

2005 – 2006



Student Health Insurance Plan Brochure

Offered by:

Chickering Benefit Planning Insurance Agency, Inc.

Administered by:

Chickering Claims Administrators, Inc.

Underwritten by:

Aetna Life Insurance Company (ALIC)

Policy No. 812832 Managed Care Plan

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 an excellent two-part health care program and maintains an on-campus Student Health & Counseling Center for regularly enrolled students and their eligible spouses. The Student Health & Counseling Center provides cost effective medical and mental health services.

The University sponsors a Student Health Insurance Plan as described in this Brochure. The Plan is designed to complement and supplement the services rendered at the Student 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 supplemental 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.

Participation in DU's outstanding two-part health care program consisting of our Health/Counseling Fee and our Student Health Insurance Plan allows students to receive exceptional medical and mental health care at our Student Health & Counseling Center for little or no out-of-pocket cost. The convenience and accessibility to our services are in most instances a tremendous student benefit. Many students and parents recognize this and purchase our plan on top of 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 Student 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,
Louise McDonald, M.D.
Director, University Health & Counseling

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Student Health Insurance Plan

Important Information

- The University of Denver (DU) requires that students have adequate health insurance coverage. This will help ensure success in the academic community in the event of unexpected medical expense.
- The DU Student Health Insurance Plan is designed to complement and supplement services at the Student 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 supplemental 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.
- 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 a PPO plan.
- Please check to see if your parents' employer has changed the dependents' age-coverage limitation for college students in response to 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 the DU Student Insurance Office for further information at **(303) 871-4136** or visit DU's website at [**www.du.edu/duhealth/**](http://www.du.edu/duhealth/).
- Compare cost. It may be less expensive to enroll in the Student Health Insurance Plan than to pay for dependent coverage under your parents' group insurance.

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 Aetna Life Insurance Company (Aetna). The Plan provides coverage for Illnesses and Injuries that occur on and off campus locally, nationally and worldwide and includes special cost-saving features to keep the coverage as affordable as possible. The University of Denver is pleased to offer the Plan as described in this Brochure.

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

Some benefits are limited and should be carefully noted. If you or your Physician has any questions regarding benefits, please contact Chickering Claims Administrators, Inc. at (877) 409-7360.

Where to Find Help

Got Questions? Get Answers with Chickering's Aetna Navigator™

As a Chickering student health insurance member, you have access to Aetna Navigator™, your secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into Aetna Navigator, you can:

- Review who is covered under your plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services and procedures to better plan your expenses.
- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your plan.
- Send an e-mail to Chickering Customer Service at your convenience.
- View the latest health information and news, and more!

How do I register?

- Go to www.chickering.com
- Click on "Find Your School."
- Enter your school name and then click on "Search."
- Click on Aetna Navigator and then the "Access Navigator" link.
- Follow the instructions for First Time User by clicking on the "Register Now" link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

Need help with registration?

Registration assistance is available toll free, Monday through Friday, from 8:30 a.m. to 5:30 p.m. at **1-800-225-3375**.

For questions about:

- Insurance Benefits
- Enrollment
- Claims Processing

Please contact:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(877) 409-7360

For questions about ID cards:

Permanent ID cards will be mailed within 10 business days of receiving final enrollment information from the University of Denver. Temporary paper ID cards can be obtained at the Health & Counseling Center website www.du.edu/duhealth/ or The Chickering Group website www.chickering.com. If you need medical attention before the ID card is received, benefits will be payable in accordance with the Policy. You do not need an ID card to be eligible to receive benefits. The temporary/ paper ID cards may be used anytime and also may be used instead of a hard permanent ID card. Present the ID card (either the temporary/ paper one or the permanent one) to the provider to facilitate payment of your claims.

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

For lost permanent ID cards, contact:

Chickering Claims Administrators, Inc.
(877) 409-7360, or visit www.chickering.com, click on “Find Your School” enter **812832** as your Policy Number.

For questions about:

- Enrollment Process
- Waiver Process

Please contact:

University of Denver
Bursar’s Office
University Hall, Suite 223
2197 S. University Boulevard
Denver, CO 80208
(303) 871-4944

For questions about:

- Status of Pharmacy Claims
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

Please contact:

Aetna Pharmacy Management
(800) 238-6279 (Available 24 hours)

For questions about:

- Enrollment Process, or
- Other questions

Contact:

University of Denver Student Health & Counseling Center/ Insurance Coordinator
Daniel L. Ritchie Sports and Wellness Center, 3rd Floor, North Side
2240 E. Buchtel Boulevard
Denver, CO 80208
(303) 871-4136

Provider Listing (Including Preferred Care Pharmacy locations):

A complete list of providers can be found at the University of Denver Student Health and Counseling Center, or use Aetna's **DocFind**[®] service located at www.chickering.com. Click on "Find Your School" enter **812832** as your Policy Number. You can use **DocFind** to find out whether a specific provider belongs to Aetna's network or to find preferred providers practicing in your area.

For questions about:

- Worldwide Emergency Travel Assistance Services

Please contact:

Assist America, Inc.
(800) 872-1414 (within U.S.)
If outside the U.S., call collect by dialing the U.S. access code plus 301-656-4152
E-mail address: medservices@assistamerica.com

Worldwide Web Access:

- The Chickering Group - www.chickering.com

University of Denver Health Insurance Requirement

All students enrolled for one or more hours of graded credit at the University of Denver are required to carry adequate health insurance coverage. Students are required to participate in the DU Student Health Insurance Plan or provide proof of other adequate health insurance as explained under 'Enrollment/Waiver Process' below. Please read the section on the Enrollment/Waiver process carefully.

Student Eligibility

All students at the University of Denver 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 the Student Health Insurance Plan. Coverage will become effective on the dates shown below provided the required payments are made by the enrollment deadline.

Students must actively attend class for at least the first 31 days after the date for which coverage has been purchased. Ineligible classes/programs are as follows: distance programs, online or internet courses, home study, classes for no credit or less than one credit, TV courses, correspondence courses, certificate programs, outreach programs and course auditing. The Carrier maintains its rights to investigate student status and attendance records to verify that the Policy Eligibility requirements have been met. If the Carrier discovers that the Eligibility requirements have not been met, its only obligation is refund of premium.

Plan Coverage Periods

Quarter Students

Fall Quarter Period	September 1, 2005-March 26, 2006
*Winter Quarter Period	January 3, 2006-March 26, 2006
Spring Quarter Period	March 27, 2006-August 31, 2006
*Summer Quarter Period	June 19, 2006-August 31, 2006

Semester (Law) Students

Fall Semester Period	August 15, 2005-December 31, 2005
Spring Semester Period	January 1, 2006-August 13, 2006
*Summer Session Period	May 30, 2006-August 13, 2006

* Coverage for Winter or Summer term only is not available to students unless they first enter DU during these periods or are study abroad students during these periods. Prorated premiums apply in these circumstances. New Students beginning in these terms, Study Abroad Students, and International Students (studying at DU for one term) may contact: The University of Denver Student Health & Counseling Center/ Insurance Coordinator, Daniel L. Ritchie Sports and Wellness Center, 3rd Floor-North, 2240 E. Buchtel Blvd., Denver, CO 80208, Tel: 303- 871-4136, Fax: 303-871-4242.

Effective and Termination Dates

Coverage under the DU Student Health Insurance Plan is effective at 12:01 a.m. in accordance with the effective dates listed above. Coverage will terminate at 12:00 midnight in accordance with the termination dates listed above.

1. Coverage for an eligible person who is enrolled during the enrollment period (see Enrollment Section above) established by the school is effective on the first day of the coverage period.

*If your class enrollment date is different from the standard enrollment periods listed in this Brochure, please contact The Chickering Group at (877) 409-7360.

2. Coverage for an eligible person who has had an involuntary loss of coverage under another insurance plan shall be the later of the date the student enrolls and pays the required premium or the day after prior coverage ends.

Premium Rates

2005-2006	Fall and Spring <i>Semi-Annual</i>	Winter or Summer <i>New Students Only or Study Abroad Students Only</i>
Student Only	\$ 900	\$ 450
Spouse	\$ 2,158	\$ 1,079
Child(ren)	\$ 2,006	\$ 1,003

The Premium Rates shown above include an administrative fee which is retained by the University.

Enrollment

All students who enroll for one (1) or more hours of graded credit in a Traditional University Program as defined by the University (including English Language Center students and DU study abroad program students) will be automatically enrolled in the Student Health Insurance Plan each Fall and Spring. The premium rate will be assessed on the student tuition bill. The student is responsible for verifying all charges on the tuition bill. The following students may also meet eligibility requirements (but may not be auto-assessed the premium on the student tuition bill) and should 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 Insurance Coordinator: students enrolling for one (1) or more hours of graded credit in a non-traditional program, new students first enrolling in Winter or Summer terms, students in DU and non-DU study abroad programs, and International students studying at DU for only one term. For these students, we also recommend calling the Insurance Coordinator at DU for more information at 303-871-4136.

Enrollment Forms may be obtained online at The Student Health & Counseling Center website www.du.edu/duhealth/ or by visiting The Student Health & Counseling Center/ Insurance Coordinator, Floor 3-North in the Ritchie Center, University of Denver, Denver, CO 80208, phone 303-871-4136, fax 303-871-4242.

Continuous Enrollment - required course work toward a degree: To enroll in the Student Health Insurance Plan as a 'Continuous Enrollment' student, the student must be eligible for "continuous enrollment" at the University of Denver, and must complete a Continuous Enrollment Form with associated continuous enrollment fee payment with the DU Office of Graduate Studies prior to enrolling for coverage in the Student Health Insurance Plan. Enrollment must take place during the usual enrollment periods. The premium **will not** be automatically assessed on the tuition bill. All coverage period enrollment deadlines apply.

Waiver Process/Procedure

The Student Health & Counseling Center offers many benefits to students participating in the DU Student Health Insurance Plan. Before waiving participation in the Plan, it is advisable to inquire about these benefits by contacting The Student Health & Counseling Center Insurance Coordinator, Floor 3-North in the Ritchie Center, University of Denver, Denver, CO 80208, phone 303-871-4136, fax 303-871-4242.

Please note: *If you elect to waive participation in the Plan for the entire year, you are considered waived for the year and are **not** eligible to re-enroll at any time during the year unless you have had an involuntary loss of coverage from your previous insurance carrier and can provide proof of such as described under the 'Change in Status/ Qualifying Event' section of this Plan Brochure.*

To remove the automatically assessed health insurance premium from their tuition bill, students must submit a completed **online** Waiver with proof of having other comparable health insurance coverage to the Bursar's Office in Student Financial Services by the waiver deadline dates listed below. Waivers **MUST** be completed and submitted for either the Annual coverage period, or for the Fall Coverage Period **AND** for the Spring Coverage Period by the waiver deadline date listed on page 11.

Waivers may only be completed and submitted online by visiting the 'My Web' website at [http://myweb.du.edu/](http://myweb.du.edu) For more information on waiving, visit the Bursar's Office in Student Financial Services, University Hall, Suite 223, University of Denver, Denver, CO 80208, phone (303) 871-4944, fax (303) 871-2341.

IF YOU DO NOT WAIVE PARTICIPATION IN THE STUDENT HEALTH INSURANCE PLAN AS DESCRIBED ABOVE WITHIN THE WAIVER DEADLINE PERIOD, YOU WILL BE ENROLLED IN THE DU STUDENT HEALTH INSURANCE PLAN AND WILL BE RESPONSIBLE FOR THE PAYMENT OF THE HEALTH INSURANCE PREMIUM.

***Once this Plan has been used, and claims have been incurred, you cannot choose to waive participation in the Plan.**

PLEASE NOTE THAT THE STUDENT HEALTH INSURANCE PREMIUM IS SEPARATE FROM, AND NOT THE SAME AS, THE STUDENT HEALTH & COUNSELING FEE. THE STUDENT HEALTH INSURANCE PLAN PREMIUM and THE STUDENT HEALTH & COUNSELING FEE ARE TWO SEPARATE CHARGES APPEARING ON YOUR TUITION BILL and MUST BE WAIVED SEPARATELY.

Waiving one does not automatically waive the other - different waiver processes apply to the Health & Counseling Fee. Contact the Bursar's Office in Student Financial Services at (303) 871-4944 for more information.

Enrollment/Waiver Deadline Dates

The enrollment/waiver deadline for each coverage period throughout the school year is 3 weeks from the first day of classes in each of the coverage terms.

Quarter Students

Annual	September 30, 2005
Fall	September 30, 2005
*Winter	January 24, 2006
Spring	April 14, 2006
*Summer	July 7, 2006

Semester (Law) Students

Annual	September 2, 2005
Fall	September 2, 2005
Spring	February 1, 2006
*Summer	June 20, 2006

* Coverage for Winter or Summer term only is not available to students unless they first enter DU during these periods or are study abroad students during these periods. Prorated premiums apply in these circumstances. New Students beginning in these terms, Study Abroad Students, and International Students (studying at DU for one term) may contact: The University of Denver Student Health & Counseling Center/ Insurance Coordinator, Daniel L. Ritchie Sports and Wellness Center, 3rd Floor-North, 2240 E. Buchtel Blvd., Denver, CO 80208, Tel: 303- 871-4136, Fax: 303-871-4242.

Premium Refund Policy

Except for medical withdrawal due to a covered Accident or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid. No refund will be allowed.

A Covered Person entering the armed forces (with the exception of those attending the University on an armed forces scholarship) of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, and any covered dependents, upon written request received by Chickering Claims Administrators, Inc. within 90 days of withdrawal from school.

Change in Status/Qualifying Event

Eligible students who have a change in status and involuntarily lose coverage under another group insurance plan are able to purchase the DU Student Health Insurance Plan. These students must provide the Carrier with proof that they have lost insurance through another group (certificate and letter of ineligibility) within 30 days of the qualifying event. The premium will be the same as it would have been at the beginning of that period, but the effective date would be the later of the date the student enrolls and pays the premium or the day after prior coverage ends.

Dependent Eligibility and Enrollment

Eligible students may also enroll their eligible Dependents. Dependent eligibility and coverage period must be concurrent with the insured student's. Dependents may not be enrolled without eligible student enrollment.

Eligible dependents are your lawful spouse and your unmarried children under age 19, (25 if in school; proof will be required by the Carrier); and dependent children who are not self-supporting and are full-time students (proof may be required by the Carrier); and dependent children with mental and physical handicaps (proof may be required by the Carrier).

Students must enroll their dependents and must pay the required premium as described below:

1. By the Enrollment Deadline dates on page 11 in this Brochure.
2. Within 31 days after you acquire a new dependent.
3. Within 31 days after a dependent's coverage is involuntarily terminated under another health plan.

The premium rate for the addition of dependents will be the same as at the beginning of that period but the effective date will be the date premium is received.

Newborn Infant Coverage and Adopted Child Coverage

A child born to a Covered Person shall be covered for Accident, Sickness, premature birth, and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the University of Denver Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional pro-rated premium starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a Covered Person for 31 days from the moment of placement, provided the child lives in the household of the Covered Person and is dependent upon the Covered Person for support. To extend coverage for an adopted child past the 31 days, the Covered Person must (1) enroll the child within 31 days of placement of such child, and (2) pay any additional pro-rated premium, if necessary, starting from the date of placement.

For further assistance with dependent eligibility, enrollment and/or premium information, please contact Chickering Benefit Planning Insurance Agency, Inc at **(877) 409-7360**.

Pre-Existing Conditions/Continuously Insured Provisions

Pre-Existing Conditions

Definition of a Pre-Existing Condition: A Pre-Existing Condition is any Injury, Sickness or condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding a covered person's date of enrollment. Pregnancy is not defined as a Pre-Existing Condition.

Limitations

Expenses incurred by a Covered Person within six months following the date of enrollment as a result of a Pre-Existing Condition will not be considered Covered Medical Expense. However, the Pre-Existing Conditions limitation will not apply to a child that is adopted or placed for adoption before attaining the age of eighteen, or to a pregnancy.

If a Covered Person has creditable coverage in force within 90 days prior to the date of enrollment in the Policy, then any limitation as to a Pre-Existing Condition under this Policy will apply for that Covered Person only to the extent that such limitation would have applied if they had remained covered under the prior creditable coverage.

Creditable Coverage is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes health benefit plans issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employee's Health Benefit Plan (FEHBP); a public health plan as defined in the regulations and any health benefit plan under Section 5 (e) of the Peace Corps Act.

Continuously Insured

Continuously Insured means a person who was insured under prior Student Health Insurance policies issued to the school and is now insured under this Policy. Persons who have remained Continuously Insured will be covered for conditions first manifesting themselves while Continuously Insured except for expenses payable under prior policies in the absence of this Policy. Previously insured students and dependents must re-enroll for coverage in order to avoid a break in coverage for conditions which existed during prior Policy coverage dates. Once a break in continuous insurance occurs that is greater than 90 days, the definition of a Pre-Existing Condition will apply in determining coverage of any condition which existed during such a break.

Utilizing Services Within the Student Health & Counseling Center

Students Who Pay the DU Health & Counseling Fee and Who Are Enrolled in the Student Health Insurance Plan

Students are encouraged to seek medical and mental health care from the Student Health & Counseling Center (SHCC) first. When a student participates in both the Health & Counseling Fee program and the Student Health Insurance Plan simultaneously, the SHCC is able to offer many additional services and supplies at no out-of-pocket cost to the student.

Students also save on medication through the SHCC's in-house prescription benefit. Please call or stop by the Student Health & Counseling Center for more details or checkout our website www.du.edu/duhealth.

Services rendered at the SHCC must be medically necessary at the time of service/treatment in order to be covered. However, if the Student Health Insurance Plan specifically excludes a service or supply from coverage, the service or supply may also be excluded from coverage at the SHCC. These expenses will not count towards meeting either the Plan Deductible or the Lifetime Aggregate Maximum. Pre-Existing Conditions are not excluded from coverage for services rendered at the Student Health & Counseling Center.

Medical services rendered by medical specialists at the SHCC are provided with no Deductible to a maximum of 6 specialist visits per Policy Year when the student participates in BOTH the Health & Counseling Fee program and the Student Health Insurance Plan simultaneously for all terms and coverage periods throughout the Policy Year. A \$10 Copay, per visit, applies for each visit to a specialist.

Mental health treatment rendered at the SHCC is provided with no Deductible to a maximum of 12 Counseling visits and 6 psychiatric visits per Policy Year when the student participates in BOTH the Health & Counseling Fee program and the Student Health Insurance Plan simultaneously for all terms and coverage periods throughout the Policy Year. After the first two free counseling visits, a \$10 per visit Copay applies for the 10 remaining counseling visits and for the 6 psychiatric visits. Further mental health visits at the SHCC are on a fee-for-service basis and, if enrolled in the Student Health Insurance Plan, may be submitted to Chickering for direct student reimbursement, subject to the annual deductible and plan provisions Certain procedures

performed at the SHCC are not covered by the combination Health & Counseling Fee and the SHIP but are covered by the Student Health Insurance Plan on the same basis as any Covered Medical Expense.

Students Who Do Not Pay the DU Health & Counseling Fee and Who Are Enrolled in the Student Health Insurance Plan, and Spouses Who are Enrolled in the Student Health Insurance Plan

Students who are not required and choose not to pay the DU Health & Counseling Fee and spouses of DU students are encouraged to seek medical care from the Student Health & Counseling Center (SHCC) first. (Mental health benefits at the Counseling Center are described below.) Services are available on a fee-for-service basis. The Student Health Insurance Plan provides benefits for such covered services on the same basis as any other Covered Medical Expense. Providers at the SHCC are always members of the Student Health Insurance Plan Preferred Provider Network.

Treatment Outside the Student Health & Counseling Center - Students & Dependent(s)

After the \$250 Policy Year Deductible has been satisfied, payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or Sickness while insured under the Plan, not to exceed a Lifetime Aggregate Maximum of \$500,000 per Accident or Sickness. See Summary of Benefits Chart on page 18 for benefit payment and Copay information. The payment of any Deductibles, Copays, or the balance above any Coinsurance amount, and any medical expense not covered are the responsibility of the Covered Person.

Benefits for Mental and Nervous Conditions, Alcoholism and Drug Abuse

Outpatient Care at the Student Health & Counseling Center

Mental health treatment rendered at the SHCC is provided with no Deductible to a maximum of 12 Counseling visits and 6 psychiatric visits per Policy Year when the student participates in BOTH the Health & Counseling Fee program and the Student Health Insurance Plan simultaneously for all terms and coverage periods throughout the Policy Year. After the first two free counseling visits, a \$10 per visit Copay applies for the 10 remaining counseling visits and for the 6 psychiatric visits. These expenses do not apply towards meeting the Deductible, nor will they be charged against the Plan Maximum. This benefit is not available to spouses or Dependent children.

Please note: Additional mental health visits at the SHCC are on a fee-for-service basis and, if enrolled in the Student Health Insurance Plan, may be submitted to Chickering for direct student reimbursement subject to the annual deductible and plan provisions.

Care Outside the Student Health & Counseling Center

The Student Health Insurance Plan will pay the eligible expenses incurred by a Covered Person for treatment of mental and nervous conditions, alcoholism and drug abuse while an inpatient or partially hospitalized, or as an outpatient in accordance with the Colorado State mandated

benefits. Biologically based mental health conditions are reimbursed as any other physical Sickness in accordance with the Colorado State mandated benefits.

Preferred Provider Network

The Chickering Group has arranged for you to access a Preferred Provider Network in your local community location. Acute care facilities and mental health networks are available nationally. The Student Health Insurance Plan for the 2005-2006 Policy Year has a Preferred Provider Organization network through Aetna.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of The University of Denver, Chickering Claims Administrators, Inc., or Aetna.

A complete listing of participating providers is available at the University of Denver Student Health and Counseling Center. You may also contact Chickering Claims Administrators, Inc. at (877) 409-7360. Additionally, you can obtain information regarding Preferred Providers through the internet by using Aetna's online **DocFind**[®] service located at www.chickering.com. Click on "Find Your School" enter **812832** as your Policy Number. You can use **DocFind** to find out whether a specific provider belongs to Aetna's network or to find preferred providers practicing in your area. Some PPO providers in your area include Centura Health Porter Adventist Hospital, Swedish Medical Center, University Hospital, Rose Medical Center, National Jewish Medical and Research Center, St. Joseph Hospital, Presbyterian-St. Luke's Medical Center, the Children's Hospital Association, and Centura Health St. Anthony Central.

Inpatient Admission Pre-Certification Program

Pre-admission certification is designed to help you receive quality, cost-effective medical care.

- All inpatient admissions, including length of stay, must be certified by contacting Chickering Claims Administrators, Inc.
- **Pre-Certification does not guarantee the payment of benefits for your inpatient admission.** Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the DU Student Health Insurance Plan. Once the certification is approved for any treatment or procedure, we will not retroactively retract the certification, unless certification was based on material misrepresentation (fraud or abuse) on the part of the insured, the provider, or the prescriber.
- If you do not secure Pre-Certification for non-emergency inpatient admissions or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a \$200 per admission Deductible.

Pre-Certification of Non-Emergency Inpatient Admissions:

The patient, Physician, or hospital must telephone at least three business days prior to the planned admission.

Notification of Emergency Admissions:

The patient, patient's representative, Physician, or hospital must telephone within one business day following admission.

Chickering Claims Administrators, Inc.
Attention: Managed Care Dept.
P.O. Box 15708
Boston, MA 02215-0014
(877) 409-7360

Description of Benefits

Payment will be made as allocated herein for Covered Medical Expenses incurred for any one Accident or any one Sickness while insured under the Plan, not to exceed an Aggregate Maximum while continuously insured of **\$500,000** for any one covered Accident or any one covered Sickness.

The payment of any Copays, Deductibles, the balance above any Coinsurance amount, and any medical expenses not covered, are the responsibility of the Covered Person. To maximize your savings and reduce out-of-pocket expenses, select a Preferred Provider. It is to your advantage to utilize a Preferred Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services.

Non-Preferred Care is subject to the Reasonable Charge allowance maximums. Any charges in excess of the Reasonable Charge allowance are not covered under the Plan.

A complete listing of Preferred Providers is available at the DU Student Health and Counseling Center, or you can contact Chickering Claims Administrators, Inc. at **(877) 409-7360** for specific provider information. You can also use Aetna's online **DocFind**[®] service located at **www.chickering.com**. Click on "Find Your School" enter **812832** as your Policy Number. You can use **DocFind** to find out whether a specific provider belongs to Aetna's network or to find preferred providers practicing in your area.

Summary of Benefits Chart

The following benefits are subject to the imposition of Policy limits and exclusions. All coverage is based on the Reasonable Charge allowance unless otherwise specified.

The Plan always pays benefits in accordance with any applicable Colorado Insurance Law(s).

If care is received outside of the United States, Covered Medical Expenses, including mental health and substance abuse, will be payable subject to all Plan provisions described below except that all charges will be reimbursed at 90% of the *billed* charges after the Policy Year Deductible has been met and according to Plan provisions. (Aetna does not have a Preferred Provider network outside of the U.S.)

Lifetime Aggregate Maximum	\$500,000 per condition.
Deductible	\$250.00 per individual per Policy Year. \$500.00 per family per Policy Year. Applies to all Covered Medical Expenses, unless noted otherwise.
Out-of-Pocket Maximum (Deductibles, Copays, and outpatient Prescription expenses do not count towards meeting the Out-of-Pocket Maximum)	After the Plan has paid \$25,000 for any covered condition, the Plan will pay 100% of the Negotiated Charge or the Reasonable Charge allowance (Preferred/Non-Preferred care respectively) up to the Plan's \$500,000 Lifetime Aggregate Maximum per condition.
Inpatient Hospitalization Benefit	
Hospital Room and Board Expense	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 60% of the Reasonable Charge for the semi-private room rate for an overnight stay.
Intensive Care Unit Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge for an overnight stay. Non-Preferred Care: 60% of the Reasonable Charge intensive care room rate for an overnight stay.

Summary of Benefits Chart Continued

Miscellaneous Hospital Expenses	<p>Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable Charge.</p> <p>Covered Medical Expenses include, but are not limited to: laboratory tests, X-rays, anesthesia, use of special equipment, medicines and use of operating room.</p>
Physician Hospital Visit Expenses	<p>Covered Medical Expenses for charges for the non-surgical services of the attending Physician or a consulting Physician are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable Charge.</p>
Surgical Benefits (Inpatient and Outpatient)	
Surgical Expense and Anesthetist Expenses	<p>Covered Medical Expenses for charges for surgical services performed by a Physician and Covered Medical Expenses for charges of an anesthetist incurred during a surgical procedure are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable Charge.</p>
Assistant Surgeon Expenses	<p>Covered Medical Expenses for the charges of an assistant surgeon during a surgical procedure for surgical services performed during a surgical operation are payable at 50% of the Negotiate Rate or Reasonable Charge.</p>

Summary of Benefits Chart Continued

Outpatient Benefits	
Covered Medical Expenses include, but are not limited to: Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, physical therapy, clinical lab, radiological facility or other similar facility licensed by the state.	
Physician's Office Visit Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge after a \$20 Copay per visit. Non-Preferred Care: 60% of the Reasonable Charge after a \$20 Deductible per visit.
Emergency Care Expenses	Covered Medical Expenses for treatment of an Emergency Medical Condition are payable as follows: Preferred Care: 90% of the Negotiated Charge after a \$50 Copay per visit. Non-Preferred Care: 90% of the Reasonable Charge after a \$50 Deductible per visit.
Lab and X-Ray Expenses (Non-Hospital)	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable Charge.
Durable Medical Equipment Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable Charge.
Physical Therapy, Occupational Therapy, and Chiropractic Care Expenses	Covered Medical Expenses are payable as follows: Preferred Care: 90% of the Negotiated Charge after a \$20 Copay per visit. Non-Preferred Care: 60% of the Reasonable Charge after a \$20 Deductible per visit. Covered Medical Expenses for Physical Therapy, Occupational Therapy, and Chiropractic care are subject to a maximum of 12 combined visits per condition per Policy Year.
Mental Health and Substance Abuse Benefits	
Inpatient Expense-Mental Health	<i>Biologically Based Mental Health Conditions</i> Covered Medical Expenses for the treatment of a biologically based mental health condition while confined as an inpatient in a licensed hospital or treatment facility, or for partial confinement, for such treatment are payable on the same basis as for any other Sickness.

Summary of Benefits Chart Continued

<p>Inpatient Expense-Mental Health (<i>continued</i>)</p>	<p><i>Non-Biologically Based Mental Health Conditions</i> Covered Medical Expenses for the treatment of a non-biologically based mental health condition while confined as an inpatient in a hospital or facility licensed for such treatment are payable and subject to a maximum of 45 days per Policy Year per condition for any one or related mental health condition or 90 days Partial Hospitalization per Policy Year.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Chickering Claims Administrators Inc. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.</p>
<p>Outpatient Expenses-Mental Health</p>	<p><i>Biologically Based Mental Health Conditions and Autism</i> Covered Medical Expenses for outpatient treatment of a biologically based mental health condition, or for the treatment of Autism, are payable on the same basis as for any other Sickness.</p> <p><i>Non-Biologically Based Mental Health Conditions</i> Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable as follows: Preferred Care: 90% of the Negotiated Charge after a \$20 Copay per visit. Non-Preferred Care: 60% of the Reasonable Charge after a \$20 Deductible per visit.</p> <p>Covered Medical Expenses for non biologically-based mental health conditions (except autism) are subject to a maximum of \$1,000 per Policy Year.</p>

Summary of Benefits Chart Continued

<p>Inpatient Expenses- Substance Abuse</p>	<p>Covered Medical Expenses for the treatment of substance abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable and subject to a maximum of 45 days per Policy Year per condition for any one or related substance abuse condition or 90 days Partial Hospitalization per Policy Year.</p> <p>Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained on a case-by-case basis by contacting Chickering Claims Administrators Inc. When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.</p>
<p>Outpatient Expenses- Substance Abuse</p>	<p>Covered Medical Expenses for the care or treatment of substance abuse by a licensed or accredited health service organization or hospital or by a fully licensed practitioner are payable as follows: Preferred Care: 90% of the Negotiated Charge after a \$20 Copay per visit. Non-Preferred Care: 60% of the Reasonable Charge after a \$20 Deductible per visit.</p> <p>Covered Medical Expenses are subject to a maximum of \$1,000 per Policy Year.</p>
<p>Maternity Benefits</p>	
<p>Maternity Expenses</p>	<p>Covered Medical Expenses for pregnancy, childbirth and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</p> <p>If a Covered Person is discharged earlier, benefits will be payable for two post-delivery home visits by a health care provider. The first such visit will occur within 48 hours of discharge.</p>

Summary of Benefits Chart Continued

Additional Benefits	
<p>Women's Health Benefit Expenses</p>	<p>Covered Medical Expenses will include one baseline mammogram for women between the ages of 35 and 40 and for a routine annual mammogram for women age 40 and older. Covered Medical Expenses are payable on the same basis as any X-ray expense with waiver of the annual deductible.</p> <p>Covered Medical Expenses include an annual Pap smear screening for women age 18 and older. Covered Medical Expenses are payable on the same basis as any outpatient expense. If follow-up diagnostic Pap Smears are Medically Necessary, they will be covered on the same basis as any outpatient expense.</p>
<p>Prostate Cancer Screening Expenses</p>	<p>Covered Medical Expenses are payable for one annual digital rectal exam and a Prostate Specific Antigen (PSA) test.</p> <p>Covered Medical Expenses are payable on the same basis as any expense.</p>
<p>Diabetic Equipment and Self-Management Education Program Expenses (<i>Please note: insulin, syringes, and testing supplies are covered under the Prescription Drug portion of the Plan</i>)</p>	<p>Covered Medical Expenses for diabetic equipment, other than those provided under the Prescription Drug portion of the Plan, and self-management education programs, are payable on the same basis as any expense.</p>
<p>Child Health Supervision Services Expenses For Insured Dependent Children to Age 13</p>	<p>Covered Medical Expenses for insured, dependent children to age 13 are payable on the same basis as any expense.</p> <p>Covered Medical Expenses include the following services:</p> <ul style="list-style-type: none"> • A review and written record of the child's complete medical history; Physical examination; Developmental and behavioral assessment at the following age intervals: • Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months and 18 months. • Ages 2, 3, 4, 5, 6, 8, 10 and 12 years. • Anticipatory guidance and education; <p>Immunizations including diphtheria, haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, any other immunization as recommended by the American Academy of Pediatrics for pediatric patients; and, Laboratory tests.</p>

Summary of Benefits Chart Continued

<p>Congenital Defects and Birth Defects Expenses</p>	<p>Covered Medical Expenses include treatment of medically diagnosed congenital defects and birth abnormalities caused by sickness or injury for a newborn dependent child during the first 31 days of life. Covered Medical Expenses will be payable on the same basis as any other illness and are not subject to policy exclusions, limitations or maximums. After the first 31 days of life to age 5, benefits for treatment of medically diagnosed birth defects and abnormalities are payable on the same basis as any expense and are subject to Policy exclusions, limitations and maximums except that coverage will be provided for charges incurred by a physician or a licensed or certified physical, occupational or speech therapist for outpatient care.</p> <p>Covered Medical Expenses are subject to the following minimums:</p> <ul style="list-style-type: none"> • 20 visits per Policy Year for physical therapy; • 20 visits per Policy Year for occupational therapy; • 20 visits per Policy Year for speech therapy.
<p>Ambulance Expenses</p>	<p>Covered Medical Expenses per trip for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 90% of the Reasonable Charge.</p>

Summary of Benefits Chart Continued

<p>Prescription Drug Benefit Expenses</p>	<p>Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Accident are payable up to a maximum of \$1,000 per Policy Year following a \$15 Copay for each Generic Prescription Drug or a \$30 Copay for each Brand-Name Prescription Drug.</p> <p>Medications not covered by this benefit include, but are not limited to: oral contraceptives, allergy sera, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.</p> <p>Prior authorization is required for growth hormones.</p> <p>For assistance, or for a complete list of excluded medications or drugs available with prior authorization, please contact Aetna Pharmacy Management at (800) 238-6279.</p> <p>Benefits are paid only when Prescriptions are filled at a Pharmacy which is a Preferred Care Provider. Please use your Chickering ID card when obtaining your Prescriptions.</p> <p>Please note: if you are a Study Abroad student, please contact Chickering Claims Administrators, Inc. at (877) 409-7360 regarding claim submission procedures for covered prescriptions filled outside of the U.S.</p>
<p>Dental Expenses</p>	<p>Covered Medical Expenses are payable at 90% of the Actual Charge for the treatment of an Injury to sound, natural teeth.</p> <p>Covered Medical Expenses are payable at 90% of the Actual Charge for the removal of impacted wisdom teeth.</p>

Summary of Benefits Chart Continued

<p>Dental Hospitalization and General Anesthesia Expenses (Applies to Insured, Dependent Children Only)</p>	<p>Covered Medical Expenses are payable on the same basis as any expense for general anesthesia when rendered in a hospital, ambulatory surgical center or other licensed health care facility and for associated hospital or facility charges for dental care provided to covered dependent children meeting one or more of the following criteria: (a) the child has a physical, mental, or medically compromising condition, or, (b) the child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy, or, (c) 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, (d) the child has sustained extensive orofacial and dental trauma.</p> <p>Coverage may be restricted to dental care that is provided by a fully accredited specialist in pediatric dentistry, a fully accredited specialist in oral and maxillofacial surgery, or to a dentist to whom hospital privileges have been granted. Note: routine dental care for which general anesthesia is required is not a Covered Medical Expense.</p>
<p>Cleft Lip/Cleft Palate Expenses (Applies to Insured, Dependent Children Only)</p>	<p>Covered Medical Expenses are payable on the same basis as any expense.</p>
<p>Home Health Care Expenses</p>	<p>Covered Medical Expenses incurred within 12 months from the date of the first home health care visit are payable as follows: Preferred Care: 90% of the Negotiated Charge. Non-Preferred Care: 60% of the Reasonable Charge.</p>

Additional Services and Discounts

As a participant in the Student Health Insurance Plan, you can also take advantage of the following services, discounts and Programs. These services, discounts, and programs are not underwritten by Aetna.

Vision One [®] Discount Program	The Vision One Discount Program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 25% discount on LASIK surgery (the laser vision correction procedure). Call (800) 793-8616 for additional Program information and provider locations, or simply use Aetna's online DocFind[®] service located at <i>www.chickering.com</i> . Click on "Find Your School" enter 812832 as your Policy Number. You can use DocFind to find a Vision One provider near you.
Fitness Program	Aetna's Fitness Program, offered in conjunction with GlobalFit [™] , offers discounted membership rates at over 1,500 independent fitness clubs nationwide, as well as discounts on certain home exercise equipment. There are no long term contracts and GlobalFit offers convenient payment options. Contact Chickering Claims Administrators, Inc. for more information.

General Provisions

State Mandated Benefits

The Plan will always pay benefits in accordance with any applicable Colorado Insurance Law(s).

Coordination of Benefits

If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

Subrogation/Reimbursement Right of Recovery Provision

Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person's Injuries or illnesses, to the full extent of benefits provided or to be provided by Aetna. In addition; if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the

right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that Injury or illness, up to and including the full amount the Covered Person receives from all potentially responsible parties. A "Covered Person" includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or Dependent of any Covered Person entitled to receive any benefits from this Plan.

As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person or on a Covered Person's behalf due to a Covered Person's Injuries or illnesses or any insurance coverage responsible for making such payment; including but not limited to:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers compensation coverage;
- No-fault automobile insurance coverage; or
- Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna's subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna's efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to Injuries sustained by the Covered Person.

The Covered Person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Covered Person and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Definitions

Accident: An occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

Actual Charge: The Actual Charge made for a covered service by the provider that furnishes it.

Aggregate Maximum: The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a Covered Person that accumulate from one year to the next.

Brand Name Prescription Drug or Medicine: A Prescription Drug which is protected by trademark registration.

Coinsurance: The percentage of Covered Medical Expenses payable by the Covered Person under DU Student Health Insurance Plan.

Copay: The amount that must be paid by the Covered Person at the time services are rendered by a Preferred Provider. Copay amounts are the responsibility of the Covered Person.

Covered Medical Expenses: Those charges for any treatment, service, or supplies covered by the Policy which are: (a) not in excess of the Reasonable Charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; and (c) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits provisions.

Covered Person: A covered student or dependent whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.

Deductible: A specific amount of Covered Medical Expenses that must be incurred by, and paid for by, the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.

Elective Treatment: Medical treatment that is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; temporomandibular joint (TMJ) dysfunction; immunizations; vaccines; treatment of infertility; and routine physical examinations.

Emergency Medical Condition: A recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that their condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

It does include an Accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, or care for non-emergency illness.

Generic Prescription Drug or Medicine: A Prescription Drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Injury: Bodily Injury caused by an Accident. This includes related conditions and recurrent symptoms of such Injury.

Medically Necessary: A service or supply that is: necessary; and appropriate; for the diagnosis or treatment of a Sickness; or Injury; based on generally accepted current medical practice.

In order for a treatment; service; or supply to be considered Medically Necessary, the service or supply must:

- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply; both as to the sickness or injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition; and
- As to diagnosis; care; and treatment; be no more costly (taking into account all health expenses incurred in connection with the treatment; service; or supply;) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances; Aetna will take into consideration:

- information relating to the affected person's health status;
- reports in peer reviewed medical literature;

- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis; care; or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical; a mental health; or a dental professional; or
- Those furnished mainly for: the personal comfort; or convenience; of the person; any person who cares for him or her; or any person who is part of his or her family; any healthcare provider; or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished; in a Physician's or a dentist's office; or other less costly setting.

Negotiated Charge: The maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under the Plan.

Non-Preferred Care: A health care service or supply furnished by a health care provider that is not a Preferred Care Provider, if, as determined by Aetna: (a) the service or supply could have been provided by a Preferred Care Provider; and (b) the provider is of a type that falls into one or more of the categories of providers listed in the Directory.

Non-Preferred Pharmacy: A Pharmacy not party to a contract with Aetna, or a Pharmacy that is party to such a contract but which does not dispense Prescription Drugs in accordance with its terms.

Non-Preferred Care Provider: A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Pharmacy: An establishment where Prescription Drugs are legally dispensed.

Physician: A legally qualified Physician licensed by the state in which he/she practices, and any other practitioner that must, by law, be recognized as a doctor legally qualified to render treatment.

Pre-Existing Condition: A Pre-Existing Condition is any Injury, Sickness or condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding a Covered Person's date of enrollment.

The Pre-Existing Condition limitation will not apply to a child that is adopted or placed for adoption before attaining the age of eighteen, or to pregnancy. The Pre-Existing limitation does not apply to a person who has remained continuously insured.

Preferred Care: Care provided by a Preferred Care Provider; or any health care provider for an emergency condition when travel to a Preferred Care Provider is not feasible.

Preferred Care Provider: A health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, with Aetna's consent, included in the Directory as a Preferred Care Provider for the service or supply involved, and the class of which the Covered Person is a member.

Preferred Pharmacy: A Pharmacy which is party to a contract with Aetna to dispense drugs to persons covered under the Policy, but only while the contract remains in effect; and when the Pharmacy dispenses a Prescription Drug under the terms of its contract with Aetna.

Prescription: An order of a prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Reasonable Charge: Only that part of a charge which is reasonable is covered. The Reasonable Charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; and
 - The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances; Aetna may have an agreement, either directly or indirectly, through a third party with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.

In determining the Reasonable Charge for a service or supply that is:

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

Sickness: A disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy.

Exclusions

The Plan neither covers nor provides benefits for the following:

1. Expenses incurred as a result of dental treatment, except for (a) treatment resulting from Injury to sound, natural teeth; or (b) extraction of impacted wisdom teeth as provided elsewhere in the Policy.
2. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or Prescriptions or examinations, except as required for repair caused by a covered Injury.
3. Expenses incurred as a result of Injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.
4. Expenses incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regularly published schedules on a regularly established route.
5. Expenses incurred as a result of an Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law.
6. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person entering the armed forces of any country, the unearned pro-rata premium will be refunded to the Policy holder. (This does not apply to students attending the University on Armed Forces scholarships.)
7. Expenses incurred for treatment provided in a governmental hospital, unless there is a legal obligation to pay such charges in the absence of insurance.

8. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.

9. Expenses incurred for plastic surgery, cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:

- a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect (including cleft lip, webbed fingers, or toes), or as direct result of disease, or surgery performed to treat a Sickness or Injury.
- b) Repair an Injury (including reconstructive surgery for a prosthetic device for a Covered Person who has undergone a mastectomy) which occurs while the Covered Person is covered under the Plan. Surgery must be performed in the Policy Year of the Accident which causes the Injury, or in the next Policy Year.

10. Expenses for Injuries sustained as a result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

11. Expenses incurred as a result of allergy shots and injections, preventive medicines, serums, vaccines, or oral contraceptives unless otherwise provided in the Policy.

12. Expense incurred for a treatment; service; or supply; which is not Medically Necessary; as determined by Aetna; for the diagnosis care or treatment of the Sickness or Injury involved. This applies even if they are prescribed; recommended; or approved; by the person's attending Physician; or dentist.

In order for a treatment; service; or supply; to be considered Medically Necessary; the service or supply must:

- be care; or treatment; which is likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the Sickness or Injury involved; and the person's overall health condition;
- be a diagnostic procedure which is indicated by the health status of the person; and be as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than, any alternative service or supply; both as to the Sickness or Injury involved; and the person's overall health condition; and
- as to diagnosis; care; and treatment; be no more costly (taking into account all health expenses incurred in connection with the treatment; service; or supply); than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances; Aetna will take into consideration: information relating to the affected person's health status; reports in peer reviewed medical literature; reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; generally recognized professional standards of safety and effectiveness in the United States for diagnosis; care; or treatment; the opinion of

health professionals in the generally recognized health specialty involved; and any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- those that do not require the technical skills of a medical; a mental health; or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person; any person who cares for him or her; or any persons who is part of his or her family; any healthcare provider; or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely; and adequately; be diagnosed; or treated; while not confined; or those furnished solely because of the setting; if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office; or other less costly setting.

13. Expenses incurred for any services rendered by a family member of a Covered Person's immediate family or a person who lives in the Covered Person's home.

14. Expenses incurred for the treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain unless otherwise provided in the Policy.

15. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.

16. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports (participation in sports clubs or intramural athletic activities are not excluded).

17. Expenses covered by any other valid and collectible medical health or accident insurance as provided in the Coordination of Benefits provision.

18. Expenses incurred for services normally provided without charge by the University and covered by the school fee programs.

19. Expenses incurred as a result of commission of a felony.

20. Expenses incurred for acupuncture.

21. Expenses incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to: by whom they are prescribed; or by whom they are recommended; or by whom or by which they are performed.

22. Expenses for contraceptive methods, devices, or aids; charges for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures; elective sterilization or its reversal.

23. Expenses incurred for or in connection with: procedures; services; or supplies that are, as determined by Aetna, to be experimental or investigational. A drug; a device; a procedure; or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or Injury involved; or
- If required by the FDA, approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- The written protocol or protocols used by the treating facility; or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment; or the written informed consent used by the treating facility, or by another facility studying the same drug, device, procedure, or treatment; states that it is experimental; investigational; or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment; and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data. In making this determination; Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;
- If Aetna determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

24. Expenses incurred for, or related to, sex change surgery or to any treatment of gender identity disorders.

25. Expenses for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policy.

26. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
27. Expenses incurred for breast reduction/mammoplasty.
28. Expenses incurred for gynecomastia (male breasts).
29. Expenses for charges that are not reasonable charges, as determined by Aetna.
30. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when medically necessary; because the Covered Person is diabetic; or suffers from circulatory problems.
31. Expenses incurred for Elective Treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Policy is in effect.
32. Expenses arising from a Pre-Existing Condition.
33. Expenses incurred for sinus surgery, except for acute purulent sinusitis.
34. Expenses for treatment of Covered Students who specialize in the mental health care field, and who receive treatment as part of their training in that field.

Any exclusion listed will not apply to the extent that coverage is required under any law that applies to the coverage.

Extension of Benefits

If a Covered Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that hospital confinement for the medical condition shall be considered an eligible Expense, but only while they are incurred during the 90 day period following such termination of insurance.

Coverage of these eligible Expenses will cease at the earliest of the: (1) the Covered Person's medical condition no longer continues; or, (2) the Covered Person reaches the Lifetime Aggregate Maximum per Condition; or (3) the Covered Person obtains other similar coverage.

Continuation Option

Covered Persons who have been continuously insured under the School's Student Health Insurance Plan for a full coverage period as defined by the University of Denver and who no longer meet the Eligibility requirements under the Policy are eligible to continue their Coverage, at a higher premium rate, for a period of not more than six months. (These students are not eligible for coverage under the regular DU Student Health Insurance Plan. **All Continuation Option purchases must be made prior to current DU Student Health Insurance Plan coverage**)

expiration.) This additional coverage (up to six months) may be purchased as long as the premium is received by Chickering Claims Administrators, Inc. PRIOR to the date the current coverage would terminate.

Please Note: If current student coverage under the DU Student Health Insurance expires, this Continuation option is not available.

Contact The Chickering Group at (877) 409-7360 for additional information regarding premium rates and for an Enrollment Form.

Claim Procedure

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by:

Chickering Claims Administrators, Inc.

P.O. Box 15708

Boston, MA 02215-0014

(877) 409-7360

(617) 218-8400 (outside United States)

Customer Service Representatives are available 8:30a.m. to 5:30 p.m., Monday through Friday (MST) for any questions.

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. When submitting a claim form, attach available itemized medical bills to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Chickering Claims Administrators Inc., within 60 days from the date appearing on the Explanation of Benefits.

Appeals Procedure

Aetna has established the following appeal procedures for resolving complaints by Covered Persons. The Covered Person, his or her designated representative, the attending Physician or ordering provider may initiate an appeal.

As used in this section, "adverse benefit determination" means a determination by Aetna that an admission; availability of care; continued stay; or other health care service; has been reviewed and, based upon the information provided, does not meet Aetna's requirements for: medical necessity; appropriateness; health care setting; level of care; effectiveness; or efficiency.

Standard Appeals

The following procedures for the review of an adverse benefit determination apply to situations where the timeframe of the review would not jeopardize the Covered Person's life, health, or his or her ability to regain maximum function.

First Level Appeal Review

A Covered Person's Appeal must be submitted in writing to Aetna within 60 days of the date that Aetna provides notice of denial. The Aetna address is on the Covered Person's ID card.

A response will be sent to the Covered Person and the attending Physician or ordering provider within 20 working days following receipt of the request for a Standard First Level Appeal Review. The response will be based on the information provided with, or after, receipt of the request for the Appeal. Such response shall include the following:

- The name, title and qualifying credentials of the Physician evaluating the appeal and the qualifying credentials of the clinical peers with whom the Physician consults (together referred to as the "reviewers"). The reviewers will not have been involved in the initial adverse benefit determination but a person that was previously involved with the denial may answer questions.
- A statement of the reviewer's understanding of the reason for the appeal.
- The reviewer's decision in clear terms. This will include the medical rationale that applies, in sufficient detail for the Covered Person to respond further to Aetna's position.
- A reference to the evidence or documentation used as the basis for the decisions, including the clinical review criteria used to make the determination, and instructions for requesting such criteria.
- A description of the process for submitting a Second Level Appeal Review.

Second Level Appeal Review

If a Covered Person is not satisfied with the First Level Appeal Review decision, he or she may request a Second Level Appeal Review.

Upon receipt of a request for a Second Level Appeal Review, Aetna shall appoint a review panel. The review panel will include a minimum of three people. It may be composed of employees of Aetna who have appropriate professional expertise. A majority of the panel members shall be health care professionals who:

- Were not previously involved in the grievance;
- Were not previously involved in the medical care that is the subject of the grievance;
- Are not a member of the board of directors of Aetna, or any of its affiliates; and
- Do not have a direct financial interest in the case or the outcome of the review.

A Covered Person has the right to:

- Attend the Second Level Appeal Review;
- Present his or her case to the review panel in person or in writing;
- Submit supporting material both before, and at, the review meeting;

- Ask questions of any representative of Aetna prior to the hearing and question any panelist at the hearing; and
- Be assisted or represented by a person of his or her choice.

Upon request, Aetna will provide to the Covered Person all relevant information that is not confidential or privileged under state or federal law.

The review panel will schedule and hold a review meeting within 45 working days of Aetna's receipt of a Covered Person's request for a Second Level Appeal Review. If the Covered Person requests the opportunity to appear in person before the panel, the review meeting will be held during regular business hours at a location reasonably accessible to the Covered Person, including accommodations for disabilities. Aetna will not discourage a Covered Person from requesting a face-to-face meeting. However, in cases where a face-to-face meeting is not practical for geographic reasons, Aetna will offer the Covered Person the opportunity to communicate with the review panel (at Aetna's expense) by conference call, video conferencing, or other appropriate technology. The Covered Person will be notified in writing at least 15 working days in advance of the review date.

If Aetna intends to have an attorney present to represent its interests, it shall notify the Covered Person at least 15 working days in advance of the review that an attorney will be present and that the Covered Person may wish to obtain legal representation. Within five working days in advance of the review, the Covered Person must inform Aetna if he or she intends to have an attorney present to represent his or her interest.

After private deliberation, the review panel shall issue a written decision to the Covered Person within five working days of the conclusion of the review meeting. The decision shall contain the following:

- The names, titles, and qualifying credentials of the members of the review panel.
- A statement of the review panel's understanding of the nature of the appeal and the material facts related thereto, including issues that the Covered Person raised and all pertinent facts.
- The rationale for the review panel's decision.
- Reference to evidence or documentation considered by the review panel in making that decision.
- In the case of adverse benefit determinations, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.
- An explanation of any further rights available under the medical plan that the Covered Person has regarding the appeal.
- Instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination, and additional appeal, review, arbitration or other options available to the Covered Person, if any.
- Notice of the Covered Person's right to request an independent external review.

Expedited Appeals

The following procedures for the review of an adverse benefit determination apply to situations where the timeframe of a Standard Appeal would seriously jeopardize the Covered Person's life, health, or his or her ability to regain maximum function, or, if he or she is disabled, create an imminent and substantial limitation in the existing ability of the Covered Person to live independently.

An Expedited Appeal shall be available to, and may be initiated by, the Covered Person or the provider acting on his or her behalf. Expedited Appeals shall be evaluated by an appropriate clinical peer(s) in the same or similar specialty as would typically manage the case under review. The clinical peer(s) shall not have been involved in the initial adverse benefit determination. Aetna shall give reasonable access, not to exceed one business day after receiving a request for an Expedited Appeal review, to a clinical peer who can perform the review.

Aetna shall provide an Expedited Appeal review to all requests concerning an admission; availability of care; continued stay; or health care service for a Covered Person who has received emergency services but has not been discharged from a facility. Adverse benefit determinations made on a retrospective basis may only be appealed through the Standard Appeal review process. All necessary information, including Aetna's decision, shall be transmitted between Aetna and the Covered Person (or the provider acting on his or her behalf) either electronically, by telephone, or facsimile.

In an Expedited Appeal review, Aetna will make a decision and notify the Covered Person (or the provider acting on his or her behalf) as expeditiously as the medical condition requires, but in no event more than 72 hours after the review is started. If the review is a concurrent review determination, the service shall be continued without liability to the Covered Person until he or she has been notified of the determination.

Aetna will provide written confirmation of its decision concerning an Expedited Appeal review within two working days of providing notification of that decision. In the case of an adverse benefit determination, the written decision shall include the same information specified under the Standard First Level Appeal Review section.

If the expedited review process does not resolve a difference of opinion between Aetna and the Covered Person (or the provider acting on his or her behalf) the Covered Person or the attending provider may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. The written grievance in this case shall be handled by the carrier as a Standard Second Level Appeal Review.

External Review Process

In this section, any reference to "Covered Person" refers to the Covered Person or his or her designated representative.

"Designated representative," means:

- i. A person, including the treating provider or an authorized person, to whom the Covered Person has given express written consent to represent him or her in an External Review; or
- ii. A person authorized by law to provide substituted consent for the Covered Person, including but not limited to a guardian, agent under power of attorney, or proxy.

If, after exhausting the internal Appeals Procedure the Covered Person, his or her Physician or the hospital is still dissatisfied with Aetna's response, the Covered Person may be eligible to request an External Review. A request for an External Review must be submitted within 60 calendar days from the date the Covered Person receives the final determination letter. This letter will include instructions on how to submit a request for an External Review, the timelines associated with an External Review, and any forms used to process an External Review, as specified by the Division of Insurance.

A Covered Person is only eligible to request an External Review for the following:

- Medical services or treatment which have been denied either because they were not Medically Necessary, were medically inappropriate; or
- Because the proposed service or treatment is considered experimental or investigational.

A Covered Person's request for an External Review must be made in writing and include a completed External Review Request Form and a signed consent authorizing Aetna to disclose protected health information, including medical records concerning the Covered Person, that are pertinent to the External Review. A request for an Expedited External Review must also include a Physician's certification that the medical condition meets the necessary criteria. At this time the Covered Person may include new information, if it is significantly different from information previously provided, for consideration by Aetna or the Independent External Review Entity. Aetna's consideration of such new information will not stop or delay the External Review.

The External Review may only be stopped if Aetna decides to reverse its final adverse benefit determination and provide coverage or payment for the health care service that is the subject of the review. If Aetna decides to reverse its adverse benefit determination, Aetna will notify the Covered Person, the assigned Independent External Review Entity, and the Commissioner of such decision. The Independent External Review Entity will stop the External Review upon receipt of such notice.

Unless otherwise noted, all notices and exchange of documents, information and materials between parties shall be made electronically, by facsimile, or by telephone, followed by a written confirmation.

Standard External Review

Upon receipt of the request for an External Review, Aetna will deliver a copy of the request to the Commissioner within two working days. If, prior to sending such notification to the Commissioner, Aetna reverses its final adverse benefit determination based on new information the Covered Person submitted, Aetna will notify the Covered Person within one working day of its reversal.

Within two working days after a request for External Review is received from Aetna, the Commissioner will randomly assign an Independent External Review Entity to conduct the review. Upon assignment, the Commissioner will notify Aetna of the name and address of the Independent External Review Entity to which the appeal should be sent.

Within two working days of this notice, Aetna will provide the Covered Person with:

- A description of the Independent External Review Entity; and
- Instructions on how to file any documentation concerning a potential conflict of interest of the Independent External Review Entity with the Commissioner.

Within two working days of receipt of Aetna's notice regarding the Independent External Review Entity, the Covered Person may provide the Commissioner with documentation relating to a potential conflict of interest on the part of the Independent External Review Entity.

If the Commissioner determines that a conflict of interest exists, a new Independent External Review Entity will be assigned within one working day of such determination. The Commissioner will notify the Covered Person of the determination regarding the potential conflict of interest and the identity of the new Independent External Review Entity, if applicable. The Commissioner will notify Aetna of the name and address of the new Independent External Review Entity to which the appeal should be sent.

Within six working days from the date Aetna receives notice as to the identity of the Independent External Review Entity, Aetna will deliver to such entity the documents and information considered in making its final adverse benefit determination, including an index of all submitted documents. If Aetna fails to provide the required documents and information within the time specified, the Independent External Review Entity may terminate the External Review and make a decision to reverse Aetna's final adverse benefit determination.

Within two working days of receipt, the Independent External Review Entity will deliver to the Covered Person the index of the material submitted to them by Aetna. Upon request, Aetna will provide the Covered Person with all relevant information supplied to the Independent External Review Entity that is not confidential or privileged under state or federal law concerning the case under review.

After receipt of the required documentation, the Independent External Review Entity will notify the Covered Person, his or her attending provider, and Aetna of any additional medical information required to conduct the review. Within five working days of such a request, the

Covered Person or the attending provider must submit the additional information, or an explanation of why the additional information is not being submitted to the Independent External Review Entity and Aetna. If the Covered Person or the attending provider fails to provide the additional information within the time specified, the Independent External Review Entity will make its decision based on the information provided by Aetna.

The Independent External Review Entity will base its determination on an objective review of relevant medical and scientific evidence. In reaching a decision, the Independent External Review Entity is not bound by any decisions or conclusions reached during Aetna's utilization review process or internal Appeals Procedure.

Within 30 working days after the date of receipt of the request for External Review by Aetna, the Independent External Review Entity will provide written notice of its decision to uphold or reverse Aetna's final adverse benefit determination to the Covered Person, his or her attending provider, Aetna, and the Commissioner. However, the Expert Reviewer may request that the Commissioner extend the deadline for the written notice of the Independent External Review Entity up to 10 days to consider additional information.

Upon receipt of the Independent External Review Entity's decision to reverse Aetna's final adverse benefit determination, Aetna will approve the coverage that was the subject of the review. For concurrent and prospective reviews, this will happen within one working day. For retrospective reviews, this will happen within five working days. Aetna will provide written notice of the approval to the Covered Person within one working day of its approval of coverage.

Expedited External Review

A Covered Person may request an Expedited External Review if he or she has a medical condition where the timeframe for completion of a Standard External Review would seriously jeopardize his or her life, health, or ability to regain maximum function or, if the Covered Person is disabled, create an imminent and substantial limitation in the ability of the Covered Person to live independently.

Upon receipt of the Covered Person's request for an Expedited External Review, Aetna will notify and send a copy to the Commissioner within one working day either electronically, by telephone, or facsimile.

Within one working day from the time the Commissioner receives a request for an Expedited External Review, the Commissioner will assign an Independent External Review Entity to conduct the review. The Commissioner will select an Independent External Review Entity that does not have a conflict of interest with the case. Upon assignment, the Commissioner will inform Aetna of the name and address of the Independent External Review Entity to which the appeal should be sent. Within one working day of this notice, Aetna will provide information to the Covered Person describing the Independent External Review Entity selected.

Within three working days from the date of receipt of the request for an Expedited External Review, Aetna will deliver the documents and information considered in making its final determination, including an index of all submitted documents, to the Independent External Review Entity. Within one working day of receipt of the request, the Independent External Review Entity will deliver to the Covered Person the index of the material submitted to them by Aetna. Upon request, Aetna will provide the Covered Person with all relevant information supplied to the Independent External Review Entity that is not confidential or privileged under state or federal law concerning the case under review.

The Independent External Review Entity will notify the Covered Person, the attending provider, and Aetna of any additional medical information required to conduct the review. Within two working days of such a request, the Covered Person or the attending provider must submit the additional information, or an explanation of why the additional information is not being submitted to the Independent External Review Entity and Aetna. If the Covered Person, or the attending provider fails to provide the additional information within the time specified, the Independent External Review Entity will make its decision based on the information provided by Aetna.

The Independent External Review Entity will base its determination on an objective review of relevant medical and scientific evidence. In reaching a decision, the Independent External Review Entity is not bound by any decisions or conclusions reached during Aetna's utilization review process or internal Appeals Procedure.

Within seven working days after the date of Aetna's receipt of the request for an Expedited External Review, the Independent External Review Entity will make a decision to uphold or reverse Aetna's final adverse benefit determination and notify the Covered Person, the attending provider, Aetna, and the Commissioner of such decision. However, the Expert Reviewer may request that the Commissioner extend the deadline for the written notice of the Independent External Review Entity up to five days to consider additional information. If the first notification the Covered Person receives from the Independent External Review Entity is not in writing, the Independent External Review Entity will provide written confirmation within two days of the initial notification.

Upon receipt of the Independent External Review Entity's notice of a decision to reverse Aetna's final adverse benefit determination, Aetna will approve the coverage that was the subject of the review within one working day. Aetna will provide written notice of the approval to the Covered Person within one working day of its approval of coverage.

Rights and Responsibilities

A Covered Person's Rights Under the Preferred Care Plan

A Covered Person has a right under the Preferred Care Plan to:

- Get up-to-date information about the Physicians and hospitals who participate in the Preferred Care plan.
- Obtain primary and preventive care (if covered under the plan) from a Physician who is a Preferred Care Provider that the Covered Person chose from the plan's network.
- Obtain timely and necessary care from specialists, hospitals and other providers that are Preferred Care Providers in a convenient manner.
- Be told by the Preferred Care Providers how to make appointments and get health care during and after office hours.
- Be told how to get in touch with the Preferred Care Physician or a back-up Physician 24 hours a day, every day.
- Call 911 in a situation that might be life-threatening.
- Be treated with respect for his or her privacy and dignity.
- Have medical records kept private, except when required by law or with the Covered Person's approval.
- Help the Preferred Care Providers make decisions about his or her health care.
- Have a Physician decide when coverage for treatment should be denied.
- Discuss with the Preferred Care Provider his or her condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that the Preferred Care Provider cannot be penalized for filing a complaint or appeal.
- Know how the plan decides what expenses are covered.
- Know how the plan pays Preferred Care Providers.
- Get up-to-date information about the expenses covered by the plan; for instance, what is, and is not covered, and any applicable limitations or exclusions.
- Get information about Copays and fees he or she must pay.
- Be told how to file a complaint, grievance, or appeal with the plan.
- Receive a prompt reply when he or she asks the plan questions or request information.
- Have the Preferred Care Provider's help in decisions about the need for services and in the appeal process.
- Suggest changes in the plan's policies and services.
- Have a family member or designated person facilitate any care when he or she unable to do so.

A Covered Person's Responsibilities Under the Preferred Care Plan

A Covered Person has a responsibility under the Preferred Care Plan to:

- Choose providers from the plan's network of Preferred Care Providers.
- Help the Preferred Care Providers make decisions about his or her health care.
- Tell the Preferred Care Provider if he or she does not understand the treatment received and to ask if he or she does not understand how to care for the illness.

- Follow the directions and advice he or she and the Preferred Care Providers have agreed upon.
- Tell the Preferred Care Providers promptly when she or she has unexpected problems or symptoms.
- See the specialists the Preferred Care Physician refers him or her to.
- Understand that Physicians and other health care providers who are Preferred Care Providers who care for him or her are not employees of Aetna and that Aetna does not control them.
- Show the I.D. card to Preferred Care Providers before getting care from them.
- Pay any applicable Copays required by the plan.
- Call Customer Services at the telephone number listed on the I.D. card if he or she does not understand how to use the benefits.
- Promptly follow the plan's appeal procedures if he or she needs to submit a grievance.
- Give correct and complete information to Physicians and other health care providers who care for him or her.
- Treat Preferred Care Providers and all other providers, their staff, and the staff of the plan with respect.
- Keep appointments with Preferred Care Providers.
- Advise Aetna about other medical insurance coverage the Covered Person may have.
- Not be involved in dishonest activity directed to the plan or any provider.
- Follow the Preferred Care plan's rules and regulations.
- Read and understand the plan and benefits. Know the Copays, Deductibles, and what expenses are covered and what expenses are not covered.

Prescription Drug Claim Procedure

When obtaining a covered Prescription, please present your Chickering ID card to an Aetna Preferred Pharmacy along with your applicable Copay. The Pharmacy will submit a claim to Aetna for the drug. Claim Forms, Pharmacy locations, and claims status information can be obtained by contacting Aetna Pharmacy Management at **(800) 238-6279**. Additionally, a listing of Pharmacy locations may be obtained at the DU Student Health and Counseling Center or by contacting Chickering Claims Administrators, Inc., at **(877) 409-7360** or by using Aetna's online **DocFind**[®] service located at **www.chickering.com**. Click on "Find Your School" enter **812832** as your Policy Number. You can use **DocFind** to find out whether a specific pharmacy belongs to Aetna's network.

The Chickering Group is committed to mailing Student Health Insurance Identification Cards within 10 business days of receiving enrollment from the University. If you need to access treatment prior to receiving your Student Health Insurance Identification Card, your prescriptions can still be processed if enrollment was sent on your behalf. To fill a prescription, without your Student Health Insurance Identification Card, at an Aetna Pharmacy, present your social security number, date of birth and the University of Denver Pharmacy Plan RX Group Number 0067-0000. This should allow you to have your prescription filled through the Aetna Pharmacy Management system. If the Pharmacy is not locating your record, you may contact the Insurance Coordinator

on campus at (303) 871-4136 for further assistance. In an emergency, please fill your prescription and bring your receipt to the Insurance Coordinator at The Student Health & Counseling Center in the Ritchie Center, 3rd floor North. That Office will assist you in submitting a completed Aetna Prescription Drug claim form for reimbursement directly from Aetna. If you fill your prescription and pay out-of-pocket, contact the SHCC Insurance Coordinator as soon as possible as adjustments can be made that allow you to request that the Pharmacy resubmit your prescription, with your insurance information, within 5 days after purchase. This would allow you to obtain a refund of your out-of-pocket costs minus your applicable per prescription copay.

***Please note:** if you do not request that the Pharmacy resubmit your prescription with your insurance information within 5 days, you may be required to pay the difference between the retail price you paid for the drug and the amount Aetna would have paid if you had presented your ID card and the Pharmacy had billed Aetna directly in addition to your copay amount.*

Accidental Death and Dismemberment Benefit

This insurance coverage provides Accidental Death and Dismemberment coverage underwritten by Unum Provident Life Insurance Company of America.

Benefits are payable for the Accidental Death and Dismemberment of the eligible insureds of up to a maximum of \$10,000. (Exclusions and limitations may apply. For definitions of eligibility and a complete loss schedule, detailing the benefits received for accidental death, dismemberment, loss of sight, speech or hearing, please refer to your Master Policy available at your School.)

To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at (877) 409-7360 for the appropriate claim forms.

Worldwide Emergency Travel Assistance Services

These services are designed to protect University of Denver students and/or eligible dependents when traveling more than 100 miles from home anywhere in the world. Medical Repatriation and Return of Mortal Remains services are also available from the participant's campus location.

If you experience a medical emergency while traveling more than 100 miles from home or campus, you have access to a comprehensive group of emergency assistance services provided by Assist America, Inc.

Eligible participants have immediate access to doctors, hospitals, pharmacies, and other services, when faced with an emergency while traveling. The Assist America Operations Center can be reached 24 hours a day, 365 days a year to provide services including: medical consultation and evaluation; medical referrals; foreign hospital admission guarantee; prescription assistance; lost luggage assistance; legal and interpreter assistance; and travel information such as Visa and passport requirements, travel advisories, etc.

Medical Evacuation and Return of Mortal Remains Services

In the event that a participant becomes injured and adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment and personnel necessary to evacuate you to the nearest facility capable of providing required care. In the event of death of a participant, Assist America will render every possible assistance in return of mortal remains including locating a sending funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container as well as paying for transport. ***Please note:*** Any third party expenses incurred are the responsibility of the participant.

An Assist America ID card will be supplied to you once you enroll in the University of Denver Student Health Insurance Plan. Please remember to carry your Assist America card and call toll-free within the U.S. at **(800) 872-1414** or outside the U.S. call collect (dial U.S. access code) plus **301-656-4152** in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of over 600,000 pre-qualified medical providers. Assist America Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider.

NOTE: ASSIST AMERICA PAYS FOR ALL ASSISTANCE SERVICES IT PROVIDES. ALL ASSISTANCE SERVICES MUST BE ARRANGED AND PROVIDED BY ASSIST AMERICA. ASSIST AMERICA DOES NOT REIMBURSE FOR SERVICES NOT PROVIDED BY ASSIST AMERICA.

The Assist America program meets and exceeds the requirements of USIA for International Students & Scholars.

Emergency Travel Assistance Services are administered by Assist America, Inc. and are provided to University of Denver students and their dependents at home or while traveling. The policy provides coverage for up to \$10,000 for Accidental Death and Dismemberment, unlimited medical evacuation and repatriation coverage, as well as extensive travel assistance services. This program is available to all domestic and international students at the University of Denver. In addition, the following services are included by contacting Assist America at **(800) 872-1414**:

- Passport and visa information
- Lost baggage services
- Prescription assistance
- Inoculation and immunization information
- Emergency ticket replacement
- Emergency medical and dental referral services
- Medical monitoring through access to multi-lingual staff of physicians, nurses, medical supervisors, and response coordinators
- Emergency messaging services
- Legal referral
- Travel advisories

- Translation and Interpretation
- Transport to join patient (if you are traveling alone and will be hospitalized for more than seven days, Assist America will provide economy roundtrip transportation to the place of hospitalization for a designated family member or friend).

Important Numbers:

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

Location

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

Health www.du.edu/duhealth/

8:30am - 5:30pm, Mon.-Fri. (All year) except holidays
 9:00am - 1:00pm, Sat. (Sept.-May) except holiday weekends
 Student Line: (303) 871-2205
 Fax: (303) 871-4242
 Nurse line: (303) 871-4133
 Prescription Refills: (303) 871-4199
 Insurance Coordinator: (303) 871-4136
 After hours: (303) 871-2205

Counseling www.du.edu/duhealth/

8:30am - 5:30pm, Mon.-Fri. (All year)
 Student Line: (303) 871-3511
 Fax: (303) 871-4242
 After hours: (303) 871-3000

Student Financial Services www.du.edu/sfs

Bursar's Office
 Student Line: (303) 871-4944
 Fax: (303) 871-4401

Important Note

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

This student plan fulfills the definition of creditable coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the Customer Service number on your ID card.

Offered by:

Chickering Benefit Planning
Insurance Agency, Inc.

Administered by:

Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(877) 409-7360
www.chickering.com



Underwritten by:

Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156

Policy No. 812832

The Chickering Group is an internal business unit of Aetna Life Insurance Company.

Notice

To obtain reimbursement rates for non-participating providers, you may contact Customer Services at the toll-free number shown on your ID card.

Colorado Law requires Aetna to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The Form must be provided automatically within three business days to a potential policyholder who has expressed interest in a particular plan. Aetna also must provide the Form, upon oral or written request, within three business days, to any person who is interested in coverage under or who is covered by a health benefits plan of Aetna.

The Colorado Consumer Protection Standards Act for the operation of Managed Care Plans (S) 10-16-704(9) of the Colorado Revised Statutes), requires a carrier to maintain an "access plan" for each managed care network that the carrier offers in Colorado. In general, an access plan lists hospitals, providers, referral procedures, grievance procedures, and emergency coverage provisions. The law requires the carrier to make access plans (except for certain confidential information, as specified in section 24-72-204 (3) of the Colorado revised Statutes) available on its business premises and to provide them to any interested party upon request. To obtain additional information regarding our Colorado access plan(s), please call Customer Service at the toll-free number on your ID card.

Enrolling in Aetna does not guarantee services by a particular provider on the list. If you wish to be sure of receiving care from specific providers listed, you should contact these providers to be sure that they are accepting additional patients for Aetna. Also, we may add physicians on a periodic basis and will provide you with a listing of newly added doctors in your local area, if you request it.

The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. In addition, not every provider listed in the directory (or shown in **DocFind**) will be accepting new patients. For the most current information, please contact the selected provider, Customer Service at the toll-free number on your ID card, or visit **DocFind**® at www.chickering.com.

If a Covered Person incurs Covered Medical Expenses which:

- Are for services and supplies that are not reasonably available from a Preferred Care Provider, as determined by Aetna; and
- Are expenses for which benefits would be paid at a Preferred Care rate, if provided by a Preferred Care Provider;
- such expenses will be deemed to be expenses incurred for Preferred Care.

As to Preferred Care expenses; if a Covered Person is responsible for a coinsurance payment based on a percentage of the bill, where applicable, the Covered Person's obligation will be determined based upon the negotiated charge established by contract with Aetna for that service or supply, either directly or indirectly through a third party, rather than the amount the provider would bill in the absence of a Negotiated Charge.

For questions regarding:

- Non-Preferred Care Provider reimbursement rates; and
- How to obtain a copy of the Colorado Network Access Plan which describes such things as the geographic accessibility of network providers, referral requirements, network adequacy guidelines, list of network providers, etc.;
- a Covered Person should contact the Customer Services toll-free number on his or her ID Card.

Notice

Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit Chickering's Student Connection Link on the internet at www.chickering.com.