ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Bariatric Surgery Expense Covered medical expenses for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Artificial Arms and Legs Expense Covered Medical Expenses include charges incurred by a covered person for artificial prosthetic devices to replace, in whole or in part, an arm or a leg as a result of an accident or sickness. Also included are fitting adjustments. Repair and replacement of such prosthetic devices are covered provided that such repair or replacement is not due to loss or misuse of the device. The initial purchase and installation of a prosthetic device is not subject to any copay or deductible. Covered Medical Expenses do not include: • Orthopedic shoes, foot orthotics or other devices to support the feet unless medically necessary to prevent the complications of diabetes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures “under an approved clinical trial” only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person’s participation in an "approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Chiropractic Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	80% of the Negotiated Charge	50% of the Recognized Charge
Inherited Enzymatic Disorders Expense Covered Medical Expenses include charges incurred by a covered person for medical foods prescribed by a physician for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic and fatty acids. Coverage is limited to the following diagnosed conditions: • Phenylketonuria; • Maple Syrup Urine Disease; • Tyrosinemia; • Homocystinuria; • Histidinemia;	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Inherited Enzymatic Disorders Expense (continued) • Urea Cycle Disorders; • Hyperlysinemia; • Glutaric Acidemias; • Methylmalonic Acidemia; and • Propionic Acidemia. Not covered are: • prescribed medical foods dispensed by a non-preferred pharmacy; and medical foods prescribed to covered persons diagnosed with: • cystic fibrosis; or lactose or soy intolerance.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hearing Aid Expenses for Covered Persons Age 19 Covered medical expenses for hearing care includes charges for hearing exams, prescribed hearing aids and hearing aid expenses as described below for covered persons to age 19 who have a hearing loss that has been verified by a licensed Physician and by a licensed audiologist. This benefit is subject to an age limit as shown on the Schedule of Benefits. Covered medical expenses for hearing aids will not include: • Charges for more than one hearing aid per ear; and • Charges in excess of any maximum amount shown on the Schedule of Benefits.	Payable in accordance with the type of expense incurred and the place where service is provided.	
SHORT-TERM CARDIAC AND PULMONARY REHABILIATION THERAPY SERVICES EXPENSE Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits. **Cardiac Rehabilitation Benefits** Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician. **Pulmonary Rehabilitation Benefits** Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.		
Cardiac Rehabilitation	80% of the Negotiated Charge	50% of the Recognized Charge
Pulmonary Rehabilitation	80% of the Negotiated Charge	50% of the Recognized Charge
SHORT-TERM REHABILITATION SERVICES EXPENSE Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if the covered person is homebound. Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.		

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Short-Term Rehabilitation and Habilitation Therapies Services Expense Outpatient Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)	80% of the Negotiated Charge	50% of the Recognized Charge
Habilitation Therapy Services-Applied Behavioral Analysis	Payable in accordance with the type of expense incurred and the place where service is provided.	
TREATMENT OF MENTAL DISORDER EXPENSE	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health Expense & Residential Mental Health Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	After a $200 Copay per admission, 80% of the Negotiated Charge	After a $200 Deductible, per admission, 50% of the Recognized Charge
Inpatient Mental Health Physician Services per Admission Expense &Residential Mental Health Treatment Physician Services Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Outpatient Mental Health Expense	After a $40 Copay per visit, 100% of the Negotiated Charge*	After a $40 Deductible per visit, 50% of the Recognized Charge*
Outpatient Mental Health Partial Hospitalization Expense	After a $200 Copay per admission, 80% of the Negotiated Charge	After a $200 Deductible, per admission, 50% of the Recognized Charge
TREATMENT OF SUBSTANCE ABUSE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	After a $200 Copay per admission, 80% of the Negotiated Charge	After a $200 Deductible, per admission, 50% of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Outpatient Substance Abuse Treatment	After a $40 Copay per visit, 100% of the Negotiated Charge*	After a $40 Deductible per visit, 50% of the Recognized Charge*

TRANSPLANT SERVICE EXPENSE	Preferred Care	Non-Preferred Care
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses.	$50 per night Maximum Benefit for Lodging Expenses per IOE patient & $50 per night Maximum Benefit for Lodging Expenses per companion up to 10,000 per transplant.	
PEDIATRIC DENTAL SERVICES EXPENSE **(**Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Benefit maximum of 1 visit every 6 months	100% of the Negotiated Charge*	50% of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	70% of the Negotiated Charge*	50% of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	50% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Orthodontia Expense • Orthodontics • Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	50% of the Negotiated Charge*	50% of the Recognized Charge
PEDIATRIC ROUTINE VISION EXPENSE **(**Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Pediatric Routine Vision Exams (including refractions and dilation) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Benefits limited to 1 exam per policy year.	100% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Visit for the fitting of prescription contact lenses	100% of the Negotiated Charge*	50% of the Recognized Charge
Comprehensive Low Vision Evaluations	Payable in accordance with the type of expense incurred and the place where service is provided.	
Preferred Optical Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	
Non-Preferred Optical Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	

PEDIATRIC ROUTINE VISION EXPENSE (continued) **(**Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.	100% of the Negotiated Charge*	50% of the Recognized Charge

PRESCRIBED MEDICINES EXPENSE

Covered Percentage*	**Preferred Care**	**Non-Preferred Care**
Preventive Care Drugs and Supplements Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.		
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	100% of the Recognized Charge
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	100% per supply	100% of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs (for two 90-day treatment regimens only)	100% per supply	100% of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	100% of the Recognized Charge
All OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	100% of the Negotiated Charge	100% of the Recognized Charge

*The prescription drug plan covered percentage is the percentage of prescription drug covered medical expenses that the plan pays after any applicable deductibles and copays have been met.

Per Prescription Copay/Deductible	Preferred Care	Non-Preferred Care
Generic Prescription Drugs For each 30 day supply filled at a retail pharmacy	$25 Copay per supply	$25 Deductible per supply
Generic Prescription Drugs For all fills of at least a 30 day supply and up to a 90 day supply filled at a mail order pharmacy	Copay per supply of 2 times the initial 30 day copay per supply	Deductible per supply of 2 times the initial 30 day deductible per supply
Preferred Brand-Name Prescription Drug	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy	$45 Copay per supply	$45 Deductible per supply
For all fills of at least a 30 day supply and up to a 90 day supply filled at a mail order pharmacy	Copay per supply of 2 times the initial 30 day copay per supply	Deductible per supply of 2 times the initial 30 day deductible per supply
Non-Preferred Brand-Name Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy	$75 Copay per supply	$75 Deductible per supply
For all fills of at least a 30 day supply and up to a 90 day supply filled at a mail order pharmacy	Copay per supply of 2 times the initial 30 day copay per supply	Deductible per supply of 2 times the initial 30 day deductible per supply
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per prescription copay/deductible and policy year deductible will not apply to risk-reducing breast cancer generic prescription drugs when obtained at a preferred care pharmacy. This means that such risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per prescription copay/deductible and policy year deductible will not apply to:

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.
- FDA-approved female:

- generic emergency contraceptives; and
- generic over-the-counter (OTC) emergency contraceptives.

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%. The per prescription copay/deductible and policy year deductible continue to apply:

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
  - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
  - brand-name and biosimilar emergency contraceptives; and
  - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives.
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

However, the per prescription copay/deductible and policy year deductible will not apply to such contraceptive methods if:

- A generic equivalent, biosimilar or generic alternative, within the same therapeutic drug class is not available; or
- A covered person is granted a medical exception; or
- A physician specifies “Dispense as Written” (DAW).

A covered person's prescriber may seek a medical exception by submitting a request to AmeriBen’s Precertification Department. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case medically necessary determination and coverage will not apply or extend to other covered persons.

Exclusions

This Plan does not cover nor provide benefits for:

1. Expense incurred for dental treatment, services and supplies except for those resulting from injury to sound natural teeth or for extraction of impacted wisdom teeth and those as specially covered under the Policy.

2. Expense incurred for services normally provided without charge by the Policyholder's school health services; infirmary or hospital; or by health care providers employed by the Policyholder.

3. Expense 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. Expense 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 regular published schedules on a regularly established route, air or space travel. This does not apply if a person is passenger, with no duties at all, or an aircraft being used to carry passengers (with or without cargo).

5. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

6. Expense incurred as a result of an 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 Policyholder.

7. Expense incurred for treatment provided in a governmental hospital unless there is a legal or regulatory obligation to pay such charges in the absence of insurance.

8. Expense incurred for elective treatment or elective surgery except as specifically covered under the Policy and provided while the Policy is in effect.

9. Expense incurred for cosmetic surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extent needed to: 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 harelip; webbed fingers; or toes; or as direct result of: disease; or surgery performed to treat a disease or injury. Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy;) which occurs while the covered person is covered under the Policy. Surgery must be performed:
   - in the policy year of the accident which causes the injury; or
   - in the next policy year.

10. Expense incurred as a result of commission of a felony.

11. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits provision.

12. Expense incurred for services normally provided without charge by the school and covered by the school health fee for services.

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

14. Treatment for injury to the extent benefits are payable under any state no-fault automobile coverage; first party medical benefits payable under any other mandatory No-fault law.

15. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).

16. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

17. Expense incurred for custodial care.

18. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization except as specifically covered in the Policy. This limitation does not apply to a donation by a covered person to a spouse; child; brother; sister; or parent.

19. Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by AmeriBen to be, experimental or investigational except as specifically covered under the Policy.

20. Expenses incurred for breast reduction/mammoplasty.

21. Expenses incurred for gynecomastia (male breasts).

22. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.

23. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person's home country; if the covered person's home country has a socialized medicine program.

24. Expense incurred for acupuncture except as specifically covered under the Policy.

25. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy unless specifically covered under the Policy.

26. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.

27. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

28. Expense incurred for hearing exams, hearing aids; the fitting; or prescription of hearing aids except as specifically covered under the Policy. Not covered are:
    - Any hearing service or supply that does not meet professionally accepted standards;
    - Hearing exams given during a stay in a hospital or other facility;
    - Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech; and
    - Routine hearing exams, except for routine hearing screenings as specifically described under Preventive Care Benefits.

29. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the covered person is eligible; but did not enroll in Part B.

30. Expense for telephone consultations (except telemedicine services); charges for failure to keep a scheduled visit; or charges for completion of a claim form.

31. Expense for personal hygiene and convenience items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a physician.

32. Expense for services or supplies provided for the treatment of obesity and/or weight control except screening and counseling services as specifically covered under the Policy. Not covered is any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, including but not limited to:
    - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery;
    - surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;
    - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
    - Counseling, coaching, training, hypnosis, or other forms of therapy; and
    - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

33. Expense for incidental surgeries; and standby charges of a physician.

34. Expense incurred for injury resulting from the plan or practice of intercollegiate sports (participating in sports clubs; or intramural athletic activities; is not excluded).

35. Expense for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; male elective sterilization; male or female elective sterilization reversal; or elective abortion; unless specifically covered in the Policy.
36. Expenses incurred for massage therapy.

37. Expense for treatment of covered students who specialize in the mental health care field; and who receive treatment as a part of their training in that field.

38. Expense incurred for a treatment; service; prescription drug, or supply; which is not medically necessary; as determined by AmeriBen; for the diagnosis, care, or treatment of the sickness or injury involved, the restoration of physiological functions, or covered preventive services. This includes behavioral health services that are not primarily aimed at treatment of sickness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed; recommended; or approved; by the person's attending physician, dentist, or vision provider.

39. Expenses incurred for vision-related services and supplies, except as specifically covered in the Policy. In addition, the plan does not cover:
    - Special supplies such as non-prescription sunglasses;
    - Vision service or supply which does not meet professionally accepted standards;
    - Special vision procedures, such as orthoptics or vision training;
    - Eye exams during a stay in a hospital or other facility for health care;
    - Eye exams for contact lenses or their fitting;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
    - Acuity tests; and
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
    - Services to treat errors of refraction.

40. Expenses incurred for orthodontic treatment except as specifically covered in the Policy.

41. Expenses incurred for routine dental exams and other preventive services and supplies, except as specifically covered in the Policy.

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

The University of Colorado Boulder Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

IMPORTANT NOTICES:

Notice of Non-Discrimination:

Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Sanctioned Countries:

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx orhttp://www.myameriben.com/ucboulder.htm**