically amended to conform to the minimum requirement of those laws. If you have questions contact the Student Insurance Office at 303-556-3399.

ELIGIBILITY

Domestic undergraduate students taking 6 or more credit hours and Graduate students taking 3 or more credit hours are eligible to enroll in the Student Plan. Annual coverage will become effective on August 17, 2009 provided that payment is made as required within the enrollment period.

Students must actively attend classes for at least 31 days after the date for which coverage is purchased. Home study, correspondence, and TV courses do not fulfill the eligibility requirements that the student actively attends classes. On-line students are eligible for coverage under this Plan. The Company retains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, the student is not eligible for coverage. See the section on Coverage Dates and Costs for details of premium refunds. Eligible students who do enroll may also insure their dependents on a separate dependent plan.

COVERAGE DATES AND COSTS

The Master Policy becomes effective August 17, 2009. Coverage becomes effective on the first day of the semester for which premium is paid by the enrollment deadline. The Master Policy terminates at 12:01 a.m. on August 23, 2010. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.
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 2 for the enrollment deadline dates.

**DEPARTMENT COVERAGE**

**(Including Newborn Enrollment and Eligibility)**

**NEWBORN CHILDREN**

In the event of the birth of a child to a covered student while the student’s health plan is in force, that child will automatically become an Insured Individual from the moment of birth. Coverage will continue without cost for 31 days. If the student wants continuing coverage for the newborn after 31 days, enrollment and payment of premium for the separate Dependent Plan 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 this Policy, coverage is subject to all Policy provisions, including the Deductible. Benefits mandated by the state of Colorado to apply to newborn infants are payable under this Policy for the first 31 days, but are detailed only in the Dependent Plan.

**LATE ENROLLMENT**

Eligible students will not be allowed to enroll in the Plan after the applicable enrollment period unless proof is furnished that the eligible student became ineligible for coverage under another group health plan during the 30 days* immediately preceding the date of the request for late enrollment in the University’s plan. 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 required 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 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 800-626-5520. 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 (except for Prescriptions – see below)**

(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:**

Subject to $20 Copay per prescription up to a 30-day supply.

Contraceptives for birth control purposes are provided at the Health Center at Auraria only for students, after a Copay of $20 per prescription for oral contraceptives, devices or a Depo Provera shot.
**SUMMARY OF BENEFITS**

Benefits will be paid when an Insured Individual incurs a Covered Medical Expense while under the Plan. The expense must be due to an Accident or Sickness, be Medically Necessary, and authorized by a Physician. 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 Ingenix with an 80th percentile reimbursement level.

**POLICY YEAR DEDUCTIBLES**

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**HEALTH CENTER AT AURARIA**

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

**CARRYOVER DEDUCTIBLE**

Although a new Deductible will apply each Policy Year, expenses incurred during the last three months of the Policy Year which are applied against the Deductible will also be applied to the Deductible for the next Policy Year and thus reducing that Policy Year’s Deductible. This carryover provision does not include or apply to the prescription drug Deductible.

**PRESCRIPTION DRUG DEDUCTIBLE**

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A separate deductible will apply for eligible Prescription Drug Expenses, per Insured Individual, per Policy Year. This deductible does not apply to prescriptions filled at the Health Center at Auraria.

**OUT-OF-POCKET MAXIMUM**

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

- $5,000 for services provided by a Participating Provider
- $10,000 for services provided by a Non-Participating Provider

Types of charges that do not apply toward the maximum out-of-pocket expense include the following: 1) prescription Copays, 2) non-covered expenses such as expenses in excess of the Reasonable and Customary allowances and charges not covered by the plan, 3) charges in excess of maximum benefits payable, 4) Copayments, and 5) the annual Policy Year deductible.
Benefits are provided through Express Scripts, a point-of-service provider. Please call 866-247-5008 for questions regarding benefits or participating pharmacies. If an Insured Individual incurs Rx claims within the first 6 weeks of enrollment, the Insured Individual 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 Accnts
Group #GWTA

After 6 weeks, the Insured Individual may go to any participating pharmacy. **For Option I, a separate $75 point-of-service Policy Year Rx Deductible must be satisfied before Copays become effective.** **For Option II, a separate $100 point-of-service Policy Year Rx Deductible must be satisfied before Copays become effective.** For both Option I and Option II: after the deductible is satisfied, a $20 Copay will apply per generic prescription. A Copay of $40 will apply per brand name prescription. A Copay of $60 will apply per non-formulary prescription.

Your Copays are for allowable drugs, for up to a 30 day supply per prescription or refill, and **up to a $2,000 maximum per year.** Mail order prescriptions not covered. **Contraceptives for birth control purposes are only covered at the Health Center at Auraria. Oral and/or injectable contraceptives are covered through Express Scripts and the Health Center when prescribed for Medical Necessity.**

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

After you have exhausted the $2,000 annual maximum, prescriptions can be purchased at a participating pharmacy at a discounted rate, but you will be responsible for payment on these prescriptions.

**Specialty Pharmacy Program** – The Specialty Pharmacy 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 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, an Insured Individual may 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).

**Pre-existing Conditions**

The Policy will not cover charges or expenses due to a pre-existing Injury or Bodily Infirmity or complication thereof. A pre-existing Injury or Bodily Infirmity is one where the Insured Individual has consulted a Physician; had medicine prescribed; or is receiving or has received medical care for that Injury or Bodily Infirmity in the 6 months prior to the Insured Individual’s Effective Date of Coverage under the Policy. **Covered Medical Expenses related to pregnancy and Health Center at Auraria charges are not subject to pre-existing condition limitations.**

However, after an Insured Individual’s insurance has been in force for 6 consecutive months, Covered Expenses incurred after this 6 month period for a pre-existing Injury or Bodily Infirmity will be payable.

**Modification to Pre-Existing Exclusion:** The Policy will not impose pre-existing limitations on an Eligible Individual who enrolls for coverage as a Federally Eligible Individual or who has satisfied the pre-existing limitation under previous Creditable Coverage. Time periods of Creditable Coverage will be counted toward satisfaction of any applicable pre-existing limitation.

If an individual was covered for a period of time under Creditable Coverage that is:

1. greater than or equal to the time periods referred to in the Pre-Existing Conditions limitation, then the pre-existing conditions limitation period will not apply to that individual.
2. less than the time periods referred to in the pre-existing conditions limitations, then the pre-existing conditions limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.
RIGHT OF REIMBURSEMENT

The Company shall have a lien against any recovery received by an Insured Individual as compensation for an Injury or Bodily Infirmity to the extent that the Insured Individual received benefits for such Injury or Bodily Infirmity under the coverage of the Policy. The Company’s lien will apply to such recovery made by the Insured Individual from any person, or entity that was responsible for causing such Injury or Bodily Infirmity or their insurers. The Insured Individual will not be required to return to the Company more than the amount which was recovered for such Injury or Bodily Infirmity.

The Insured Individual (or a parent or a guardian if the Insured Individual is not able to execute such papers) will execute and deliver such papers as may be required by the Company. Also, the Insured Individual 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 Individual or the individual’s assignee.

MAXIMUM BENEFIT

The Maximum Benefit is $100,000, per Accident or Sickness, per Policy Year.

GENERAL PLAN PROVISIONS

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

COVERED MEDICAL EXPENSES

The Benefits payable are as defined in and subject to all provisions of the Policy and any endorsements thereto. After the Deductible has been satisfied, Benefits will be paid up to the Maximum Benefit for each service as specified below and as provided for in the Schedule of Medical Benefits.

State Mandated Covered Medical Expenses

1. Biologically-based Mental Illness (schizophrenia, schizoaffective disorder, Bi-polar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder) as mandated by Colorado law is paid as any other Sickness. If benefits are paid under this provision for any Covered Expense, payment for that same expense will not be duplicated under any other Plan provision. Benefits paid under this provision for any Covered Expense is not subject to the limitations applicable to non-biologically based mental health conditions detailed in Covered Medical Expenses item 8.

2. The cost of Cervical Cancer Vaccines for all females for whom a vaccination is recommended by the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services. The recommended age for vaccines is females 11 to 12 years of age. Catch-up vaccinations are recommended for females aged 13 to 26 years who have not been previously vaccinated. If you start the series of vaccines at age 25 and turn age 26, the rest of the series of vaccines will be covered.

3. Benefits for Cleft lip and Cleft palate for newborn infants as mandated by Colorado law.

4. Treatment of Diabetes including insulin, insulin syringes, insulin infusion pumps, and outpatient self-management training and education including medical nutrition therapy, as mandated by Colorado law. Diabetic supplies are not covered under the prescription drug plan, but these supplies will be covered under the Medical Plan.

5. Mammograms – Routine including radiology charges, as mandated by Colorado law. Pays the lesser of $200 or the actual charge, not subject to the deductible, for each routine low-dose mammography screening according to the following schedule: Baseline 35-39 years of age; once every two years for women from 40 years of age and under 50 years of age; or once annually if ordered by a Physician; and once annually for women from 50 to 65 years of age. If a participant has a family history of breast cancer, the baseline routine mammogram can be done after age 25.

6. Maternity – Covered Expenses for pregnancy are payable on the same basis as Covered Expenses for any other Bodily Infirmity. Coverage includes prenatal care and counseling, normal pregnancy, postnatal care and counseling, and Complications of Pregnancy.

Pregnancy coverage shall also include post-delivery inpatient Hospital care for a mother and her newly born Child in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists which is 48 hours following a vaginal delivery, or 96 hours following a caesarean section; except if the 48 or 96 hours end after 8 P.M., coverage will continue until 8 A.M. the following morning. A decision to shorten the length of stay may be made by the attending Physician in consultation with the mother.

7. Medical foods prescriptions for inherited enzymatic disorders as mandated by Colorado law.

8. Inpatient and outpatient treatment of Mental Health Conditions (other than Biologically-Based Mental Illness and Mental Disorders, as defined in this policy), as mandated by Colorado law are payable as follows:

   Inpatient treatment:
   • up to 45 days per Policy Year while confined in a Hospital; or
   • up to 90 days for partial hospitalization per Policy Year.

Partial hospitalization means treatment must be continuous for at least 3 but less than 12 hours in any 24-hour period. Two days of partial hospitalization will count as one day of inpatient confinement. Each day of inpatient care will reduce by two days the 90 days available for partial hospitalization care.

Outpatient treatment
   • up to 30 visits per Policy Year for outpatient treatment in a Hospital. Medically Necessary services may be provided by a registered professional nurse, licensed clinical social worker, licensed professional counselor or licensed marriage and family therapist, when acting within the scope of his/her license, or under the direct supervision of a Doctor or a licensed psychologist.

As used in this provision, the term “Hospital” includes a psychiatric hospital or, for outpatient treatment only, a community mental health center or mental health clinic which meets all requirements set by state law.

Autism is not considered to be a Mental Health Condition.
9. Covered Expenses for Mental Disorders, as mandated by Colorado law, are payable on the same basis as Covered Expenses for any other Bodily Infirmitiy. Mental Disorders mean:
   a. posttraumatic stress disorder;
   b. drug and alcohol disorders;
   c. dysthymia;
   d. cyclothymia;
   e. social phobia;
   f. agoraphobia with panic disorder,
   g. general anxiety disorder, and
   h. 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).

10. Prostate Cancer Screening as mandated by Colorado law. One screening per year for men over the age of 40 who are in high-risk categories as determined by the Insured Individual’s Physician. One screening per year for all men over the age of 50 years. Benefits will pay up to $65 per Policy Year. Not subject to the Deductible.

11. Routine Newborn Care, while hospital confined and routine nursery care provided immediately after birth. Refer to the Covered Medical Expenses item for Maternity.

12. Telemedicine Services as mandated by Colorado law.

All Other Covered Medical Expenses


14. Ambulance Services, ground or air transportation to a Hospital.

15. Anesthetist Services: professional services administered in connection with inpatient and outpatient surgery.

16. Assistant Surgeon Fees: professional services administered in connection with inpatient and outpatient surgery.

17. Benefits will be paid as for any Sickness for Attention Deficit Disorder (ADD).

18. Blood and/or plasma and the equipment for its administration on an inpatient basis.

19. Colorectal Cancer Screening: Coverage includes testing for the early detection of colorectal cancer and adenomatous polyps for those Insured Individuals who are Asymptomatic, average risk adults who are fifty years of age or older and Insured Individuals who are at high risk for colorectal cancer, including Insured Individuals who have 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 the provider.

20. Congenital Birth Defects and Abnormalities:

21. Consultant services as per the Schedule of Medical Benefits.

22. Contraceptives are covered as follows:
   - when prescribed for birth control purposes and obtained from the Health Center at Auraria for students over age 18. A $20 Copay will apply for oral contraceptives, contraceptive devices and Depo Provera injections.
   - When oral contraceptives are prescribed for Medical Necessity purposes and obtained through Express Scripts or the Health Center.

23. Family and Group Counseling services (the Insured Individual must be present for the counseling session).

24. Dental treatment of Injury to sound natural teeth resulting from an accident. This includes replacement of teeth and any related x-rays. Injury as a result of chewing or biting will not be considered an accident or Injury.

25. Dialysis: limited to one visit per day.

26. Durable Medical Equipment: Charges for the following listed types of orthopedic or prosthetic devices or Hospital equipment:
   a. man-made limbs or eyes for the replacing of natural limbs or eyes;
   b. casts, splints or crutches;
   c. purchase of a truss or brace;
   d. oxygen and equipment for giving oxygen;
   e. wheelchair or hospital bed;
   f. dialysis equipment and supplies;
   g. colostomy bags and ureterostomy bags;
   h. two external post-operative breast prostheses.

No benefits will be paid for rental charges in excess of purchase price. Benefits are payable up to $5,000 per Accident or Sickness. Charges for prosthetic arms and legs will be covered over the Durable Medical Equipment maximum as required by Colorado law.

27. Hearing test, if for the diagnosis of an Accident or Sickness.

28. Charges by a Home Health Care agency when such care is ordered by a Physician and the Insured Individual is confined to his/her home. Such care shall be for part-time nursing, physical, occupational or speech therapy and shall be limited to $100 per day maximum/100 visits per Policy Year.

29. Hospital Miscellaneous Expenses: 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.


31. Magnetic Resonance Imaging (MRI), only when medically necessary, subject to the X-rays and Laboratory maximum.

32. Mammograms – Diagnostic mammograms are paid same as any other Sickness and are subject to the deductible.

33. Maternity Testing. The Policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered, if all other policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Screening and Chromosome Testing. Fetal Stress/Non-Stress tests are payable.

34. Nasal and Sinusitis surgery.
35. **Outpatient Surgery Miscellaneous**: in connection with outpatient 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 texts and X-ray examinations, including professional fees, anesthesia; drugs or medicines; and supplies.

36. **Pap Smear** (cytologic screening): one Pap smear provided every year after the age of 18 including office visits. Subject to Deductible except at the Health Center at Auraria.

37. **Physician’s Visits** (outpatient): charges for diagnosis and treatment by a Doctor (not a Close Relative of or same legal residence as the Insured Individual). More than one visit per day allowed, provided the second or subsequent visits are not with the same Doctor.

38. **Physical Therapy** services, as defined, not including supplies, which are incurred while not confined in a Hospital and which are billed by a Physician, physiotherapist, or qualified practitioner. Benefits are limited to one visit per day.

39. **Podiatry** treatment of metabolic or peripheral-vascular disease and medically necessary foot-care, except as excluded in the Policy.

40. **Post-Mastectomy Coverage**: Coverage of a Medically Necessary mastectomy will also include coverage of the following:
   a. physical complications during any stage of the mastectomy, including lymphedemas;
   b. reconstruction of the breast;
   c. surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
   d. two external breast prostheses.

Covered Expenses for the above are payable on the same basis as Covered Expenses for any other surgery. This coverage will be provided in consultation with the attending Physician and the patient.

41. **Pre-admission Testing** as per the Schedule of Medical Benefits.

42. **Preventive Health Services** are provided at the Health Center at Auraria only (except for pap smears, prostate screening and mammograms). Benefits include one comprehensive physical per Policy Year and one HIV/syphilis test per year (includes pre/post test counseling). For men the benefit covers the office visit charge and may include a gonorrhea/Chlamydia test, a hemoglobin, and urine test, as indicated. For men over 50 a hemoccult and PSA test is included. For women, an annual examination includes the office visit charge and a pap smear. A Gonorrhea/Chlamydia test, a hemoglobin and a urine test may be done as indicated. For women over age 50 a hemoccult test is included. Pap smears are also covered at Participating and Non-Participating providers.

43. **Private Duty Nursing Services**: when Medically Necessary, while Hospital confined and ordered by a licensed Physician. General nursing care provided by the Hospital is not covered under this benefit.

44. **Radiation** therapy and chemotherapy, including the administration of oral chemotherapy drugs.

45. **Reconstructive surgery** when needed to correct damage caused by an Injury or for breast reconstruction following a total or partial mastectomy as mandated by Colorado law. Benefits for congenital birth defects are limited to children born after the insured’s effective date and who are covered by the Plan.

**MEDICAL EVACUATION BENEFIT**

Subject to prior approval from the Company or its authorized administrator, as an additional benefit the Policy will cover, up to a maximum benefit of $50,000, charges for air evacuation of an injured or sick Insured Individual and a Health Care Provider or Escort, if directed by the attending Physician, to the individual’s home city or for International students, to his or her home country or country of regular domicile, provided air evacuation: 1) is upon the attending Physician’s written certification; and 2) results from a covered Injury or Bodily Infirmitry. “Home City” means the location within the United States where the Insured Individual intends to reside following medical evacuation.

**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:

1. **Acupuncture**;
2. **Addiction**, such as nicotine addiction;
3. **Autistic disease** for childhood, hyperkinetic syndromes, milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the Policy;
4. **Biofeedback**;
5. **Circumcision**, except for newborn infants, while still Hospital confined;
6. **Cosmetic procedures**, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the Policy;
7. **Dental treatment**, except for accidental Injury to Sound, Natural Teeth. Injury as a result of chewing or biting will not be considered an Accident or Sickness;
8. **Elective Surgery** or Elective Treatment;
9. **Elective abortion**;
10. **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 eye surgery;
11. **Foot care** including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

12. **Hearing examinations** or hearing aids; or other treatment for hearing defects and problems. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

13. **Immunizations**; preventive medicines or vaccines; except where required for treatment of a covered Injury (accidental exposure is a covered Injury) or as stated otherwise in the Policy;

14. **Inpatient convenience** items such as guest meals, telephone, televisions, etc.;

15. **Injury sustained** while a) participating in any interscholastic, intercollegiate, or professional sport, contest, or competition; b) traveling to or from such sport, contest or competition as a participant; or c) while participating in any practice or conditioning program for such sport, contest or competitions;

16. **Marital counseling**;

17. **Massage therapy**;

18. Medical treatment, services, supplies, or prescription drugs which are not **Medically Necessary**, as defined in the Policy;

19. **Medical care**, treatment, services or supplies normally given without charge and provided by employees or Physicians employed by, under contract with, or retained by the Policyholder;

20. **Medical care**, treatment, services, or supplies for which benefits are Excluded, Excepted, or limited elsewhere in the Policy;

21. **Medical care**, treatment, services and supplies for which no charge is made or for which no payment would be required if the Insured Individual did not have this insurance; or to the extent the Insured Individual received any discount, credit or reduction due to an agreement with the provider;

22. **Medical or non-medical** self-care or self-help training, recreation therapy, educational therapy, dance therapy, art therapy, except as described in the Master Policy;

23. **Non-Medically Necessary Maintenance Care** Expenses. Example: physical therapy or chiropractic maintenance care as opposed to treatment of a condition. Maintenance Care means treatment which is administered after the patient’s status remains the same and no further improvement is expected; remaining symptoms are considered residual; it is indicated by infrequent, sporadic treatment (i.e., once a month or every other week);

24. **Organ transplants**, including organ donation;

25. **Psychological testing**;

26. **Pre-existing conditions**, except as described in the Pre-Existing Conditions provision on page 8;

27. **Prescription Drugs**, services or supplies as follows:
   a. therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; except as provided under Benefits for Diabetes as mandated by Colorado law;
   b. birth control and/or contraceptives, oral or whether medication or device, except as specifically provided in the Policy;
   c. immunization agents, biological sera, blood and blood products administered on an outpatient basis;
   d. drugs labeled, “Caution – limited by federal law to investigational use” or experimental drugs;
   e. products used for cosmetic purposes;

28. Charges in excess of the **Reasonable and Customary** charge;

29. **Reproductive/infertility services** including but not limited to: family planning; fertility test; 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; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;

30. **Routine physical examinations** and routine testing; preventive testing or treatment; screening exams or testing in the absence of Accident or Sickness, except as specifically provided in the Policy or as provided at the Health Center at Auraria;

31. **Services** mainly rendered for custodial, or in-vivo therapy; (except for rehabilitation facility treatment charges incurred for the treatment of Mental Health Conditions);

32. **Services** provided normally without charge by the Health Service of the Policyholder or services covered or provided by the student health fee;

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 Individual to pay for such treatment;

35. **War** or any act of war, declared or undeclared, insurrection, participation in a riot or civil disorder; or while in the armed forces or any country;

36. **Weight management** services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity (including morbid obesity), and surgery for removal of excess skin or fat. Exceptions: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders, including anorexia nervosa and bulimia nervosa; and

37. Injury or Bodily Infirmitry if covered to any extent under any occupational benefit plan, Workers Compensation or similar law or medical payments under individual automobile insurance (except no-fault).
This chart summarizes Copayment amounts paid by the Plan. Note: The chart column entitled “Health Center at Auraria” applies to Insured Individuals. Coverage outside of the country for eligible charges is reimbursable at 80%. If a Participating Provider is not available in the network area, benefits will be at the Participating Provider level of benefits. If the Covered Medical Expense is due to an Emergency Medical Condition, benefits will be paid at the Participating Provider level of benefits.

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTIONS</th>
<th>HEALTH CENTER AT AURARIA</th>
<th>GREAT-WEST PPO</th>
<th>NON-PPO</th>
<th>ADDITIONAL LIMITATIONS AND EXPLANATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>Does Not Apply</td>
<td>Yes ($300)</td>
<td>Yes ($600)</td>
<td>Applies unless stated otherwise.</td>
</tr>
<tr>
<td>Pre-Existing Condition Limitations</td>
<td>N/A</td>
<td>Applies</td>
<td>Applies</td>
<td>Does not apply to pregnancy.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>N/A</td>
<td>80%</td>
<td>80% of R&amp;C</td>
<td>Ground or air transportation to a hospital.</td>
</tr>
<tr>
<td>Anesthetist (Inpatient and Outpatient)</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon Fees</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Biologically-Based Mental Illness (BBMI)</td>
<td>100%</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Applies to Inpatient and Outpatient. Health Center at Auraria only provides Outpatient services.</td>
</tr>
<tr>
<td>Consultant Physician Fees</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Contraceptives</td>
<td>$20 Copay</td>
<td>See Prescriptions</td>
<td>See Prescriptions</td>
<td>Includes oral contraceptives, devices or Depo Provera shots.</td>
</tr>
<tr>
<td>Dental Treatment for an Injury</td>
<td>N/A</td>
<td>80%</td>
<td>80% of R&amp;C</td>
<td>Treatment for injury to sound, natural teeth.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>N/A</td>
<td>80%</td>
<td>80% of R&amp;C</td>
<td>$5,000 maximum per Accident or Sickness.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Maximum payment of $100 per day, 100 day maximum per Policy Year.</td>
</tr>
<tr>
<td>Immunizations, preventive medicines or vaccines</td>
<td>100%</td>
<td>100% after payment of a $10 Copayment. No Deductible.</td>
<td>Not covered.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Room and Board/Hospital Misc.</td>
</tr>
<tr>
<td>HPV (Cervical Cancer Vaccine)</td>
<td>100%</td>
<td>100% No Deductible</td>
<td>100% No Deductible</td>
<td></td>
</tr>
<tr>
<td>Mammograms - Diagnostic</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Mammograms - Routine</td>
<td>N/A</td>
<td>100%, No Deductible</td>
<td>100% of R&amp;C, No Deductible</td>
<td>Up to a Maximum of $200 per Policy Year. Includes radiology readings.</td>
</tr>
<tr>
<td>Medical Emergency</td>
<td>100%</td>
<td>80%</td>
<td>80% of R&amp;C</td>
<td>Emergency Medical Condition only, as defined. Inpatient Claims paid at the PPO level of benefit if admitted.</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>100%</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Mental Health Conditions – Inpatient (other than BBMI and Mental Disorders)</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Limited to 45 days per Policy Year. See Covered Medical Expenses for information on partial hospitalization.</td>
</tr>
<tr>
<td>Mental Health Conditions – Outpatient (other than BBMI and Mental Disorders)</td>
<td>100%</td>
<td>50%</td>
<td>50% of R&amp;C</td>
<td>Limited to 30 visits per Policy Year maximum.</td>
</tr>
<tr>
<td>Outpatient Surgery Miscellaneous</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>See limitations under Covered Medical Expenses item 35, Outpatient Surgery Miscellaneous is based on the Outpatient Surgical Facility Charge Index.</td>
</tr>
<tr>
<td>Pap Smears (Cytologic Screening)</td>
<td>100%</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Limited to once per Policy Year after age 18.</td>
</tr>
<tr>
<td>Physical Therapy - Inpatient</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Limited to one visit per day.</td>
</tr>
<tr>
<td>Physical Therapy - Outpatient, Limited to one visit per day.</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Includes Outpatient Occupational, Speech, Respiratory, Physical Therapy and Dialysis.</td>
</tr>
<tr>
<td>Physician Visits (Inpatient and Outpatient)</td>
<td>100%</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>See Covered Medical Expenses item 37.</td>
</tr>
<tr>
<td>Preadmission Testing (Within 10 Days of Admission)</td>
<td>N/A</td>
<td>100%, No Deductible</td>
<td>100% of R&amp;C, No Deductible</td>
<td>Within 10 days of admission to a hospital.</td>
</tr>
<tr>
<td>Preadmission Testing (Prior to 10 Days of Admission)</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>More than 10 days before admission to a hospital</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$20 Copay per 30 day supply. See page 7.</td>
<td>See page 7</td>
<td>See page 7</td>
<td>Separate $75 per Policy Year Deductible for prescriptions not filled at the Health Center at Auraria.</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>100%</td>
<td>Not covered</td>
<td>Not covered</td>
<td>See Covered Medical Expenses item 42.</td>
</tr>
<tr>
<td>PSA (Prostate Cancer Screening)</td>
<td>100%</td>
<td>100%, No Deductible</td>
<td>100% of R&amp;C, No Deductible</td>
<td>Paid up to $65 per Policy Year. See Covered Medical Expenses item 10.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>N/A</td>
<td>75%</td>
<td>50% of R&amp;C</td>
<td>See limitations under Covered Medical Expenses item 50.</td>
</tr>
<tr>
<td>Surgery (Inpatient or Outpatient)</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>PPO only, up to $2,000 payable per Accident or Sickness, then benefits are payable at 50%.</td>
</tr>
<tr>
<td>X-Ray Services &amp; Laboratory</td>
<td>100%</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Additional benefits are shown in the Covered Medical Expenses section of this brochure.</td>
</tr>
<tr>
<td>All Other Covered Medical Expenses</td>
<td>100%</td>
<td>80%</td>
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<td></td>
</tr>
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This chart summarizes Copayment amounts paid by the Plan. Note: The chart column entitled “Health Center at Auraria” applies to Insured Individuals. Coverage outside of the country for eligible charges is reimbursable at 70%. If a Participating Provider is not available in the network area, benefits will be at the Participating Provider level of benefits. If the Covered Medical Expense is due to an Emergency Medical Condition, benefits will be paid at the Participating Provider level of benefits.

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<th>NON-PPO</th>
<th>ADDITIONAL LIMITATIONS AND EXPLANATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>Does Not Apply</td>
<td>Yes ($3,000)</td>
<td>Yes ($6,000)</td>
<td>Applies unless stated otherwise.</td>
</tr>
<tr>
<td>Pre-Existing Condition Limitations</td>
<td>N/A</td>
<td>Applies</td>
<td>Applies</td>
<td>Does not apply to pregnancy.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>N/A</td>
<td>70%</td>
<td>70% of R&amp;C</td>
<td>Ground or air transportation to a hospital.</td>
</tr>
<tr>
<td>Anesthetist (Inpatient and Outpatient)</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon Fees</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
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<tr>
<td>Consultant Physician Fees</td>
<td>N/A</td>
<td>70%</td>
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<tr>
<td>Contraceptives</td>
<td>$20 Copay</td>
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<td>Dental Treatment for an Injury</td>
<td>N/A</td>
<td>70%</td>
<td>70% of R&amp;C</td>
<td>Treatment for injury to sound, natural teeth.</td>
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<tr>
<td>Durable Medical Equipment</td>
<td>N/A</td>
<td>70%</td>
<td>70% of R&amp;C</td>
<td>$5,000 maximum per Accident or Sickness.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>Maximum payment of $100 per day, 100 day maximum per Policy Year.</td>
</tr>
<tr>
<td>HPV (Cervical Cancer Vaccine)</td>
<td>100%</td>
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<tr>
<td>Immunizations, preventive medicines or vaccines</td>
<td>100%</td>
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<td>Not covered.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>Room and Board/Hospital Misc.</td>
</tr>
<tr>
<td>Mammograms - Diagnostic</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Mammograms - Routine</td>
<td>N/A</td>
<td>100%, No Deductible</td>
<td>100% of R&amp;C, No Deductible</td>
<td>Up to a Maximum of $200 per Policy Year. Includes radiology readings.</td>
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<tr>
<td>Medical Emergency</td>
<td>100%</td>
<td>70%</td>
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<td>100%</td>
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<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Mental Health Conditions – Inpatient (other than BBMI and Mental Disorders)</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>Limited to 45 days per Policy Year. See Covered Medical Expenses for information on partial hospitalization.</td>
</tr>
<tr>
<td>Mental Health Conditions – Outpatient (other than BBMI and Mental Disorders)</td>
<td>100%</td>
<td>50%</td>
<td>50% of R&amp;C</td>
<td>Limited to 30 visits per Policy Year maximum.</td>
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<tr>
<td>Outpatient Surgery Miscellaneous</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>See limitations under Covered Medical Expenses item 35, Outpatient Surgery Miscellaneous is based on the Outpatient Surgical Facility Charge Index.</td>
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<td>50% of R&amp;C</td>
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</tr>
<tr>
<td>Physical Therapy - Inpatient</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>Limited to one visit per day. Includes Outpatient Occupational, Speech, Respiratory, Physical Therapy and Dialysis.</td>
</tr>
<tr>
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<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Physician Visits - Inpatient</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Physician Visits - Outpatient</td>
<td>100%</td>
<td>100% after applicable Copayment, No Deductible</td>
<td>50% of R&amp;C</td>
<td>See Covered Medical Expenses item 37. Copayments: $20 Primary Care Physician $40 Specialist</td>
</tr>
<tr>
<td>Preadmission Testing (Within 10 Days of Admission)</td>
<td>N/A</td>
<td>100%, No Deductible</td>
<td>100% of R&amp;C, No Deductible</td>
<td>Within 10 days of admission to a hospital.</td>
</tr>
<tr>
<td>Preadmission Testing (Prior to 10 Days of Admission)</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>More than 10 days before admission to a hospital.</td>
</tr>
<tr>
<td>Prescriptions See page 7 for additional information.</td>
<td>$20 Copay per 30 day supply. See page 7</td>
<td>See page 7</td>
<td>See page 7</td>
<td>Separate $100 per Policy Year Deductible for prescriptions not filled at the Health Center at Auraria.</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>100%</td>
<td>Not covered</td>
<td>Not covered</td>
<td>See Covered Medical Expenses item 42.</td>
</tr>
<tr>
<td>PSA (Prostate Cancer Screening)</td>
<td>100%</td>
<td>100%, No Deductible</td>
<td>100% of R&amp;C, No Deductible</td>
<td>Paid up to $65 per Policy Year. See Covered Medical Expenses item 10.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>N/A</td>
<td>75%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Surgery (Inpatient or Outpatient)</td>
<td>N/A</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>See limitations under Covered Medical Expenses item 50.</td>
</tr>
<tr>
<td>X-Ray Services &amp; Laboratory</td>
<td>100%</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>PPO only, up to $2,000 payable per Accident or Sickness, then benefits are payable at 50%.</td>
</tr>
<tr>
<td>All Other Covered Medical Expenses</td>
<td>100%</td>
<td>70%</td>
<td>50% of R&amp;C</td>
<td>Additional benefits are shown in the Covered Medical Expenses section of this brochure.</td>
</tr>
</tbody>
</table>
EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Accident or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Accident or Sickness will continue to be paid as long as the condition continues, 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 PLAN

At the end of the semester, students who were covered under the insurance plan can purchase the Continuation of Benefits Plan in monthly increments for up to 6 months. Determination of the length of coverage and payment must be made at the time of application.

Additional information and enrollment forms for the Continuation of Benefits Plan are available at the Student Insurance Office, Tivoli Student Union, Suite 303, 303-556-6273.

You have 14 days to submit your enrollment form and payment after you terminate coverage under this plan. Submit your enrollment form and payment:
- at the Student Insurance Office;
- on-line at www.eciservices.com; or
- by mail to ECI (P.O. Box 264, Jefferson, CO 80456). Note – your mailed enrollment form and payment must be postmarked within the 14-day enrollment period).

COORDINATION OF BENEFITS

If the Insured Individual has other group type, governmental, or automobile no fault medical benefits coverage, the benefits payable under the Policy will be coordinated with the other coverage so that the combined benefits paid or provided by all plans will not exceed 100% of the allowable expense. One plan will be determined to be primary under the policy rules and its benefits will be payable first. The plan paying second takes the benefits of the primary plan into account when it determines its benefits.

DISPUTED CLAIMS

If you have reason to believe a claim in part or whole has not been settled properly, or a claim has been improperly denied, please contact AmeriBen at 800-626-5520 within 60 days after the claim payment date or the notice of denial of benefit and request a second review. Your claim appeal will be reviewed by someone other than the person who made the initial determination.

If the result of this review is not satisfactory, please follow the directions for an appeal contained in the Explanation of Benefits or the notice of denial of benefit. Contact AmeriBen at 800-626-5520 or in writing at P.O. Box 7186 Boise, ID 83707. If you contact AmeriBen in writing, please include the name of the student, the ID number from your student Policy ID card, the name of the patient, and state in clear and concise terms the reason for disagreement with the handling of the claim. AmeriBen and/or Great-West Life & Annuity Insurance Company will analyze the previously and newly submitted information and will conduct their own review. You may be asked to provide additional information related to your appeal. You will be notified promptly of the decision, but not later than the timeframes mandated by Colorado. If applicable, an explanation of the scientific or clinical judgment for the determination applying the terms of the Policy to your medical circumstances will be provided free of charge upon request.

Please keep in mind, the decision to proceed with the service and personally incur the expense is between you and your healthcare provider.

DEFINITIONS

“Accident” means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual and independent of any other such force or event.

“Average Semiprivate Charge” means (1) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or (2) 80% of the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semiprivate accommodations.

“Bodily Infirmitiy” means a Medical Condition of an Insured Individual caused by, arising out of, resulting from the cause of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual.

“Child” means an Eligible Student’s natural Child; step-Child; adopted Child or a Child Placed For Adoption which means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of the adoption of such Child; the Child’s placement with the Eligible Student is considered terminated upon the termination of such legal obligation.

“Close Relative” means the student, student’s spouse, and the children, brothers, sisters and parents of either the student or student’s spouse.

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

“Complications of Pregnancy” is defined as follows:
- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar conditions of comparable severity. This does not include false labor, occasional spotting, Physician-prescribed bed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy but not creating a distinct complication of pregnancy.
DEFINITIONS (CON'T)

- Non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

“Copayment or Copay” means that portion of a Covered Expense an Insured Individual is required to pay out of his or her pocket before benefits will be paid for any remaining portion.

“Covered Medical Expenses” means reasonable charges which are: 1) not in excess of Reasonable and Customary charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Medical Benefits; 3) made for services and supplies not excluded under the Policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Medical Benefits; and 6) in excess of the amount stated as a Deductible, if any. Covered Medical Expenses will be deemed “incurred” only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Individual for such services.

“Creditable Coverage” means any of the following coverage that an Insured Individual had prior to enrollment under the Policy; an employee group health plan; health insurance coverage; a student health plan, individual or group, including coverage through a Health Maintenance Organization (HMO); Medicare; Medicaid; TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families; a medical care program of the Indian Health Service or of a tribal organization; a state health risk pool; a health plan offered under the Federal Employee Health Benefits Program; a public health plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government or a foreign country, that provides health care to individuals who are enrolled in the plan; a health benefit plan established by the Peace Corps Act; or a State Children’s Health Insurance Program (S-CHIP).

Coverage provided by the Policy may be considered Creditable Coverage for individuals moving from coverage under the Policy to group coverage by another plan.

Days of Creditable Coverage that occur before a Significant Break in Coverage do not count toward satisfaction of the pre-existing limitation. A Significant Break in Coverage means a period of 90 days during all of which the individual does not have Creditable Coverage.

“Deductible” means the amount of Covered Expenses an Insured Individual is required to pay out of his or her pocket before benefits will be paid for any remaining portion. The Deductible will apply per Policy Year as specified in the Schedule of Medical Benefits.

“Doctor or Physician” means a legally licensed practitioner of the healing arts acting within the scope of his/her license and who is not an Insured Individual, a Close Relative of the Insured Individual, or residing at the same legal residence as the Insured Individual. It will also include any other licensed practitioner of the healing arts, including Licensed Addiction Counselors, required to be recognized by law, when that person is acting within the scope of his/her license and is performing a service for which Medical Benefits are provided under the Policy.

“Elective Surgery” or “Elective Treatment” mean those health care services or supplies that do not meet the health care need for an Accident or Sickness. 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.

“Emergency” means an Injury or Emergency Medical Condition that reasonably requires an Insured Individual to seek immediate medical care within 48 hours after the Injury or the onset of the Emergency Medical Condition.

“Emergency Care” means covered services furnished or required to screen and stabilize an Emergency Medical Condition, which may include but shall not be limited to, health care services that are provided in a Hospital’s emergency facility.

“Emergency Medical Condition” means the sudden, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required. Emergency Medical Conditions may include, but are not limited to: 1) placing the patient’s health in serious jeopardy; 2) serious impairment of bodily functions; 3) serious dysfunction of any bodily organ or part; 4) inadequately controlled pain; or 5) with respect to pregnant women having contractions: a) inadequate time to effect a safe transfer to another Hospital before delivery; or b) a transfer to another Hospital may pose a threat to the health or safety of the woman or unborn Child.

“Experimental, Investigational or Unproven” means a service or supply, such as medication, that meets any of the following criteria: 1. for a service or supply that is subject to Federal Drug Administration (FDA) approval: ▶ it does not have FDA approval; or ▶ it has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use is a use that is: ▶ established based on reliable evidence as defined below; or ▶ included and favorably recognized for treatment of the indication in at least one of the following publications: DrugDex, Drug Facts and Comparisons, Clinical Pharmacology or other established reference compendia as designated by the Company, and the data are sufficiently conclusive as to efficacy to allow recognition of the off-label use; or 2. is being provided pursuant to phase I, II, III, or IV clinical trials; or 3. is being provided pursuant to a written protocol that describes among its primary objectives determination of maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives; or 4. is being provided pursuant to a written informed consent used by the treatment provider that refers to the service or supply as experimental, investigational, unproven, or research; or 5. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the Department of Health & Human Services (HHS) and the FDA; or 6. based upon review and analysis of the published peer-reviewed medical literature, the weight of the evidence demonstrates that it is the predominant opinion of independent experts that the
service or supply:

- is substantially confined to use in research settings; or
- is subject to further research studies or clinical trials, in order to determine maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives; or
- is experimental, investigational or unproven; or
- 7. is not a covered service or supply as defined under Medicare because it is considered investigational or experimental as determined by HHS or the Centers for Medicare & Medicaid Services (CMS); or
- 8. is not currently the subject of active investigation because prior investigations and/or studies have failed to establish proven efficacy and/or safety.

In making the determination whether a service or supply is Experimental, Investigational or Unproven, the Company reserves the right to certify coverage of a service or supply, notwithstanding that the service or supply meets one of the above criteria, if there is reliable evidence as defined in this provision, that would support use of the service or supply as efficacious in the unique circumstances present in a particular case.

For these purposes, “reliable evidence” means evidence of all of the following:

1. there are at least two articles in peer-reviewed U.S. scientific medical or pharmaceutical publications supporting use of the service or supply outside the investigational setting; and
2. the published articles evidence a well-designed investigation that has been reproduced by non-affiliated authoritative sources with measurable, clinically meaningful results; and
3. the investigation evidences that the probable benefits of using the service or supply in the unique circumstances in the particular case in question outweigh the risks associated with such use in situations where conventional alternatives have not or would not be efficacious.

“Federally Eligible Individual” means an individual who meets all of the following:

1. the individual has at least 18 months of Creditable Coverage as of the date on which the individual seeks coverage under the Policy
2. the individual’s most recent prior Creditable Coverage was under one of the following types of plans or an insurance plan offered in connection with any of these plans:
   a. an employee group health plan;
   b. a governmental plan; or
   c. a church plan;
3. the individual is not eligible for coverage under another group health plan, Medicare or Medicaid;
4. the individual does not have other health insurance coverage;
5. the individual’s most recent coverage was not terminated because of nonpayment of premiums or fraud; and
6. if the individual has the option to continue coverage under a COBRA continuation or similar State program, such coverage was elected and exhausted.

“Hospital” means only such a place that meets all of the following conditions:

1. operates as a Hospital pursuant to law for the care and treatment of sick or injured individuals;
2. has permanent and full-time care for bed patients;
3. has a staff of one or more licensed Physicians available at all times;
4. provides 24-hour a day care by registered nurses on duty or call;
5. has surgical facilities; and
6. is not primarily engaged in business as a nursing home, home for the aged, or any similar establishment or any separate wing, ward or section of a Hospital used as such.

“Hospital” also means a “free standing surgical center” that meets all of the following standards:

1. is a licensed public or private place;
2. has an organized medical staff of Doctors;
3. has permanent facilities that are equipped and operated mainly for doing surgery and giving skilled nursing care; and
4. has R.N. services when a patient is in the facility.

“Hospital Admission” means a single period of hospital confinement or outpatient care for one or more causes.

“Injury” means a Medical Condition of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforeseen force or event external to that Insured Individual.

“Interscholastic” means organized competition occurring or conducted between or among schools.

“Medical Condition” means any bodily or mental disease, illness or injury requiring treatment by a Physician.

“Medically Necessary” means health care services and supplies (such as medication) that a Doctor, exercising prudent clinical judgment, provides to an Insured Individual for the purpose of preventing, evaluating, diagnosing or treating a Medical Condition or its symptoms, and are:

1. in accordance with generally accepted standards of medical practice; and
2. clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Insured Individual’s Medical Condition; and
3. not deemed to be cosmetic or Experimental, Investigational or Unproven as defined in the Policy; and
4. specifically allowed by the licensing statutes which apply to the Doctor who provides the service or supply; and
5. at least as medically effective as any standard care and treatment; and
6. not primarily for the convenience, psychological support, education or vocational training of the Insured Individual, Doctor or other health care provider; and
7. not more costly than an alternative service, supply or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Insured Individual’s Medical Condition.

For these purposes, “generally accepted standards of medical practice” means the:

1. standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
2. recommendations of an American Medical Association-recognized Doctor specialty society;
3. prevalent practices of Doctors in the relevant clinical area; or
4. any other relevant factors.
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The Company may require satisfactory proof in writing that any type of service or supply received is Medically Necessary. Medical Necessity will be determined by the Company, in accordance with the definition above.

“Mental Health Condition” means neurosis, psychoneurosis, psychosis, or mental disease or disorder of any kind resulting from any cause including, but in no way limited to, biological cause.

“Participating Provider” means a Doctor or a Hospital that agrees to provide Medically Necessary care and treatment at set rates. The availability of specific providers is subject to change without notice. You should always confirm that a provider is participating at the time services are required by calling AmeriBen at 800-626-5520, or accessing Great-West’s website at www.mygreatwest.com.

“Participating Provider Allowance” means the amount a Participating Provider will accept as payment in full for Covered Medical Expenses. “Non-Participating” 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 Benefits. “Network Area” means the 50 mile radius around the local school campus the Named Insured is attending.

“Physical Therapy” means treatment of Bodily Infirmity or Injury by the use of physical means including, but not limited to, air, heat, light, water, electricity, manipulation, acupuncture or active exercise. Includes outpatient occupational, speech and respiratory therapy and dialysis treatment.

“Placed For Adoption” means the assumption and retention of a legal obligation for the total or partial support of a Child in anticipation of adoption. Placement is considered terminated upon termination of legal obligation.

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

“Primary Care Physician” means a Doctor that is a family physician, general practitioner, internist, pediatrician or OB/GYN who acts as an Insured Individual’s personal Physician.

“Reasonable and Customary” means, with regard to charges for medical services or supplies, the lowest of:
1. the usual charge by the provider for the same or similar medical services or supplies;
2. the usual charge of most providers of similar training and experience in the same or similar geographic ‘area’ for the same or similar service or supplies; or
3. the actual charge for the services or supplies.

‘Area’ means the location where the medical care or supplies are given within a region (determined by the Company) large enough to get a cross section of providers of medical care or supplies.

“Sickness” means all Medical Conditions of an Insured Individual caused by, arising out of, resulting from the cause of One Period of a weakened, deteriorated, infirm, diseased or otherwise ill physical or mental state of that Insured Individual. One Period commences

DEFINITIONS (CON’T)

with the onset of the initial (or only) Bodily Infirmity that occurred during the Sickness, and ends when the Insured Individual has not received medical care or treatment (including prescription medication) for a Bodily Infirmity that occurred during that Sickness for ninety (90) consecutive days.

“Specialist” means any Doctor who is not a family physician, general practitioner, internist, or pediatrician. An OB/GYN is considered a Primary Care Physician.

“Student Health Center” means an ambulatory care facility affiliated or contracted with the Policyholder that at a minimum maintains a staff consisting of a nurse director/nurse practitioner, staff nurses and a staff physician or an arrangement with a physician to perform office visits. For purposes of this brochure, the Student Health Center is referred to as “Health Center at Auraria”.

MEDICAL MANAGEMENT PROGRAM

Great-West Life & Annuity Insurance Company has a professional Medical Management department to assist Insured Individuals in determining whether or not proposed services are appropriate for reimbursement under the plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits or validate eligibility. The medical professionals who conduct the program focus their review on the appropriateness of hospital stays and proposed surgical procedures.

Admission Notification

1. PRETREATMENT AUTHORIZATION OF NON-EMERGENCY MEDICAL HOSPITALIZATIONS: The Insured Individual or Insured Individual’s provider should telephone AmeriBen at 800-626-5520 at least five working days prior to the planned admission.

2. PRETREATMENT AUTHORIZATION OF EMERGENCY MEDICAL CONDITION ADMISSIONS: The Insured Individual or Insured Individual’s provider should telephone 800-626-5520 within 48 hours (two working days) of the admission to provide notification of any admission due to Emergency Medical Conditions.

IMPORTANT: Failure to follow the above procedure will not affect benefits otherwise payable under the Policy. Pretreatment authorization is not a guarantee that benefits will be paid.

When calling, it will be necessary to provide the program with your name, the patient’s name, the name of the Physician and hospital, the reason for the hospitalization and any other information needed to complete the review.

AmeriBen is open for Admission notification calls from 7:00 a.m. to 6:00 p.m. M.S.T., Monday through Friday.

Case Management (CM)

CM is designed to help manage the care of patients who have catastrophic or extended care Accident or Sickness.

The primary objective of CM is to identify and coordinate cost effective medical care alternatives meeting accepted standards of medical practice. CM also monitors the care of the patient, offers emotional support to the family and coordinates communications among health care providers, patients and others. Examples of Accident or Sickness that would be appropriate for CM include, but
are not limited to:
• terminal sicknesses
• cancer
• AIDS
• chronic illnesses: renal failure, cardiac obstructive pulmonary disease, multiple sclerosis, cardiac conditions
• accident victims requiring long-term rehabilitative therapy
• newborns with high risk complications or multiple birth defects
• diagnosis involving long-term IV therapy

**Medical Management (MM) Program**

MM will review and make an authorization determination for urgent, concurrent and prospective inpatient medical services for Insured Individuals covered under the Policy. MM will also review the Medical Necessity of inpatient services that have already been provided (i.e. retrospective review).

MM will determine the Medical Necessity of inpatient care and the appropriate length of stay. If a pretreatment request does not follow the MM procedures, the provider will be notified of the established procedures no later than 5 days after receipt of the request. To obtain pretreatment authorization, the Insured Individual, or the Insured Individual's provider should telephone AmeriBen at 800-626-5520.

Once you have obtained pretreatment authorization, such authorization cannot be revoked except for fraud, abuse or as otherwise permitted by law or regulation. Care received in an emergency room does not require pretreatment authorization. However, if hospitalization or surgery is required because of an Emergency, the Insured Individual, the Insured Individual's representative, provider or hospital should telephone AmeriBen at 800-626-5520 within 48 hours after care is given.

Pretreatment authorization is provided for certain inpatient services and supplies, including, but not limited to:
• Hospital admissions, including partial hospitalization programs for mental health treatment.
• Skilled nursing facilities.
• Transplant evaluations.

For more information about inpatient services and supplies that should be authorized, contact AmeriBen at the phone number on the ID card. MM will review and render an authorization determination as described below.

**Urgent Care Requests**

For an urgent care request, MM will notify the Insured Individual and the provider of the authorization decision:
• no later than 24 hours after receipt of a request involving concurrent care, if the request is made at least 24 hours prior to the expiration of the previously approved care; and
• no later than 72 hours after receipt of any other urgent care request.

**Appeal of an adverse determination involving urgent care may be submitted either orally or in writing and will be expedited.**

**Non-urgent Care Requests**

For a non-urgent care request, MM will notify the Insured Individual and provider of an authorization decision no later than 15 days after receipt of the request. If an authorization decision cannot be made within the 15-day period, an extension of up to 15 days may be requested. If additional information is needed, the Insured Individual or provider will be notified within the initial 15-day period and given details as to what information is required. The requested information should be provided within 45 days after receipt of the request or the authorization request may be denied. An authorization decision will be made no later than 15 days after MM receives the requested information, unless the Insured Individual or provider agrees to a voluntary extension of time. MM will send the Insured Individual and the provider written notice of all authorization determinations.

If an Insured Individual receives notice of an adverse determination, in whole or in part, the Insured Individual or the Insured Individual’s Authorized Representative can appeal the decision.

In the case of an adverse determination of a prospective review of care, the provider, on behalf of the Insured Individual, may request a peer-to-peer conversation regarding the adverse determination. The conversation will occur within five (5) days of the receipt of the request and will be between the provider rendering the service and the reviewer who made the adverse determination, or a clinical peer designated by the reviewer if the reviewer who made the adverse determination cannot be available within five (5) days. A peer-to-peer conversation is not a prerequisite to an appeal.

**Appeal of a Medical Management Decision**

Appeal of a MM decision should be requested within 180 days after receipt of an adverse determination. Under Colorado law, you have the right to two levels of appeal. For more information, contact AmeriBen at the number on your ID card.

You may also request an external review after you have exhausted the Level I appeal, or the Voluntary Level II appeal. An external review is a review of the dispute by an organization independent of Great-West, as chosen by the State of Colorado. A request for an External Review should be made within sixty (60) days from the date of receipt of the final adverse determination. Forms for making a request for an external review may be obtained by contacting the State of Colorado Department of Insurance at 303-894-7499, or 1-800-930-3745. A request for an external review must be made in writing. For more information about requesting an external review, please refer to your denial letter. Submit your written request to Great-West at:

**GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY**
Payer Solutions Medical Outreach
P.O. Box 66719 F1-66
St. Louis, MO 63166-6719
Telephone: (888) 760-2825

**IMPORTANT NOTICE**

Federal regulations now permit the time you are on the UCD - Downtown Denver Campus Student Accident and Sickness Health Plan to be counted as a credit toward satisfying pre-existing condition 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, you are eligible to receive a certificate showing the amount of time you were covered under the University Policy.

Please call AmeriBen at 800-626-5520 to obtain a certificate.
PRIVACY POLICY

The HIPAA Privacy Rule requires protection of your personal health information. As the third party administrator of your student health plan, AmeriBen is dedicated to protecting the confidentiality of your personal health information. A Notice of Privacy Practices outlining these protections will be provided to enrollees on the health plan. If you would like a copy of the Great-West Notice of Privacy Practices, administered by AmeriBen, you may write to AmeriBen at PO Box 7186 Boise, ID 83707 Attn: Privacy Office or call 1-800-626-5520.

INSURANCE COMPANY

Great-West Life & Annuity Insurance Company
Form Number: SIP-B (COHSDD) – Policy Number: 0190389

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: Send Prescription claims to:
Great-West Healthcare Express Scripts, Inc.
1000 Great-West Drive P.O. Box 66583
Kennett, MO 63857-3749 St. Louis, MO 63166-6583
NEIC #80705 Attn: STD Acct

866-247-5008
Group Rx # GWTA

CLAIMS, ELIGIBILITY AND BENEFIT QUESTIONS

AmeriBen
800-626-5520 – Group #0190389
https://services.ameriben.com

PARTICIPATING PROVIDER ORGANIZATION

Great-West Healthcare
For Participating Provider Information, call AmeriBen
toll-free at 800-626-5520
www.mygreatwest.com

MEDICAL MANAGEMENT PROGRAM

Great-West Medical Management
For Admission Notification
Call AmeriBen toll-free at 800-626-5520