Student Accident and Sickness Health Plan
2010-2011
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Dear Student,

The University of Colorado at Colorado Springs is pleased to offer students a blanket health insurance plan for the 2010-2011 academic year. Offered and underwritten by Connecticut General Life Insurance Company, this program provides Accident and Sickness coverage for students. Undergraduate students must be degree-seeking and enrolled for at least 9 credit hours (6 for degree seeking graduate students) to be eligible for coverage.

The University highly recommends that you consider this voluntary program to protect yourself against health emergencies which might arise. Without adequate medical protection your ability to maintain health and meet education expenses could be seriously jeopardized. If you are not currently covered by other medical insurance, we urge you to take advantage of this opportunity to purchase health protection at a reasonable cost.

The UCCS Student Accident and Sickness Health Plan is designed to complement the health services available on campus. The Student Health Center’s facilities are limited to minor illnesses and injuries and do not include the costs of more specialized care and services. The benefits of the UCCS insurance plan are described in this brochure. Be sure to read about the exclusions and limitations as well as the benefits, since it is important to know what a policy does and does not cover. If you have any questions about the plan, please contact our health insurance plan representative, Jennifer O’Connell, Student Health Center, 719-255-4444. Or you may contact the claims administrator, AmeriBen, directly: 800-626-5220. Our group number is 0190388.

Sincerely,

Jennifer O’Connell
Student Health Insurance Coordinator

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 brochure.

The description in this brochure is generalized information. In all cases the contract with Connecticut General Life 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 CGLIC, NEIC #80705 at 1000 Great-West Drive, Kennett, MO 63857-3749. Correspondence concerning claims status, eligibility and benefits should be directed to AmeriBen by calling 800-626-5520, reference the School’s Group #0190388.

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 Health Center at 719-255-4444.

ELIGIBILITY

Degree-seeking Undergraduate students taking 9 or more credit hours; Graduate students taking 6 or more credit hours; full-time intern students and students enrolled in certain approved certificate-seeking programs at UCCS are eligible to enroll in the Student Plan. Annual coverage will become effective on August 23, 2010 provided that payment is made by the enrollment deadline. Semester coverage dates and enrollment deadlines can be found in Section “Coverage Dates and Costs” on page 3.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study and TV courses do not fulfill the eligibility requirements that the student actively attends classes. 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.
The Master Policy becomes effective August 23, 2010. 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 22, 2011. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

**Choice of Plan**

Each eligible student has a choice of deductible amount. Option A has a low Deductible amount and Option B has a higher deductible amount. The Deductible must be met before benefits payments may be made for Covered Medical Expenses. Choosing Option A Deductible allows for benefit payments to be paid sooner and less out-of-pocket expenses for an Insured Individual than Option B. Option A has a higher premium, because earlier benefit payments allow for a richer plan. Make your selection carefully; you cannot change plan options after the initial purchase of the plan if coverage for the entire Policy year is elected.

**Option A:** Annual Deductible is $250  
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<th>Spring</th>
<th>Spring/Summer</th>
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**Option B:** Annual Deductible is $3,000  
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**Choosing the Correct Period**

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 Accident and Sickness Health Plan. The entire cost of the coverage will be refunded (including Dependents covered under a separate dependent plan) if the withdrawal or drop below the required credit hours occurs within the first 31 days. 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 you elect Annual coverage, or any other Semester coverage, and want to terminate coverage at a later date due to any reason except for entrance into the Armed Forces or if you withdraw from school within 31 days of the semester in which you enrolled for insurance, **you cannot terminate** coverage under this plan and get a refund.

### 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 Health Center within that 30 day period.*

### DEPENDENT 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 of Policy 0190388 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 Plan, 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 Plan for the first 31 days, but are detailed only in the Dependent Plan.

**DEPENDENT PLAN**

The Dependent Plan is described in a separate brochure. The Dependent plan contains different benefits, limitations and exclusions. Please contact the Student Health Center for a description of the Dependent Plan.

### ENROLLMENT PROCESS

All fee-paying students attending credit courses at the University of Colorado at Colorado Springs enrolled in 9 credit hours or more as a degree-seeking undergraduate, or 6 hours or more as a degree-seeking graduate student or full-time intern students, may enroll in the Plan. After verifying your eligibility by calling the Student Health Center at 719-255-4444, visit them to fill out a paper enrollment form and make your payment.

Open enrollment for the Insurance is limited to the Fall semester only, except for new students in the Spring or Summer semesters; or students who did not meet the eligibility requirements in the Fall semester. Students enrolled for Fall Insurance may then also enroll for subsequent semesters. Students enrolled in the Spring may purchase Summer Insurance without attending classes. Students may not switch Plan options in the middle of the Plan Year (ie, you may not choose Option B for the Fall semester and then Option A for the Spring semester).

A specified period of time will be allowed for the beginning of each semester for enrolling in the plan. See “Coverage Dates and Costs” on page 3 for the enrollment deadline dates.

Beth-El College of Nursing and Health Sciences students and International students require adequate medical coverage and are required to participate in the College-sponsored health insurance program, unless proof can be provided that a student has comparable outside health insurance coverage that is currently valid. Please contact the Student Health Center at 719-255-4444, or visit them for more information.
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.

Student Health Center: 719-255-4444

Call to find out the availability of daily access, appointments and hours of the Health Center.

After a Copayment, covered medical expenses are paid at 100%. Copayments are as follows:

- $2 per Office Visit
- $5 per Prescription
- $5 per STD test
- $5 per Laboratory Test
- $5 per Supply
- $5 per Office Visit for Injections

Connecticut General Life Insurance Company:

University of Colorado at Colorado Springs has a specially-designed Participating Network through GWH-CIGNA PPO. The following hospitals are in the network (certain services are payable at the 80% reimbursement level):

- Colorado Springs
  - Colorado Springs Valley Hope
  - Memorial Hospital
  - Penrose Community Urgent Care
  - Penrose Hospitul
  - Pikes Peak Mental Health Center
  - PSI Cedar Springs Hospital
  - St. Francis Health Center
- Aurora
  - Medical Center at Aurora North Campus
  - Medical Center at Aurora South Campus
  - Spalding Hospital
  - University of CO Hospital
- Parker
  - Parker Adventist Hospital
  - Parker Valley Hope

NOTE: This is not an all-inclusive list of hospitals. For a more complete list and verification of hospitals, facilities and physician providers in the Participating Providers Network call AmeriBen at 800-626-5520 or visit www.mycignaforthealth.com.

Admission Notification:

For pretreatment authorization of emergency and non-emergency hospitalizations, call AmeriBen at 800-626-5520. Refer to the Medical Management Program section on page 27 for details.

STUDENT HEALTH CENTER BENEFITS

The Student Health Center is committed to providing quality medical care for illnesses/injuries and accurate health education information so that students can make informed choices regarding their health care and behavior alternatives as applicable. Students are encouraged to take advantage of the Center’s convenient location and reasonable charges.

When the Student Health Center is closed you are encouraged to go to a Participating Provider to eliminate unnecessary costs. You may obtain Participating Provider information from the Student Health Center or by calling AmeriBen at 800-626-5520 or visit www.mycignaforthealth.com. All deductibles must be met before benefits are paid when services are rendered outside the Student Health Center.

AVAILABLE SERVICES

Many professional services are provided including evaluation and treatment of illnesses, health problems and injuries. Examples include:

- Acute illness care
- Minor injury care
- Pregnancy test
- Blood pressure check
- Work/General/Sports physicals
- Annual gynecological exam
- “PAP” smears/breast screening
- Asthma Care
- Free brochures on health topics
- Mental Health Consultations and Treatment or Referral if needed
- Select lab testing
- Limited medications in stock – must be prescribed by SHC staff
- Health education
- X-Ray referral
- Smoking cessation
- Crutch rental
- Birth control information and supplies
- Massage therapy
- Weight, nutrition and eating disorders
- Hernia or prostate check
- Sexually transmitted disease related screening and treatment
- Immunizations including, Gardasil, MMR, flu vaccine, meningococcal, HepB, PPD and Tdap
- Referral services to specialists as appropriate

The Student Accident and Sickness Health Plan coordinates its benefits with services provided at the Student Health Center. Please note: Not all of the above “Available Services” are covered by the Student Accident and Sickness Health Plan.

After a Copayment, Covered Medical Expenses are paid at 100%. Copayments are as follows:

- $2 per Office Visit
- $5 per Prescription
- $5 per STD test
- $5 per Laboratory Test
- $5 per Supply
- $5 per Office Visit for Injections

Limited medications can be furnished in conjunction with your visit to the Student Health Center. However, there is no pharmacy at the Student Health Center; therefore prescriptions from other providers cannot be filled here.

HEALTH CENTER HOURS

Monday 9:00 am – 7:00 pm
Tuesday, Wednesday, Thursday 9:00 am – 5:00 pm
Friday 9:00 am – 4:00 pm

During breaks and summer semesters, the clinic hours vary. Please call or email for those hours. The clinic is closed 12:30 pm to 1:00 pm, and the last appointment is seen 30 minutes before closing.

CONTACT

Phone: 719-255-4444  E-mail address: hlthcenter@uccs.edu
Fax: 719-255-4446  Website: http://www.uccs.edu/shc
LOCATION
The Health Center is located in the Public Safety/Parking Garage building directly east of Columbine Hall. Enter the garage, make an immediate right and go straight to the inner wall. Park in the space for “Reserved Health Clinic Patients.”

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

STUDENT HEALTH CENTER DEDUCTIBLES
For services performed at the Student Health Center, the Individual Deductible will be waived.

INDIVIDUAL DEDUCTIBLES
You may pick Option A or B:

Option A: $250 of covered Medical Expenses, per Insured Individual, per Policy Year.
Option B: $3,000 of covered Medical Expenses, per Insured Individual, per Policy Year.

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 DRUGS
A separate $50 deductible will apply for eligible Prescription Drug Expenses, per Insured Individual, per Policy Year. This deductible does not apply to prescriptions filled at the Student Health Center.

PRESCRIPTION DRUG PLAN
CIGNA PHARMACY
Benefits are provided through CIGNA Pharmacy. Please call 800-325-1404 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 CIGNA Pharmacy after the 6th week at:

Connecticut General Life Insurance Company
Pharmacy Service Center
PO Box 3598
Scranton, PA 18505-0598

After 6 weeks, the Insured Individual may go to any participating pharmacy. A separate $50 point-of-service Policy Year Rx Deductible must be satisfied before Copays become effective. After the deductible is satisfied, a $15 Copay will apply per generic prescription. A Copay of $30 will apply per brand name prescription. A Copay of $45 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 $1,500 maximum per year. Maintenance medications may be filled up to a 90 day supply. A Copay of $30 generic, $60 brand or $90 non-formulary will apply per prescription for a 31-60 day supply. A Copay of $45 generic, $90 brand or $135 non-formulary will apply per prescription for a 61-90 day supply.

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.

After you have exhausted the $1,500 annual maximum, prescriptions can be purchased at a participating pharmacy at a discounted rate, but you will be responsible for payment on these prescriptions. If you do not use a participating pharmacy, you are responsible for the full cost of the prescription. For information about participating pharmacies or to obtain other information, please call CIGNA Pharmacy at 800-325-1404.

Specialty Drug Program – The Specialty Drug Program covers certain drugs commonly referred to as high-cost specialty drugs. Please refer to the school website at www.uccs.edu/shc for a list of these specialty drugs. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through the CIGNA Home Delivery program. The Specialty Drug Program through CIGNA Home Delivery specializes in dispensing and delivering drugs that require special handling; and provides 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 drug prescription, an Insured Individual may contact Member Services or access the internet website address shown on the Insured Individual’s medical identification card to identify the drugs contained on the Specialty Drug list. An Insured Individual may also contact Member Services or access the internet website for assistance with using CIGNA Home Delivery to obtain specialty drug 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 networked CIGNA retail Pharmacy before using the CIGNA Home Delivery Specialty Drug program.

PRESCRIPTION DRUG PLAN
AT THE STUDENT HEALTH CENTER
Limited medications can be furnished in conjunction with your visit to the Student Health Center. There is no pharmacy located at the Student Health Center therefore prescriptions from other providers cannot be filled here. The Copayment for certain prescriptions at the Student Health Center is $5.
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 Student Health Center 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 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 $200,000, 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. Autism Spectrum Disorders: Coverage is provided for the assessment, diagnosis, and treatment of Autism Spectrum Disorders for a child from birth to age 19. For a child from birth to age 9, the annual maximum benefit for applied behavior analysis for autism spectrum disorders is $34,000. For a child age 9 to age 19, the annual maximum benefit for applied behavior analysis for autism spectrum disorders is $12,000. All charges incurred for the treatment of autism spectrum disorders will be subject to the same deductible, coinsurance, or copayments that apply to other physical conditions.

For a child whose who is receiving Early Intervention Services, from birth to age 3, services for the treatment of autism will be considered the primary service. Early Intervention Services will be "in addition to" services provided to treat autism spectrum disorders.

For a child with a congenital disability, age 3 to age 6, who is receiving occupational therapy, physical therapy, or speech therapy the level of benefits may exceed the limit of twenty visits for each therapy if the therapy is medically necessary to treat autism spectrum disorders.

“Autism Spectrum Disorders” or “ASD” includes 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 the diagnosis. Treatment for autism spectrum disorders must be prescribed or ordered by a licensed physician or licensed psychologist.

The following treatments are not considered experimental or investigational and are considered appropriate, effective or efficient for the treatment of autism. Treatment for autism spectrum disorders includes the following:

- Evaluation and assessment of services;
- Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for autism spectrum disorders provided by autism services providers;
- Habilitative or rehabilitative care, including but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies;
- Pharmacy care and medication;
- Psychiatric care;
- Psychological care, including family counseling; and
- Therapeutic care.

2. Biologically-based Mental Illness (schizophrenia, schizo-affective disorder, Bipolar 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 are not subject to the limitations applicable to non-biologically based mental health conditions detailed in Covered Medical Expenses item 9.

3. 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 the Insured Individual starts the series of vaccines at age 25 and turns age 26, the rest of the series of vaccines will be covered.

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

5. 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.

6. 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.

7. 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.

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

9. 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 20 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.

10. Covered Expenses for Mental Disorders, as mandated by Colorado law, are payable on the same basis as Covered Expenses for any other Bodily Infirmity.

   **Mental Disorders** mean:
   - posttraumatic stress disorder;
   - drug and alcohol disorders;
   - dysthymia;
   - cyclothymia;
   - social phobia;
   - agoraphobia with panic disorder,
   - general anxiety disorder, and
   - 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).

11. 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.

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

13. 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) and Attention Deficit Hyperactivity Disorder (ADHD).

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

21. Dental treatment of Injury to sound natural teeth resulting from an Accident. This includes replacement of teeth and any related x-rays.

22. Dialysis: limited to one visit per day.

23. Durable Medical Equipment: Charges for the following listed types of orthopedic or prosthetic devices or Hospital equipment:
   - man-made limbs or eyes for the replacing of natural limbs or eyes;
   - casts, splints or crutches;
   - purchase of a truss or brace;
   - oxygen and equipment for giving oxygen;
   - wheelchair or hospital bed;
   - dialysis equipment and supplies;
   - colostomy bags and urostomy bags;
   - 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.

24. Hearing test, if for the diagnosis of an Accident or Sickness.
## SCHEDULE OF MEDICAL BENEFITS

This chart summarizes coinsurance amounts paid by the Plan. For services outside the country, benefits are payable at the Non-Participating network level of benefits. If care is received from a Participating Provider any Covered Medical Expenses will be paid at the Participating Provider level of benefits. If a Participating Provider is not available in the Network Area, benefits will be paid 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 PPO level of benefits. Services provided by a Non-Participating Provider at a Participating Provider facility will be paid at the Participating Provider level of benefits. In all other situations, reduced or lower benefits will be provided when a Non-Participating Provider is used.

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTIONS</th>
<th>STUDENT HEALTH CENTER</th>
<th>GWH-CIGNA PPO</th>
<th>NON-PPO</th>
<th>ADDITIONAL LIMITATIONS AND EXPLANATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible:</td>
<td>Option A</td>
<td>Yes ($250)</td>
<td>Yes ($3,000)</td>
<td>Applies unless stated otherwise within this Schedule of Medical Benefits.</td>
</tr>
<tr>
<td></td>
<td>Option B</td>
<td>Yes ($3,000)</td>
<td>Yes ($250)</td>
<td></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>75%</td>
<td>75% of R&amp;C</td>
<td>Ground or air transportation to a hospital.</td>
</tr>
<tr>
<td>Anesthetist (Inpatient)</td>
<td>N/A</td>
<td>80%</td>
<td>75% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Anesthetist (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>Applies to Inpatient and Outpatient.</td>
</tr>
<tr>
<td>Biologically-Based Mental Illness (BBMI)</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Includes devices and shots in the Physician’s office. Oral contraceptives are payable under the Prescription Drug plan.</td>
</tr>
<tr>
<td>Contraceptive Devices and Shots</td>
<td>$5 Copay</td>
<td>80%, No Deductible</td>
<td>50% of R&amp;C, No Deductible</td>
<td>Benefits are payable at the Non-Participating network level of benefits.</td>
</tr>
<tr>
<td>Dental Treatment for an Injury</td>
<td>N/A</td>
<td>75%</td>
<td>50% 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>75%</td>
<td>50% of R&amp;C</td>
<td>$5,000 maximum per Accident or Sickness.</td>
</tr>
<tr>
<td>Emergency Services (Emergency Medical Conditions only, as defined.)</td>
<td>N/A</td>
<td>80%</td>
<td>80% of R&amp;C</td>
<td>Inpatient Claims paid at the PPO level of benefit if admitted.</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>Hospital Services - Inpatient</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>HPV (Cervical Cancer Vaccine) for Insured Female Students</td>
<td>100%</td>
<td>100%, No Deductible</td>
<td>100%</td>
<td>No Deductible</td>
</tr>
<tr>
<td>HPV Vaccine for Insured Male Students</td>
<td>100%</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Injections</td>
<td>$5 Copay for office visit</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>$5 Copay per lab test</td>
<td>80%</td>
<td>50% of R&amp;C</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 Benefit of $200 per Policy Year. Includes radiology readings.</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>N/A</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 maximum. See Covered Medical Expenses item 9 for information on partial hospitalization.</td>
</tr>
<tr>
<td>Mental Health Conditions - Outpatient (other than BBMI and Mental Disorders)</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Limited to 20 visits per Policy Year maximum.</td>
</tr>
<tr>
<td>Pap Smears (Cytologic Screening)</td>
<td>$7 Copay (Copay includes $2 for office visit and $5 for lab test)</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, Respiratory, Physical Therapy and Dialysis.</td>
</tr>
<tr>
<td>Physician Office Visits (Outpatient)</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Includes consultant services.</td>
</tr>
<tr>
<td>Physician Office Visits (Outpatient)</td>
<td>$2 Copay per office visit</td>
<td>100% after a $20 Copayment</td>
<td>50% of R&amp;C</td>
<td>Limited to one visit per day per provider.</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>X-ray and lab tests performed 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>X-ray and lab tests performed more than 10 days before admission to a hospital.</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$5 Copay per prescription</td>
<td>Not covered</td>
<td>Separate $50 per Policy Year Deductible for prescriptions not filled at the Student Health Center.</td>
<td></td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>$2 Copay for office visit and $5 Copay per lab test</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Except for pap smears, prostate screening and mammograms as provided for in the Policy. See Covered Medical Expenses item 40.</td>
</tr>
<tr>
<td>PSA (Prostate Cancer Screening)</td>
<td>N/A</td>
<td>100%, No Deductible</td>
<td>100% of R&amp;C, No Deductible</td>
<td>See Covered Medical Expense item 11.</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>STD Testing</td>
<td>$5 Copay per test</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Surgery (Inpatient &amp; Outpatient)</td>
<td>100% (limited services)</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td>Outpatient Surgery miscellaneous is based on the Outpatient Surgical Facility Charge Index.</td>
</tr>
<tr>
<td>X-Ray Services</td>
<td>N/A</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>All Other Covered Medical Expenses</td>
<td>100%</td>
<td>80%</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
</tbody>
</table>
25. 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.
26. Hospice charges by a licensed agency for the care of terminally ill patients. Care must be ordered by a Physician and reviewed monthly. Benefits are paid as specified in the Policy.
27. 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.
28. HPV Vaccine for Insured Male Students up to age 26. If the Insured Individual starts the series of vaccines at age 25 and turns 26, the rest of the series of vaccines will be covered.
29. Injections (outpatient): 1) when administered in the Physician’s office; and 2) charged on the Physician’s statement (allergy injections are excluded).
30. Magnetic Resonance Imaging (MRI), only when medically necessary.
31. Mammograms – Diagnostic mammograms are paid same as any other Sickness and are subject to the deductible.
32. 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.
33. Nasal and Sinusitis surgery.
34. 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 tests and X-ray examinations, including professional fees, anesthesia; drugs or medicines; therapeutic services; and supplies.
35. 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). For Preventive Health Services see Covered Medical Expenses item 40.
36. 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.
37. Podiatry treatment of metabolic or peripheral-vascular disease and medically necessary foot-care, except as excluded in the Policy.
38. 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 lymph edemas;
   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.
39. Pre-admission Testing as per the Schedule of Medical Benefits.
40. Preventive Health Services are provided at the Student Health Center only. Benefits include immunizations and one annual examination/routine physical per Policy Year. For women, an annual examination includes the office visit, a pap smear and lab work. Pap smears are also covered for participating & non-participating providers.
41. Radiation therapy and chemotherapy, including the administration of oral chemotherapy drugs.
42. 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.
43. Room and Board Expense: 1) daily semi-private room rate when Hospital confined; 2) general nursing care provided and charged for by the Hospital and 3) for accommodations in an intensive care unit.
44. Skilled Nursing Facility care when such care cannot be provided at home or on an outpatient basis.
45. Speech therapy from a qualified practitioner to restore speech loss due to Accident or Sickness.
46. Surgery: Physician fees for inpatient and outpatient surgery. Includes coverage for multiple surgeries performed through the same incision.
47. Tests and Procedures, diagnostic services and medical procedures performed by a Physician other than Physician’s Visits, physical therapy, X-rays and lab procedures.
48. Transcutaneous Electrical Nerve Stimulation (TENS) units.
49. Ultrasounds, only when medically necessary.
50. X-Rays and Laboratory as per the Schedule of Medical Benefits.

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 Infirmity. “Home City” means the location within the United States where the Insured Individual intends to reside following medical evacuation.
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. Allergies (including allergy testing);
4. 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.
5. Biofeedback;
6. Circumcision, except for newborn infants, while still Hospital confined;
7. Congenital Birth Defects and Abnormalities except as mandated by Colorado law;
8. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the Policy;
9. 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 Injury;
10. Elective Surgery or Elective Treatment;
11. Elective abortion;
12. Eye examinations, eye refractions, glaucoma testing, 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;
13. 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;
14. 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;
15. Immunizations; preventive medicines or vaccines; except where required for treatment of a covered Injury (accidental exposure is a covered Injury) or at the Student Health Center;
16. Inpatient convenience items such as guest meals, telephone, televisions, etc.;
17. 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;
18. Marital counseling;
19. Massage therapy;
20. Medical treatment, services, supplies, or prescription drugs which are not Medically Necessary, as defined in the Policy;
21. 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;
22. Medical care, treatment, services, or supplies for which benefits are Excluded, Excepted, or limited elsewhere in the Policy;
23. 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;
24. 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;
25. 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);
26. Organ transplants, including organ donation;
27. Psychological testing;
28. Pre-existing conditions, except as described in the Pre-Existing Conditions provision on page 9;
29. 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. immunization agents, biological sera, blood and 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, unless morbidly obese;
   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 year of date of the prescription.
30. Private Duty Nursing services.
32. 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;
33. 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 Student Health Center;
34. Services mainly rendered for custodial, or in-vivo therapy; (except for rehabilitation facility treatment charges incurred for the treatment of Mental Health Conditions);
35. Services provided normally without charge by the Health Service of the Policyholder or services covered or provided by the student health fee;
36. Sleep disorders;
37. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Policy;
38. Treatment in a Government hospital, unless there is a legal obligation for the Insured Individual to pay for such treatment;
39. 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;
EXCLUSIONS AND LIMITATIONS (CON’T.)

40. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity (treatment of morbid obesity is covered). Morbid obesity is defined as follows: Morbid obesity is associated with serious and life threatening disorders such as diabetes mellitus and hypertension. Morbid obesity means a body weight of two times the 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. Exceptions: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders, including anorexia nervosa and bulimia nervosa;

41. Injury or Bodily Infirmity 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).

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 OF BENEFITS 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. Such coverage will be a continuation of the same plan of benefits for which the student was covered as an active student (changes in plan options are not allowed). Determination of the length of coverage and payment must be made at the time of application. Those enrolled in the Continuation of Benefits Plan may not access the Student Health Center for medical treatment or benefits.

Additional information and enrollment forms for the Continuation of Benefits Plan are available by calling ECI toll free at 1-866-780-3824.

You have 14 days to submit your enrollment form and payment after you terminate coverage under this plan. Submit your enrollment form and payment:

- 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 CGLIC 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 Infirmity” 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 coverage 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 (SCHIP).

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 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.

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 CGLIC’s website at www.mycignaforhealth.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 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.
DEFINITIONS (CON’T.)

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

“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 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.

“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.

MEDICAL MANAGEMENT PROGRAM

CGLIC 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.

MEDICAL MANAGEMENT PROGRAM (CON’T.)

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 longterm rehabilitative therapy
- newborns with high risk complications or multiple birth defects
- diagnosis involving longterm 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.
MEDICAL MANAGEMENT PROGRAM (CON’T.)

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 CGLIC, 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 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 CGLIC at:

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
Payer Solutions Medical Outreach
P.O. Box 66719 FO-66
St. Louis, MO 63166-6719
Telephone: (888) 760-2825

IMPORTANT NOTICE
Federal regulations now permit the time you are on the UCCS 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.