**PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS**

UNIVERSITY OF DENVER

2013-2014

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

University of Denver

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.

UnitedHealthcare®

A UnitedHealth Group Company

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $1,000,000 for each Injury or Sickness that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-866-648-8472. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

Dear Student,

Good health is essential for you to obtain the most benefit from participation in University life. Because the University of Denver recognizes this and desires to safeguard your good health, the University has established a two-part health care program and maintains an on-campus Health & Counseling Center for regularly enrolled students and their eligible spouses. The Health & Counseling Center provides cost effective medical and mental health services.

The University sponsors a Student Injury and Sickness Insurance Plan offered by UnitedHealthcare **Student**Resources and underwritten by UnitedHealthcare Insurance Company and described in this brochure. The Insurance Plan is designed to complement the services rendered at the Health & Counseling Center. All students enrolled for one or more hours of graded credit at the University of Denver are required to carry adequate health insurance coverage. Although students with other health insurance may waive participation in the Student Injury and Sickness Insurance Plan, we strongly encourage careful evaluation of the plan since it may be valuable as additional coverage. The plan is especially beneficial to those students who have been removed from their parents' policy because of attainment of a specified age. It is very important for out-of-state students who are currently covered under either a Health Maintenance Organization (HMO) or a Preferred Provider organization (PPO) plan to review their insurance policy for allowable benefits in the Denver area. The UnitedHealthcare **Student**Resources program also includes out of country coverage, Dental and Vision discounts and other services.

Participation in DU's two-part health care program consisting of our Health/Counseling services and our Student Injury and Sickness Insurance Plan allows students to receive medical and mental health care at our Health & Counseling Center for little or no out-of-pocket cost. Many students and parents recognize the convenience and accessibility of the Insurance Plan and purchase our plan in addition to the coverage they already have to ensure the best health care coverage situation possible at DU. If you would like to discuss how to maximize the many benefits offered under our health care program, please call us to schedule an appointment.

The staff at the Health & Counseling Center welcomes each of you to the University of Denver. We look forward to assisting you in maintaining good health while you pursue your educational goals.

Sincerely,

Alan Kent Ph.D.

Executive Director, University of Denver Health & Counseling Center

Table of Contents

Student Injury and Sickness Insurance Plan 1
The University of Denver Student Injury and Sickness Insurance Plan 2
Important Phone Numbers 4
Privacy Policy 5
Eligibility 5
How to Enroll 5
Enrollment/Waiver Deadlines 6
Effective and Termination Dates 6
Student Health Insurance Plan Coverage Periods 6
Extension of Benefits After Termination 7
Health and Counseling Center (HCC) Referral Required Students Only 7
Pre-Admission Notification 7
Schedule of Medical Expense Benefits 8
UnitedHealthcare Pharmacy Benefits 14
Preferred Provider Information 15
Maternity Testing 16
Accidental Death & Dismemberment Benefit 17
Coordination of Benefits 17
Mandated Benefits 18
- Benefits for Prosthetic Devices 18
- Benefits for Biologically Based Mental Illness 18
- Benefits for Diabetes 18
- Benefits for Cervical Cancer Vaccines 18
- Benefits for Prostate Cancer Screening 18
- Benefits For Telemedicine Services 19
- Benefits For Medical Foods 19
- Benefits For Therapies For Congenital Defects And Birth Abnormalities 19
- Benefits For Child Health Supervision Services 20
- Benefits For Cleft Lip Or Cleft Palate 20
- Benefits For Hospitalization And General Anesthesia For Dental Procedures For Dependent Children 20
- Benefits For Hearing Aids For Minor Children 21
- Benefits For The Treatment Of Autism Spectrum Disorders 21
- Benefits For Preventive Health Care 22
- Benefits For Oral Anticancer Medication 23

Definitions 24
Exclusions and Limitations 25
FrontierMEDEX: Global Emergency Assistance Services 27
Notice Of Appeal Rights 28
Online Access to Account Information 31
ID Cards 31
UnitedHealth Allies 31
Claim Procedure .... Back Cover

Student Injury and Sickness Insurance Plan

Important Information

The University of Denver (DU) requires that students have adequate health insurance coverage.

The DU Student Injury and Sickness Insurance Plan is designed to complement the benefits of the Health and Counseling Fee and services at the Health & Counseling Center to assure the availability of good health care at a reasonable cost.

For those students covered under other insurance, a careful evaluation of the Student Injury and Sickness Insurance Plan is encouraged before waiving participation as the plan may be valuable additional coverage and beneficial to those students who seek treatment outside their other insurance network coverage area. The DU Student Injury and Sickness Insurance Plan provides excellent coverage locally, nationally and worldwide.

The DU Student Injury and Sickness Insurance Plan provides international coverage for study abroad students.

Persons who have health insurance through either an HMO or a PPO Plan should determine the level of benefits that are payable in the Denver area. This is very important for out-of-state students covered by either an HMO or PPO plan.

The DU Student Injury and Sickness Insurance Plan can provide coverage for a student's family members. Please contact UnitedHealthcare **Student**Resources for further information at 1-866-648-8472 or visit the website at www.uhcsr.com/du.

The University of Denver Student Injury and Sickness Insurance Plan

The University of Denver Student Injury and Sickness Insurance Plan has been developed especially for University of Denver students. The plan is underwritten by UnitedHealthcare Insurance Company. The plan provides coverage for illnesses and injuries that occur on and off campus locally, nationally and worldwide and includes special cost-saving features. The University of Denver is pleased to offer the plan as described in this brochure.

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 payment of benefits.

Some benefits are limited and should be carefully noted. If you or your healthcare provider has any questions regarding benefits, please contact UnitedHealthcare **Student**Resources at 1-866-648-8472.

By logging on to www.uhcsr.com/du, you can:

- Review who is covered under the plan
- View claims status
- View Explanation of Benefits (EOB's)
- Find health care professionals and facilities that participate in the plan network
- Request ID Cards
- Send an email to Customer Service at your convenience

How do I create an online account?

- Go to www.uhcsr.com/du
- Select the "Create an Account" link
- Follow the simple, onscreen directions to establish an online account in minutes
- You will need your DU email address to create an online account.

Need help with creating your online account?

- Contact our Customer Service Department at 1-866-648-8472

For questions about:

- Insurance benefits
- Enrollment
- Claims Processing

Please contact:

UnitedHealthcare **Student**Resources

PO Box 809025, Dallas, TX 75380-9025

1-866-648-8472

For questions about ID cards:

Permanent ID cards will be available by logging into your My Account online at www.uhcsr.com/du after receiving final enrollment information from the University of Denver. If you need medical attention before the ID card is available, benefits will be payable in accordance with the Master Policy. You do not need an ID card to be eligible to receive benefits. Present the ID card to the provider to facilitate claims processing.

Note: Please be advised you will receive a unique member ID number on your permanent ID card.

For lost permanent ID cards, log on to www.uhcsr.com/du and go to your account to print an ID card or call 1-866-648-8472 to request a new ID card.

For questions about:

- Enrollment process
- Waiver process

Please contact:

University of Denver Health and Counseling Center
2240 E. Buchtel Boulevard
Denver, CO 80208-3230
(303) 871-2205
info@hcc.du.edu

For questions about:

- Status of Claims
- Pharmacy Claim Forms
- Excluded Drugs

Please contact:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025
1-866-648-8472

Important Phone Numbers

* For a life-threatening emergency, call campus security at (303) 871-3000 or call 911.

Location

Health & Counseling Center
Daniel L. Ritchie Sports & Wellness Center,
3rd floor North
2240 East Buchtel Boulevard
Denver, CO 80208-3230

Health and Counseling www.du.edu/duhealth/

8:00am - 5:00pm, Mon., Wed., Thurs., Fri. and 9:00 am - 5:00 pm, Tues.
(All year) except DU holidays and school closures.

Student Line:	**(303) 871-2205**
Fax:	**(303) 871-4242**
After hours:	**(303) 871-2205**

Student Financial Services www.du.edu/bursar/

Bursar's Office

Student Line:	**(303) 871-4944**
Fax:	**(303) 871-4401**

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 1-866-648-8472 or by visiting us at www.uhcsr.com/du.

Eligibility

Policy # 2013-5893-1 (Domestic) Eligibility - All degree-seeking students enrolled in six or more hours (8 for Law Students) of graded credit and are actively attending classes or completing other required course work toward a degree are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished. All degree-seeking students enrolled for one or more hours of graded credit and who are actively attending classes or completing other required course work toward a degree are eligible to enroll in this insurance Plan. Students on approved medical stop-outs may continue coverage for one semester term with the approval of the University. Degree-seeking students are defined by the University of Denver. For additional information regarding the definition of degree-seeking and eligibility, please visit www.du.edu/duhealth.

Policy # 2013-5893-4 (International) Eligibility - All registered International students, scholars or other persons with a current passport and student visa engaged in educational activities at the university are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse, husband or wife, or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Brochure for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Dependent coverage must be applied for by filling out the Dependent Insurance Enrollment Card and by paying the required premium.

How to Enroll

Students who meet eligibility requirements but are not enrolled in enough hours to be auto-assessed the premium on the student tuition bill or who are not considered traditional students by the University of Denver must contact the Health & Counseling Center during the indicated enrollment periods to purchase the Student Health Insurance Plan by submitting a completed Enrollment Form and premium payment. Online enrollment forms may be obtained at The Health & Counseling Center website www.du.edu/duhealth or by calling 303-871-2205, or emailing info@hcc.du.edu.

Students enrolled in certificate or special programs, pursuing degrees in programs that are primarily on-line, or attending off-campus programs are not eligible for the Student Health Insurance Plan or the Health and Counseling Fee. The Health and Counseling Fee is mandatory for Undergraduate Students enrolled in six or more hours. Graduate Students may waive the Health and Counseling Center Fee each term. All students may waive the Student Health Insurance Plan during the fall and spring terms or academic year upon providing proof of adequate health insurance before the posted deadlines.

Enrollment/Waiver Deadlines

Quarter (Resident and Study Abroad) Students: Fall 09/27/13; *Winter 01/24/14; Spring 04/11/14; *Summer: 07/03/14

Law Students: Fall 09/06/13, Spring 01/31/14, *Summer 06/14/14

***Winter and Summer enrollment periods are available to first time new DU students and Study Abroad students only. Otherwise, enrollment in the Student Health Insurance Plan MUST be either Fall or Spring.**

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., September 1, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m. August 31, 2014.

For Law Students: The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m. July 31, 2014.

Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Refunds of premiums are allowed only upon entry into the armed forces.

The Policy is a Non-Renewable One Year Term Policy.

Alternative Coverage - If you do not meet the eligibility requirements of the plan, please call 1-800-980-7395 for information on alternative coverage. This information can also be accessed at our website: www.goldenrulehealth.com/studentresources.

Student Health Insurance Plan Coverage Periods

Quarter (Resident) Students

Fall	*Winter	Spring	*Summer
09/01/13 to 03/23/14	01/06/14 to 03/23/14	03/24/14 to 08/31/14	06/16/14 to 08/31/14
$1,210	$605	$1,210	$605

Study Abroad Students

Fall	*Winter	Spring	*Summer
09/01/13 to 03/23/14	01/06/14 to 03/23/14	03/24/14 to 08/31/14	06/16/14 to 08/31/14
$1,210	$605	$1,210	$605

Law Students

Fall	Spring	*Summer
08/01/13 to 12/31/13	01/01/14 to 07/31/14	06/01/14 to 07/31/14
$1,210	$1,210	$605

NOTE: The amounts stated above 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.

If the University is not remitting the premium, you must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 14 days after the coverage expiration date.

***Winter and Summer enrollment periods are available to first time new DU students and Study Abroad students only. Otherwise, enrollment in the Student Health Insurance Plan MUST be either Fall or Spring.**

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 After Termination" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Health and Counseling Center (HCC) Referral Required Students Only

The student should use the resources of the Health and Counseling Center first where treatment will be administered, or referral issued. Expenses incurred for medical treatment rendered outside of the Health and Counseling Center for which no prior approval or referral is obtained will be paid at the Out-of-Network level of benefits as specified in the Schedule of Benefits. A referral issued by the Health and Counseling Center must accompany the claim when submitted. Only one referral is required for each Injury or Sickness Per Policy Year.

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

1. Medical Emergency.
2. When the HCC is closed.
3. Medical care received when the student is more than 50 miles from campus.
4. Medical care obtained when a student is no longer able to use the HCC due to a change in student status.
5. Maternity, obstetrical and gynecological care.

Pre-Admission Notification

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

Schedule of Medical Expense Benefits

Injury and Sickness

Maximum Benefit: $1,000,000 Paid As Specified Below
(For Each Injury or Sickness)

Deductible Preferred Provider: $250 (Per Insured Person, Per Policy Year)

Deductible Preferred Provider:
$500 (For all Insureds in a Family, Per Policy Year)

Deductible Out-of-Network: $500 (Per Insured Person, Per Policy Year)

Deductible Out-of-Network:
$1,000 (For all Insureds in a Family, Per Policy Year)

Coinsurance Preferred Provider: 80% except as noted below

Coinsurance Out-of-Network: 60% except as noted below

Out-of-Pocket Maximum Preferred Provider:
$1,500 (For Each Injury or Sickness)
Out-of-Pocket Maximum Out-of-Network:
$5,000 (For Each Injury or Sickness)

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred 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 up to the Maximum Benefit of $1,000,000 for each Injury or Sickness.

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

If care is rendered outside of the United States, Covered Medical Expenses will be payable subject to all policy provisions, except that all charges will be reimbursed at 80% of Billed Charges after the Deductible of $250 Per Policy Year has been met. After the Insured has paid $5,000 for a covered Injury or Sickness; Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year for that Injury or Sickness up to the benefit maximum. Usual and Customary Charges will be paid at the 90th percentile on all foreign bills.

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 HCC. Pre-Existing Conditions are not excluded from coverage when services are rendered at HCC.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. 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. Covered Medical Expenses include:

PA = Preferred Allowance	U&C = Usual & Customary Charges	
INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Room and Board Expense, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	80% of PA	60% of U&C
Intensive Care	80% of PA	60% of U&C
Hospital Miscellaneous Expense, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of U&C
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
Physiotherapy	80% of PA	60% of U&C
Surgeon's Fees, 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.	80% of PA	60% of U&C
Assistant Surgeon	50% of PA	50% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing, payable within 14 working days prior to admission.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Surgeon's Fees, 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.	80% of PA	60% of U&C
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of U&C
Assistant Surgeon	50% of PA	50% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	80% of PA $20 Copay per visit	60% of U&C $20 Deductible per visit *(The $20 Deductible is in addition to the Policy Deductible.)*
Physiotherapy, Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. 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. *(20 visits combined maximum for each Injury or Sickness, Per Policy Year)*	80% of PA $20 Copay per visit	60% of U&C $20 Deductible per visit
Medical Emergency Expenses, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	80% of PA $75 Copay per visit	80% of U&C $75 Deductible per visit *(The $75 Deductible is in addition to the Policy Deductible.)*
Diagnostic X-ray Services	80% of PA	60% of U&C
Radiation Therapy	80% of PA	60% of U&C
Chemotherapy	80% of PA	60% of U&C
Laboratory Services	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C
Prescription Drugs, (Mail order Prescription Drugs through UHCP at 2 times the retail Copay up to a 90 day supply.)	UnitedHealthcare Pharmacy (UHCP) $15 Copay per prescription for Tier 1 $30 Copay per prescription for Tier 2 up to a 31-day supply per prescription.	No Benefits

OTHER	Preferred Providers	Out-of-Network Providers
Ambulance Services	80% of PA	80% of U&C
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. *(See also Benefits for Prosthetic Devices)*	80% of PA	60% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	80% of PA $30 Copay per visit *(In Lieu of Preferred Provider Deductible)*	60% of U&C $30 Deductible per visit *(In addition to the Policy Deductible)*
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *(Benefits are not subject to the $1,000,000 Maximum Benefit.)*	80% of U&C	80% of U&C
Dental Treatment, benefits paid for removal of impacted wisdom teeth only.	80% of U&C	80% of U&C

OTHER	Preferred Providers	Out-of-Network Providers
Mental Illness Treatment, services received on an Inpatient and outpatient basis. *(See also Benefits for Biologically Based Mental Illness)*	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. *(See also Benefits for Biologically Based Mental Illness)*	Paid as any other Sickness	
Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion *(Elective Abortion benefits are not subject to the $1,000,000 Maximum Benefit.)*	Paid as any other Sickness	
Preventive Care Services, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. See also Benefits for Preventive Health Care.	100% of PA	No Benefits

OTHER	Preferred Providers	Out-of-Network Providers
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.	Paid as any other Sickness	
Diabetes Services	See Benefits for Diabetes	
Home Health Care, 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, and pursuant to a home health plan.	80% of PA	60% of U&C
Urgent Care Center, 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.	80% of PA $20 Copay per visit	60% of U&C $20 Deductible per visit *(The Deductible is in addition to the Policy Deductible.)*
Sleep Disorders Testing and Treatment	Paid as any other Sickness	

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com/du or call 1-855-828-7716 for the most up-to-date tier status.

$15 per prescription order or refill for a Tier 1 Prescription Drug to a 31 day supply.

$30 per prescription order or refill for a Tier 2 Prescription Drug to a 31 day supply.

Mail order Prescription Drugs are available at 2 times the retail Copay up to a 90 day supply.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com/du and log into your online account or call 1-855-828-7716.

Definitions

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com/du or call Customer Service at 1-855-828-7716.

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-2.

4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

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 UnitedHealthcare Choice Plus.

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 at 1-866-648-8472 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.

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 levels specified on the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call (866) 648-8472 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 UnitedHealthcare Choice Plus will be paid at the Coinsurance levels specified on 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.

Maternity Testing

This policy does not cover all routine, preventive, or screening examinations or testing. The following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met.

Initial screening at first visit:

- Pregnancy test: urine human chorionic gonatropin (HCG)
- Asymptomatic bacteriuria: urine culture
- Blood type and Rh antibody
- Rubella
- Pregnancy-associated plasma protein-A (PAPPA) **(first trimester only)**
- Free beta human chorionic gonadotrophin (hCG) **(first trimester only)**
- Hepatitis B: HBsAg
- Pap smear
- Gonorrhea: Gc culture
- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

- Ultrasound (anatomy scan)
- Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a

Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS)

Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-866-648-8472.

Accidental Death & Dismemberment Benefit

Loss of Life, Limb or Sight

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

For Loss of:

Life	$ 10,000
Two or More Members	$ 10,000
One Member	$ 5,000
Thumb or Index Finger	$ 2,500

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

Coordination of Benefits

Benefits will be coordinated with any other eligibile 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.

Mandated Benefits

Benefits for Prosthetic Devices

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

Prosthetic device means an artificial device to replace, in whole or in part, an arm or leg.

Benefits are limited to the most appropriate model that adequately meets the medical needs of the Insured as determined by a Physician. Repairs and replacements of Prosthetic Devices are also covered unless necessitated by misuse or loss.

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

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 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 Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits For Telemedicine Services

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

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

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

Benefits For Medical Foods

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

If the policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Sickness for Medical Foods, to the extent Medically Necessary, for home use for which a Physician has issued a written, oral or electronic prescription. Benefits will not be provided for alternative medicine.

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

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

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

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

Benefits For Therapies For Congenital Defects And Birth Abnormalities

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

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

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

Benefits For Child Health Supervision Services

Benefits will be paid for the Usual and Customary Charges for Child Health Supervision Services from birth up to the age of 13. Benefits are payable on a per visit basis to one health care provider per visit.

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

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

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

Advisory Committee on Immunization Practices, www.cdc.aov/nip/acip;

American Academy of Pediatrics, www.aap.org;

American Academy of Family Physicians, www.aafp.org.

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

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

Benefits For Cleft Lip Or Cleft Palate

Benefits will be paid the same as any other Sickness for treatment of newborn children born with cleft lip or cleft palate or both. Benefits shall include the Medically Necessary care and treatment including oral and facial surgery; surgical management; the Medically Necessary care by a plastic or oral surgeon; prosthetic treatment such as obturators, speech appliances, 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 Hospitalization And General Anesthesia For Dental Procedures For Dependent Children

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

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

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

Benefits For Hearing Aids For Minor Children

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

Benefits shall include the purchase of the following:

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.

"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 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 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 service:

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) 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.

For the purposes of this mandate:

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

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

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

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

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

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

Benefits For Oral Anticancer Medication

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

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

The medication provided pursuant to this benefit shall:

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.

Definitions

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.

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

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 by reason of an Injury or Sickness for which benefits are payable under this policy.

Pre-existing Condition (FOR 2013-5893-1 ONLY) means any condition for which an Insured Person: 1) incurred charges; 2) received medical treatment; 3) consulted a health care professional; or 4) took Prescription Drugs within the 6 months immediately prior to the Insured's Effective Date under this policy. "Pre-existing Condition" does not include pregnancy.

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

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

Exclusions and Limitations

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

1. Acupuncture;
2. Nicotine addiction; except as specifically provided in the policy;
3. Learning disabilities, developmental delay or disorder or mental retardation;
4. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;
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 as specifically provided in the Schedule of Benefits;
7. Elective Surgery or Elective Treatment;
8. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
9. Flat foot conditions; supportive devices for the foot; subluxations of the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);
10. Hearing examinations; hearing aids, except as specifically provided in the policy; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
11. Hirsutism; alopecia;
12. 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;
13. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
14. 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;
15. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
16. Investigational services;
17. Lipectomy;
18. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
19. Pre-existing Conditions **(FOR 2013-5893-1 ONLY)** for a period of 6 months, except for: individuals who have been continuously insured for at least 6 consecutive months under the school's student insurance policy. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under prior Creditable Coverage if such Creditable Coverage was continuous to a date not more than 90 days prior to the Insured's Effective Date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;

20. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; except as specifically provided in the policy;
    b) Immunization agents, except as specifically provided in the policy; biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra; or
    h) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
21. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
22. 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;
23. Routine Newborn Infant Care, well-baby nursery and related Physician; except as specifically provided in the policy;
24. Preventive Care Services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
25. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
26. Temporomandibular joint dysfunction; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
27. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
28. Residential treatment of eating disorders, such as anorexia or bulimia;
29. Supplies, except as specifically provided in the policy;
30. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
31. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
32. War or any act of war, declared or undeclared; or while in the armed forces of any country other than the United States (a pro-rata premium will be refunded upon request for such period not covered); and
33. Weight management, weight reduction, treatment for obesity, and surgery for removal of excess skin or fat, except as specifically provided in the policy.

FrontierMEDEX:
Global Emergency Assistance Services

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

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

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

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

Key Services include:

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

Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(800) 527-0218 Toll-free within the United States

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

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

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

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

Notice Of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

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

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
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 866-648-8472 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

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 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

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

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

Standard External Review

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

Expedited External Review

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

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

   or

2. The Insured Person or the Insured Person's Designated Representative has received a Final Adverse Determination, and
   a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
   b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

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

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

Where to Send External Review Requests

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

Claims Appeals

UnitedHealthcare **Student**Resources

PO Box 809025

Dallas, TX 75380-9025

888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service at 866-648-8472 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to ***My Account*** at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "create My Account Now" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare **Student**Resources' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account has been enhanced to include *Message Center* - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

ID Cards

One way we are becoming greener is to no longer automatically mail out ***ID Cards***. Instead, we will send an email notification when the digital ID card is available to be downloaded from ***My Account***. An Insured student may also use ***My Account*** to request delivery of a permanent ID card through the mail. ID Cards may also be accessed via our mobile site at my.uhcsr.com.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to ***My Account*** as described above and select *UnitedHealth Allies Plan* to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Health and Counseling Center (HCC) for treatment or referral, or when the HCC is closed, to their Physician or Hospital.
2) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-866-648-8472

customerservice@uhcsr.com

claims@uhcsr.com

www.uhcsr.com/du

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 payment of benefits.

This Brochure is based on Policy #'s 2013-5893-1 (Domestic) and 2013-5893-4 (International)

UnitedHealthcare®
A UnitedHealth Group Company

POLICY NUMBER: 2013-5893-1/4

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC #1

1. Changed item #2 in the Health and Counseling Section to read 'When the HCC is closed'.
2. Changed #1 item in the Claims Procedures Section to read 'Report to the Health and Counseling Center (HCC) for treatment or referral, or when the HCC is closed, to their Physician or Hospital'.