STUDENT
2016
2017
HEALTH PROGRAM
DOMESTIC STUDENTS

Designed Specifically for The Students of
Colorado State University
Welcome to Colorado State University

Good health is essential for your academic success and the CSU Health Network is here to provide high quality health care, counseling, education and prevention services at our campus facility. The program outlined in this brochure provides benefits both within the CSU Health Network (CSUHN) and when services are provided outside of the CSU Health Network through benefits provided in the student injury and sickness insurance policy underwritten by UnitedHealthcare Insurance Company. Please take some time to review this brochure and to educate yourself about the benefits that are available to you through the Student Health Program. If you have questions, please contact the CSU Health Network Insurance Office at (970) 491-5118 or visit www.health.colostate.edu.

CSU Health Network

All enrolled students are eligible to access care at the CSU Health Network. Payment for services not covered by the Campus Advantage Benefits or the student injury and sickness insurance plan benefits may be made at the time of treatment with cash, check, or credit card or billed to your student account.

Campus Advantage Benefits

(included with enrollment in the Student Health Program available to students who enroll in the student health insurance)

Students enrolled in the Student Health Program are eligible for additional benefits provided at the CSU Health Network.

- Covers up to $1500 for medical costs per school year at the CSU Health Network including in-house lab/x-ray, physical therapy, tests/procedures and other services
- $100 Flex Services per policy year available for use at the CSU Health Network
- Prescription drug benefits with no copay or deductible at the CSU Health Network Pharmacy.
- For more detailed information see page 3
- Campus Advantage Benefits are not provided or underwritten by UnitedHealthcare Insurance Company

Student Health Insurance Plan

- Underwritten by UnitedHealthcare Insurance Company
- Cofinity PPO Network (inside Colorado) First Health Network (outside of Colorado)
- No policy deductible or co-pay for services received at the CSU Health Network. Co-insurance may apply
- $1,000 Preferred (In-Network) / $2,000 (Out-of-Network) Non-Preferred Care deductible (outside the CSU Health Network)
- Out of Pocket Maximum - $6,850 (In-Network) Preferred / $13,700 (Out-of-Network) Non-Preferred (per individual / per plan year)
- Includes coverage outside the U.S. and its possessions, Canada, or Mexico 24/7 when traveling for academic study abroad programs, business or pleasure.
- Prescription drug benefit with $10/$35/$60 copay for Magellan RX network pharmacies (no copay at CSUHN pharmacy)
- No Lifetime Benefit Maximum
- Hospital Room and Board Expense benefits
- Surgical Expense benefits
- Outpatient Expense benefits
- For additional benefit coverage and more detailed information see pages 5-28

BR-CO (202865-1)
Eligibility For Health Insurance

ALL students enrolled in 6 or more resident instruction credit hours will be required to be covered by an insurance plan that is “Health Care Reform” compliant.

Domestic Students:
• Domestic undergraduate students enrolled in 6 credit hours or more.
• Domestic Graduate students enrolled in 1 credit hour or more.
• Graduate students enrolled in Continuous Registration.
• OnlinePlus students enrolled in 6 credit hours or more.

Any Student withdrawing from school during the first thirty-one (31) days of the period for which coverage is purchased, will not be covered under this Policy and a full refund of premium will be made minus the cost of any claim for benefits made by Us. Students withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed.

Students eligible for faculty/administrative professional or state classified health insurance are ineligible for coverage under this policy.

Students must actively attend classes for at least the first 31 days of the period for which coverage is purchased. Home study and correspondence courses do not fulfill this requirement for actively attending classes. The carrier maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If the carrier discovers that the eligibility requirements have not been met, a refund of premium, less any claims paid will occur.

Graduate Students

All domestic graduate students who are enrolled in 6 or more resident instruction credit hours are subject to the mandatory insurance requirement and will be automatically enrolled in and billed for the SHIP each semester. In order to opt out of enrollment in the Plan and have the SHIP charge removed from your student account, students must demonstrate proof of comparable coverage via the waiver request process. (See Waiver Request Process section below). Students who have been granted a waiver in the fall semester will be automatically waived in the spring semester as well. Graduate students who are enrolled in 5 or less credit hours are not subject to the mandatory insurance requirement and may opt in to coverage by completing the form available at the CSU Student Insurance Office or enroll online at www.health.colostate.edu. All waiver and opt in requests must be made no later than the Enrollment/Cancellation Deadline shown on page 4.

Undergraduate Students

All domestic undergraduate students who are enrolled in 6 or more resident instruction credit hours are subject to the mandatory insurance requirement and will be automatically enrolled in and billed for the SHIP each semester. In order to opt out of enrollment in the Plan and have the SHIP charge removed from your student account, students must demonstrate proof of comparable coverage via the waiver request process. (See Waiver Request Process section below). Students who have been granted a waiver in the fall semester will be automatically waived in the spring semester as well. All waiver requests must be made no later than the Enrollment/Cancellation Deadline shown on page 4.

Waiver Request Process

For additional details on the opt out/waiver request process, please visit the CSU Health Network website at: www.health.colostate.edu.

Effective And Termination Dates

Policy year effective and termination dates: August 18, 2016 - August 17, 2017

Insured Person: Coverage becomes effective at 12:01 a.m. standard time on the later of:
• The effective date of the Policy;
• The first day of the term of coverage for which premium is paid;
• The day Policy specified date received on which the enrollment form and premium are received by our representative

Insured Person: Coverage will terminate at 11:59 p.m. standard time at on the earliest of:
• The termination date of the Policy;
• The last day of the term of coverage for which premium is paid;
• The date a Insured Person enters full time active military service. We will refund the unearned pro-rata premium to such person upon request.

It is your responsibility to verify your enrollment or waiver status each semester.

The student health insurance policy is a Non-Renewable One Year Term Policy.
The CSU Health Network at Colorado State University is fully accredited by the Accreditation Association for Ambulatory Health Care Inc. (AAAHC). Emphasizing seamless, and innovative health care services, the professional staff through the CSU Health Network provides high quality health care for our students. The professional medical and mental health staff consists of board certified and licensed providers, psychiatrists, psychologists, nurse practitioners, physician assistants, pharmacists, and professional technicians.

Services encompass a wide range of outpatient care including individual, group, and family counseling, Learning Assistance consultations, substance abuse prevention/treatment, stress management, sports performance programs and the following:

- Women’s Clinic
- Medical Clinic (including Men’s Health)
- Psychiatric Services
- Triage

Ancillary services include: X-ray, Laboratory, and Pharmacy.

In addition, the CSU Health Network provides a number of specialty clinics, such as:

- Allergy/Asthma
- Dental
- Optometry
- Physical Therapy
- Orthopedic/Sports Medicine
- Therapeutic Massage
- Immunization

Health Education and Prevention Services are available to help promote and support healthy lifestyle choices through education and counseling.

Health records of patients are kept completely confidential. Health information is not released to anyone without written approval.

Students who have health problems are encouraged to establish a relationship with a health care provider upon arriving on campus and to provide previous medical records.

The CSU Health Network hours are:

<table>
<thead>
<tr>
<th></th>
<th>Academic Year</th>
<th>Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday – Friday</td>
<td>7:45 a.m. – 5:00 p.m.</td>
<td>7:30 a.m. – 4:30 p.m.</td>
</tr>
</tbody>
</table>

The CSU Health Network is located west of Morgan Library and east of the intramural field on the main campus.

In order to be eligible for the student health program, the student must also pay the Student Health Access and Counseling Fees.
The CSU Health Network is pleased to offer the following benefits (that are in addition to the benefits outlined on pages 6-16) to students enrolled in the CSU Student Health Program. A portion of the amounts outlined in the Schedule of Costs (page 4) are allocated for the additional benefits shown below.

There are 3 benefit components under the Campus Advantage program: One component for medically necessary services when rendered at the CSU Health Network and another component for prescription drugs dispensed at the CSU Health Network. The third component is a $100 Flex Services benefit available for use toward non-covered health related services provided at the CSU Health Network. To reduce out of pocket expenses, students should access services at the CSU Health Network first before seeking medical care in the community.

<table>
<thead>
<tr>
<th>CSUHN Medical Care Benefit per Plan Year (Not including prescription drugs)</th>
<th>$1,500</th>
<th>• Physical Therapy • X-Ray • Laboratory • Consultations • Intravenous Care • Tests/Procedures • Surgical Procedures • Infirmary • Braces / Casting • Appliances</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSUHN Prescription Drug Benefit</td>
<td>$ 500</td>
<td>Includes birth control. Once the $500 benefit has been exhausted, student health insurance plan benefits become available at the CSUHN Pharmacy with no co-pay, no deductible.</td>
</tr>
<tr>
<td>Flex Services</td>
<td>$ 100</td>
<td>Flex Services may be used at the CSU Health Network for health related services not otherwise covered under the Campus Advantage benefits (Excluding Over-The-Counter Medications, Coinsurance, No Show and Late Appointment Fees).</td>
</tr>
</tbody>
</table>

Medical Care and Prescription Drug benefits do not cover:

▲ Dental care
▲ Massages
▲ Routine eye exams
▲ Administrative fees
▲ Charges deemed not medically necessary
▲ Copies of x-rays/medical records
▲ Services or supplies not rendered at CSU Health Network
▲ Preventive or elective and/or over-the-counter medications
▲ Services not listed above

Some of these exclusions may be covered under the Flex Services benefit

Students – Medical expenses incurred under Campus Advantage at the CSU Health Network do not require a claim form, are not subject to deductible and/or copays. Any ineligible expense not payable under the benefits outlined above may be considered by the student health insurance plan. In the event those charges are not eligible under that plan they will be charged to your student account.

Please contact the Student Insurance Office at (970) 491-5118 with any questions.

A referral from a CSU Health Network Provider is required for services received outside of the health center. See Referral Requirement section on page 6

Campus Advantage benefits are not administered or underwritten by UnitedHealthcare Insurance Company.

BR-CO (202866-1)
Purchasing The Insurance

All domestic graduate and undergraduate students registered for 6 or more resident instruction credit hours are REQUIRED to maintain coverage under a Health Care Reform compliant plan of insurance or be enrolled in the CSU Student Health Insurance plan.

Additional information regarding this requirement, enrollment in the CSU student health insurance plan and waiving out of the requirement with proof of compliant coverage, is posted on the CSUHN website (shown in the Waiver Request Process section on page 1) and will be e-mailed to students prior to the beginning of the semester.

Eligible Graduate and Continuous Registration Students taking less than 6 credit hours may sign up in the Student Insurance Office or online at www.health.colostate.edu prior to the enrollment/cancellation dates shown below.

<table>
<thead>
<tr>
<th>Semester</th>
<th>Enrollment/Cancellation Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Semester</td>
<td>September 7, 2016</td>
</tr>
<tr>
<td>Spring/Summer Semester</td>
<td>February 1, 2017</td>
</tr>
<tr>
<td>Summer</td>
<td>May 15, 2017</td>
</tr>
</tbody>
</table>

If you withdraw from classes within the enrollment period, your coverage will terminate retroactive to the effective date of coverage and a full refund, less any claims paid will be made. No refund will be given if a withdrawal is made after the enrollment period ends and the insurance will remain in force.

NOTE: The amounts stated below include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school’s administrative costs associated with offering this health plan.

<table>
<thead>
<tr>
<th>Schedule Of Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
</tr>
<tr>
<td>Student</td>
</tr>
</tbody>
</table>

Coverage Dates For 2016/2017 School Year

<table>
<thead>
<tr>
<th>Semester</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>August 18, 2016 - January 14, 2017</td>
</tr>
<tr>
<td>Spring/Summer</td>
<td>January 15, 2017 - August 17, 2017</td>
</tr>
<tr>
<td>Summer</td>
<td>May 15, 2017 - August 17, 2017</td>
</tr>
</tbody>
</table>

The CSU Student Health Insurance Plan does not maintain a coverage option for spouse, domestic partner and/or children. Please see the Student Insurance Office or Health Network webpage for additional information.

Under the terms of the insurance policy, no enrollments or cancellations may be made after the published Enrollment/Cancellation Deadlines outlined above and therefore, no refunds can be made after this date.

A copy of the Plan document is available upon request.

How Do I Find A Preferred Provider?

When you need health care, please access the CSU Health Network first for treatment or to obtain a referral to a Preferred Provider. When referred to a Preferred Provider or in the event of a Medical Emergency, benefits will be paid at a higher level if you obtain treatment or medical services from a provider in the Cofinity PPO Network (in Colorado) First Health (outside of Colorado). You are strongly encouraged to utilize these providers whenever possible as this can reduce your out-of-pocket expenses. Detailed information about Preferred Care network providers is available by visiting www.cofinity.com, www.health.colostate.edu or by calling AmeriBen at (855) 258-2656.

For benefit and claims questions, please call: (855) 258-2656.

Network providers are subject to change. Please contact the provider prior to obtaining medical care/treatment in order to confirm their participation in the Cofinity PPO Network (in Colorado) First Health (outside of Colorado).

How Do I File A Claim?

Individuals enrolled on the plan and who obtain services from an in-network provider will usually not be required to submit a claim form; most offices will bill AmeriBen directly. However, if you receive a bill from a provider’s office, you can submit the claim for processing:

1. Make a copy of the bill for your own records, and ensure the bill indicates:
   • The insured student’s name, address and University identification number
   • Itemized services
   • Group # 0816007
   • Colorado State University Fort Collins

2. Mail the bill to address shown:

3. Prescription claim Reimbursement:
   • Please refer to www.health.colostate.edu.

Claim information must be received as soon as possible and no later than 90 days after the date you received treatment or services.

You have the right to request an independent medical review if health care services have been improperly denied, modified, or delayed based on medical necessity.

Online Services

Please visit the claim administrator’s website at www.myameriben.com to obtain claim status information and Health Benefit Resources.

Other Questions?

Please call (970) 491-5118 or stop by the Student Insurance Office, at the CSU Health Network. You may also e-mail the office at: CSUHN_Insurance@mail.colostate.edu

Or find us online at www.health.colostate.edu
## Schedule of Medical Expense Benefits

<table>
<thead>
<tr>
<th>METALLIC LEVEL - SILVER WITH ACTUARIAL VALUE OF 77.864 %</th>
</tr>
</thead>
</table>

### Injury and Sickness Benefits

<table>
<thead>
<tr>
<th>No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible Preferred Providers</strong> — $1,000 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td><strong>Coinsurance Preferred Providers</strong> — 80% except as noted below</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum Preferred Providers</strong> — $6,850 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td><strong>Deductible Out-of-Network</strong> — $2,000 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td><strong>Coinsurance Out-of-Network</strong> — 60% except as noted below</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum Out-of-Network</strong> — $13,700 (Per Insured Person, Per Policy Year)</td>
</tr>
</tbody>
</table>

The Preferred Provider for this plan is Cofinity PPO (inside of Colorado) and First Health (outside of Colorado).

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 80% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Covered Medical Expenses for Prescription Drugs and Preventive Care will be paid at 100% at the Student Health Center.

Injury or Sickness is covered outside the United States and its possessions, Canada, or Mexico only when traveling for academic study abroad programs, business or pleasure. Under these circumstances, Covered Medical Expenses will be payable subject to all policy provisions, at 80% of billed charges after the $1,000 Preferred Provider Policy Year Deductible has been met.

### Student Health Center (SHC) Referral Required

**OUTPATIENT SERVICES ONLY**

The student should use the services the Health Center first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A SHC referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. The student must return to SHC for necessary follow-up care.
2. When the Student Health Center is closed.
3. When service is rendered at another facility during break or vacation periods.
4. Medical care received when the student is more than 25 miles from campus.
5. Medical care obtained when a student is no longer able to use the SHC due to a change in student status.
6. Maternity, obstetrical and gynecological care.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Please refer to the Medical Expense Benefits - Injury and Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Preferred provider</th>
<th>Out-of-network provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board Expense</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Surgery</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
</tbody>
</table>

If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
# Student Health Insurance Plan Schedule of Benefits

## INPATIENT

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Allowance</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant Surgeon Fees</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Registered Nurse’s Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician’s Visits</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Pre-admission Testing</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Payable within 7 working days prior to admission.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## OUTPATIENT

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Allowance</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Day Surgery Miscellaneous</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Assistant Surgeon Fees</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician’s Visits</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Medical Emergency Expenses</td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. The Copay/per visit Deductible will be waived if admitted to the Hospital. Includes coverage for emergency Periapical abscess.</td>
<td>$100 Copay per visit</td>
<td>$100 Deductible per visit</td>
</tr>
<tr>
<td>Diagnostic X-ray Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Tests &amp; Procedures</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Injections</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Except as specifically provided for in Preventive Care Services, Vaccinations/Immunizations that are required to attend CSU or required to complete program of study are covered under this benefit.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>OUTPATIENT</td>
<td>PREFERRED PROVIDER</td>
<td>OUT-OF-NETWORK PROVIDER</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Magellan Rx</td>
<td>100% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Mail order is available through Magellan RX Management at 3 times the Copay for 90 day supply.</td>
<td>$10 Copay per prescription for generic drugs</td>
<td>$10 Deductible per prescription for generic drugs</td>
</tr>
<tr>
<td></td>
<td>$35 Copay per prescription for brand name drugs</td>
<td>$35 Deductible per prescription for brand name drugs</td>
</tr>
<tr>
<td></td>
<td>$60 Copay per prescription for non-preferred brand drugs</td>
<td>$60 Deductible per prescription for non-preferred brand drugs</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Consultant Physician Fees</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Dental Treatment</td>
<td>100% of Preferred Allowance</td>
<td>100% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Benefits paid on Injury to Sound, Natural Teeth only.</td>
<td>Preferred Allowance</td>
<td>100% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Dental Treatment</td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Benefits paid for removal of impacted wisdom teeth only.</td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Mental Illness Treatment</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>See also Benefits for Biologically Based Mental Illness</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>See also Benefits for Biologically Based Mental Illness</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Maternity</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Elective Abortion</td>
<td>Preferred Allowance</td>
<td>Usual and Customary</td>
</tr>
<tr>
<td>Complications of Pregnancy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>100% of Preferred Allowance</td>
<td>Usual and Customary</td>
</tr>
<tr>
<td>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. See also Benefits for Preventive Health Care.</td>
<td>Usual and Customary</td>
<td>Preven</td>
</tr>
<tr>
<td>Please visit <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a> for a complete list of services provided for specific age and risk groups.</td>
<td>Preven</td>
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</tr>
<tr>
<td>Reconstructive Breast Surgery Following Mastectomy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Diabetes Services</td>
<td>See Benefits for Diabetes</td>
<td>See Benefits for Diabetes</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>Preferred Allowance</td>
<td>Usual and Customary</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Preferred Allowance</td>
<td>Usual and Customary</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Preferred Allowance</td>
<td>Usual and Customary</td>
</tr>
<tr>
<td></td>
<td>$50 Copay per visit</td>
<td>$50 Deductible per visit</td>
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</tbody>
</table>

BR-CO (202865-1)
Student Health Insurance Plan Schedule of Benefits

<table>
<thead>
<tr>
<th>OTHER</th>
<th>PREFERRED PROVIDER</th>
<th>OUT-OF-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Outpatient Facility or Clinic</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Approved Clinical Trials</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>TMJ Disorder</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Acupuncture in Lieu of Anesthesia</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Infertility</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Covered Medical Expenses are limited to charges made by a Physician to</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>diagnose and to surgically treat the underlying cause of infertility.</td>
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<td></td>
</tr>
<tr>
<td>Transplant Travel and Lodging</td>
<td>100% of Actual Charges</td>
<td>100% of Actual Charges</td>
</tr>
<tr>
<td>Benefit maximum of $10,000 per transplant</td>
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</tr>
<tr>
<td>Sexually Transmitted Disease Testing</td>
<td>100% of Preferred Allowance</td>
<td>100% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Except as specifically provided under Preventive Care Services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Extension of Benefits after Termination

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

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

After this “Extension of Benefits” provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Preferred Provider Information

“Preferred Providers” are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

- Cofinity (inside Colorado) and First Health (outside of Colorado).

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company Cofinity (inside of Colorado) at 1-800-831-1166 and First Health (outside of Colorado) at 1-800-226-5116 and/or by asking the provider when making an appointment for services.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

“Out-of-Network” providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured’s responsibility.

“Network Area” means the 25 mile radius around the local school campus the Named Insured is attending.

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call 1-855-238-2656 for information about Preferred Hospitals.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by Cofinity (inside of Colorado) and First Health (outside of Colorado) will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.
Medical Expense Benefits – Injury and Sickness

This section describes Covered Medical Expenses for which benefits are available in the Schedule of Benefits. Benefits are payable for Covered Medical Expenses (see “Definitions”) less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance, Copayment or per service Deductible amounts set forth in the Schedule of Benefits or any benefit provision hereof. Read the “Definitions” section and the “Exclusions and Limitations” section carefully.

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

Inpatient

1. Room and Board Expense.
   Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.
2. Intensive Care.
   If provided in the Schedule of Benefits.
3. Hospital Miscellaneous Expenses.
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
   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.
   • Supplies.
4. Routine Newborn Care.
   While Hospital Confined and routine nursery care provided immediately after birth.
   Benefits will be paid for an inpatient stay of at least:
   • 48 hours following a vaginal delivery.
   • 96 hours following a cesarean section delivery.

   If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.
5. Surgery (Inpatient).
   Physician’s fees for Inpatient surgery.
6. Assistant Surgeon Fees.
   Assistant Surgeon fees in connection with Inpatient surgery.
   Professional services administered in connection with Inpatient surgery.
8. Registered Nurse’s Services.
   Registered Nurse’s services which are all of the following:
   • Private duty nursing care only.
   • Received when confined as an Inpatient.
   • Ordered by a licensed Physician.
   • A Medical Necessity.

   General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.
   Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.
    Benefits are limited to routine tests such as:
    • Complete blood count.
    • Urinalysis.
    • Chest X-rays.
    If otherwise payable under the policy, major diagnostic procedures such as those listed below will be paid under the “Hospital Miscellaneous” benefit:
    • CT scans.
    • NMR’s.
    • Blood chemistries.

Outpatient

11. Surgery (Outpatient).
    Physician’s fees for outpatient surgery.
12. Day Surgery Miscellaneous (Outpatient).
    Facility charge and the charge for services and supplies in connection with outpatient day surgery, excluding nonscheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician’s office; or clinic.
13. Assistant Surgeon Fees (Outpatient).

   Assistant Surgeon fees in connection with outpatient surgery.
    Professional services administered in connection with outpatient surgery.
15. Physician’s Visits (Outpatient).
    Services provided in a Physician’s office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery or Physiotherapy.
    Physician’s Visits for preventive care are provided as specified under Preventive Care Services.
16. Physiotherapy (Outpatient).
    Includes but is not limited to the following rehabilitative services (including Habilitative Services):
    • Physical therapy.
    • Occupational therapy.
    • Cardiac rehabilitation therapy.
    • Manipulative treatment.
    • Speech therapy.
    Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from injury, trauma, stroke, surgery, cancer, or vocal nodules.
17. Medical Emergency Expenses (Outpatient).
    Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies.
    All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. Diagnostic X-ray Services (Outpatient).
    Diagnostic X-rays are only those procedures identified in Physicians’ Current Procedural Terminology (CPT) as codes 70000 – 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
19. Radiation Therapy (Outpatient).
    See Schedule of Benefits.
20. Laboratory Procedures (Outpatient).
    Laboratory Procedures are only those procedures identified in Physicians’ Current Procedural Terminology (CPT) as codes 80000 – 89999 inclusive. Laboratory Procedures for preventive care are provided as specified under Preventive Care Services.
21. Tests and Procedures (Outpatient).
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
• Physician’s Visits.
• Physiotherapy.
• X-rays.
• Laboratory Procedures.
The following therapies will be paid under the Tests and procedures (Outpatient) benefit:
• Inhalation therapy.
• Infusion therapy.
• Pulmonary therapy.
• Respiratory therapy.
Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. Injections (Outpatient).
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. Chemotherapy (Outpatient).
See Schedule of Benefits.

24. Prescription Drugs (Outpatient).
See Schedule of Benefits.

Other

See Schedule of Benefits.

26. Durable Medical Equipment.
Durable medical equipment must be all of the following:
• Provided or prescribed by a Physician. A written prescription must accompany the claim when submitted.
• Primarily and customarily used to serve a medical purpose.
• Can withstand repeated use.
• Generally is not useful to a person in the absence of Injury or Sickness.
• Not consumable or disposable except as needed for the effective use of covered durable medical equipment.
For the purposes of this benefit, the following are considered durable medical equipment:
• Braces that stabilize an injured body part and braces to treat curvature of the spine.
• External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. Repair is covered unless necessitated by misuse.
• Orthotic devices that straighten or change the shape of a body part.
If more than one piece of equipment or device can meet the Insured’s functional needs, benefits are available only for the equipment or device that meets the minimum specifications for the Insured’s needs. Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

27. Consultant Physician Fees.
Services provided on an Inpatient or outpatient basis.

28. Dental Treatment.
Dental Treatment when services are performed by a Physician and limited to the following:
• Injury to Sound, Natural Teeth.
• Removal of impacted wisdom teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. Pediatric dental benefits are provided in the Pediatric Dental Services provision.

29. Mental Illness Treatment.
Benefits will be paid for services received:
• On an Inpatient basis while confined to a Hospital including partial hospitalization/ day treatment received at a Hospital.
• On an outpatient basis including intensive outpatient treatment.
See also Benefits for Biologically Based Mental Illness.

30. Substance Use Disorder Treatment.
Benefits will be paid for services received:
• On an Inpatient basis while confined to a Hospital including partial hospitalization/ day treatment received at a Hospital.
• On an outpatient basis including intensive outpatient treatment.
See also Benefits for Biologically Based Mental Illness.

31. Maternity.
Same as any other Sickness.

Benefits will be paid for an inpatient stay of at least:
• 48 hours following a vaginal delivery.
• 96 hours following a cesarean section delivery.
If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.

32. Complications of Pregnancy.
Same as any other Sickness.

33. Preventive Care Services.
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
• Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.
• Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
• With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
• With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

34. Reconstructive Breast Surgery Following Mastectomy.
Same as any other Sickness and in connection with a covered mastectomy.

Benefits include:
• All stages of reconstruction of the breast on which the mastectomy has been performed.
• Surgery and reconstruction of the other breast to produce a symmetrical appearance.
• Prostheses and physical complications of mastectomy, including lymphedemas.
Medical Expense Benefits – Injury and Sickness

35. Diabetes Services.
   See Benefits for Diabetes.

   Services received from a licensed home health agency that are:
   • Ordered by a Physician.
   • Provided or supervised by a Registered Nurse in the Insured Person’s home.
   • Pursuant to a home health plan.
   Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.

37. Hospice Care.
   When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less.
   Hospice care includes:
   • Physical, psychological, social, and spiritual care for the terminally ill insured.
   • Short-term grief counseling for immediate family members while the insured is receiving hospice care.

38. Inpatient Rehabilitation Facility.
   Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

39. Skilled Nursing Facility.
   Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
   • In lieu of Hospital Confinement as a full-time inpatient.
   • Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

40. Urgent Care Center.
   Benefits are limited to:
   • The facility or clinic fee billed by the Urgent Care Center.
   All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

41. Hospital Outpatient Facility or Clinic.
   Benefits are limited to:
   • The facility or clinic fee billed by the Hospital.
   All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

42. Approved Clinical Trials.
   Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured’s participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured’s participation would be appropriate.

   “Routine patient care costs” means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include:
   • The experimental or investigational item, device or service, itself.
   • Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
   • A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

   “Life-threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

   “Approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
   • Federally funded trials that meet required conditions.
   • The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
   • The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

43. Transplantation Services.
   Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.
   Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under this policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this policy to be primary.
   No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.
   Travel expenses are not covered. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

44. TMJ Disorder.
   Same as any other Sickness and limited to the following services only:
   • Diagnostic X-ray Services.
   • Laboratory procedures.
   • Physical therapy.
   • Surgery.
**Mandated Benefits**

**BENEFITS FOR PROSTATE CANCER SCREENING**
Benefits will be paid for actual charges incurred for an annual screening by a Physician for the early detection of prostate cancer. Benefits will be payable for one screening per year for any male Insured 50 years of age or older. One screening per year shall be covered for any male Insured 40 to 50 years of age who is at risk of developing prostate cancer as determined by the Insured’s Physician. The screening shall consist of the following tests:

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

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

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

**BENEFITS FOR BIOLOGICALLY BASED MENTAL ILLNESS**

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

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

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

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

**BENEFITS FOR DIABETES**

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

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

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

**BENEFITS FOR CERVICAL CANCER VACCINES**
Benefits are payable for the cost of cervical cancer vaccinations for all female Insured Persons for whom a vaccination is recommended by the Advisory Committee on Immunization practices of the United States Department of Health and Human Services.

**BENEFITS FOR MEDICAL FOODS**

Benefits will be paid for the Usual and Customary Charges for all medically necessary and appropriate formulas, pre-mixed dietary regimens, and similar products intended to meet the nutritional needs of a patient, including a wearable instrument or device designed to aid or compensate for impaired human function. Benefits shall include the purchase of the following:

1. Initial Hearing Aids and replacement Hearing Aids not more frequently than every five years;
2. A new Hearing Aid when alterations to the existing Hearing Aid cannot adequately meet the needs of the Child; and
3. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to professional standards.

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

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

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

**BENEFITS FOR HEARING AIDS FOR MINOR CHILDREN**

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

Benefits shall include the purchase of the following:

1. Initial Hearing Aids and replacement Hearing Aids not more frequently than every five years;
2. A new Hearing Aid when alterations to the existing Hearing Aid cannot adequately meet the needs of the Minor Child; and
3. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to professional standards.

**BENEFITS FOR CLEFT LIP OR CLEFT PALATE**

Benefits will be paid the same as any other Sickness for Covered Medical Expenses related to the assessment, diagnosis and treatment, including Applied Behavior Analysis, of Autism Spectrum Disorders. Treatment for Autism Spectrum Disorders shall include the Medically Necessary care and treatment including oral and facial surgery; surgical management; the Medically Necessary care by a plastic or oral surgeon; prosthetic treatment such as obturators, speech appliances, feeding appliances; Medically Necessary orthodontic and prosthodontic treatment; habilitative speech therapy, otolaryngology treatment; and audiological assessments and treatment.

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

**BENEFITS FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS**

Benefits will be paid the same as any other Sickness for Covered Medical Expenses related to the assessment, diagnosis and treatment, including Applied Behavior Analysis, of Autism Spectrum Disorders. Treatment for Autism Spectrum Disorders shall include the Medically Necessary care and treatment including oral and facial surgery; surgical management; the Medically Necessary care by a plastic or oral surgeon; prosthetic treatment such as obturators, speech appliances, feeding appliances; Medically Necessary orthodontic and prosthodontic treatment; habilitative speech therapy, otolaryngology treatment; and audiological assessments and treatment.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.
Disorders must be prescribed or ordered by a licensed Physician or license psychologist.

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

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

“Treatment for Autism Spectrum Disorders” shall be for treatments that are Medically Necessary, appropriate, effective, or efficient. Treatment for Autism Spectrum Disorders shall include:
1. Evaluation and assessment services;
2. Behavior training and behavior management and applied behavior analysis, including but not limited to, consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers;
3. Habilitative or rehabilitative care, including but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies;
4. Psychiatric care;
5. Psychological care, including family counseling;
6. Therapeutic care; and
7. Pharmacy care and medication if provided for in the policy.

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

**BENEFITS FOR PREVENTIVE HEALTH CARE**

Benefits will be provided for the cost of the following Preventive Health Care services, in accordance with the A or B Recommendations of the Task Force for the particular Preventive Health Care services:
1. Alcohol misuse screening and behavioral counseling interventions for adults by their Physician;
2. Cervical Cancer Screening;
3. Breast Cancer Screening with Mammography:
   a. Benefits shall be determined on a Policy Year basis and shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy;
   b. If an Insured Person who is eligible for a preventive mammography screening has not utilized the benefit during the Policy Year, then the coverage shall apply to one diagnostic screening for that same Policy Year. Any other diagnostic screenings shall be subject to all applicable policy provisions;
   c. Benefits shall also be provided for an annual breast cancer screening with mammography for an Insured Person possessing at least one risk factor including, but not limited to, a family history of breast cancer; being forty years of age or older, or a genetic predisposition to breast cancer;
4. Cholesterol screening for lipid disorders;
5. Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps. Benefits shall also be provided to an insured Person who is at a high risk for colorectal cancer, including an Insured Person who has a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn’s disease, or ulcerative colitis; or other predisposing factors as determined by a Physician;
6. Child health supervision services and childhood immunizations pursuant to the schedule established by the ACIP;
7. Influenza vaccinations pursuant to the schedule established by the ACIP;
8. Pneumococcal vaccinations pursuant to the schedule established by the ACIP; and
9. Tobacco use screening of adults and tobacco cessation interventions by the Insured Person’s Physician.

Any other preventive services included in the A or B Recommendation of the Task Force or required by federal law.

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

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

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

“Task force” means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal Department of Health and Human Services. The policy Deductible, Copays and Coinsurance will not be applied to this benefit.

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

**BENEFITS FOR ORAL ANTICANCER MEDICATION**

Benefits will be provided for prescribed, orally administered anticancer medication that has been approved by the Federal Food and Drug Administration and is used to kill or slow the growth of cancerous cells.

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

The medication provided pursuant to this benefit shall:
1. only be prescribed upon a finding that it is Medically Necessary by the treating Physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice;
2. be clinically appropriate in terms of type, frequency, extent site, and duration; and
3. not be primarily for the convenience of the Insured or Physician.

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

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

**Coordination of Benefits Provision**

Benefits will be coordinated with any other eligible medical, surgical, or hospital plan or coverage so that combined payments under all programs will not exceed 100% of allowable expenses incurred for covered services and supplies.
Definitions

**COINSURANCE** means the percentage of Covered Medical Expenses that the Company pays.

**COMPLICATION OF PREGNANCY** means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

**CONGENITAL CONDITION** means a medical condition or physical anomaly arising from a defect existing at birth.

**COPAY/COPAYMENT** means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

**COVERED MEDICAL EXPENSES** means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

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

**CUSTODIAL CARE** means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**DEDUCTIBLE** means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable to the Company under this policy before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

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

**EMERGENCY SERVICES** means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

**HABILITATIVE SERVICES** means outpatient occupational therapy, physical therapy and speech therapy prescribed by the Insured Person’s treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

Habilitative services do not include services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Insured Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

**HOSPITAL** means a health institution planned, organized, operated, and maintained to offer facilities, beds, and services over a continuous period exceeding twenty four (24) hours to individuals requiring diagnosis and treatment for illness, Injury, deformity, abnormality, or pregnancy. Clinical laboratory, diagnostic X-ray, and definitive medical treatment under an organized medical staff shall be provided within the institution. Treatment facilities for emergency and surgical services shall be provided either within the institution or by contractual agreement for those services with another licensed Hospital. Services provided by contractual agreement shall be documented by a well-defined plan for the provision of contracted services, related to community needs. Definitive medical treatment may include obstetrics, pediatrics, psychiatry, physical medicine and rehabilitation, X-ray therapy, and similar specialized treatment.

**HOSPITAL CONFINED/HOSPITAL CONFINEMENT** means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

**INJURY** means bodily injury which is all of the following:

1. directly and independently caused by specific accidental contact with another body or object.
2. unrelated to any pathological, functional, or structural disorder.
3. a source of loss.
4. treated by a Physician within 30 days after the date of accident.
5. sustained while the Insured Person is covered under this policy.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy’s Effective Date will be considered a Sickness under this policy.

**INPATIENT** means an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which benefits are payable under this policy.

**INPATIENT REHABILITATION FACILITY** means a long term acute inpatient rehabilitation center, a Hospital (or special unit of a Hospital designated as an inpatient rehabilitation facility) that provides rehabilitation health services on an Inpatient basis as authorized by law.
Definitions

INSURED PERSON means the Named Insured. The term “Insured” also means Insured Person.

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

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

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

Expenses incurred for “Medical Emergency” will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor injuries or minor Sicknesses.

MEDICAL NECESSITY/ MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

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

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

1. The Insured requires acute care as a bed patient.
2. The Insured cannot receive safe and adequate care as an outpatient.

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

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

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

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child’s parent.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person’s immediate family.

The term “member of the immediate family” means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means short-term outpatient rehabilitation therapies (including Habilitative Services) administered by a Physician.

POLICY YEAR means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

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

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

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

SKILLED NURSING FACILITY means a Hospital or nursing facility that is licensed and operated as required by law.

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

**SUBSTANCE USE DISORDER** means a Sickness that is listed as an alcoholism and substance use disorder in the current Diagnostic and Statistical Manual of the American Psychiatric Association. Substance use disorder does not mean a Mental Disorder as defined in the Benefits for Biologically Based Mental Illness. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

**URGENT CARE CENTER** means a facility that provides treatment required to prevent serious deterioration of the Insured Person’s health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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

**Exclusions and Limitations**

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

1. Acupuncture, except as specifically provided in the policy.
2. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
4. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
5. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
6. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As specifically provided in the Schedule of Benefits.
   - This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
7. Elective Surgery or Elective Treatment.
8. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
9. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, and bunions (except capsular or bone surgery).
   - This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
10. Health spa or similar facilities. Strengthening programs.
11. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing, apart from the disease process. This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of an infection or Injury.
   - Hearing Aids specifically provided for in Benefits for Hearing Aids for Minor Children.
   - Hearing exams and tests to determine the need for hearing correction.
13. Hypnosis.
14. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
15. Injury or Sickness for which benefits are paid or payable under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation.
16. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except when traveling for academic study abroad programs, business, or pleasure.
17. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
18. Injury sustained while:
   - Participating in any intercollegiate, or professional sport, contest or competition.
   - Traveling to or from such sport, contest or competition as a participant.
   - Participating in any practice or conditioning program for such sport, contest or competition.
19. Investigational services.
20. Lipectomy.
21. Marital or family counseling.
22. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
23. Prescription Drugs, services or supplies as follows:
   - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
   - Immunization agents, except as specifically provided in the policy. Biological sera.
   - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
   - Products used for cosmetic purposes.
   - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
   - Anorectics - drugs used for the purpose of weight control.
   - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, etc.
Exclusions and Limitations

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Profasi, Metrodin, Serophene, or Viagra.
• Growth hormones.
• Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

24. Reproductive/infertility services including but not limited to the following, except as specifically provided in the policy:
• Genetic testing.
• Cryopreservation of reproductive materials. Storage of reproductive materials.
• Premarital examinations.
• Impotence, organic or otherwise.

25. Research or examinations relating to research studies, or any treatment for which the patient or the patient’s representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.

26. Residential treatment of eating disorders, such as anorexia or bulimia.


This exclusion does not apply as follows:
• When due to a covered Injury or disease process.
• To benefits specifically provided in Pediatric Vision Services.

28. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.

29. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.

30. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.

31. Speech therapy, except as specifically provided in the policy. Naturopathic services.

32. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.

33. Supplies, except as specifically provided in the policy.

34. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.

35. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

36. War or any act of war, declared or undeclared; or while in the armed forces of any country other than the United States (a pro-rata premium will be refunded upon request for such period not covered).

37. Weight management. Weight reduction programs. Weight management programs. Nutrition programs and related nutritional supplies. Treatment for obesity. Treatment for Morbid Obesity associated with serious and life threatening disorders such as diabetes mellitus and hypertension is covered. 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. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.
If you are a member insured with this insurance plan, you are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

Domestic students: you are eligible for UnitedHealthcare Global services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to $5,000.00 payment
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit http://health.colostate.edu/student-health-insurance/ for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.

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

Services are also accessible via e-mail at assistance@UHCGlobal.com.

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

- Caller’s name, telephone and (if possible) fax number, and relationship to the patient;
- Patient’s name, age, sex, and UnitedHealthcare Global ID Number as listed on your Medical ID Card;
- Description of the patient’s condition;
- Name, location, and telephone number of hospital, if applicable;
- Name and telephone number of the attending physician; and
- Information of where the physician can be immediately reached.

UnitedHealthcare Global is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. Please refer to the UnitedHealthcare Global information at http://health.colostate.edu/student-health-insurance/ for additional information, including limitations and exclusions.
Benefits are provided for Covered Dental Services for Insured Persons UNDER THE AGE OF 19. Benefits terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person’s coverage under the policy terminates.

Accessing Pediatric Dental Services

Network Benefits apply when the Insured Person chooses to obtain Covered Dental Services from a Network Dental Provider. Insured Persons generally are required to pay less to the Network Dental Provider than they would pay for services from a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will the Insured Person be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, the Insured must obtain all Covered Dental Services directly from or through a Network Dental Provider. Insured Persons must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. Participation status can be verified by calling the Insured Person’s ID card. If necessary, the Company can provide assistance in referring the Insured Person to a Network Dental Provider.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 1-855-258-2656 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured’s ID card.

Non-Network Benefits apply when Covered Dental Services are obtained from non-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. As a result, an Insured Person may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. In addition, when Covered Dental Services are obtained from non-Network Dental Providers, the Insured must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

Benefits are eligible for Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider. Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, the Insured Person may receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the policy. A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets the Insured Person know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If the Insured Person does not obtain a pre-authorization, the Company has a right to deny the claim for failure to comply with this requirement.

Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:
A. Necessary.
B. Provided by or under the direction of a Dental Provider.
C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure.
D. Not excluded as described in Section 3: Pediatric Dental Services exclusions.

Network Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider’s billed charge. The Company’s negotiated rate with the provider is ordinarily lower than the provider’s billed charge.

A Network provider cannot charge the Insured Person or the Company for any service or supply that is not Necessary as determined by the Company. If the Insured Person agrees to receive a service or supply that is not Necessary, the Network provider may charge the Insured. However, these charges will not be considered Covered Dental Services and benefits will not be payable.

Non-Network Benefits:

Benefits for Eligible Dental Expenses from non-Network providers are determined as a percentage of Usual and Customary Fees. The Insured Person must pay the amount by which the non-Network provider’s billed charge exceeds the Eligible Dental Expense.

Out-of-Pocket Maximum

Any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this benefit applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits.

Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.
## Pediatric Dental Services Benefits

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC SERVICES</strong></td>
<td></td>
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</tr>
<tr>
<td>Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.</td>
<td>100% 70%</td>
<td></td>
</tr>
<tr>
<td>Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.</td>
<td>100% 70%</td>
<td></td>
</tr>
<tr>
<td>Periodic Oral Evaluation (Checkup Exam) Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.</td>
<td>100% 70%</td>
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<tr>
<td><strong>PREVENTIVE SERVICES</strong></td>
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<tr>
<td>Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.</td>
<td>100% 70%</td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.</td>
<td>100% 70%</td>
<td></td>
</tr>
<tr>
<td>Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.</td>
<td>100% 70%</td>
<td></td>
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<tr>
<td>Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.</td>
<td>100% 70%</td>
<td></td>
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<tr>
<td><strong>MINOR RESTORATIVE SERVICES, ENDODONTICS, PERIODONTICS AND ORAL SURGERY</strong></td>
<td></td>
<td></td>
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<tr>
<td>Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.</td>
<td>70% 50%</td>
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<tr>
<td>Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.</td>
<td>70% 50%</td>
<td></td>
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<tr>
<td>Endodontics (Root Canal Therapy)</td>
<td>70% 50%</td>
<td></td>
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<tr>
<td>Periodontal Surgery (Gum Surgery) Limited to 1 quadrant or site per 36 months per surgical area.</td>
<td>70% 50%</td>
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<tr>
<td>Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.</td>
<td>70% 50%</td>
<td></td>
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<tr>
<td>Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.</td>
<td>70% 50%</td>
<td></td>
</tr>
<tr>
<td>Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.</td>
<td>70% 50%</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery, including Surgical Extraction</td>
<td>70% 50%</td>
<td></td>
</tr>
</tbody>
</table>
## Pediatric Dental Services Benefits

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADJUNCTIVE SERVICES</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Services (including Dental Emergency treatment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered as a separate benefit only if no other service was done during the visit other than X-rays.</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td>General anesthesia is covered when clinically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occlusal guards limited to 1 guard every 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MAJOR RESTORATIVE SERVICES</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns (Partial to Full Crowns)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed Prosthetics (Bridges)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removable Prosthetics (Full or partial dentures)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relining and Rebasing Dentures</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per 6 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IMPLANTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Placement</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Supported Prosthetics</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Maintenance Procedures</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repair Implant Supported Prosthesis by Report</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\* Benefits are shown as a percentage of Eligible Dental Expenses.
### Pediatric Dental Services Benefits

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abutment Supported Crown (Titanium) or Retainer Crown for FPD – Titanium Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Repair Implant Abutment by Support Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**MEDICALLY NECESSARY ORTHODONTICS**

Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon’s syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company’s dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be prior authorized.

**Orthodontic Services**

Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.

<table>
<thead>
<tr>
<th></th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Pediatric Dental Exclusions

1. Any Dental Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prostheses if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person’s Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person’s family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prostodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the policy.

Claims for Pediatric Dental Services
When obtaining Dental Services from a non-Network provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

Reimbursement for Dental Services
The Insured Person is responsible for sending a request for reimbursement to the Company, on a form provided by or satisfactory to the Company.

Claim Forms
It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Insured Person’s name and address.
- Insured Person’s identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began.
- A statement indicating that the insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage the Insured Person must include the name of the other carrier(s).

To file a claim, submit the above information to the Company at the following address:
AmeriBen
P.O. Box 6947
Boise, ID 83707
1-855-258-2656

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-800-258-2656. This number is also listed on the Insured’s Dental ID Card. If the Insured does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.
Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy definitions.

**Covered Dental Service** - a Dental Service or Dental Procedure for which benefits are provided under this endorsement.

Dental Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to the Insured Person while the policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are the Company’s contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary Fees, as defined below.

Usual and Customary Fees are determined solely to provide Dental Services to Insured Persons. The participation status of providers will change from time to time.

**Network Benefits** - benefits available for Covered Dental Services when provided by a Dental Provider who is a Network Dentist.

Non-Network Benefits - benefits available for Covered Dental Services obtained from Non-Network Dentists.

Usual and Customary Fee - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary Fees are determined solely in accordance with the Company’s reimbursement policy guidelines. The Company’s reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that the Company accepts.

Benefits are provided for Vision Care Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person’s coverage under the policy terminates.

Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Insured Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
  - For treating a life threatening dental disease or condition.
  - Provided in a clinically controlled research setting.
  - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this endorsement. The definition of Necessary used in this endorsement relates only to benefits under this endorsement and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.
Benefits are provided for Vision Care Services for Insured Persons UNDER THE AGE OF 19. Benefits terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person’s coverage under the policy terminates.

Benefits for Pediatric Vision Care Services
Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-855-258-2656. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When Vision Care Services are obtained from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then seek reimbursement from the Company as described under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, the Insured Person will be required to pay any Copayments at the time of service.

Network Benefits:
Benefits for Vision Care Services are determined based on the negotiated contract fee between the Company and the Vision Care Provider. The Company’s negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider’s billed charge.

Non-Network Benefits:
Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider’s billed charge.

Out-of-Pocket Maximum - any amount the Insured Person pays in Coinsurance for Vision Care Services under this endorsement applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for Vision Care Services under this endorsement does not apply to the policy Deductible stated in the policy Schedule of Benefits.

Policy Deductible:
Benefits for pediatric Vision Care Services provided under this endorsement are not subject to any policy Deductible stated in the policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for Vision Care Services under this endorsement does not apply to the policy Deductible stated in the policy Schedule of Benefits.

Benefit Description
Benefits
When benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Frequency of Service Limits
Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copayments and Coinsurance stated under each Vision Care Service in the Schedule of Benefits below.

Routine Vision Examination
A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing - far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well the Insured Sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontational visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses - Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames - A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Contact Lenses - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts. The Insured Person is eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Insured Person selects more than one of these Vision Care Services, the Company will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision - Benefits are available to an Insured Person who has severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by the Company. This benefit includes:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.
## Pediatric Vision Care Services Benefits

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Vision Examination or Refraction only in lieu of a complete exam.</td>
<td>Once per year.</td>
<td>100%</td>
<td>60% of the billed charge.</td>
</tr>
<tr>
<td><strong>Eyeglass Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single Vision</td>
<td>Unlimited.</td>
<td>100%</td>
<td>60% of the billed charge.</td>
</tr>
<tr>
<td>• Bifocal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trifocal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lenticular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lens Extras</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Polycarbonate Lenses</td>
<td>Unlimited.</td>
<td>100%</td>
<td>60% of the billed charge.</td>
</tr>
<tr>
<td>• Standard scratch-resistant coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eyeglass Frames</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost up to $130.</td>
<td>Unlimited.</td>
<td>100%</td>
<td>60% of the billed charge.</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $130 - 160.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $160 - 200.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $200 - 250.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost greater than $250.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Covered Contact Lens Selection</td>
<td>Unlimited.</td>
<td>100%</td>
<td>60% of the billed charge.</td>
</tr>
<tr>
<td>• Necessary Contact Lenses</td>
<td></td>
<td>100%</td>
<td>60% of the billed charge.</td>
</tr>
<tr>
<td><strong>Low Vision Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Services, the Insured will be required to pay all billed charges at the time of service. The Insured may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.</td>
<td>Once every 24 months</td>
<td>100% of the billed charge.</td>
<td>60% of the billed charge.</td>
</tr>
<tr>
<td>• Low Vision Testing</td>
<td></td>
<td>100%</td>
<td>60% of the billed charge.</td>
</tr>
<tr>
<td>• Low Vision Therapy</td>
<td></td>
<td>100%</td>
<td>60% of the billed charge.</td>
</tr>
</tbody>
</table>

### Pediatric Vision Exclusions and Claim Procedures

Except as may be specifically provided under Section 1: Benefits for Pediatric Vision Care Services, benefits are not provided for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in Section 1: Benefits for Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company.

**Reimbursement for Vision Care Services**

To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), the Insured Person must provide all of the following information at the address specified below:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

**By mail:**

AmeriBen
P.O. Box 6947
Boise, ID 83707

Submit claims for payment within 90 days after the date of service. If the Insured doesn’t provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

**Reimbursement for Low Vision Services**

To file a claim for reimbursement for Low Vision Services, the Insured Person must provide all of the following information at the address specified below:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

**By mail:**

AmeriBen
P.O. Box 6947
Boise, ID 83707

Submit claims for payment within 90 days after the date of service. If the Insured doesn’t provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.
The following definitions are in addition to the policy DEFINITIONS:

COVERED CONTACT LENS SELECTION - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

SPECTERA EYECARE NETWORKS - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the policy.

VISION CARE PROVIDER - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

VISION CARE SERVICE - any service or item listed in Section 1: Benefits for Pediatric Vision Care Services.
Standard Internal Appeal

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

The written Internal Appeal request should include:
1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person’s Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider’s name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 1-855-258-2656 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: AmeriBen, P.O. Box 6947, Boise, ID 83707.

Expedited Internal Appeal

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

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

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

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

At the same time an Insured Person or a Designated Representative files an EIR request, the Insured Person or the Designated Representative may file:
1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person’s ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person’s treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

To request an Expedited Internal Appeal, please contact Claims Appeals at 1-855-258-2656. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, AmeriBen, P.O. Box 6947, Boise, ID 83707.

Right to External Independent Review

After exhausting the Company’s Internal Appeal process, the Insured Person, or the Insured Person’s Designated Representative, has the right to request an External Independent Review when the service or treatment in question:
1. Is a Covered Medical Expense under the Policy; and
2. Is not covered because it does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level or care, or effectiveness, or the treatment is determined to be experimental or investigational.

Standard External Review

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

Expedited External Review

An Expedited External Review may be submitted either orally or in writing when:
1. The Insured Person or the Insured Person’s Designated Representative has received an Adverse Determination, and
   a. The Insured Person, or the Insured Person’s Designated Representative, has submitted a request for an Expedited Internal Appeal; and
   b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or
2. The Insured Person or the Insured Person’s Designated Representative has received a Final Adverse Determination, and
   a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or
   b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

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

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations. Where to Send External Review Requests

All types of External Review requests shall be submitted to the Company at the following address:
AmeriBen
P.O. Box 6947
Boise, ID 83707

Questions Regarding Appeal Rights

Contact Customer Service at 1-855-258-2656 with questions regarding the Insured Person’s rights to an Internal Appeal and External Review.

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY
Administrative Office: AmeriBen
P.O. Box 7186
Boise, ID 83707
1-855-258-2656
Email: webinqueries@ameriben.com
www.ameriben.com

Sales/Marketing Services:
UnitedHealthcare StudentResources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
1-800-237-0903
E-mail: info@uhcsr.com
www.uhcsr.com

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

This Brochure is based on Policy # 2016-202865-1
What Should You Do In An Emergency?

Life-Threatening Emergencies
Dial 911 and seek care at the nearest hospital emergency room facility. Poudre Valley Hospital in Fort Collins is closest to campus and is a Preferred Provider.

*Poudre Valley Hospital Emergency Department — 2.0 miles from campus
1024 S. Lemay Ave.,
Fort Collins, CO 80524
(970) 495-7261

Emergency room visits are subject to plan deductible, reimbursement rate based upon network status of provider and $100 copay, which is waived if admitted. Choose care at a Preferred Provider hospital if possible.

Non-Life-Threatening Care
During business hours, seek care at the CSU Health Network first where there is no deductible or copay for services.

If the CSU Health Network is closed (afterhours, weekends, holidays), or if you are outside of the Fort Collins area, seek services at the nearest Preferred Provider urgent care facility.

Urgent care visits are subject to plan deductible, reimbursement rate based upon network status of provider and $50 copay.

Emergency and Afterhours Care Contact Information
For emergency and after hours care, please consider the following resources:
• 24/7 CSU Health Network Nurse Helpline: (970) 491-7121
  *Note: The Nurse Helpline is not able to provide prescription refills or schedule appointments. These services are only available during normal business hours.
• Ambulance/Emergency/Police/Fire: 911
• CSU Health Network Mental Health Crisis Intervention: 970-491-7111
• Poison Control: 1-800-332-3073
• Suicide Prevention Hotline: 1-800-273-8255
• Crossroads Safehouse (domestic violence): 970-482-3502
• CSU Victim’s Assistance Team: 970-491-7111

Local Urgent Care Services
The following Urgent Care Services appear in directories related to Urgent Care in Fort Collins. Please check the directories for additional listings or convenient care services. CSU does not endorse any specific clinic or service.

*Concentra — 1.4 miles from campus
620 S Lemy Ave,
Fort Collins, CO 80524
(970) 482-6620

*Associates in Family Medicine Urgent Care — 3.3 miles from campus
3519 Richmond Dr,
Fort Collins, CO 80526
(970) 204-0300

*University of Colorado Urgent Care Center — 5.8 miles from campus
2127 E Harmony Rd Ste 140
Fort Collins, CO 80528
(970) 297-6250

*The Preferred Providers for the CSU Student Health Insurance Plan
Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

This Brochure is based on Policy # 2016-202865-1.

Privacy Policy
We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or visiting us at www.uhcsr.com.

Insurance Company:
UnitedHealthcare Insurance Company
Policy Number:
2016-202865-1

ADMINISTERED BY:
AmeriBen
P.O. Box 6947
Boise, ID 83707-0947
Toll Free - (855) 258-2656
Fax - Please call for reference number
www.myameriben.com
Hours of Operation: 7:00 a.m. to 6:00 p.m.
Mountain Time

Colorado State University
The CSU Health Network
Fort Collins, CO 80523-8031
www.health.colostate.edu
then “click” on student insurance

Colorado State University is an equal opportunity/affirmative action institution and complies with all Federal and Colorado State laws, regulations, and executive orders regarding affirmative action requirements in all programs. The Office of Equal Opportunity is located in 101 Student Services. In order to assist Colorado State University in meeting its affirmative action responsibilities, ethnic minorities, women, and other protected class members are encouraged to apply and to so identify themselves.

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits. Any discrepancy between this brochure and the master policy will be governed by the master policy.