

**PLEASE NOTE:
THIS DOCUMENT HAS
CHANGED. PLEASE SEE THE
BACK COVER FOR DETAILS**



2023-2024 Student Health Insurance Plan for Colorado School of Mines

Who is eligible to enroll?

All domestic degree-seeking students, regardless of credit hours, must purchase the plan, unless proof of comparable coverage is furnished. Online only degree students are not eligible. All international student (F and J visas), regardless of degree seeking status, are automatically enrolled in this insurance plan unless proof of comparable coverage is furnished.

The student (Named Insured, as defined in the Certificate) 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 and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

Where can I get more information about the benefits available?

Please read the certificate of coverage to determine whether this plan is right before you enroll. The certificate of coverage provides details of the coverage including benefits, exclusions, and reductions or limitations and the terms under which the coverage may be continued in force. Copies of the certificate of coverage are available from the College and may be viewed at www.uhcsr.com. This plan is underwritten by UnitedHealthcare Insurance Company and is based on policy number 2023-4059-1. The Policy is a Non-Renewable One-Year Term Policy.

Who can answer questions I have about the plan?

If you have questions please contact Customer Service at 1-800-767-0700 or customerservice@uhcsr.com.

Highlights of Coverage offered by UnitedHealthcare Student Resources

Coverage Dates and Plan Cost

Rates	Annual 8-1-2023 to 7-31-2024	Spring/Summer 1-1-2024 to 7-31-2024	Summer 5-13-2024 to 7-31-2024
Student	\$2,494.00	\$1,451.00	\$545.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

The Insured Person must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Insured Person's premium must be received within 14 days after the coverage expiration date. It is the Insured Person's responsibility to make timely premium payments to avoid a lapse in coverage.

Other Coverage

Accident coverage for Intercollegiate sports injury is provided under a separate policy, 2023-4059-8.

Highlights of the Student Health Insurance Plan Benefits

METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 91.310%

Preferred Providers: The Preferred Provider Network for this plan is UnitedHealthcare Choice Plus. Preferred Providers can be found using the following link: [UHC Choice Plus](#)

Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Routine/Preventative Labs referred by the SHC to LabCorp will be paid at 100%. All Other labs referred by the SHC to Lab Corp will be paid at 80%. Policy Exclusions and Limitations do not apply.

	Preferred Providers	Out-of-Network Providers
Overall Plan Maximum	There is no overall maximum dollar limit on the policy	
Plan Deductible	\$0 Per Insured Person, per Policy Year	\$1,000 Per Insured Person, per Policy Year
Out-of-Pocket Maximum <i>After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any applicable benefit maximums. Refer to the plan certificate for details about how the Out-of-Pocket Maximum applies.</i>	\$2,000 Per Insured Person, Per Policy Year	\$4,000 Per Insured Person, Per Policy Year
Coinsurance <i>All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copays as described in the plan certificate.</i>	80% of Allowed Amount for Covered Medical Expenses	60% of Allowed Amount for Covered Medical Expenses
Prescription Drugs <i>Prescriptions must be filled at a UHCP network pharmacy.</i>	\$15 Copay for Tier 1 \$30 Copay for Tier 2 \$60 Copay for Tier 3 Up to a 30-day supply per prescription filled at a UnitedHealthcare Pharmacy (UHCP) Retail Network Pharmacy not subject to Deductible	No Benefits
Preventive Care Services <i>Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit www.healthcare.gov/preventive-care-benefits/ for a complete list of the services provided for specific age and risk groups.</i>	100% of Allowed Amount	Allowed Amount after Deductible
The following services have per service Copays <i>This list is not all inclusive. Please read the plan certificate for complete listing of Copays.</i>	Physician's Visits: \$25 Medical Emergency: \$100	Physician's Visits: \$25 after Deductible Medical Emergency: \$100 not subject to Deductible
Outpatient Mental Illness/Substance Use Disorder Treatment, except Medical Emergency and Prescription Drugs	Office Visits: \$25 100% of Allowed Amount Other Outpatient Services: Allowed Amount	Office Visits: \$25 Allowed Amount after Deductible Other Outpatient Services: Allowed Amount after Deductible
Pediatric Dental and Vision Benefits	Refer to the plan certificate for details (age limits apply).	

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. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Learning disabilities. Milieu therapy. Parent-child problems.
This exclusion does not apply to benefits specifically provided in the Policy.
2. Biofeedback, except as specifically provided in the Policy.
3. Cosmetic procedures, except as specifically provided in the Policy or reconstructive procedures to:
 - Correct an Injury or treat a Sickness.
 - Treat a congenital hemangioma on the face or neck for an Insured age 18 or younger.
 - Correct a congenital defect, disease or anomaly for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
4. 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.
5. Dental treatment except:
 - For accidental Injury to Sound, Natural Teeth.
 - As specifically provided in the Schedule of Benefits.
 - As described under Dental Treatment in the Policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
6. Elective Surgery or Elective Treatment.
7. Foot care for the following, except as specifically provided in the Policy:
 - Flat foot conditions.
 - Supportive devices for the foot.
 - Subluxations of the foot.
 - Fallen arches.
 - Weak feet.
 - Chronic foot strain.
 - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care to conditions associated with metabolic, neurologic, or peripheral vascular disease.
8. Health spa or similar facilities. Strengthening programs.
9. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
This exclusion does not apply to:
 - Hearing defects or hearing loss as a result of an infection or Injury.
 - Hearing Aids specifically provided for in Benefits for Hearing Aids for Minor Children.
 - Hearing exams and tests to determine the need for hearing correction.
10. Hypnosis.
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
12. Injury sustained while:
 - Participating in any contest or competition of intercollegiate.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
13. Investigational services.
14. 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.
15. Commission of or attempt to commit a felony. Fighting.
16. Prescription Drugs, services or supplies as follows, except as specifically provided in the Policy:
 - 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.
 - Immunization agents, except as specifically provided in the Policy.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs.

- Growth hormones.pg.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
17. Reproductive services for the following, except as specifically provided in the Policy:
 - Genetic counseling and genetic testing.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests.
 - Infertility treatment (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.
 18. 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, except as specifically provided in the Policy.
 19. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses.
This exclusion does not apply as follows:
 - When due to a covered Injury or disease process.
 - To benefits specifically provided in Pediatric Vision Services.
 - To benefits specifically provided in the Policy.
 20. Preventive care services which are not specifically provided in the Policy, including:
 - Routine physical examinations and routine testing.
 - Preventive testing or treatment.
 - Screening exams or testing in the absence of Injury or Sickness.
 21. Speech therapy, except as specifically provided in the Policy. Naturopathic services.
 22. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
 23. Supplies, except as specifically provided in the Policy.
 24. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
 25. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
 26. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
 27. Weight management. Weight reduction programs. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Treatment for Morbid Obesity associated with serious and life threatening disorders such as diabetes mellitus and hypertension is covered. Morbid Obesity means a body weight of two times the normal weight or greater, or 100 pounds in excess of normal body weight based on normal body weight using generally accepted height and weight tables for a person of the same age, sex, height and frame. Benefits will be provided only upon written request for treatment with a treatment plan written by a Physician, and services or treatment must meet the Company's medical criteria. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

ID Cards

Insured students will receive emailed instructions on how to create a My Account and access their electronic ID card. From the uhcsr.com/myaccount website, ID cards can be downloaded, faxed, emailed or printed. Additionally, students can request delivery of an ID card through the U.S. mail from their My Account. Access to ID card information is also available on the UHCSR mobile app, available on the App Store or Google Play.

This Summary Brochure is based on Policy #2023-4059-1.

NOTE: The information contained herein is a summary of certain benefits which are offered under a student health insurance policy issued by UnitedHealthcare. This document is a summary only and may not contain a full or complete recitation of the benefits and restrictions/exclusions associated with the relevant policy of insurance. This document is not an insurance policy document and your receipt of this document does not constitute the issuance or delivery of a policy of insurance. Neither you nor UnitedHealthcare has any rights or responsibilities associated with your receipt of this document. Changes in federal, state or other applicable legislation or regulation or changes in Plan design required by the applicable state regulatory authority may result in differences between this summary and the actual policy of insurance.

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English

Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian

Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic

የጽንዖት ለርዳታ አገልግሎቶች በነጻ ይገኛሉ። ለባዘዎ ወይ 1-866-260-2723 ይደውሉ።

Arabic

تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian

Ձեզ մատչելի են անվճար լեզվաբան օգնությունները և առանց փողերի ներկրում կարող եք օգտագործել 1-866-260-2723 համարով:

Bantu- Kirundi

Uronswa ku buntu serivisi zifatye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)

Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala

ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese

ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer

សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee

ᏍᏈᏃᏃᏁᏃᏁᏃ ᏍᏈᏃᏃᏁᏃᏁᏃ ᏍᏈᏃᏃᏁᏃ ᏍᏈᏃᏃᏁᏃᏁᏃ ᏍᏈᏃᏃᏁᏃᏁᏃ ᏍᏈᏃᏃᏁᏃᏁᏃ ᏍᏈᏃᏃᏁᏃᏁᏃ ᏍᏈᏃᏃᏁᏃᏁᏃ 1-866-260-2723.

Chinese

您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw

Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo

Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch

Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French

Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole

Gen sèvis ed pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German

Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek

Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati

ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કોલ કરો.

Hawaiian

Kōkua manuahi ma kāu 'ōlelo i loa'a 'ia. E kelepona i ka helu 1-866-260-2723.

Hindi

आप के लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong

Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo

Enyemaka na-ahazi asusu, bu n'efu, diri gi. Kpoo 1-866-260-2723.

Ilocano

Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian

Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian

Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese

無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

Karen

ကျွန်တို့၏ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့်အတွက် အခမဲ့ရရှိနိုင်ပါသည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Korean

언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa

Bot ba hola ni kobol mahop ngui nsaa wogui wo ba ye ha i nyuu yonj. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani

خزمەتگێڕی یازمەتی زامانی بەخۆڕای بی بۆ تۆ دابین دەکەین. تکلیه تەلەفۆن بکە بۆ ژمارە 1-866-260-2723.

Laotian

ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໃຫ້ຫາຕີ 1-866-260-2723.

Marathi

भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे.
त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese

Kwomaron ßök jermal in jipañ in kajin ilo ejjelök wöññän. Jouj im kallok 1-866-260-2723.

Micronesian- Pohnpeian

Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo

Saad bee áka'e'eyeed bee áka'nida'wo'igii t'áá jíik'eh bee nich'i'í bee ná'ahoot'i'. T'áá shoqdi kohji'í 1-866-260-2723 hodiilnih.

Nepali

भाषा सहायता सेवाहरु निःशुल्क उपलब्ध छन्। कृपया
1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka

Kák è kuny ajuser è thok atò tinè yin abac të cin wëu yeke thiëë. Yin col 1-866-260-2723.

Norwegian

Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch

Schprooch iwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi

خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره
1-866-260-2723 تماس بگیرید.

Polish

Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese

Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi

ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ
1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian

Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian

Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa

O loo maua fesoasoani mo gagana mo oe ma e lē totoogia.
Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian

Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali

Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa.
Fadlan wac 1-866-260-2723.

Spanish

Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde

E woodi wallinde dow wolde caahu ngam maada. Noodu 1-866-260-2723.

Swahili

Huduma za msaada wa lugha zinapatikana kwa ajili yako bure.
Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian

1-866-260-2723

Tagalog

Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu

1-866-260-2723

Thai

1-866-260-2733

Tongan- Fakatonga

1-866-260-2723.

Trukese (Chuukese)

1-866-260-2723.

Turkish

1-866-260-2723 numarayı arayınız.

Ukrainian

1-866-260-2723.

Urdu

1-866-260-2723 پر کال کریں۔

Vietnamese

1-866-260-2723.

Yiddish

1-866-260-2723.

Yoruba

1-866-260-2723.

POLICY NUMBER: 2023-4059-1

NOTICE:

The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC7 - 11/21/2023

NOC7 11/21/2023

Policy: NA

Certificate:

Updated SHC wording on SOB Header

From: Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Policy Exclusions and Limitations do not apply.

To: Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Routine/Preventative Labs referred by the SHC to LabCorp will be paid at 100%. All Other labs referred by the SHC to Lab Corp will be paid at 80%. Policy Exclusions and Limitations do not apply.

Summary Brochure:

Updated SHC wording

From: Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Policy Exclusions and Limitations do not apply.

To: Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Routine/Preventative Labs referred by the SHC to LabCorp will be paid at 100%. All Other labs referred by the SHC to Lab Corp will be paid at 80%. Policy Exclusions and Limitations do not apply.

NOC6 - 11/10/2023

NOC6 11/10/2023

Policy: NA

Certificate: NA

Summary Brochure:

In Copay box,

Preferred Providers:

Changed Physician's Visits: From \$25 To: \$25 per visit

Changed Medical Emergency From: \$100 To: \$100 per visit

Added: Room and Board \$250 per Hospital Confinement

Added; Urgent Care: \$35 per visit

Out of Network Providers:

Changed Physician's Visits: From \$25/after Deductible To: \$25 per visit/after Deductible

Changed Medical Emergency: From \$100/not subject to Deductible To: \$100 per visit/not subject to

Deductible

Added Urgent Care: \$35 per visit/not subject to Deductible

NOC5 - 10/02/2023

NOC5 10/2/2023

Policy: NA

Certificate:

Section 22: Sales/Marketing Services, address changed

From: 805 Executive Center Drive West, Suite 220, St. Petersburg, FL 33702

To: 11399 16th Court North, Suite 110, St. Petersburg, FL 33702

Section 23: Pediatric Dental Services Benefits, under Dental Services Deductible changed Non-Network to Out-of-Network. Removed from Out-of-Pocket Maximum: Any amount the Insured Person pays in Copayments for pediatric Dental Services under this section applies to the Out-of-Pocket Maximum stated in the Policy Schedule of Benefits.

Schedule of Benefits:

Prescription Drugs, Preferred Provider Benefits removed "not subject to Deductible"

Mental Illness Treatment, added parenthetical "See also Benefits for Gender Affirming Care for Gender Dysphoria"

Summary Brochure: NA

NOC4 - 09/06/2023

NOC4 9/6/2023

Policy: NA

Certificate:

SOB Header for OOP Max paragraph added the below.

Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network Provider Benefits.

Summary Brochure: NA

NOC3 - 08/17/2023

NOC3 8/17/2023

Policy: NA

Certificate:

SOB, Added line item for:

Adult Routine Eye Exam Age 19 or older, (One exam, per Policy Year for eyeglasses or contact lenses, not both)

PP: \$25 Copay per visit, 100% of Allowed Amount

OON: Allowed Amount, not subject to Deductible

Summary Brochure: NA

NOC2 - 08/08/2023

Bid Policy:

N/A

Certificate:

N/A

Summary Brochure:

1. Updated the Summer rate to \$545.00.

NOC1 - 08/04/2023

NOC1 8/4/2023

Policy: NA

Certificate:

Updated Routine Eye Exam exclusion

From:

1. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.

This exclusion does not apply as follows:

- When due to a covered Injury or disease process.
- To benefits specifically provided in Pediatric Vision Services.

To:

1. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses.

This exclusion does not apply as follows:

- When due to a covered Injury or disease process.
- To benefits specifically provided in Pediatric Vision Services.
- To benefits specifically provided in the Policy.

Added below line item to SOB:

Vision, Including Surgical Treatment of Injuries or Illness: PP: Paid as any other Sickness OON: Paid as any other Sickness

In SOB Header added the below:

Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Policy Exclusions and Limitations do not apply.

SOB Added line item below:

Vision Including Surgical Treatment of Injuries and Illnesses – PP: PAAOS OON: PAAOS

In UHCP Endorsement under Rebates and Other Payments removed the below:

Maximum Allowable Amount means the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our review and change from time to time and varies by Therapeutic Class.

Summary Brochure:

Added SHC Benefits paragraph below to Highlights Table:

Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Policy Exclusions and Limitations do not apply.

For Mental Health for Preferred Provider for Outpatient Office Visits added 100% of Allowed Amount Under OON Provider for Outpatient Office Visits added Allowed Amount

Removed Fall from Rates and dates table

Updated Spring/Summer Rate to reflect \$1,450.00

Updated Summer Period effective date to 5/13/2023

Updated Routine Eye Exam exclusion

From:

2. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.

This exclusion does not apply as follows:

- When due to a covered Injury or disease process.
- To benefits specifically provided in Pediatric Vision Services.

To:

3. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses.

This exclusion does not apply as follows:

- When due to a covered Injury or disease process.
- To benefits specifically provided in Pediatric Vision Services.
- To benefits specifically provided in the Policy.