Student’s Dependent Accident and Sickness Health Plan

2010-2011
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ELIGIBILITY

Eligible Dependents/Domestic Partners of Students enrolled in Policy #0190388 may participate in this Dependent Plan on a voluntary basis.

Eligible Dependents are the Spouse and Domestic Partner and is the Eligible Student’s unmarried Child under the age of 25 if: the Child is a full-time student, or the Child has the same legal residence as the Eligible Student, or the Child is financially dependent upon the Eligible Student. Dependent/Domestic Partner eligibility expires concurrently with that of the Insured Student.

In the event of the birth of a Child to a covered student under the Student Insurance Plan, the newborn Child will automatically become an Insured Individual under the Student Insurance Plan from the moment of birth. For enrollment to continue after 31 days, written notice of birth and required premium must be furnished within 31 days of the date of birth. The newborn will then be covered under this Plan.

ENROLLMENT INFORMATION

If you are a Dependent of a student enrolled in the Student Insurance Plan, you may enroll in this plan. Please contact the Student Health Center by calling 719-255-4444, or visit them to drop off enrollment form with payment. The Student must be already enrolled in the Student Plan.

COVERAGE DATES AND COSTS

The Master Policy on file at the school becomes effective as per the Master Policy. Coverage becomes effective on the first day of the semester for which premium is paid by the enrollment deadline. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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<td>06-20-2011</td>
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REFUNDS

Refunds will be made upon the entry of any Insured Individual into the armed forces of any country. Refund rates are not pro-rated. A refund will be returned to such person upon request less any claims paid.

RENEWING COVERAGE

It is the Insured’s responsibility to obtain coverage the following year in order to maintain continuity of coverage. Insureds who have not received information regarding a subsequent Plan prior to the Policy’s Termination Date should inquire regarding such coverage with the school or its agent.

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 for 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 health insurance plan can purchase the Continuation of Benefits Plan in monthly increments for up to 6 months. A student enrolling in the Continuation of Benefits Plan may also enroll eligible dependents that were covered under the dependent health insurance plan for the same length of time as the student is enrolling. Such coverage will be a continuation of the same plan of benefits for which the student and dependent(s) were covered while the student was 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:
• at the Student Health Center;
• on-line at www.uccs.edu/shc; or
• by mail to ECI (P.O. Box 264, Jefferson, CO 80456).

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.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight
If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Individual or beneficiary may request the Company to pay the applicable amount below. Payment under this benefit will not exceed the Policy Maximum Benefit.

For loss of:

- Life .................................................. $5,000
- Two or More Members .............................. $5,000
- One Member ........................................ $2,500
- Thumb or Index Finger .............................. $2,500
The Policy will not impose 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 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 Eligible Student has a dependent that does not meet the Federally Eligible Individual definition, the Eligible Dependent will be subject to the pre-existing limitations as defined in the Policy.

The Policy will not impose pre-existing limitations on a Child who was covered by Creditable Coverage within 31 days of birth, adoption or Placement for Adoption, provided the Child has not subsequently been without Creditable Coverage for more than 90 days.

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 period will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

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. The Plan pays 100% up to a $100 maximum per Policy Year.

Benefits will be paid when an Insured Individual incurs a Covered Medical Expense while covered 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, 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.

After the Deductible has been satisfied, Covered Medical Expenses will be paid as listed for the provider selected up to $50,000 for each Accident or Sickness. The Benefits payable are as defined in and subject to all provisions of the Policy and any endorsements thereto. 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 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:

a. Evaluation and assessment of services;

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

2. Biologically-based Mental Illness (schizophrenia, schizoaffective 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 is not subject to the limitations applicable to non-biologically based mental health conditions detailed in Covered Medical Expense item 13.

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 you start the series of vaccines at age 25 and turn 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. Benefits for Child Health Supervision Services, as mandated by Colorado law, are payable for a dependent Child from birth to age 13. Benefits are payable on a per visit basis to one health care provider per visit.

   Visits are limited to:
   • Six well-child visits and one PKU test from birth through 12 months;
   • Three well-child visit from 13 through 35 months;
   • Four well-child visits from three through six years of age;
   • Four well-child visits from seven through 12 years of age.

Child Health Supervision Services means the periodic review of a child’s physical and emotional status by a Physician or other provider as above. A review shall include but not be limited to a history, physical exam, growth and developmental assessment, anticipatory guidance and education, appropriate immunizations (according to prevailing medical standards), lab tests and safety and health education counseling.

6. Care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities for Medically Necessary physical, occupational and speech therapy for a covered Child from the Child’s third birthday to the Child’s sixth birthday. Coverage includes up to 20 visits per Policy year for each therapy, whether the purpose of the therapy is to maintain or to improve.

7. General anesthesia and associated facility charges are covered for dental procedures, as mandated by Colorado law, for a dependent Child who: a) has a physical, mental or medically compromising condition; b) has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; c) is extremely uncooperative, unmanageable, anxious, or uncommunicative and who has dental needs deemed sufficiently important that dental care cannot be deferred; or d) has sustained extensive orofacial and dental trauma.

8. Treatment of Diabetes including insulin, insulin syringes, insulin infusion pumps, and outpatient self-management training and education including medical nutrition therapy, and 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.

9. Early Intervention Services for eligible children, as mandated by Colorado law, from birth to the child’s third birthday, when services are provided by a qualified early intervention service provider, and when the Child has been identified as eligible for services under Part C of the Individuals with Disabilities Act (IDEA). Coverage will be limited to a $6,036 calendar year maximum per Child.

10. Mammograms – Routine including radiology charges, as mandated by Colorado law. Pays the lesser of $100.00 or the actual charge, not subject to the deductible, for each routine low-dose mammography screening according to the following schedule: Baseline or screening mammogram for women 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 or screening mammogram can be done after age 25.

11. 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.

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

13. 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.

14. 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:
   a. posttraumatic stress disorder;
   b. drug and alcohol disorders;
   c. dysthymia;
   d. cyclothymia;
15. **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.

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

17. **Telemedicine Services** as mandated by Colorado law.

**All Other Covered Medical Expenses**

18. **Ambulance Services**, ground or air transportation to a Hospital, up to a maximum benefit of $750.

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

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

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

22. **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 50 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.

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 up to an overall maximum benefit of $200. This includes replacement of teeth and any related x-rays.

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. rental of 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. Medical care, treatment, supplies or services for the Insured Individual in his/her **home country** or country of regular domicile, with respect to covered dependents of International Students.

28. **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.

29. **Magnetic Resonance Imaging** (MRI), only when medically necessary.

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

31. **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.

32. **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.

33. **Pap smear** (cytologic screening): One cytologic screening will be payable every three years (excluding females who have had a hysterectomy) for female Insured Individuals over age eighteen years.

34. **Outpatient Physical Therapy** services (as defined), not including supplies, are payable only for a condition that required Surgery or Hospital Confinement; a) within the 30 days immediately preceding such Physical Therapy; or b) within the 30 days immediately following the Attending Physician’s release for rehabilitation.

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).

36. **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.

37. **Pre-admission Testing**, limited to routine tests such as: complete blood count; urinalysis and chest X-rays. If otherwise payable under the Policy, major diagnostic procedures such as cat scans, NMR’s and blood chemistries will be paid under the Hospital Miscellaneous benefit. This benefit is payable within 3 working days prior to admission. Testing performed more than 3 days prior to admission will not be considered a Covered Expense.

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

39. **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.
2. No benefits will be paid for: a) loss or expense caused by, contributed to, or
Insured Individual intends to reside following medical evacuation.
5. 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 Individual and a Health
Care Provider or Escort, if directed by the attending Physician, to the individ-
ual’s home city or for International students, to his or her home country or coun-
try 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.

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. Acne;
2. Acupuncture;
3. Allergies; including allergy testing;
4. Addiction, such as nicotine addiction;
5. Autistic disease of childhood, hyperkinetic syndromes, milieu therapy,
learning disabilities (to include attention deficit disorder), behavioral prob-
lems, parent-child problems, conceptual handicap, developmental delay or
disorder or mental retardation;
6. Biofeedback;
7. Circumcision, except for newborn infants, while still Hospital confined;
8. Congenital disorders, except as mandated by Colorado law;
9. Cosmetic procedures, except cosmetic surgery required to correct an Injury
for which benefits are otherwise payable under the Policy;
10. 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;
11. Elective abortion;
12. Elective Surgery or Elective Treatment;
13. 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;
14. Foot care including flat foot conditions, supportive devices for the foot,
subluxations of the foot, care of corns, bunions (except capsular or bone sur-
gery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and
symptomatic complaints of the feet;
15. 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;
16. Hirsutism, alopecia;
17. Hypnosis;
18. Immunizations; preventive medicines or vaccines; except where required
for treatment of a covered Injury or as specifically covered elsewhere in the
plan;
19. Injury or Bodily Infirmity from a Mental Health Condition or chemical
dependency, except as listed in the Covered Expense section;
20. 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 competi-
tions;
21. Inpatient convenience items such as guest meals, telephone, televisions, etc;
22. Marital counseling;
23. Massage therapy;
24. Medical treatment, services, supplies, or prescription drugs which are not
Medically Necessary, as defined in the Policy;
25. 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;
26. Medical care, treatment, services, or supplies for which benefits are
Excluded, Excepted, or limited elsewhere in the Policy;
27. 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;
28. Medical or non-medical self-care or self-help training and occupational
therapy, recreation therapy, educational therapy, dance therapy, art therapy,
except as described in the Master Policy;
29. Nasal and Sinus surgery;
30. Non-Medically Necessary Maintenance Care Expenses. Example: physical
therapy or chiropractic maintenance care as opposed to treatment of a con-
dition. 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);
31. Organ transplants, including organ donation;
32. Pre-existing conditions, except as described in the Pre-Existing Conditions
provision;
33. Private Duty Nursing Care;
34. Psychological testing;
35. Prescription Drugs provided on an outpatient basis, except as described in
the Prescription Drug Plan provision describing the benefits provided
through a prescription drug program;
36. 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;
b. birth control and/or contraceptives, oral or other, whether medication
or device;
c. immunization agents, biological sera, blood and blood products admin-
istered on an outpatient basis;
d. drugs labeled, “Caution – limited by federal law to investigational use”
or experimental drugs;
e. products used for cosmetic purposes;
f. drugs used to treat or cure baldness; attention deficit disorder; anabolic
steroids used for body building;
g. anorectics – drugs used for the purpose of weight control;
h. fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal,
Clomid, Profasi, Metrodin, Serophene, Viagra;
SCHEDULE OF MEDICAL EXPENSE BENEFITS ACCIDENT AND SICKNESS
UP TO $50,000 MAXIMUM BENEFIT PAID AS SPECIFIED BELOW
FOR EACH ACCIDENT OR SICKNESS
DEDUCTIBLE $50 PER INSURED INDIVIDUAL, PER POLICY YEAR

The Policy provides benefits for 100% of the Reasonable and Customary Charges incurred by any Insured Individual for loss due to a covered Accident or Sickness up to the Maximum Benefit of $50,000 for each Accident or Sickness. Coverage outside of the country for Covered Medical Expenses is reimbursable at 50%. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. Covered Medical Expenses include:

INPATIENT
Room and Board Expense, daily semi-private room rate; and general nursing care provided by the Hospital ................................................................. Reasonable & Customary/$300 per day
Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory test, x-ray examinations .................................................... Reasonable & Customary/$700 per day

Charges for inpatient care may be reasonable and customary charges, subject to the limits stated below. Charges paid to doctors, other health care providers, hospitals, and laboratories must include charges for all services and supplies related to the inpatient care, including professional fees; anesthesia; drugs or medicines; and supplies. Charges do not include services that are not related to the accident or sickness, and are paid under other policies.

Intensive Care ................................................................................................. Paid under Room & Board Expense
Physical Therapy ............................................................................................. Paid under Outpatient Miscellaneous

Surgery (includes surgeon’s fees, Assistant Surgeon’s fees and professional charges of an Anesthetist) ............................................................... Reasonable & Customary/$1,500 maximum per Accident or Sickness

Physicians Visits, benefits are limited to one visit per day and do not apply when related to surgery .................................................................................... $30 per day

Pre-Admission Testing, this benefit is payable within 3 working days prior to admission only ............................................................................................................. Paid under Hospital Miscellaneous Expenses

Mental Health Conditions (other than Biologically-based Mental Illness or Mental Disorders), ......................................................................................... Paid as any other Sickness

Biologically-based Mental Illness and Mental Disorders, see Covered Expense items for details ................................................................. Paid as any other Sickness

Routine Newborn Care, while Hospital Confined and routine nursery care provided immediately after birth ................................................................. Paid as any other Sickness

OUTPATIENT

Surgery’s Fees .................................................................................................. Reasonable & Customary/$1,500 maximum per Accident or Sickness

Outpatient Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Reasonable and Customary Charges for Outpatient Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.

Physicians Visits, benefits are limited to one visit per day. Benefits for Physician’s Visits ......................................................................................... Paid under Outpatient Miscellaneous

Physical Therapy ........................................................................................... $30 per day

Outpatient Miscellaneous Benefits, includes benefits designated as “Paid as Outpatient Miscellaneous” ........................................................................ Reasonable & Customary/$2,000 maximum per Accident or Sickness

Physical Therapy, benefits are limited to one visit per day ......................................................................................................................... Paid under Outpatient Miscellaneous

Medical Emergency Expenses, use of the emergency room and supplies ............................................................................................................. Paid under Outpatient Miscellaneous

Diagnostic X-ray & Laboratory Services ........................................................ Paid under Outpatient Miscellaneous

Tests and Procedures, diagnostic services and medical procedures performed by a Physician. ..................................................................................... Paid under Outpatient Miscellaneous

Mental Health Conditions (other than Biologically-based Mental Illness or Mental Disorders), includes all related ancillary charges incurred ............................................................................................................. 20 visits maximum per Policy Year

Biologically-based Mental Illness and Mental Disorders, see Covered Expense items for details ........................................................................ Paid as any other Sickness

Radiation Therapy, Chemotherapy & Injections when administered in the Physician’s office ..................................................................................... Reasonable & Customary/$1,000 max per Accident or Sickness

Hospitals, see Covered Expense items for details ................................................................................................................................. 100%

OTHER

Ambulance Services, ground or air transportation to a hospital ................................................................................................................................. Reasonable & Customary/$750 maximum per Accident or Sickness

Consultant Physician Fees, when requested and approved by the attending physician ................................................................. Reasonable & Customary/$100 maximum per Accident or Sickness

Dental, made necessary by Injury to Sound, Natural Teeth only ................................................................................................................................. Reasonable & Customary/$200 maximum per Accident or Sickness

HPV (Cervical Cancer Vaccine) for eligible Insured Female Dependents ................................................................................................................................. 100%

Maternity ............................................................................................................ Paid as any other Sickness

Complications of Pregnancy ............................................................................... Paid as any other Sickness

Prescription Drugs, Prescriptions must be filled at a CIGNA Pharmacy ................................................................................................................................. Reasonable & Customary/$100 maximum per Policy Year
“Accident” means all Medical Conditions of an Insured Individual caused by, arising out of, or resulting from a violent, sudden, and unforesen 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.
- 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.

“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 (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.

“Domestic Partner” means two adults, of the same sex, engaged in a spouse-like relationship characterized by mutual caring and dependency. To qualify for coverage of a Domestic Partner, both individuals must meet each of the following qualifications:

- individuals are at least eighteen (18) years of age and mentally competent to consent to a contract;
- individuals are each other’s sole Domestic Partner and intend to remain so indefinitely;
- individuals are not married to or legally separated from anyone else;
- individuals are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside;
- individuals are living together in the same residence and intend to do so indefinitely;
- individuals are engaged in a committed relationship of long standing, mutual caring and support and are jointly responsible for each other’s common welfare and living expenses.

A Domestic Partner must meet no less than three of the following four conditions:

- relationship has been in existence for a period of at least six consecutive months;
- joint ownership of a residence;
- designated each other as the beneficiaries of their wills, and/or 401(k) and/or life insurance policies;
- have at least two of the following:
  - joint ownership of a motor vehicle;
  - joint checking, bank or investment account;
  - joint credit account; or
  - lease for a residence identifying both partners as tenants.

“Elective Surgery” or “Elective Treatment” means 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 being provided pursuant to phase I, II, III, or IV clinical trials; or
3. are 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. are 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 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
6. 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
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
DEFINITIONS (CON’T.)

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 Necessarily. 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.

“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. Other Outpatient Therapy Services: The Policy also covers outpatient occupational and respiratory therapy and dialysis treatment. Services are limited to one visit per day per therapy.

“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.

“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.

“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.
MEDICAL MANAGEMENT PROGRAM

Connecticut General Life 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 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 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:

CONNECTICUT GENERAL LIFE INSURANCE COMPANY  
Payer Solutions Medical Outreach  
P.O. Box 66179 FO-66  
St. Louis, MO 63166-6719  
Telephone: (888) 760-2825

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.

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.