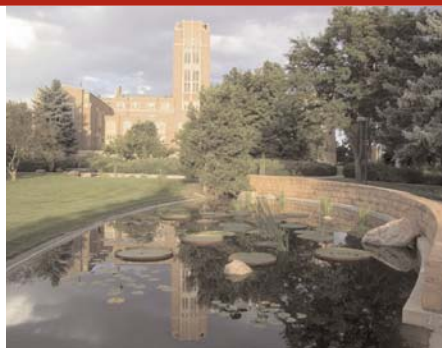
UNIVERSITY OF
DENVER



2010-2011

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Domestic Students of

University of Denver

06-BR-CO (Rev 09)

05-5893-1

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 Health Insurance Plan offered by UnitedHealthcare **Student**Resources and described in their brochure. The 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 Health 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, marriage, or other reasons. 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 Health 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 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 programs, 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 heath while you pursue your educational goals.

Sincerely,

Sam Alexander, M.D.

Executive Director, University of Denver Health & Counseling Center

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Student Health Insurance Plan

Important Information

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

The DU Student Health 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 Health 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 Health Insurance Plan provides excellent coverage locally, nationally and worldwide.

The DU Student Health Insurance Plan provides international coverage for study abroad students.

Many employers' group health insurance plans contain an age limit for covering dependents. Check the plan description before assuming you are covered under your parents' insurance plan.

If financial independence has been declared to obtain financial aid, coverage through a group health insurance program may no longer be in effect. Please check to see if your group health insurance requires children to be financially dependent upon the parents to qualify for coverage.

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.

Please check to see if your parent's employer has changed the dependents' age-coverage limitation for college students in response the the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The DU Student Health 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 Health Insurance Plan

The University of Denver Student Health 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 online at www.uhcsr.com/du after receiving final enrollment information from the University of Denver. Temporary ID cards can be obtained at the Health & Counseling Center website www.du.edu/duhealth or online at www.uhcsr.com/du. If you need medical attention before the ID card is received, benefits will be payable in accordance with the Master Policy. You do not need an ID card to be eligible to receive benefits. The temporary ID cards may be used anytime and also may be used instead of the permanent ID card. Present the ID card (either temporary or permanent) 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) 871-4136
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

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

info@hcc.du.edu

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

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, unless proof of comparable insurance 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 medical stop-outs may continue coverage 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.

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

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse or Domestic Partner and unmarried children under 19 years of age or 25 years if a full-time student at an accredited institution of higher learning who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student. See the Definitions section of the Brochure for the specific requirements needed to meet Domestic Partner eligibility.

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 come to 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 to the Health & Counseling Center. Enrollment Forms may be obtained online at The Health & Counseling Center website www.du.edu/duhealth or by visiting The Health & Counseling Center, Floor 3-North in the Ritchie Center, University of Denver, Denver CO 80208, phone 303-871-4136, fax 303-871-4242, email 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 10/01/10; *Winter 1/21/11; Spring 4/08/11; *Summer: 7/01/11

Semester (Law) Students: Fall 9/03/10; Spring 1/28/11; *Summer 6/17/11

***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 September 1, 2010 (August 1, 2010 for Law students). 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 August 31, 2011 (July 31, 2011 for Law students). 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
09/01/10 to 03/20/11	01/03/11 to 03/20/11	03/21/11 to 08/31/11	06/13/11 to 08/31/11
$1,210	$605	$1,210	$605

Semester (Law) Students

Fall	Spring	*Summer
08/01/10 to 12/31/10	01/01/11 to 07/31/11	06/01/11 to 07/31/11
$1,210	$1,210	$605

Study Abroad Students

Fall	*Winter	Spring	*Summer
09/01/10 to 03/20/11	01/03/11 to 03/20/11	03/21/11 to 08/31/11	06/13/11 to 08/31/11
$1,210	$605	$1,210	$605

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 must 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.

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

1. Medical Emergency;
2. When service is rendered at another facility during break or vacation periods;
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; or
5. Maternity.

Pre-Admission Notification

UMR Care Management 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.

UMR Care Management 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

Up To $1,000,000 Maximum Lifetime Benefit Paid as Specified Below
(For Each Injury or Sickness)
Preferred Provider Deductible $250 (Per Insured Person) (Per Policy Year)
($500 Maximum Per Family)
Out of Network Deductible $500 (Per Insured Person) (Per Policy Year)
($1,000 Maximum Per Family)

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

The Policy provides worldwide benefits for the Usual and Customary Charges for Out-of-Network Providers incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Lifetime Benefit of $1,000,000 for each Injury or Sickness.

If care is received from a Preferred Provider any Covered Medical Expenses 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.

Out-of-Pocket maximum: After the Insured has paid $1,500 for Preferred Providers or $5,000 for Out-of-Network 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. Policy Deductible and coinsurance applies to the Insured's out-of-pocket maximum.

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 & Customary Charges will be paid at the 90th percentile on all foreign bills.

Pre-Existing Conditions are not excluded from coverage when services are rendered at HCC. The Policy Deductible is waived and Covered Medical Expenses will be paid at 80% at the HCC.

All maximums are combined Preferred Provider and Out-of-Network, unless noted below. Benefits will be paid up to the maximum benefit for each service as scheduled below. Covered Medical Expenses include:

PA = Preferred Allowance **U&C = Usual & Customary Charges**

INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Intensive Care	80% of PA	60% of U&C
Hospital Expense, daily semi-private room rate; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses, 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. Four days Hospital Confinement expense maximum.	Paid as any other Sickness	

INPATIENT	Preferred Providers	Out-of-Network Providers
Physiotherapy	Paid under Hospital Expense	
Surgeon's Fees, in accordance with data provided by Ingenix. 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 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, benefits are limited to one visit per day and 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.	Paid under Hospital Expense	
Psychotherapy, benefits are limited to one visit per day.	Paid as any other Sickness	
Biologically Based Mental Illness	Paid as any other Sickness / See Benefits for Biologically Based Mental Illness	
OUTPATIENT		
Surgeon's Fees, in accordance with data provided by Ingenix. 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; therapeutic services 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 are limited to one visit per day. 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

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Medical Emergency, 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
Urgent Care	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
Diagnostic X-ray & Laboratory Services	80% of PA	60% of U&C
Injections	No Benefits	
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-Rays and Lab Procedures.	80% of PA	60% of U&C
Chemotherapy & Radiation Therapy	80% of PA	60% of U&C
Physiotherapy, including Occupational Therapy, 20 visits combined maximum per Injury or Sickness, Per Policy Year. Benefits are limited to one visit per day.	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
Prescription Drugs, prior authorization is required for growth hormones. Mail order prescriptions through UnitedHealthcare Network Pharmacy (UHPS) are available at 2.5 times the retail copay up to a 90 day supply. Oral contraceptives are covered if a Medical Necessity.	UnitedHealthcare Network Pharmacy (UHPS) / $15 copay per prescription for Tier 1 / $30 copay per prescription for Tier 2 / up to a 31-day supply per prescription / $1,000 maximum Per Policy Year	No Benefits
Psychotherapy, benefits are limited to one visit per day.	Paid as any other Sickness / $20 copay per visit	Paid as any other Sickness / $20 Deductible per visit / The $20 Deductible is in addition to the Policy Deductible
Biologically Based Mental Illness	Paid as any other Sickness / See Benefits for Biologically Based Mental Illness	

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. Replacement equipment is not covered. Exception: See Benefits for Prosthetic Devices (page 15)	80% of PA	60% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth and removal of impacted wisdom teeth only.	80% of U&C	80% of U&C
Consultant Physician Fees, when requested and approved by the 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.)
Alcoholism/Drug Abuse	Paid as any other Sickness / See Benefits for Biologically Based Mental Illness	
Maternity and Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	Paid as any other Sickness	
Repatriation/Medical Evacuation	Benefits provided by Scholastic Emergency Services, Inc.	
Home Health Care, limited to Covered Medical Expenses incurred within 12 months from the date of first Home Health Care visit.	80% of PA	60% of U&C
Allergy Testing, allergy treatment is excluded. See Exclusion number 1.	80% of PA	60% of U&C
Sleep Disorders Treatment, testing is not covered, except for an oximetry study.	Paid as any other Sickness	
Annual Gynecological Exams, benefit includes annual pap smear screening and follow-up diagnostic pap smears as medically necessary, as any outpatient expense.	Paid as any other Sickness	

Maximum Lifetime Benefit

Amounts paid to the Insured under this policy, and under all prior years' policies for any one Injury or Sickness, will be considered payments accrued under the Maximum Lifetime Benefit of $1,000,000.

UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network 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 is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com/du or call 1-877-417-7345 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 2.5 times the retail copay up to a 90 day supply.

Your maximum allowed benefit is $1,000 maximum Per Policy Year.

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 877-417-7345.

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 1-877-417-7345.

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 members of 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 Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance levels specified on the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call (866) 648-8472 for information about Preferred Hospitals.

OUT-OF-NETWORK HOSPITALS - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital 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.

Insureds will be responsible for all out of pocket expenses in excess of the policy limits contained in the Schedule of Benefits.

Maternity Testing

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered if all other policy provisions have been met: 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, and HIV: HIV-ab; 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); and 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. Payment under this benefit will not exceed the policy Maximum Benefit.

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 medical, surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges 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 Mammography

Benefits will be paid for the actual expense incurred up to the policy Maximum Benefit for low-dose screening mammography for the presence of occult breast cancer. Benefits will be provided according to the following guidelines:

1. A single baseline mammogram for women thirty-five to thirty-nine years of age.
2. A mammogram not less than once every two years for women forty years of age and under fifty years of age or more often for women with risk factors to breast cancer if recommended by her Physician.
3. A mammogram every year for women fifty to sixty-five years of age.

"Low-dose mammography" means the x-ray examination of the breast, using equipment dedicated specifically for mammography including but not limited to the x-ray tub, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

The policy Deductible 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 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 under the age of 20 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 up to $65 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 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.

Additional Benefits

Benefits are provided as mandated by the State of Colorado such as Benefits for Telemedicine Services, Colorectal Cancer Screening, Hearing Aids for Minor Children, Medical Foods, Child Health Supervision Services, Therapies for Congenital Defects and Birth Abnormalities, Cleft Lip or Cleft Palate, Hospitalization and General Anesthesia for Dental Procedures for Dependent Children and Treatment of Autism Spectrum Disorders. A detail of these benefits may be found in the Master Policy on file at the University.

Definitions

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: 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; and 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.

PRE-EXISTING CONDITION 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 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. 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:

1. Acupuncture; allergy, except as specifically provided in the policy;
2. Addiction, such as nicotine addiction;
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 disease process;
9. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
10. Hearing examinations or hearing aids, except as specifically provided in the policy; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
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. Injections (outpatient);
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
15. 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;
16. 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;
17. Investigational services;
18. Lipectomy;
19. Participation in a riot or civil disorder; commission of or attempt to commit a felony, except for Injury resulting from fighting when unprovoked or in self-defense;
20. Pre-existing Conditions for a period of 6 months, except for: 1) individuals who have been continuously insured for at least 6 consecutive months under the school's student insurance policy; or 2) a child that is adopted or placed for adoption before attaining eighteen years of age. 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;
21. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; except as provided under Benefits for Diabetes;
    b) Birth control and/or contraceptives, oral or other, whether medication or device, except as specifically provided in the policy;
    c) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
    d) Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs;

e) Products used for cosmetic purposes;

f) Drugs used to treat or cure baldness; anabolic steroids used for body building;

g) Anorectics - drugs used for the purpose of weight control;

h) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;

i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;

22. 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; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
23. 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;
24. Routine Newborn Infant care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery. If forty-eight hours following a vaginal delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning;
25. 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;
26. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
27. Temporomandibular joint dysfunction; nasal and sinus surgery, except for treatment of chronic purulent sinusitis;
28. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
29. Residential treatment of eating disorders, such as anorexia or bulimia;
30. Supplies, except as specifically provided in the policy;
31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
33. 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
34. Weight management, weight reduction, treatment for obesity, and surgery for removal of excess skin or fat, except as specifically provided in the policy.

Scholastic Emergency Services: Global Emergency Assistance Services

If you are a student insured with this insurance plan, you and your insured spouse and minor child(ren) are eligible for Scholastic Emergency Services (SES). The requirements to receive these services are as follows:

Domestic Students, insured spouse or Domestic Partner and insured minor child(ren): You are eligible for SES 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 and Return of Mortal Remains services provided by SES meet U.S. visa 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 SES services must be arranged and provided by SES, any services not arranged by SES will not be considered for payment.

Key Services include:

* Medical Consultation, Evaluation and Referrals
* Foreign Hospital Admission Guarantee
* Emergency Medical Evacuation
* Medically Supervised Repatriation
* Emergency Counseling Services
* Prescription Assistance
* Critical Care Monitoring
* Return of Mortal Remains
* Transportation to Join Patient
* Interpreter and Legal Referrals
* Lost Luggage or Document Assistance
* Care for Minor Children Left Unattended Due to a Medical Incident

Please log into your online account at www.uhcsr.com/du for additional information on SES Global Emergency Assistance Services, including service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States

(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

When calling SES's 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 Reference Number;
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; or
6. Information of where the physician can be immediately reached.

SES 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 SES. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide for additional information, including limitations and exclusions pertaining to the SES program.

Grievance Procedure

The Company will notify the Insured in writing of an Adverse Determination of a claim or any part of a claim. The notice will include the specific reason or reasons for the Adverse Determination and the reference to the pertinent plan provision(s) on which the Adverse Determination was based.

If the Insured has a complaint about an Adverse Determination, the Insured may call our Member Services telephone number 1-866-648-8472 for further explanation to informally resolve the complaint. If the Insured is not satisfied with the explanation of why the claim was denied, the Insured may request an internal review of the Adverse Determination by filing a grievance, in writing, with the Company at the Claims address on the following page.

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, Explanation of Benefits, correspondence and coverage information via My Account at www.uhcsr.com/du. Insureds can also print a temporary ID card, request a replacement ID card and locate network providers from My Account.

If you don't already have an online account, simply select the "Create an Account" link from the home page at www.uhcsr.com/du. Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from www.uhcsr.com/du to access your account information.

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Health and Counseling Center for treatment or referral, or when not in school, 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 College 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.

This 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 # 2010-5893-1