

COLORADO SCHOOL OF MINES

Student Health Insurance Program

2013 -14



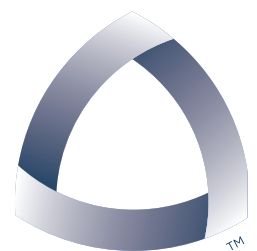
Eligibility

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Dates & Rates

Summary of Benefits

**This Plan Brochure is for the 2013-14 Policy year:
August 20, 2013 - August 18, 2014.**



Notice Regarding Student Health Insurance Coverage

This Student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are \$100,000 for policy years before September 23, 2012 and \$500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. This student health insurance coverage puts a policy year limit of \$2,000,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-767-0700. Be advised that an Insured Person may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if an Insured Person is under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.



WELCOME TO THE MINES STUDENT HEALTH INSURANCE PROGRAM (MINES SHIP)

June 3, 2013

Dear Students and Parents,

The Colorado School of Mines is pleased to offer a student health insurance program that is designed to provide quality student coverage and program value. This program provides worldwide coverage for injury and sickness, on- or off-campus.

The Student Health Insurance Program, *Mines SHIP*, is comprised of a fully insured Student Injury and Sickness Insurance Plan, underwritten by UnitedHealthcare Insurance Company, designed especially for Mines students, and a self-funded component for local, extended outpatient mental health and basic dental care through the Dental Clinic at the Colorado School of Mines

Please read this brochure to discover the value and quality of benefits that the Mines SHIP offers. Mines uses a “hard waiver,” which means you have to show proof of comparable coverage in order to waive. Review your current health plan to determine if it “**measures up**” to the requirements listed on page 7. The Preferred Provider for this plan is UnitedHealthcare Choice Plus, giving you access to one of the largest network of providers and hospitals worldwide.

All students eligible for the 2013–14 *Mines SHIP* must complete the enrollment/waiver process at the start of their enrollment at Mines, and annually thereafter. The annual premium of the *Mines SHIP* for the 2013-14 policy year is \$1596. Students, enrolling during the Fall semester, will see a \$798 charge on their bill at the beginning of fall semester; plan members will see a \$798 charge on their bill at the beginning of spring semester (covers through the Summer as well.) The coverage period for fall semester is August 20, 2013, to January 7, 2014, and the coverage period for spring /summer is January 8 to August 18, 2014.

Highlights of the program include:

- ✓ No Preferred Provider Deductibles or exclusions for pre-existing conditions
- ✓ 90% coverage of Preferred Provider Preferred Allowance except as noted.
- ✓ Separate policy for student participants in Intercollegiate Sports at no additional cost.
- ✓ Basic dental benefits provided by the Mines Dental Clinic, with low co-pays.
- ✓ Expanded, local outpatient mental health care, with \$15 co-pay per visit.
- ✓ Prescription drug benefits through UnitedHealthcare Pharmacy.
- ✓ On-campus assistance for eligibility and program information by Mines Student Health Benefits Office staff who are knowledgeable about Mines students.
- ✓ \$1,500 Out-of-Pocket Maximum for Preferred Providers Per Insured Person Per Policy Year
- ✓ \$2,000,000 maximum benefit Per Insured Person, Per Policy Year
- ✓ Emergency travel assistance through FrontierMedex.

Enclosed you'll find information on eligibility criteria, enrollment/waiver procedures, and benefits. More detail can be found on the *Mines SHIP* website: <http://studentinsurance.mines.edu>. In order to make the most of your coverage, and to be sure that you are aware of deadlines, policies, and procedures that affect you, please review the information found in this brochure and online carefully.

Please feel free to contact our office with any questions. We look forward to serving you!

Ron Brummett, MBA, MA
Director of Student Services





CONTACT SECTION

Service	Student Health Program	Phone	Web Site
Primary Care	Coulter Student Health Center After hours and weekends, New West Physicians	303-273-3381 303-278-4600	http://healthcenter.mines.edu www.nwphysicians.com (@Golden View Location)
Counseling	Counseling Center	303-273-3377	http://counseling.mines.edu
Dental Care	Dental Clinic	303-273-3377	http://healthcenter.mines.edu/SHC-Dental-Clinic
Sports Medicine for NCAA-Sanctioned Intercollegiate Sports	CSM Athletic Trainer	303-273-3375	http://athletics.mines.edu
Emergencies and Crisis Intervention	Life-Threatening Emergencies CSM Public Safety Counseling Center Suicide and Crisis Hot-Line	911 303-273-3333 303-273-3377 303-425-0300	N/A http://publicsafety.mines.edu http://counseling.mines.edu www.suicidehotlines.com/colorado
On-Campus Service	CSM Student Health Benefits Program Coordinator	303-273-3388	http://studentinsurance.mines.edu
Insurance Benefits (including vision care), and Claims Information	UnitedHealthcare StudentResources	800-767-0700	www.uhcsr.com/CSM
Identification Cards (download from website)	UnitedHealthcare StudentResources		www.uhcsr.com/CSM
Emergency Services while Abroad	FrontierMEDEX	800-527-0218	www.uhcsr.com/frontiermedex
Confidential Secure Messaging for Student Health Insurance Program (available to all students regardless of type of personal health insurance coverage)	WordSecure	303-273-3381	To subscribe visit: https://csm.wordsecure.com/



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Mines Health Insurance Requirement



Unless otherwise specified in this brochure, the following students must, as a condition of enrollment, regardless of the semester in which enrollment begins, have health insurance that meets or exceeds Mines' coverage requirements (Please see "Does Your Plan Measure Up on page 7.):

1. All degree-seeking U.S. citizen and permanent resident students, and
2. All international students regardless of degree-seeking status.

J-1 visa non-degree students will have coverage periods the same as any other student. International students will not be allowed to waive out of the SHIP unless proof of purchase of a group plan, with a claims office in the U.S., that meets the waiver criteria or have a pre-approved embassy, government or US employer sponsored plan as determined by the Student Health Insurance Program. Travel insurance is not acceptable.

ELIGIBILITY

All eligible students must meet the following requirements:

1. Students must be enrolled in the SHIP prior to the enrollment/waiver deadline, Census Day. Students who waive coverage for the fall semester will not be allowed to change this decision for the spring/summer coverage periods except as specifically allowed for Qualified Late Enrollees (refer to voluntary SHIP Classes page 9.) Requests for changing a SHIP waiver will not be considered after the enrollment/waiver deadline.
2. Students must regularly attend scheduled classes for the first 31 days of each coverage period unless the student has an approved medical withdrawal from Mines (page 12).

3. The student has not been enrolled in the SHIP for more than nine years while in a single degree program.
4. Students are required to establish that they are pursuing a degree and making successful progress toward degree completion. For graduate degree students, two consecutive occurrences of unsatisfactory progress indication and/ or dismissal from a graduate degree program will result in termination of coverage at the end of the current coverage period.
5. All Mines intercollegiate athletes are required to meet both the Mines insurance requirement and the NCAA catastrophic coverage requirement. Intercollegiate athletes may petition to waive participation in the SHIP by submitting documentation of coverage that fulfills both requirements. (See page 12.)

INELIGIBLE

The following students are not eligible to enroll in the SHIP:

- Non-degree U.S. Citizens and Permanent Residents, regardless of the number of credit hours, and
- Non-degree, concurrently enrolled J-1 visa students when another higher education institution holds the Visa documentation.

TERMINATION

Coverage terminates the day prior to the start of the spring semester for Covered Students who:

- Graduate in December,
- Withdraw from the University after the fall Census Day,
- Are academically suspended after the fall Census Day, or
- Otherwise, lose eligibility as described in this document or the Master Policy.

Coverage terminates the day prior to the start of the fall semester for Covered Students who:

- Graduate in May, Summer I or Summer II,
- Withdraw from the University after the spring Census Day,
- Are academically suspended after spring Census Day, or
- Otherwise, lose eligibility as described in this document or the Master Policy.

DOES YOUR HEALTH PLAN “MEASURE UP?”



If your plan does not meet these criteria, you will be enrolled in the SHIP or required to purchase a plan that does meet these standards.

- has a maximum benefit of at least \$2,000,000 (with no yearly or per condition maximum benefit that would reduce coverage);
- includes participating health care providers in the Denver metro area for both emergency and non-emergency health care services;
- includes prescription drug benefits;
- provides at least 20 outpatient visits for mental health care services and provides at least 30 days of inpatient mental health care services (including emergency psychiatric admissions);
- coverage is in effect on the first day of classes without any waiting period or preexisting condition exclusion and will remain in effect for the 2013-14 academic year
- has a deductible of \$5000 or less; and
- has coverage while traveling abroad (if current plan does not have this coverage, students must purchase additional travel insurance).

****Students must have a valid and active Mines email address in order to enroll in or submit a waiver petition for the Student Health Insurance Program.****

INSURANCE RATES FOR THE 2013 -14 POLICY YEAR

	Annual: August 20, 2013 - August 18, 2014	Special Coverage Period: Au- gust 1, 2013 - August 19, 2013*	Fall: August 20, 2013 - January 7, 2014	Spring: January 8, 2014 - August 18, 2014 CONTINUING STUDENTS	Spring/Sum- mer: January 8, 2014 - August 18, 2014 NEW STUDENTS	Summer I: May 12, 2014 - August 18, 2014	Summer II: June 23, 2014 - August 18, 2014
Student	\$1,596	\$79	\$798	\$798	\$975	\$432	\$249
Spouse	\$1,596	NA	\$798	\$798	\$975	\$432	\$249

Each Child	\$1,596	NA	\$798	\$798	\$975	\$432	\$249
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* For students required to be on campus prior to the first day of class; i.e. athletes and residence assistants.

Upon a student's bona fide request and submission of appropriate documentation, the School may grant a waiver of the insurance requirement based on the student's sincerely held religious belief, which prevents the student from buying or having health insurance. All waiver requests must be in writing and will be reviewed by the Student Health Insurance Program Coordinator.

Sanctions by Mines may be imposed if students are found to have intentionally falsified an official Mines required document.

Annual Online Enrollment/Waiver Process – September 4, 2013 deadline!



The SHIP is an annual program, beginning August 20. The cost for the fall semester coverage will appear on the student's bill at the start of the fall semester. For students enrolled in the program during the fall semester, the cost of coverage for spring/summer will appear on the student's bill in the spring semester for the SHIP unless they submit an approved waiver request by September 4, 2013 for the fall/spring coverage, January 23, 2014 for spring/summer coverage, May 16, 2014 for Summer I and graduate research, and June 27, 2014 for Summer II. Accounts of all eligible new students are charged for coverage at the start of the semester, and the student must have the waiver request **APPROVED** by the deadline to have that charge removed.

Instructions for Using the SHIP Online Enrollment/Waiver Process

All students must use the online process to enroll. All U.S. citizen and Permanent Resident degree-seeking students must use the online process to petition to waive. All international students cannot use the online system to waive, and must use a paper waiver. After Census Day, all late waiver petitions must be submitted with a paper waiver.

Enrollment/Waiver Process

- log into Trailhead;
- click on Student;
- click on Registration;
- scroll to bottom, click Enroll/Petition to Waive in Student Health Insurance Program (SHIP);
- follow instructions on page in pop-up window. Please be sure pop-up blocker is off;
- a notice indicating approval or denial will be emailed within 72 hours;
- print for your records, and
- additional confirmation will be sent to your Mines email account.

If you encounter problems or have questions, please contact the Student Benefits Coordinator at 303-273-3388 or kebeling@mines.edu.

Enrolling Your Dependents in SHIP

Students wanting to enroll a spouse, domestic partner, or child(ren) in the SHIP must visit the Student Health

Benefits office to complete an enrollment form and have the additional cost of coverage added to their tuition/fee billing. Eligible dependents may only be enrolled during the annual open enrollment period and must complete a new enrollment form annually. Continued annual dependent coverage is not automatic. This form must be completed by Mines' Census Day.

Late Waivers

Petitions for waiving SHIP coverage after the deadlines stated here will be considered on an individual basis. If granted, SHIP waiver petitions after the enrollment/waiver deadline will be subject to a \$125 late waiver fee for requests submitted prior to October 4, 2013 (February 23, 2014 for Spring, May 19, 2014 for Summer I and graduate research, and July 1, 2014 for Summer II). Late fees are not appealable.

Waiver Petition Denial Appeals Process

The School of Mines reserves the right to audit all waiver petitions, and may reverse a previously granted waiver. A waiver will be denied when a student does not provide documentation of current coverage that meets Mines requirements. Appeals process [Formal]

- Level 1 Appeal - SHIP Appeals Committee comprised of faculty and students.
- Level 2 Appeal - Plan Administrator

Refund information can be found on page 12.

COBRA and Extension of Eligibility/Benefits

The Student Health Insurance Program is not subject to the extension of eligibility provisions required under Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).





NOTICES

The SHIP provided by Mines complies with the standards for student health insurance/benefit programs recommended by the American College Health Association, www.acha.org.

The Colorado School of Mines complies with the Health Insurance Portability and Accountability Act of 1996. Privacy policies for the Coulter Student Health Center and the Counseling Center may be obtained by visiting either facility or at the following websites: healthcenter.mines.edu or counseling.mines.edu.

Annual Open Enrollment

The SHIP is an annual program. The cost of coverage for the fall semester will appear on the student's bill at the start of the fall semester; the cost of coverage for spring/summer will appear on the student's bill at the start of the spring semester. Students who waive enrollment in the SHIP are not eligible for enrollment until the next annual open enrollment period, except for provisions established for Qualified Late Enrollees. For example, a student who waives enrollment in the SHIP for the fall semester is not eligible to enroll in the subsequent spring/summer coverage period. Note that students who are Covered by the SHIP for the spring semester automatically have coverage through the summer, including students who are graduating in May. Students who enroll in the SHIP for the fall semester may discontinue purchasing the SHIP for the spring semester if they have acquired other group health insurance coverage that meets Mines' insurance requirements. Students (other than NCAA athletes) may withdraw from the SHIP during any coverage period if they acquire other group health insurance, but no refunds are provided. Pro-rated refunds are provided only if the student enters into the armed services. See Effective and Termination Dates on page 12.

Voluntary SHIP Eligibility Classes

Spouses, domestic partners, and children of SHIP-Covered students are also eligible for participation in the SHIP. Eligible dependents are the spouse (except in the event of divorce or annulment), domestic partner, and children younger than 26 years of age. Pro-rated costs are available for newly acquired dependents only.

Approved Medical Withdrawal/Leave of Absence
Please see page 12.

Qualified Late Enrollees

An eligible student will only be allowed to enroll in the SHIP after the applicable enrollment/waiver period if proof is furnished that the student became involuntarily ineligible for coverage under another group's insurance plan during the 30 days immediately preceding the date of the request for late enrollment in the SHIP. In such cases, the student's effective date of coverage under the SHIP will be the first day of the month in which the student involuntarily loses coverage. The 30-day period in the provision may be extended if the student can establish that he or she was unaware of the involuntary loss of coverage.

Unqualified Late Enrollees

Unqualified Late Enrollees cannot purchase SHIP dependent coverage until the next Annual Open Enrollment Period. Situations that would result in a student being viewed as an Unqualified Late Enrollee are: a student is found to have misrepresented his or her plan coverage on the waiver form; a student loses coverage and seeks enrollment in the plan more than 30 days after the loss of his/her previous plan; or a student wishes to enroll in the SHIP without a qualifying event (see above).



Health and Wellness Services at Mines



*W. Lloyd Wright Student Wellness Center
1770 Elm Street, Golden, CO 80401
<http://wellnesscenter.mines.edu>*

Convenient healthcare services on campus saves time and money, and contributes to a quality residential campus experience at Mines.

Student access to the Mabel Coulter Student Health Center, Dental Clinic and Counseling Center begins when a student is required to pay all student fees. **None** of these programs accepts or bills insurance. The Student Health Center fee is a mandatory fee. Please see <http://healthcenter.mines.edu> for more information. The mandatory Student Services fee includes paying for professional counseling services. Please visit <http://counseling.mines.edu> for more information.

SHIP Benefits Provided by the Coulter Student Health Center

- Certain laboratory services
- Travel Clinic
- Immunizations



*Debra Roberge, A.N.P.
Director of the Student Health Center*



*Mark Pattridge, M.D.,
Medical Director*

Self-funded Services provided to Covered Students (excludes dependents)

Funded and Administered by the Colorado School of Mines. Funding for the Counselor Referral Network and the Dental Clinic is derived from reserve funds from the SHIP. UnitedHealthcare does not cover the self-funded outpatient mental health benefits and dental benefits. Also, UnitedHealthcare has no responsibility for administration of dental claims or Counselor Referral Network benefits.

Counselor Referral Network

Referral must be made by the Counseling Center for SHIP-covered students. Copay = \$15. Maximum of 30 visits (aggregate). For further information contact the Counseling Center, 303-273-3377. Providers are licensed and contracted to Mines.



Counseling Center Waiting Area



Dental Clinic



Student Injury and Sickness Insurance Plan

Designed especially for the students at the Colorado School of Mines by UnitedHealthcare.

Dental Clinic Fee Schedule 2013-14

The Dental Clinic is not a participating provider with private dental insurance plans. A billing statement will be provided upon request for students to submit to private dental plans for reimbursement.

Covered Services	SHIP Covered Students	Pri- vately Insured Students
Examinations		
Initial, with X-rays as needed	15	40
Emergency exam with X-rays as needed	5	25
Preventative/Diagnostic		
Prophylaxis/Cleaning	21	45
Four bitewing X-rays	15	35
Sealant per tooth	12	30
Full mouth x-rays	17	45
Periapical films	0	10
Vitality testing	0	20
Flouride Treatment	12	35
F-Paste (at cost)	10	10
Restorative		
Amalgam-1 surface	25	50
Amalgam-2 surfaces	30	55
Amalgam -3 surfaces	35	60
Amalgam-4 surfaces	40	65
Resin-1 surface	25	50
Resin-2 surfaces	30	55
Resin-3 surfaces	35	60
Resin-4 surfaces	40	65
Emergency		
Pulpectomy/pulpotomy	25	50
Sedative filling/interim restoration	17	45
Periodontics		
Limited scaling/root cleaning	32	50
Peiro scaling/root planiing/hour	38	75
Perio maintenance	25	50
Oral Surgery		
Extraction (simple)	35	65
Incision and abscess drainage	22	35

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or visiting us at www.uhcsr.com/csm.

Eligibility

All degree-seeking U.S. citizens and permanent resident students and all international students regardless of degree-seeking status are automatically enrolled in this insurance plan at registration unless proof of comparable coverage is furnished.

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

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

Dependent Eligibility expires concurrently with that of the Insured student.



Intercollegiate Sports Coverage

Accident coverage for Intercollegiate Sports injuries is provided under a separate policy number 2013-4059-8. Contact the school for information on the Intercollegiate Sports plan. Plan information is also available at www.uhcsr.com/csm.

Approved Medical Leave of Absence

Students who are taking an approved medical leave of absence from CSM, granted by the Associate Dean of Students for undergraduate students and the Associate Provost for Graduate Studies for graduate students, may request enrollment in the CSM policy in effect for two academic semesters, provided they were enrolled in the CSM policy in effect for the period of coverage immediately preceding the period of absence.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 20, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 18, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Refunds of premiums are allowed only upon entry into the armed forces. The Policy is a Non-Renewable One Year Term Policy.

Extension of Benefits After Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the termination date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

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

Pre-Admission Notification

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

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

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

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



Schedule of Medical Expense Benefits

INJURY and SICKNESS

Maximum Benefit: \$2,000,000 Paid As Specified
Below (Per Insured Person, Per Policy Year)

Deductible Preferred Provider: \$0

Deductible Out-of-Network: \$1,000
(Per Insured Person, Per Policy Year)

Deductible Out-of-Network: \$3,000

(For all Insureds in a Family, Per Policy Year)

Coinsurance Preferred Provider: 90% except as noted
below

Coinsurance Out-of-Network: 70% except as noted
below

Out-of-Pocket Maximum Preferred Providers: \$1,500
(Per Insured Person, Per Policy Year)

Out-of-Pocket Maximum Preferred Providers: \$3,000
(For all Insureds in a Family, Per Policy Year)

Out-of-Pocket Maximum Out-of-Network: \$3,000
(Per Insured Person, Per Policy Year)

Out-of-Pocket Maximum Out-of-Network: \$9,000
(For all Insureds in a Family, Per Policy Year)

The Preferred Provider for this plan is
UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any
Covered Medical Expenses will be paid at the
Preferred Provider level of benefits. If the Covered
Medical Expense is incurred due to a Medical
Emergency, benefits will be paid at the Preferred
Provider level of benefits. In all other situations,
reduced or lower benefits will be provided when an
Out-of-Network provider is used.

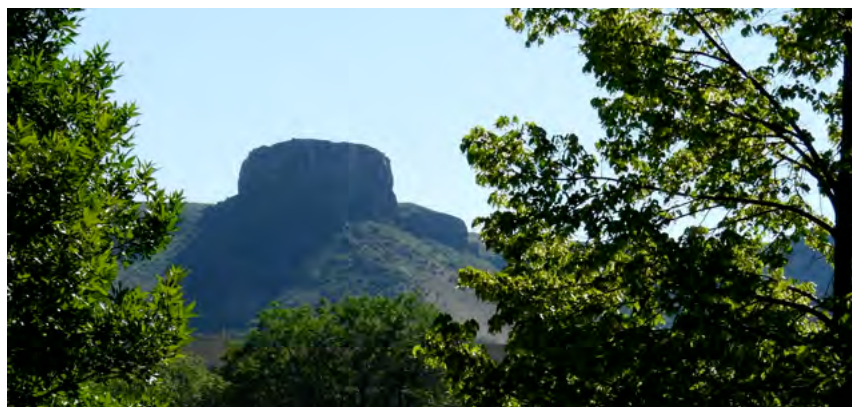
The Policy provides benefits for the Covered Medical
Expenses incurred by an Insured Person for loss due
to a covered Injury or Sickness up to the Maximum
Benefit of \$2,000,000.

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

Coulter Student Health Center Benefits: The
Deductible will be waived and benefits will be paid at
100% for Covered Medical Expenses incurred when
treatment is rendered at or referred by the Coulter
Student Health Center for the following services:

- Certain laboratory services
- Travel Clinic
- Immunizations – as indicated on the approved SHC
Fee Schedule.

Benefits are subject to the policy Maximum Benefit
unless otherwise specifically stated. Benefits will be
paid up to the maximum benefit for each service as
scheduled below. All benefit maximums are combined
Preferred Provider and Out-of-Network unless
otherwise specifically stated.



Student Health Insurance Program



Covered Medical Expenses include:

INPATIENT	Preferred Providers	Out-of-Network Providers
Room and Board Expense, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	90% of PA / \$250 Copay per visit	70% of U&C / \$750 Deductible per visit
Intensive Care	90% of PA	70% of U&C
Hospital Miscellaneous Expense, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	Paid under Room and Board Expense	
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
Physiotherapy	90% of PA	70% of U&C
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of PA	70% of U&C
Assistant Surgeon	90% of PA	70% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	90% of PA	70% of U&C
Registered Nurse's Services, private duty nursing care.	90% of PA	70% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	90% of PA	70% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	90% of PA	70% of U&C
OUTPATIENT	Preferred Providers	Out-of-Network Providers
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of PA	70% of U&C
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	90% of PA / \$250 Copay per visit	70% of U&C / \$750 Deductible per visit
Assistant Surgeon	90% of PA	70% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	90% of PA	70% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of PA / \$25 Copay per visit	70% of U&C / \$25 Deductible per visit
Physiotherapy, Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	90% of PA / \$25 Copay per visit	70% of U&C

Student Health Insurance Program



Medical Emergency Expenses, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. (The Copay/per visit Deductible will be waived if admitted to the Hospital.)	90% of PA / \$100 Copay per visit	70% of U&C / \$100 Deductible per visit
Diagnostic X-ray Services	90% of PA	70% of U&C
Radiation Therapy	90% of PA	70% of U&C
Chemotherapy	90% of PA	70% of U&C
Laboratory Services	90% of PA	70% of U&C
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	90% of PA	70% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	90% of PA	70% of U&C
Prescription Drugs (Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.) UnitedHealthcare Pharmacy (UHCP)	\$15 Copay per prescription for Tier 1 \$30 Copay per prescription for Tier 2 \$60 Copay per prescription for Tier 3 up to a 31-day supply per prescription	No Benefits

OTHER	Preferred Providers	Out-of-Network Providers
Ambulance Services (Benefit includes air ambulance payable at 90% of Preferred Allowance In-Network / 70% of Usual and Customary Charges Out-of-Network.)	100% of PA / \$200 Copay per trip	100% of U&C / \$200 Deductible per trip
Consultant Physician Fees, when requested and approved by attending Physician.	100% of PA / \$25 Copay per visit	70% of U&C / \$25 Deductible per visit
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. (\$5,000 maximum Per Policy Year)(Durable Medical Equipment benefits payable under the \$5,000 maximum are not included in the \$2,000,000 Maximum Benefit.) (See also Benefits for Prosthetic Devices.)	90% of PA	70% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. (Benefits are not subject to the \$2,000,000 Maximum Benefit.)	90% of U&C	90% of U&C
Mental Illness Treatment, services received on an Inpatient and outpatient basis. (See also Benefits for Biologically Based Mental Illness.)	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. (See also Benefits for Biologically Based Mental Illness.)	Paid as any other Sickness	
Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	No Benefits	

Student Health Insurance Program



Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.	Paid as any other Sickness	
Diabetes Services in connection with the treatment of diabetes	See Benefits for Diabetes.	
Urgent Care Center, facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.	90% of PA / \$35 Copay per visit	70% of U&C / \$35 Deductible per visit
Skilled Nursing Facility, services received while confined as a full-time Inpatient in a licensed Skilled Nursing Facility in lieu of or within 24 hours following a Hospital Confinement.	90% of PA / \$250 Copay per admission (Copayment waived if admitted directly from an Inpatient acute facility.)	70% of U&C / \$750 Deductible per admission
Hospice Care, services received from a licensed hospice agency and when recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. (Benefits for Hospice Care are not subject to the \$2,000,000 Maximum Benefit)	90% of PA	70% of U&C
Vision (One exam Per Policy Year) (Coverage includes exam, refractions and associated fittings for either eyeglasses or contacts. No copay applies to visits for fittings. Vision benefits are not subject to the \$2,000,000 Maximum Benefit.)	100% of PA / \$25 Copay per visit	70% of U&C / \$25 Deductible per visit
Acupuncture, (12 visits maximum Per Policy Year.) (Acupuncture benefits are not subject to the \$2,000,000 Maximum Benefit.)	100% of PA / \$25 Copay per visit	70% of U&C / \$25 Deductible per visit
Allergy Injections, (If not billed with a Physician's office visit.)	90% of PA	70% of U&C
Learning Disability Testing, (Benefits payable for learning disability testing.) (\$600 maximum Per Policy Year.) (Learning disability testing benefits are not subject to the \$2,000,000 Maximum Benefit.)	Paid as any other Sickness	No Benefits
Preventive Care Services, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; 2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. (See also Benefits for Preventive Health Care.)	100% of PA	No Benefits

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits

are subject to supply limits and Copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.



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

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

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

\$60 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply

Mail order Prescription Drugs are available at 2.5 times the retail Copay up to a 90 day supply.

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

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed(days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.

3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3.
4. Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a prescription order or refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

Definitions

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



definition includes insulin.

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

Preferred Provider Information

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"Out-of-Network" providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Expenses:

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of

Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call (800) 767-0700 for information about Preferred Hospitals.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Choice Plus will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Maternity Testing

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

Initial screening at first visit:

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



- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

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

Once during second trimester if age 35 or over:

Amniocentesis or Chorionic villus sampling (CVS)

Once during second or third trimester: 50g Glucola

(blood glucose 1 hour postprandial) Once during

third trimester: Group B Strep Culture

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

Coordination of Benefits Provision

Benefits will be coordinated with any other eligible medical, surgical or hospital plan or coverage so that combined payments under all programs will not exceed 100% of allowable expenses incurred for covered services and supplies.

MANDATED BENEFITS

BENEFITS FOR PROSTHETIC DEVICES

Benefits will be paid for the Usual and Customary Charges for the purchase of Prosthetic Devices. Prosthetic device means an artificial device to replace, in whole or in part, an arm or leg. Benefits are limited to the most appropriate model that adequately meets the medical needs of the Insured as determined by a Physician. Repairs and replacements of Prosthetic Devices are also covered unless necessitated by misuse or loss. Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR TELEMEDICINE SERVICES

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

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

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid for actual charges incurred for an annual screening by a Physician for the early detection of prostate cancer. Benefits will be payable for one screening per year for any male Insured 50 years of age or older. One screening per year shall be covered for any male Insured 40 to 50 years of age who is at risk of developing prostate cancer as determined by the Insured's Physician. The screening shall consist of the following tests:

- 1) A prostate-specific antigen (PSA) blood test; and
- 2) Digital rectal examination.

The policy Deductible will not be applied to this benefit and this benefit will not reduce any diagnostic benefits otherwise allowable under the policy. Benefits shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the policy.



BENEFITS FOR BIOLOGICALLY BASED MENTAL ILLNESS

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

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

“Mental Disorder” means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. Mental Disorder also includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient, day treatment, and in-patient basis, exclusive of residential treatment.

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

BENEFITS FOR DIABETES

Benefits will be paid for the Usual and Customary Charges for all medically appropriate and necessary equipment, supplies, and outpatient diabetes self-management training and educational services including nutritional therapy if prescribed by a Physician.

Diabetes outpatient self-management training and education shall be provided by a Physician with expertise in diabetes.

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

BENEFITS FOR CERVICAL CANCER VACCINES

Benefits are payable for the cost of cervical cancer vaccinations for all female Insured Persons for whom a vaccination is recommended by the Advisory Committee on Immunization practices of the United States Department of Health and Human Services.

BENEFITS FOR MEDICAL FOODS

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

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

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

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

Medical foods means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy that are specifically designed and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and



fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered internally either via tube or oral route under the direction of a Physician.

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

BENEFITS FOR CHILD HEALTH SUPERVISION SERVICES

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

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

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

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

Advisory Committee on Immunization Practices
www.cdc.gov/nip/acip

American Academy of Pediatrics
www.aap.org

American Academy of Family Physicians,
www.aafp.org

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

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

BENEFITS FOR THERAPIES FOR CONGENITAL DEFECTS AND BIRTH ABNORMALITIES

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

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

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

BENEFITS FOR CLEFT LIP OR CLEFT PALATE

Benefits will be paid the same as any other Sickness for treatment of newborn children born with cleft lip or cleft palate or both. Benefits shall include the Medically Necessary care and treatment including oral and facial surgery; surgical management; the Medically Necessary care by a plastic or oral surgeon; prosthetic treatment such as obturators, speech appliances, feeding appliances; Medically Necessary orthodontic and prosthodontic treatment; rehabilitative



speech therapy, otolaryngology treatment; and audiological assessments and treatment.

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

BENEFITS FOR HOSPITALIZATION AND GENERAL ANESTHESIA FOR DENTAL PROCEDURES FOR DEPENDENT CHILDREN

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

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

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

BENEFITS FOR HEARING AIDS FOR MINOR CHILDREN

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

Benefits shall include the purchase of the following:

- 1) Initial Hearing Aids and replacement Hearing Aids not more frequently than every five years;
- 2) A new Hearing Aid when alterations to the existing Hearing Aid cannot adequately meet the needs of the Minor Child; and
- 3) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to professional standards.

“Hearing Aid” means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. “Hearing Aid” shall include any parts or ear molds.

“Minor Child” means an Insured Person under the age of eighteen.

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

BENEFITS FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Sickness for Covered Medical Expenses related to the assessment, diagnosis and treatment, including Applied Behavior Analysis, of Autism Spectrum Disorders. Treatment for Autism Spectrum Disorders must be prescribed or ordered by a licensed Physician or license psychologist.

“Applied behavior analysis” means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

“Autism Spectrum Disorders” include the following neurobiological disorders: autistic disorder, asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise



specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time of diagnosis.

“Treatment for Autism Spectrum Disorders” shall be for treatments that are Medically Necessary, appropriate, effective, or efficient. Treatment for Autism Spectrum Disorders shall include:

- 1) Evaluation and assessment services;
- 2) Behavior training and behavior management and applied behavior analysis, including but not limited to, consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers;
- 3) Habilitative or rehabilitative care, including but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies;
- 4) Psychiatric care;
- 5) Psychological care, including family counseling;
- 6) Therapeutic care; and
- 7) Pharmacy care and medication if provided for in the policy.

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

BENEFITS FOR PREVENTIVE HEALTH CARE

Benefits will be provided for the cost of the following Preventive Health Care services, in accordance with the A or B recommendations of the Task Force for the particular Preventive Health Care service:

- 1) Alcohol misuse screening and behavioral counseling interventions for adults by their Physician;
- 2) Cervical Cancer Screening;
- 3) Breast Cancer Screening with Mammography:
 - a) Benefits shall be determined on a Policy Year basis and shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy;
 - b) If an Insured Person who is eligible for a preventive mammography screening has not utilized

the benefit during the Policy Year, then the coverage shall apply to one diagnostic screening for that same Policy Year. Any other diagnostic screenings shall be subject to all applicable policy provisions;

- c) Benefits shall also be provided for an annual breast cancer screening with mammography for an Insured Person possessing at least one risk factor including, but not limited to, a family history of breast cancer, being forty years of age or older, or a genetic predisposition to breast cancer;
- 4) Cholesterol screening for lipid disorders;
- 5) Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps. Benefits shall also be provided to an Insured Person who is at a high risk for colorectal cancer, including an Insured Person who has a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn’s disease, or ulcerative colitis; or other predisposing factors as determined by a Physician;
- 6) Childhood immunizations pursuant to the schedule established by the ACIP;
- 7) Influenza vaccinations pursuant to the schedule established by the ACIP;
- 8) Pneumococcal vaccinations pursuant to the schedule established by the ACIP; and
- 9) Tobacco use screening of adults and tobacco cessation interventions by the Insured Person’s Physician.

For the purposes of this mandate:

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



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

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

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

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

BENEFITS FOR ORAL ANTICANCER MEDICATION

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

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

The medication provided pursuant to this benefit shall:

1) only be prescribed upon a finding that it is Medically Necessary by the treating Physician for the

purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice

2) be clinically appropriate in terms of type, frequency, extent site, and duration; and

3) not be primarily for the convenience of the Insured or Physician.

This benefit does not require the use of orally administered medications as a replacement for other cancer medications, nor does it prohibit the Company from applying an appropriate formulary or other clinical management to any medication described in this benefit.

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

EXCLUSIONS AND LIMITATIONS

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

1. Nicotine addiction, except as specifically provided in the policy;
2. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation; except as specifically provided in the policy;
3. Biofeedback;
4. Circumcision;
5. Congenital conditions
6. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn children;
7. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for



- domiciliary or Custodial Care;
8. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
 9. Elective Surgery or Elective Treatment;
 10. Elective abortion;
 11. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process; except as specifically provided in the policy;
 12. Health spa or similar facilities; strengthening programs;
 13. Hearing examinations; hearing aids, except as specifically provided in the policy; or cochlear implants; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
 14. Hypnosis;
 15. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
 16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
 17. Injury or Sickness outside the United States and its possessions;
 18. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
 19. Injury sustained while (a) participating in any intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
 20. Investigational services;
 21. Lipectomy;
 22. Marital or family counseling;
 23. Nuclear, chemical or biological Contamination, whether direct or indirect. "Contamination" means the contamination or poisoning of people by nuclear and/or chemical and/or biological substances which cause Sickness and/or death;
 24. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
 25. Prescription Drugs, services or supplies as follows:
 - a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
 - b. Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
 - c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - d. Products used for cosmetic purposes;
 - e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
 - f. Anorectics - drugs used for the purpose of weight control;
 - g. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
 - h. Growth hormones; or
 - i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
 26. Reproductive/Infertility services including



- but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
27. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;
 28. Residential treatment of eating disorders, such as anorexia or bulimia;
 29. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
 30. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
 31. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
 32. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
 33. Supplies, except as specifically provided in the policy;
 34. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
 35. Treatment in a Government hospital, unless there is a legal obligation for the Insured

- Person to pay for such treatment;
36. War or any act of war, declared or undeclared; or while in the armed forces of any country other than the United States (a pro-rata premium will be refunded upon request for such period not covered); and
 37. Weight management, service and supplies related to weight reduction programs, weight management programs, nutrition programs, related nutritional supplies and treatment for obesity.

FrontierMEDEX: Global Emergency Medical Assistance

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

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

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

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

Key Services include:

- Transfer of Insurance Information to Medical



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

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

To access services please call:
(800) 527-0218 Toll-free within the United States
(410) 453-6330 Collect outside the United States

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

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

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and FronterMEDEX ID Number as listed on your Medical ID Card;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;

5. Name and telephone number of the attending physician; and

6. Information of where the physician can be immediately reached

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

Notice Of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

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

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or



other material relevant to the claim.

Please contact the Customer Service Department at 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

For Urgent Care Requests, an Insured Person or a Designated Representative may submit a request, either orally or in writing, for an Expedited Internal Appeal (EIR) of an Adverse Determination:

1. involving Urgent Care Requests; and
2. related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received emergency services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or a Designated Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Designated Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Insured Person has been notified of the final determination.

At the same time an Insured Person or a Designated Representative files an EIR request, the Insured Person or the Designated Representative may file:

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage

based on the determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

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

Right to External Independent Review

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

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

Standard External Review

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

Expedited External Review

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

1. The Insured Person or the Insured Person's Designated Representative has received an Adverse Determination, and
 - a. The Insured Person, or the Insured Person's Designated Representative, has submitted a request for an Expedited Internal Appeal; and
 - b. Adverse Determination involves a medical condition for which the time frame for completing an



Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

2. The Insured Person or the Insured Person's Designated Representative has received a Final Adverse Determination, and

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

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

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

Where to Send External Review Requests

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

Claims Appeals

UnitedHealthcare **StudentResources** PO Box 809025
Dallas, TX 75380-9025
888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service at 800-767-0700 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Online Access to Account Information

UnitedHealthcare **StudentResources** Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to My Account at www.uhcsr.com/csm/myaccount.

Insured students who don't already have an online account may simply select the "create My Account Now" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare **StudentResources**' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information. My Account has been enhanced to include Message Center - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Email Preferences and making the change there.

UnitedHealth Allies

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

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.



ID Cards

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

of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits. This Brochure is based on Policy # 2013-4059-1

Claim Procedure

In the event of Injury or Sickness, students should:

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

The Plan is Underwritten by

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare **StudentResources**

P.O. Box 809025

Dallas, Texas 75380-9025 1-800-767-0700

customerservice@uhcsr.com claims@uhcsr.com

Sales/Marketing Services: UnitedHealthcare

StudentResources

805 Executive Center Drive West, Suite 220 St.

Petersburg, FL 33702 1-800-237-0903

Email: info@uhcsr.com

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some

W. Lloyd Wright Student Wellness Center



Coulter Student Health Center
303-273-3381

Counseling Center
303-273-3377

Dental Clinic
303-273-3377

Student Health Plan Office
303-273-3388

Student Disability Services
303-384-2595

NOW OPEN TO SERVE MINES STUDENTS

1770 Elm Street, Golden, CO 80401

Colorado School of Mines
Student Health Insurance Program
1770 Elm Street, #207
Golden, CO 80401