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This is only a brief description of the coverage available under policy S30749NUFIC-CO-UCB (Rev. 4-15) (“the Policy”). The Policy contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy on file with the Policyholder. If there is any conflict between the contents of this document and the Policy, the Policy will govern in all cases. Travel assistance services are provided by Travel Guard Group, Inc. (“Travel Guard”). Insurance and services are provided by member companies of American International Group, Inc. Coverage may not be available in all jurisdictions and is subject to actual policy language. For additional information, please visit our website at www.AIG.com.
CU-Boulder Health Insurance Requirement

CU-Boulder’s goal is to provide students with the best educational experience possible. Because health and wellness can directly affect the quality of this experience, CU-Boulder requires all students to be covered by a health insurance plan. Students may elect to have coverage under their own insurance, through their employer or their parents’ policies, or the CU-Boulder Student Gold Health Insurance Plan (“the Plan”). The University of Colorado Boulder encourages students to research various health plan options so that they may make informed healthcare choices.

All degree-seeking CU-Boulder students will be automatically enrolled in and billed each semester for coverage under the Plan, unless a waiver of Plan coverage is submitted and approved by the applicable waiver deadline date. (See “Eligibility”, “How to Select or Waive Coverage” and “Enrollment Deadlines” on page 4). The Plan provides coverage for services on campus at Wardenburg Health Services (WHS) as well as for services received locally and nationally (Please see “Participating Provider Organizations (PPO)” on page 24).

Eligibility

Students

- Degree-seeking undergraduate students enrolled in six or more credit hours and graduate students enrolled in one credit hour are eligible for and will be automatically enrolled in and charged premium for coverage under the Plan unless a waiver of Plan coverage is submitted by the applicable waiver deadline date. (See page 4)
- Continuing Education, ACCESS and Study Abroad students enrolled in six or more credit hours, and paying the base student and WHS fees, are eligible to enroll in the Plan on a voluntary basis and may do so by visiting Patient Services Office at WHS and completing an enrollment form and remitting the full applicable premium payment.

Eligible students must actively attend classes for at least the first 31 days after the date for which coverage is purchased.

NOTE: Home study, correspondence and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have not been met. If the Company discovers the Policy eligibility requirements have not been met, its only obligation is to refund premium.
Automatic enrollment
All degree-seeking undergraduate students enrolled for 6 or more credit hours and graduate students enrolled in 1 credit hour will be automatically enrolled in and charged premium for coverage under the Plan each semester unless a waiver of Plan coverage is submitted by the applicable waiver deadline date.

Students Continuing from Fall Semester into Spring/Summer Semester
If you enrolled in the Plan for the Fall Semester, you will be automatically enrolled and charged premium for coverage under the Plan for the Spring/Summer Semester unless you waive coverage under the Plan by the Spring/Summer Semester waiver deadline date. If you waived coverage under the Plan for the Fall Semester but want to enroll in the Plan for the Spring/Summer Semester, you must enroll and pay the appropriate premium by the Spring/Summer Semester deadline date.

New Spring 2016 Students
If you are a new student starting at the University in the Spring Semester or a returning student following a break in attendance (for example, a Study Abroad student returning following a break in attendance in the Fall), you will be automatically enrolled in and charged the premium for coverage under the Plan for the Spring/Summer Semester unless a waiver is submitted by the Spring/Summer Semester waiver deadline date. If you are a new student in the Spring and you are automatically enrolled in and charged the premium for coverage under the Plan, coverage will continue into the Summer Semester whether you are taking classes or not.

To waive coverage under the Plan, please follow the instructions located at: www.colorado.edu/studentinsurance

Voluntary enrollment: Continuing Education, ACCESS and Study Abroad students enrolled in six (6) or more credit hours, and paying the base student and WHC fees; and students approved for the Time Off or Stay Connected programs for medical reasons may enroll for coverage in the Plan on a voluntary basis by the appropriate enrollment deadline date. Enrollment is available only under the following conditions: (a) during an initial or subsequent open enrollment period; (b) within 31 days of a marriage, birth or adoption; or (c) within 31 days of ineligibility under another creditable plan.

To select coverage under the Plan, please go to the Patient Services Office at WHC and complete the enrollment process by the applicable enrollment deadline date.

Enroll or Waive Coverage
Students must either enroll or waive coverage under the Plan by the appropriate 2015/2016 Enrollment/ Waiver Deadline Dates.

2015/2016 Enrollment/ Waiver Deadline Dates:
Fall Semester: September 4, 2015
Spring/Summer Semester: January 22, 2016
Summer Semester: May 30, 2016

How to Enroll in the Optional Dental Treatment Expense and/or Optional Vision Care Expense
The Optional Dental Treatment Expense and Optional Vision Care Expense coverages are available to Covered Persons at initial enrollment under the Plan each Policy Year. Covered Persons may enroll by completing the online enrollment and payment process at: www.studentinsurance.com/Schools/CO/CUB/

Plan details on pages 20 and 21.
Gold Plan Dates & Cost

<table>
<thead>
<tr>
<th></th>
<th>FALL Semester</th>
<th>SPRING/ SUMMER Semester</th>
<th>SUMMER ONLY (New Students to the University in the Summer Semester Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVERAGE PERIOD</td>
<td>8/18/15 – 12/31/15</td>
<td>1/1/16 – 8/17/16</td>
<td>5/1/16 – 8/17/16</td>
</tr>
<tr>
<td>Student</td>
<td>$1,840</td>
<td>$1,840</td>
<td>$817</td>
</tr>
</tbody>
</table>

Plan Costs include an administrative fee.

2015/2016 Enrollment/ Waiver Deadline Dates:

Fall Semester - September 4, 2015
Spring/Summer Semester - January 22, 2016
Summer Semester – May 30, 2016

Effective and Termination Dates:

The Master Policy on file at the University becomes effective at 12:01 a.m. August 18, 2015. The coverage of an eligible student who enrolls for coverage under the Policy shall take effect at 12:01 a.m. on the latest of the following dates: (1) the Policy Effective Date; (2) the date for which the first premium for the Covered Student’s coverage is received by the Company; (3) the date the Policyholder’s term of coverage begins; or (4) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the Policyholder.

The Master Policy terminates at 11:59 p.m. August 17, 2016. Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur: (a) the date the Policy terminates; (b) the last day for which any required premium has been paid; or (c) the date on which the Covered Student withdraws from the school because of: (1) entering the armed forces of any country (premium will be refunded on a pro-rata basis (less any claims paid when written request is made); or (2) withdrawal from school during the first 31 days of the period for which enrollment was made.

If withdrawal from the Policyholder’s school is for other than (1) or (2) above, no premium refund will be made. Students will be covered for the Policy term for which they are enrolled and for which premium has been paid.

Late Enrollment—what do you do if you miss the enrollment deadline or lose coverage after the deadline?

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage may elect to enroll for coverage under the Plan within 31 days of ineligibility under another creditable coverage plan.

A student eligible to enroll on a voluntary basis who does not enroll himself or herself during an open enrollment period may not apply for coverage under the Plan until the next subsequent open enrollment period unless an enrollment form is completed for coverage within 31 days of ineligibility under another creditable coverage plan.

What to do if you miss the waiver deadline?

If a student misses the deadline to waive coverage, they can request that the insurance premium be removed from their account by contacting Patient Services at Wardenburg Health Services, and providing proof of private insurance up to two weeks past the semester deadline. A $50 late fee will be charged to the student’s tuition bill. After the late deadline has passed, a student may petition their enrollment by contacting Patient Services and completing a formal appeal process. For more information visit www.colorado.edu/studentinsurance.

Extension of Benefits

If the Covered Person is confined to a Hospital on the date his or her coverage terminates as a result of a Sickness or Injury for which benefits were payable prior to the date his or her coverage terminated, benefits will be payable for Eligible Expenses incurred until the earliest of: (1) the date the Hospital confinement ends; (2) the end of the 90 day period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

Stay Connected Program—applicable to degree-seeking main campus undergraduate students only

If a Covered Student wishes to extend coverage under this Plan, he or she may do so by exercising a “Semester Stop Out”. A “Semester Stop Out” is an option available only once to a Covered Student who decides to not attend school for a semester due to a medical reason approved by the University. An enrollment form must be completed and submitted to the Patient Services Office and the required premium must be paid in order for coverage to extend beyond the date the Covered Student exercises this option. Continuation of coverage will be subject to all the terms of the Policy.
Time Off Program - applicable to Graduate, Law, and MBA students only

A Covered Student may become eligible for a medical leave of absence when approved by the University. During the approved leave, coverage may continue for the Covered Student until the earlier of (1) the date the approved medical leave ends; or (2) the end of the period for which premium has been paid. In no event will the approved leave extend beyond 12 months. Coverage will be subject to all the terms of the Policy.

Students approved for the Stay Connected or the Time-Off program for medical reasons are eligible to enroll in the Plan on a voluntary basis and may do so by visiting the Patient Services Office at WHS and completing an enrollment form and remitting the full applicable premium payment.

Overview of the Student Gold Health Insurance Plan

The Plan has been developed for CU-Boulder students. The Plan provides certain benefits for medical, orthopedic, women’s health, pharmacy, psychological health and psychiatry coverage at WHS and for Eligible Expenses not available at WHS.

The Plan includes special design features in an effort to keep coverage and medical services affordable. Examples include:

1. **Primary Medical Provider:** WHS is the primary medical provider for Covered Students for services such as acute care visits. Chronic illness management, routine healthcare, in-house Doctor-ordered lab and/or X-ray, mental health visits are available at WHC (see the following pages for details). Eligible Expenses incurred at WHC are not subject to deductibles or co-pays (other than pharmacy). Benefits for covered hospitalization, emergency room charges, obstetrical care, specialized care and testing outside WHC are outlined in the Schedule of Benefits.

2. **Preferred Provider Organization ("PPO"):** Cofinity (inside Colorado) and First Health (outside Colorado) provide 24-hour helplines and web support at www.myameriben.com. These organizations are groups of Doctors, Hospitals and medical care providers who have agreed to provide medical services at reduced costs for CU-Boulder insured students requiring care outside of WHC. PPO discounts can significantly reduce out-of-pocket expenses by reducing the cost of the Covered Person’s deductible and coinsurance payments.

3. **Pharmacy Benefit Manager:** Catamaran is a nationwide pharmacy benefit manager providing a 24-hour helpline staffed by qualified customer service staff and pharmacy technicians. Catamaran provides prescription drug support services and discount pharmacy benefits to Covered Persons.

4. **Dental and Vision:** Covered Persons may enroll in the optional dental treatment expense and optional vision care expense coverages. Details and enrollment are available at: http://www.studentinsurance.com/ Schools/CO/CUB/
Wardenburg Health Services (WHS) Referral Requirement

You must receive a referral from WHS before you receive medical care outside of WHS (exceptions noted below). If you need urgent care when WHS is closed or you need emergency care, you must return to WHS for necessary follow-up care, except as stated below.

WHS Referral Requirement

The Covered Student must first utilize the resources of WHS where treatment will be administered or a referral issued. No benefits will be paid for Eligible Expenses incurred for medical treatment rendered outside WHS for which no referral was obtained. A referral from WHS must accompany the claim when submitted. Exceptions to the referral requirement are as follows:

1. Emergency Medical Condition. Please note, the Covered Student must return to WHS for necessary follow-up care, except when referred to a specialist as a result of an emergency room visit. See definition of Emergency Medical Condition on page 18;
2. When WHS is closed. WHS is not a 24-hour facility;
3. When a covered service is rendered at another facility during school breaks or vacation times;
4. Medical care is received when the Covered Student is more than 15 miles from campus;
5. Medical care is obtained by a Covered Student who is not eligible to use the WHC;
6. Services provided for dermatology, maternity, annual OB/GYN Care, home health care, dental treatment or eye care; or
7. Preventive Services not covered at WHS.

Call WHS at 303-492-5107 to determine whether a Preventive Service is available at WHS.

Visit www.colorado.edu/studentinsurance to find a provider in the Cofinity PPO Network if being treated within the State of Colorado or First Health.

Services and Benefits at WHS

WHS is the primary medical provider for Covered Students enrolled in the Student Health Insurance Plan. These services and benefits are not insured benefits under the Student Health Insurance Plan but are provided by WHS to all Covered Students enrolled in the Student Health Insurance Plan. Services rendered at WHS are not subject to the coinsurance, co-pay or deductible amounts applicable to the Student Health Insurance Plan.

Medical Clinic
- Primary care for Sicknesses and Injuries
- Routine vaccinations
- Travel Clinic services (excluding specialty travel vaccinations)
- Men’s health services including one annual exam per policy year and including HPV (Human Papilloma virus) vaccines
- Sexual health and infection testing
- Allergy injections

Nutrition Services
- Counseling for a variety of nutrition-related concerns

Laboratory and X-Ray
- Coverage for laboratory and x-ray services when ordered by a WHS provider only

Counseling and Psychiatric Services
- Initial assessment/urgent care
- Individual, couples, and group therapy
- Medical evaluation and medication management
- Stress management services
- Evaluation and treatment of a variety of mental health concerns: including eating disorders and substance abuse.
- Crisis Care
- 50% coverage of psychological testing
- $20 copay applies after the 20th visit

Sports Medicine
- 25 physical therapy visits per policy year
- 10 chiropractic visits per policy year
- Orthopedic surgeon consultations

Women's Clinic
- One annual exam per policy year
- Gynecology services and consultations that do not require the services of a specialist outside of WHC
- Birth control consultations
- Human Papillomavirus (HPV) vaccination
- Sexual health and infection testing

Eye Exam
- One routine eye exam per plan year through WHS’s contracted optical provider. Glasses, contacts and contact lens fittings are not covered.
These services are offered at WHS, but not covered by the Gold Plan:

- Acupuncture
- Bike fits
- Copies of X-rays and medical records
- Custom knee braces
- Vaccinations for Japanese encephalitis, rabies, yellow fever, and typhoid
- Loaned equipment
- Massage therapy
- Missed appointment fees
- Patient-requested lab tests (not Medically Necessary)
- Replacement of medical supplies

Students who are covered under the Plan but leave school mid-year may not receive any services at WHS unless they:

- Completed the spring semester but are not enrolled for the summer or
- Withdrew after the 31st day of the semester in which case you will be eligible for treatment at WHS until the end of the semester.
# Gold Plan Schedule of Benefits

(Refer to WHS Referral Requirement, page 7.)

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Policy Year Maximum Benefit</th>
<th>Deductible per Covered Person per Policy Year (PPO and Non-PPO are applied separately)</th>
<th>Out-of-Pocket Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unlimited</td>
<td>$500 PPO / $1,000 Non-PPO</td>
<td>$5,000 PPO / $10,000 Non-PPO applied separately</td>
</tr>
</tbody>
</table>

Once the Out-of-Pocket Limit has been satisfied, Eligible Expenses will be payable at 100% for the remainder of the Policy Year, not to exceed any benefit maximum that may apply. The Policy Year Deductible, copays and coinsurance apply toward meeting the Out-of-Pocket maximum. Non-covered charges, charges above the Reasonable and Customary Charge, and any charges above the service limit will not apply toward the Out-of-Pocket Limit.

## INPATIENT

<table>
<thead>
<tr>
<th></th>
<th>PREFERRED PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO = Allowable Charges</td>
<td>R&amp;C = Reasonable and Customary Charges</td>
<td></td>
</tr>
<tr>
<td>Anesthetist—Professional Services</td>
<td>80% of PPO</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Biologically Based Mental Illness</td>
<td>Paid as any other Sickness</td>
<td>See page 17 for more details.</td>
</tr>
<tr>
<td>Doctor Visits (non-surgical)</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Expense</td>
<td>$200 copay per admission 80% of PPO</td>
<td>$200 copay per admission 50% of R&amp;C</td>
</tr>
<tr>
<td></td>
<td>The per admission copay is in addition to the per Policy Year Deductible. Eligible Expenses include Hospital room and board charges (limited to average semi-private room rate except if ICU or CCU) and general nursing care provided by the Hospital; and Miscellaneous expenses such as the cost of the operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the days payable under this benefit, the date of admission will be counted, but not the date of discharge.</td>
<td></td>
</tr>
<tr>
<td>Intensive Care</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>Paid as any other Sickness</td>
<td>See Benefits for Mental Disorders on page</td>
</tr>
<tr>
<td>Physiotherapy/Occupational Therapy</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
</tbody>
</table>
### INPATIENT

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Admission Testing</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td>Payable within 14 Days prior to admission.</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Surgeon’s Fees</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td>If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the applicable covered percentage levels for the first procedure and second procedures and 25% of the third and subsequent procedures.</td>
</tr>
</tbody>
</table>

PPO = Allowable Charges  
R&C = Reasonable and Customary Charges

### OUTPATIENT

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthetist</td>
<td>80% of PPO</td>
<td>80% of R&amp;C</td>
<td>Related to scheduled surgery performed in a Hospital, or an outpatient surgical facility including the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines (excluding take-home drugs); and supplies</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td>Not otherwise covered by Preventive Benefits</td>
</tr>
<tr>
<td>Chemotherapy &amp; Radiation Therapy</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Day Surgery Facility/Miscellaneous Procedures (for Scheduled Surgery)</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-ray and Laboratory Services</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Doctor’s Visits (non surgical)</td>
<td>$40 copay per visit</td>
<td>$40 copay per visit</td>
<td>Includes charges for the chicken pox vaccination for all Covered Persons who have not had chicken pox. Benefits for chicken pox vaccination will be paid at 100% and will not be subject to the Deductible or Co-payment Amounts when services are rendered by a PPO provider.</td>
</tr>
<tr>
<td></td>
<td>100% of PPO</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy Year deductible does not apply.</td>
<td>Policy Year deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room and Non-Scheduled Surgery</td>
<td>$150 copay per visit</td>
<td>$150 copay per visit</td>
<td>For use of Hospital Emergency Room, including attending Doctor’s charges, operating room, laboratory and x-ray examinations, supplies. 1) The $150 copay is waived if admitted. Policy Year Deductible does not apply. 2) Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.</td>
</tr>
<tr>
<td></td>
<td>100% of PPO</td>
<td>100% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Injections</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
<td>Administered in the Doctor’s office and charged on the Doctor’s statement.</td>
</tr>
</tbody>
</table>

$40 copay per visit includes charges for the chicken pox vaccination for all Covered Persons who have not had chicken pox. Benefits for chicken pox vaccination will be paid at 100% and will not be subject to the Deductible or Co-payment Amounts when services are rendered by a PPO provider.

1. The $150 copay is waived if admitted. Policy Year Deductible does not apply.
2. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.
<table>
<thead>
<tr>
<th>OUTPATIENT</th>
<th>PREFERRED PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Disorders</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Biologically Based Mental Illness</td>
<td>Refer to Doctor Visit Benefit on page 10.</td>
<td>Refer to page 17 - “Benefits for Mental Disorders”</td>
</tr>
<tr>
<td>Rehabilitative Services/Habilitative Services (Physiotherapy, Occupational Therapy, Speech Therapy, Cardiac/Pulmonary)</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>• $25 copay per prescription for Generic</td>
<td>Benefit includes birth control with no copay.</td>
</tr>
<tr>
<td></td>
<td>• $45 copay per prescription for Formulary Brand Name</td>
<td>Insulin covered at 100% and are not subject to the maximum per Policy Year.</td>
</tr>
<tr>
<td></td>
<td>• $75 copay per prescription for Non-formulary Brand Name</td>
<td>Prescribed pre-natal vitamins are covered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail order Prescription Drugs through Catamaran at 2 times the copay. See page 14 for details.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If a Covered Person’s Doctor chooses a brand or non-formulary drug and a Generic is available, the Covered Person will pay the difference between the brand/non-formulary drug and the generic (low tier) cost and the applicable copay. The Gold Plan Deductible Amount per Policy Year will be waived.</td>
</tr>
<tr>
<td>Surgeon</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Tests &amp; Procedures</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75 copay per visit 100% of PPO Policy Year deductible does not apply.</td>
<td>$75 copay per visit 50% of R&amp;C Policy Year deductible does not apply.</td>
</tr>
<tr>
<td>OTHER</td>
<td>PREFERRED PROVIDERS</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Alcoholism Expense</td>
<td>Paid as any other Sickness</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80% of PPO</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Biofeedback Coverage</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Bone Density Testing</td>
<td>100% of PPO</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>CAT Scan/MRI</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Club Sports Injury</td>
<td>Paid as any other Injury</td>
<td>Injury resulting from membership and participation in club sports activities sponsored by CU Boulder.</td>
</tr>
<tr>
<td>Dental Treatment (Accidental Injury)</td>
<td>80% of PPO</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Diabetic Expense</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (Diagnostic &amp; Routine Colonoscopy)</td>
<td>Diagnostic: paid as any other Sickness/deductible applies Routine: paid as any other Sickness/ deductible waived</td>
<td>Not otherwise covered by Preventive Services</td>
</tr>
<tr>
<td>Dialysis Treatment</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment and Orthopedic Braces &amp; Appliances</td>
<td>80% of PPO</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Fertility Testing</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>OTHER</td>
<td>PREFERRED PROVIDERS</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>PPO = Allowable Charges</strong></td>
<td><strong>R&amp;C = Reasonable and Customary Charges</strong></td>
<td></td>
</tr>
<tr>
<td>HPV Vaccine</td>
<td>100% of PPO Policy Year deductible does not apply.</td>
<td>Not otherwise covered by Preventive Services. Benefits include charges incurred for cervical cancer immunization for covered females under age 26. If the initial shot in the series is received prior to the Covered Person turning age 26, subsequent immunizations are covered according to standard protocol. (Doctor’s visit copay will apply.)</td>
</tr>
<tr>
<td></td>
<td>100% of R&amp;C Policy Year deductible does not apply.</td>
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<tr>
<td></td>
<td>100% of R&amp;C Policy Year deductible does not apply.</td>
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<tr>
<td>Intramural Sports Injury</td>
<td>Paid as any other Injury</td>
<td>Injury resulting from membership and participation in intramural sports activities sponsored by CU Boulder.</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Mammography</td>
<td>100% of PPO Policy Year deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of R&amp;C Policy Year deductible does not apply.</td>
<td></td>
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<tr>
<td></td>
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<tr>
<td>Maternity &amp; Complications of Pregnancy</td>
<td>Paid as any other Sickness</td>
<td></td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Nutritional Counseling</td>
<td>100% of PPO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Preventive Services Benefit</td>
<td>100% of PPO not subject to deductible, copayment, or coinsurance</td>
<td>As specified by the Patient Protection and Affordable Care Act (PPACA). (To view a list of covered preventive services, log onto <a href="http://www.healthcare.gov">www.healthcare.gov</a>)</td>
</tr>
<tr>
<td></td>
<td>100% of R&amp;C not subject to deductible, copayment, or coinsurance.</td>
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<tr>
<td>Prostate Cancer Screening</td>
<td>100% of PPO Policy Year deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of R&amp;C Policy Year deductible does not apply.</td>
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<tr>
<td>Reconstructive Breast Surgery</td>
<td>Paid as any other Sickness</td>
<td>Benefits are payable for Eligible Expenses for Breast Reconstructive Surgery after a mastectomy. This includes coverage for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1) All stages of the reconstruction of the breast on which the mastectomy has been performed;</td>
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<td></td>
<td></td>
<td>2) Surgery and reconstruction of the other breast to produce symmetrical appearance; and 3) prostheses and physical complications at all stages of mastectomy, including lymphedemas.</td>
</tr>
<tr>
<td>OTHER</td>
<td>PREFERRED PROVIDERS</td>
<td>OUT-OF-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------</td>
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</tr>
<tr>
<td><strong>PPO = Allowable Charges</strong></td>
<td><strong>R&amp;C = Reasonable and Customary Charges</strong></td>
<td></td>
</tr>
<tr>
<td>Repatriation and Medical Evacuation - Refer to page 23 - Travel Assist/Student Assist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Routine Eye Exam</td>
<td>100% of PPO</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Routine Hearing Exam</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>100% of PPO</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>80% of PPO</td>
<td>50% of R&amp;C</td>
</tr>
<tr>
<td>Sexual Reassignment Surgery and Related Therapy</td>
<td>Paid as any other Sickness</td>
<td>Eligible Expenses include: a) mental health counseling; b) hormone replacement therapy; c) sexual reassignment surgery, (limited to $10,000 per Policy Year). 1) for female to male: mastectomy, hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prosthesis, phalloplasty; or 2) (2) male to female: orchiectomy, penectomy, vaginoplasty, clitoroplasty, labiaplasty, breast augmentation.</td>
</tr>
<tr>
<td>Treatment of Temporomandibular Joint Dysfunction</td>
<td>80% of PPO</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Human Organ and Tissue Transplant Expense</td>
<td>Paid as any other Sickness</td>
<td>Benefits are payable for Eligible Expenses incurred for covered organ and tissue transplant services and procedures. See the Policy on file with the University for full details.</td>
</tr>
</tbody>
</table>
Repatriation and Medical Evacuation Benefits

Combined Maximum Limit of $1,000,000

REPATRIATION OF REMAINS

If a Covered Person suffers loss of life due to Injury or emergency Sickness while outside his or her home country, the
Company will pay for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary
residence, but not exceeding the Maximum Amount per Covered Person.

Eligible Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles
adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical
conveyance and route possible.

Travel Guard Group, Inc. (“Travel Guard”) must make all arrangements and must authorize all expenses in advance for this
benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was
not reasonably possible to contact Travel Guard in advance.

Please see page 23 for a description of the Travel Guard services and procedures on how to contact Travel Guard.

MEDICAL EVACUATION

The Company will pay for Eligible Medical Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury
or emergency Sickness that warrants his or her Medical Evacuation while outside his or her home country, but not exceeding
the Maximum Amount per Covered Person for Medical Evacuations due to all Injuries from the same accident or all
Emergency Sicknesses from the same or related causes.

The Doctor ordering the Medical Evacuation must certify that the severity of the Covered Person’s Injury or emergency
Sickness warrants his or her Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must
be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for any Medical Evacuation benefits
to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably
possible to contact Travel Guard in advance.

Please see page 23 for a description of the Travel Guard services and procedures on how to contact Travel Guard.

Prescription Drugs

The Student Gold Health Insurance Plan provides pharmacy
coverage through a prescription card program administered
by Catamaran. A Covered Person may purchase
prescription drugs at over 60,000 network pharmacies
nationwide. The latest listing of participating pharmacies is
available at: www.colorado.edu/studentinsurance.

Prescription Benefits are based on a Mandatory Generic
Formulary, which means that participating pharmacies will fill
generic prescriptions on all covered formulary medications if
there is a generic drug on the market. If a Covered Person’s
Doctor chooses a brand or non-formulary drug and a generic
is available, the Covered Person will pay the difference
between the brand/non-formulary drug and the generic (low
tier) cost and the applicable copay.

Prescription benefits are subject to all Plan provisions.
Please refer to the Schedule of Benefits for your benefit
information (pages 9-14).

The following Prescription Drugs, services or supplies are not
covered:

a) Therapeutic devices or appliances, including:
hypodermic needles, syringes, support garments and
other medical substances, regardless of intended use;
except as provided under Benefits for Diabetes;
b) Biological sera, blood or blood products administered on
an outpatient basis;
c) Drugs labeled, “Caution—limited by federal law to
investigational use” or experimental drugs;
d) Products used for cosmetic purposes;
e) Drugs used to treat or cure baldness; anabolic steroids
used for body building;
f) Anorectics—drugs used for the purpose of weight
control;
g) Fertility agents or sexual enhancement drugs, such as
Parlodel, Pergonal, Clomid, Profasi, Metrodin,
Serophene, or Viagra;
h) Growth hormones; or
i) Refills in excess of the number specified or dispensed
after one (1) year of date of the prescription.
To receive the network discount at a participating pharmacy, present your Student Health Insurance ID card when you purchase the prescription. For a list of participating pharmacies, access the Catamaran link at www.colorado.edu/studentinsurance

Maternity Testing

Benefits are payable for Eligible Expenses incurred by a Covered Person for routine maternity tests and screening exams. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits. The Company will pay the benefit for the Eligible Expense on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

Benefits will be paid for Eligible Expenses incurred for the following tests:

a) pregnancy tests;
b) CBC - once each trimester;
c) Hepatitis B Surface Antigen - once, 1st trimester;
d) Rubella Screen - once, 1st trimester;
e) Syphilis Screen - once, 1st trimester;
f) Chlamydia - once, 1st trimester;
g) HIV - once, 1st trimester;
h) Gonorrhea - once, 1st trimester;
i) Toxoplasmosis;
j) Blood Typing ABO;
k) RH Blood Antibody Screen - once, 1st trimester;
l) Urinalysis - each visit, including the 1st visit;
m) Urine Bacterial Culture - each visit, including the 1st visit;
n) Microbial Nucleic Acid Probe;
o) AFP Blood Screening - once, 2nd semester;
p) Pap Smear - once, 1st trimester;
q) Glucose challenge Test - once during 2nd or 3rd trimester;
r) Estriol, hCG, inhibin-a, or, QUAD screen test – once during 2nd trimester;
s) Group B strep culture – once during 3rd trimester.

One ultrasound test may be administered during the 1st trimester and one during the 2nd trimester. Eligible Expenses for subsequent ultrasound tests may be payable if such additional tests are determined to be Medically Necessary. In addition, for a female Covered Person over 35 years of age, charges for the following tests may be considered Eligible Expenses:

a) amniocentesis/AFP Screening/Chronic Cillus Sampling (CVS) - once during 2nd trimester; and
b) chromosome testing/PAPPA/Free Beta HCG - once during 1st trimester.

For additional information regarding Maternity Testing, please call AmeriBen at 1-855-639-8676.

Accidental Death and Dismemberment Benefit

Loss of Life, Limb or Sight

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

For Loss of:

- Life .................................................. $10,000
- Both Hands or Both Feet .......................... $10,000
- Sight of Both Eyes ................................. $10,000
- One Hand and One Foot .......................... $10,000
- One Hand and Sight of One Eye ............... $10,000
- One Foot and Sight of One Eye ............... $10,000
- One Hand or One Foot ........................... $5,000
- The Sight of One Eye ............................ $5,000
- Thumb or Index Finger .......................... $2,500

“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means the total, irrevocable loss of the entire sight in that eye.

“Loss” of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits. “Severance” means the complete separation and dismemberment of the part from the body.

Benefits Mandated by the State of Colorado

Benefits for Prosthetic Devices

Benefits will be paid for the Reasonable and Customary Charges for the purchase of Prosthetic Devices. Prosthetic Device means an artificial device to replace, in whole or in part, an arm or leg. Benefits are limited to the most appropriate model that adequately meets the medical needs of the Covered Person as determined by the attending Doctor. Repairs and replacements of Prosthetic Devices are also covered unless necessitated by misuse or loss.
Benefits for Biologically Based Mental Illness

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

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

“Mental Disorder” means post-traumatic stress disorder, drug and alcohol disorders, dysmthymia, cyclothymia, social phobia, agoraphobia with panic disorder and general anxiety disorder. The term includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an outpatient, day treatment, and inpatient basis, exclusive of residential treatment. For purposes of this coverage, Mental Disorder does not include autism.

Additional Benefits Mandated by the State of Colorado

Benefits are provided for the items listed below as mandated by the State of Colorado. A detail of these benefits may be found in the Master Policy on file at the University’s Student Insurance Office. These benefits include Benefits for Medical Foods, Benefits for Mammography, Diabetes, Cervical Cancer Vaccine, Colorectal Cancer Screening, Prostate Cancer Screening, and any other applicable mandated benefits.

Benefits shall be subject to all Policy Year Deductible, copayment, coinsurance, limitations, and any other provisions of the policy.

Exclusions

The Policy does not cover nor provide benefits for loss or expenses incurred:

1. For surgery and/or treatment of: acupuncture; gynecomastia; family planning; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; learning disabilities; premarital examinations; vasectomy; alopecia. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.

2. For elective abortions.

3. For addiction and co-dependency services and supplies related to: caffeine; and non-chemical addictions, such as gambling, sex, spending, shopping, working and religion; and treatment for co-dependency.

4. 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 Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.

5. As a result of committing or attempting to commit an assault or felony or participation in a felony, riot or civil commotion.

6. For breast reconstruction and implantation or removal of breast prostheses unless such care and services are performed solely and directly as a result of a Medically Necessary mastectomy.

7. For any period of care designed to help a Covered Person in the activities of daily living not requiring continuous attention by trained medical or paramedical personnel. Such care may involve: preparation of special diet; supervision over medication that can be self-administered; and assisting the person getting in or out of bed, walking, bathing, dressing, eating and using the toilet.

8. For cosmetic surgery except that “cosmetic surgery” shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part. It also shall not include breast reconstructive surgery after a mastectomy.

9. For rest cures or custodial care.

10. As a result of dental treatment, except as specifically provided. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.

11. For donor expenses in relation to organ transplants.

12. For elective treatment or elective surgery.

13. For treatment, services, drugs, device, procedures or supplies that are experimental or investigational.

14. For eye examinations, eyeglasses, contact lenses, or prescription for such, or treatment for visual defects and problems except as specifically provided. “Visual defects” means any physical defect of the eye which does or can impair normal vision apart from the disease process. Vision examinations not related to prescription or fitting of lenses will be covered only when performed in connection with the diagnosis or treatment of Sickness or Injury. Except as specifically provided, eye refraction is not covered. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.

15. For eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

16. For treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.

17. For any services rendered by a Covered Person’s Immediate Family Member.

18. For Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, or professional sports activity, including travel to and from the activity and practice.

19. For maintenance therapy which is defined as those therapy services rendered to a Covered Person who is no longer making documentable progress to maintain the level of progress previously attained.
20. For a treatment, service or supply which is not Medically Necessary, except as specifically provided.
21. For personal items or services such as television, telephone or transportation.
22. For preventive treatment, testing, medicines, serums, or vaccines except as specifically provided. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
23. For routine physical examinations or health examinations, except as specifically provided for in the Policy. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
24. For elective sterilization or its reversal, unless otherwise provided.
25. For services normally provided without charge by the Policyholder's Health Service/Center, Infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Service/Center fee.
26. After the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
27. For chiropractic care or treatment not related to the treatment of Sickness or Injury.
28. For Injury or Sickness resulting from war or act of war, declared or undeclared.
29. Weight management, services and supplies related to weight reduction programs; weight management programs, related nutritional supplies and treatment for obesity, (except for surgery for morbid obesity).
   Treatment of morbid obesity is covered. Morbid obesity is defined as follows: Morbid obesity associated with serious and life-threatening disorders such as diabetes mellitus and hypertension. Morbid obesity means a body weight two times the normal weight or greater, or 100 pounds in excess of normal body weight based on normal body weight using generally accepted height and weight tables for a person of the same age, sex, height and frame. Benefits will be provided only upon written request for treatment with a treatment plan written by a Doctor, and services and treatment must meet the requirements of Medical Necessity. Surgery for removal of skin or fat, except as specifically provided in the Policy.
30. As a result of an Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law.

**Coordination of Benefits**

If the Covered Person has other group type, governmental, or automobile no fault medical benefits coverage, the benefits payable under the Policy will be coordinated with the other coverage so that the combined benefits paid or provided by all plans will not exceed 100% of the allowable expense. The plan paying second takes the benefits of the primary plan into account when it determines benefits.

**Definitions**

“**Accident**” means 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.

“**Act**” means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

“**Allowable Charges**” means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

“**Covered Person**” means a Covered Student insured under the Policy.

“**Covered Student**” means a student of this Policyholder who is insured under the Policy.

“**Deductible/Deductible Amount**” means the dollar amount of Eligible Expenses a Covered Person must pay before benefits become payable.

“**Doctor**” means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person's Immediate Family Member.

“**Elective Treatment**” means medical treatment, which is not necessitated by a pathological change in the function or structure in any body part, occurring after the Covered Person’s effective date of coverage.

Elective treatment includes, but is not limited to: vasectomy; breast reduction unless as a result of mastectomy; submucous resection and/or other surgical correction of deviated nasal septum, other than necessary treatment of acute purulent sinusitis; treatment for weight reduction; learning disabilities; botox injections; treatment of infertility.
“Eligible Expense” means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) with respect to the Preferred Provider, is the Allowable Charge; (d) is the negotiated rate, if any and (e) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

“Emergency Medical Condition” means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, that a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

“Emergency Services” means the following:
(a) a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition; (b) such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

“Essential Health Benefits” means the essential health benefits defined in Section 1302(b) of the Act. This includes at least the following general categories and the items and services covered within the categories: (a) Ambulatory patient services; (b) Emergency services; (c) Hospitalization; (d) Maternity and newborn care; (e) Mental health and substance use disorder services, including behavioral health treatment; (f) Prescription drugs; (g) Rehabilitative and habilitative services and devices; (h) Laboratory services; (i) Preventive and wellness services and chronic disease management; (j) Pediatric services, including oral and vision care.

“Hospital” means a facility which meets all of these tests: (a) provides in-patient services for the care and treatment of injured and sick people; and (b) it provides room and board services and nursing services 24 hours a day; and (c) it has established facilities for diagnosis and major surgery; and (d) it is supervised by a Doctor; and (e) it is run as a Hospital under the laws of the jurisdiction which it is located; and (f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders; or substance abuse. The term “Hospital” includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

“Medical Necessity/Medically Necessary” means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service shall not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is experimental/investigational or for research purposes; or (e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual or Center for Medicare and Medicaid Services Issues Manual; or (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Doctor may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

“Reasonable and Customary” means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing. “Geographic area” means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply. Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective date.
“Sickness” means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered One Sickness.

Optional Vision Care Expense

The University of Colorado Boulder recognizes that routine eye exams are important and is pleased to offer Covered Students the option to enroll in this Optional Vision Care Expense benefit.

ELIGIBILITY: Participants must be enrolled in the Plan in order to enroll in this Optional Vision Care Expense benefit.

<table>
<thead>
<tr>
<th>PREMIUM</th>
<th>Policy Year (or any part thereof, no pro-ration)</th>
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</thead>
<tbody>
<tr>
<td>Student</td>
<td>$119</td>
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</table>

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<tr>
<th>BENEFIT OVERVIEW</th>
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</thead>
<tbody>
<tr>
<td>Policy Year Benefit Maximum Amount*</td>
</tr>
<tr>
<td>Policy Year Deductible per Covered Person</td>
</tr>
<tr>
<td>Covered Percentage</td>
</tr>
</tbody>
</table>

*Policy Year Maximum Amount applicable to Covered Persons age 19 and older.

The Optional Vision Care Expense is available to Covered Persons at initial enrollment under the Plan each Policy Year. Covered Persons may enroll by completing the online enrollment and payment process at: be [http://www.studentinsurance.com/Schools/CO/CUB/](http://www.studentinsurance.com/Schools/CO/CUB/).

Once enrolled, present your Student Health Insurance Plan Identification Card to your vision care provider.

Except as specifically provided, the Optional Vision Care Expense benefits are subject to all Plan provisions.

ELIGIBLE EXPENSES: This Optional Vision Care Expense benefit provides for both examination and corrective eyewear/lenses to Covered Persons.

If a Covered Person incurs Eligible Expenses that are received while insured under this Plan and performed or prescribed by an optometrist or other Doctor, the Company will pay 100% of the Eligible Expense in excess of the $50 Optional Vision Care Expense Deductible. The Company will not pay more than a Maximum Amount of $250 per Policy Year. Eligible Expenses include the following:

A. Charges made for vision examination by an optometrist or ophthalmologist once every 12 months, including:
   - An external or an ophthalmoscopic exam;
   - An ocular case history;
   - A refraction;
   - A binocular measure;
   - Tonometry;
   - Any other vision test that is Medically Necessary;
   - A summary and findings of the exam; or
   - A prescription for any needed corrective lenses; and inspection of those lenses.

B. Charges made for lenses every 12 months.

C. Charges incurred for frames. But, the Company will not pay for more than one frame every 12 months.

ENROLL ONLINE FOR OPTIONAL VISION BENEFITS AT
Optional Dental Treatment Expense

Good for your Health
University of Colorado Boulder recognizes that good dental health is important to overall health and is pleased to offer Covered Students the option to enroll in this Optional Dental Treatment Expense benefit.

With dental benefits, which promote regular visits to the dentist, serious oral health problems can be detected early and treated more economically. A healthy mouth promotes better general health and well-being.

The Optional Dental Treatment Expense benefit provides coverage for preventive care, basic and restorative care. ELIGIBILITY: Participants must be enrolled in the Plan in order to enroll in this Optional Dental Treatment Expense benefit.

The Optional Dental Treatment Expense benefit is available to Covered Persons at initial enrollment under the Plan each Policy Year. Covered Persons may enroll by completing the online enrollment and payment process at: http://www.studentinsurance.com/Schools/CO/CUB/

Once enrolled, present your Student Health Insurance Identification Card to your dental health care provider.

Except as specifically provided, the Optional Dental Treatment Expense benefits are subject to all Plan provisions.

<table>
<thead>
<tr>
<th>PREMIUM</th>
<th>Policy Year (or any part thereof, no pro-ration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$470</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BENEFIT OVERVIEW</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Year Benefit Maximum*</td>
<td>$1,000</td>
</tr>
<tr>
<td>Policy Year Deductible per Covered Person</td>
<td>$50</td>
</tr>
<tr>
<td>Preventive Service Covered Percentage</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Service Covered Percentage</td>
<td>80%</td>
</tr>
<tr>
<td>Major Service Covered</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic Service</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*Policy Year Maximum Amount applicable to Covered Persons age 19 and older.

PARTIAL LIST OF PLAN PROVISIONS

<table>
<thead>
<tr>
<th>PREVENTIVE (Not subject to Policy Year Deductible)</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral examinations*</td>
<td>100%</td>
</tr>
<tr>
<td>Cleanings, including scaling and polishing*</td>
<td>100%</td>
</tr>
<tr>
<td>Fluoride*</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants (permanent molars only*)</td>
<td>100%</td>
</tr>
<tr>
<td>Full mouth series X-rays*/Bitewing X-rays</td>
<td>100%</td>
</tr>
<tr>
<td>Space maintainers</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root canal therapy, with X-rays and cultures.</td>
</tr>
<tr>
<td>Anterior teeth/bicuspid teeth</td>
</tr>
<tr>
<td>Amalgam (silver) fillings/ Composite fillings</td>
</tr>
<tr>
<td>(Anterior teeth only)</td>
</tr>
<tr>
<td>Stainless steel crowns</td>
</tr>
<tr>
<td>Scaling &amp; root planing*</td>
</tr>
<tr>
<td>Uncomplicated extraction of erupted teeth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAJOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root canal therapy, with X-rays and cultures.</td>
</tr>
<tr>
<td>50%</td>
</tr>
<tr>
<td>Osseous surgery*</td>
</tr>
<tr>
<td>Surgical removal of impacted tooth (partial bony/full bony)</td>
</tr>
<tr>
<td>General anesthesia/intravenous sedation</td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns</td>
</tr>
<tr>
<td>Full &amp; partial dentures</td>
</tr>
<tr>
<td>Denture repairs</td>
</tr>
<tr>
<td>Pontics</td>
</tr>
</tbody>
</table>

DENTAL EXCLUSIONS
Orthodontic services for which treatment began prior to the policy are excluded; and any gold foil restoration, gold fillings, inlays, crowns, bridges, cosmetic procedures and dentures are excluded.

No benefits will be paid for expenses incurred for broken appointments or for care or treatment of a condition for which you are entitled to or eligible for benefits under any Worker’s Compensation Act or similar act.

DENTAL LIMITATIONS
- Two (2) of each of the following per Policy Year: Oral Exams
- One (1) of each of the following per Policy Year: Bitewing X-rays, Topical Fluoride applications, Pulp Vitality test
- One (1) full mouth X-ray every three years

Benefits for fluoride applications and space maintainers are available only to participants under the age of 19. * Frequency and/or age limitations may apply to these services. These limits are described in the Master Policy.

NOTE: Full details of this coverage is contained in the Policy on file with the Policyholder. Not all dental services are covered.
24-Hour Student Emergency Care Hotline

AMERICAN HEALTH HOLDING, INC.
(American Health Holding, Inc. is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)

For confidential health care advice and information, 24 hours a day, 365 days a year,

CALL TOLL-FREE
866-315-8756

Comprehensive Resources and Advice from Registered Nurses

- Direct access to an extensive Health Information Library, covering issues ranging from women’s health to pediatrics. Detailed directories with topic codes and instructions for access to health-related topics.
- Choose to talk directly to a nurse. Discuss a current illness or health issue, or receive counseling on chronic conditions. Nurses can also educate callers about treatments, lifestyle choices and self-care strategies.
- Integrated phone services to specially trained personnel, trained to provide referral services for mental health concerns.

Special Care for Emergencies

- Integrated Emergency Support Services are available whenever members are in an emergency room or unexpectedly hospitalized. In serious emergencies, the clinical team including Doctors and registered nurses, assist patients and their families so they can make informed decisions about their care and treatment.
- The clinical team provides emotional reassurance, explains medical terms, discusses hospital culture and common routines, recommends resources and facilitates communications between patient and family to help them through the emergency.

Medical Management Program

AmeriBen Medical Management, Inc. is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.

University of Colorado Boulder has contracted with a third-party administrator for professional health care management to assist Covered Persons in determining whether or not proposed services are appropriate for reimbursement under the plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits or validate eligibility. The medical professionals, who conduct the program focus their review on the appropriateness and medical necessity of hospital stays.

PRE-ADMISSION NOTIFICATION

Covered Persons should call AmeriBen Medical Management, Inc. at 800-388-3193, option 1, between 8:00 a.m. to 5:00 p.m. MST, Monday through Friday, before any elective admission to a hospital. Covered Persons must also call within 48 hours (2 working days) of any emergency admission. When calling, it will be necessary to provide the program with your name, the patient's name, the name of the physician and hospital, the reason for the hospitalization, clinical documentation supporting the medical necessity of the stay and, any other information needed to complete the review.

SPECIAL CASE MANAGEMENT

Special Case Management is designed to help manage the care of patients who have catastrophic or extended care sickness or injury. The primary objective of Special Case Management is to identify and coordinate cost effective medical care alternatives meeting accepted standards of medical practice. Special Case Management also monitors the care of the patient, offers emotional support to the family and coordinates communications among health care providers, patients and others. Examples of sickness or injury that would be appropriate for Special Case Management include, but are not limited to:

- Terminal sicknesses
- Cancer
- AIDS
- Chronic illnesses: renal failure, cardiac obstructive pulmonary disease, multiple sclerosis, cardiac conditions
- Accident victims requiring long-term rehabilitative therapy
- Newborns with high risk complications or multiple birth defects
- Diagnosis involving long-term IV therapy
- Mental health or substance abuse
- Sickness not responding to medical care
Travel Guard and Student Assist Services

Procedures on How to Access Travel Guard and Student Assist Services 24-Hour Assistance Call Center

Who is Travel Guard:

Multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help participants should the need arise while traveling.

The Travel Guard Medical Staff consists of full-time, on-site Registered Nurses and Emergency Doctors who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a Doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.

When to Contact Travel Guard:

Before you incur expenses.

• If you are 100+ miles from home and require medical assistance or have a medical emergency.
• If you are 100+ miles from home and need assistance with a non-medical situation such as lost luggage, lost documents, legal help, etc.

How to Contact Travel Guard:

• Inside the US and Canada, dial 1-877-249-5362 toll-free.
• Outside the US and Canada:
  o Request an international operator.
  o Ask the international operator to connect to an AT&T operator.
  o Request the AT&T operator to place a collect call to the USA at 1-715-295-9625.
  o Our fax number is 1-262-364-2203.

Travel Guard is available 24-hours-a-day/7-days-a-week/365 days-a-year

What information will you need to provide when you call:

• Advise Travel Guard who you are insured by.
• Provide your Policy Number or School Name
• Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

Description of Services

General Information: Services include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency exchange rates, local Bank/Government holidays, and by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage & relay and translation services.

• Visa & Immunization
• Weather & Exchange Rates
• Environmental & Political Warnings

Technical: Services include assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers & vehicle return in the event of illness or accident, provide legal referrals, and help with arrangements for members who encounter enroute emergencies that force them to interrupt their trips.

• Legal Referral
• Enroute Travel Assistance
• Claims-related Assistance
• Telephone Interpretation
• Embassy/Consulate Information
• Lost/Stolen Luggage & Personal Effects Assistance
• Lost Document Assistance & Cash Transfer Assistance

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard’s Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler’s behalf. These services include Doctor/ dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains and insurance claims coordination.

Medical Assistance:

• Medical Referral
• Out-patient Assistance
• In-patient Assistance

TRAVEL ASSIST/STUDENT ASSIST STUDENT ASSIST SERVICES

Concierge Services: You receive the comfort, care, and attention of Travel Guard’s Personal Assistance Coordinators available 24/7 to respond to virtually any request — large or small.

Personal Security Assistance: You can feel safe and secure with Travel Guard’s Personal Security Assistance at home or while traveling. To activate personal security services, please log on to: http://aig.com/travelguardassistance. For initial setup, your login is 9497178 and the password is “security.”
PRIVACY POLICY
The HIPAA Privacy Rule requires protection of your personal health information. As the third party administrator for your student health plan AmeriBen is dedicated to protecting the confidentiality of your personal health information. A Notice of Privacy Practices outlining these protections will be provided to enrollees on the health plan. If you would like a copy of the Notice of Privacy Practices, administered by AmeriBen, you may write to AmeriBen at PO Box 6577, Boise, ID 83707, Attn: Privacy Office or call 1-855-639-8676.

INSURANCE UNDERWRITTEN BY
Administrator Policy Number: CHH8017736
Underwriter Reference Number: CAS9148827
To sign up for the Student Gold Health Insurance Plan, go to www.colorado.edu/studentinsurance.

THIRD PARTY ADMINISTRATOR:
AmeriBen
PO Box 6577, Boise, ID 83707

Claims Procedures
Written notice of claim must be given to the Company within 60 days after the occurrence or commencement of any loss covered by this Plan, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to the Company at AmeriBen, PO Box 6577, Boise, ID 83707, with information sufficient to identify the Covered Person, shall be deemed notice to the Company.

Written proof of loss must be given to the Company within 90 days after the date of such loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible. Proof given by or on behalf of the claimant or the beneficiary to the Company at AmeriBen, PO Box 6577, Boise, ID 83707, with information sufficient to identify the Covered Person, shall be deemed proof to the Company.

Contact Information
CLAIMS, ELIGIBILITY AND BENEFIT QUESTIONS
AmeriBen Telephone:
1-855-639-8676
cub.ameriben.com
AmeriBen
PO Box 6577, Boise, ID 83707

PARTICIPATING PROVIDER ORGANIZATIONS (PPO)
Inside Colorado: Cofinity 1-800-850-2249
www.cofinity.com
Outside Colorado: First Health 1-888-685-7774
http://www.myfirsthealth.com
Catamaran Customer Care: 1-800-880-1188
Sign Up for the Student Gold Health Insurance Plan

Wardenburg Health Center is located on campus at the corner of 18th Street and Broadway.

Wardenburg Health Center
University of Colorado Boulder
119 UCB
Boulder, CO 80309-0119

303-492-5101
www.colorado.edu/healthcenter