STUDENT HEALTH INSURANCE

UNC | UNIVERSITY OF NORTHERN COLORADO

2018–2019 | POLICY # 2018A4A00 | FORM # AHP-Bro(18)NGL-CO


BEARS

UNIVERSITY OF
NORTHERN COLORADO

Dear UNC Student,

The staff of the Student Health Insurance Office would like to welcome you to the new school year and wishes you the best of health during your college experience at the University of Northern Colorado. Because unexpected health problems and accidents occur to students, we believe that UNC offers the best health care that is possible.

It is a policy of the UNC Board of Trustees that all degree seeking undergraduate students taking nine (9) or more credit hours REGARDLESS of the type of class (on campus, off campus or online) and all degree seeking graduate students taking six (6) or more credit hours REGARDLESS of the type of class (on campus, off campus or online) are required to have health insurance. This is to ensure that health care costs will not interfere with your academic goals. All students are automatically enrolled in the university student health insurance plan and billed along with other university services. If you prefer to have other insurance, it will be necessary for you to complete and submit the online waiver located in the URSA Financial Tab, by the 10th day of classes. CICP and Medicaid are considered comparable insurance.

I encourage you to review the benefits of the university student health insurance plan that is described in this brochure. Because of the large number of students who enroll in the plan, we are able to keep the costs reasonable. The cost is $1,265 for each semester. The $1,265 cost includes administrative fees, non-insured services, and certain federal, health care fees/ assessments. The spring semester cost provides coverage through the summer regardless of whether a student is attending classes in the summer. The plan provides benefits for sickness and injury with coverage, 24 hours a day, including school breaks.

The university student health insurance plan is accepted by Doctors and other medical providers across the United States. If you are enrolled in a health maintenance organization (HMO), you should determine the level of benefits that are payable in the Greeley area. Also, if you have declared yourself financially independent from your parents for the purposes of obtaining financial aid, you may no longer be eligible for coverage under your parents' insurance policy. Please consider all of these factors in making your decision.

If you have any questions about UNC's Student Health Insurance Program please feel free to contact the Insurance Office in Cassidy Hall at (970) 351-1915 or by e-mail at ***student.health.insurance@unco.edu***. We look forward to helping you reach your academic and career goals while attending the University of Northern Colorado.

Sincerely,

Nicky Weglin
Insurance Coordinator

Student Health Insurance Program

UNIVERSITY OF NORTHERN COLORADO

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Eligible Students

- All degree seeking undergraduate students taking nine (9) or more credit hours REGARDLESS of the type of class (on campus, off campus or online) and all degree seeking graduate students taking six (6) or more credit hours REGARDLESS of the type of class (on campus, off campus or online) are required to have health insurance and are automatically enrolled. These students have the option to waive the insurance if they complete an on-line waiver in URSA by the 10th day of classes.

  If you discover after the 10th day that you are not being billed for the insurance, you can complete an enrollment form. No back-dating of the coverage will be done. Coverage will begin on the date the insurance company receives the enrollment.

- Students who waived the student insurance in a previous semester but want to be on the insurance for the current semester may complete a request for re-enrollment. If you request the re-enrollment during the open enrollment period at the start of the semester (no later than the 10th class day), you will be insured with the student insurance beginning on the effective date of coverage for that semester. You must meet the other enrollment criteria as stated in this document.

  If you want to enroll in the student insurance after the open enrollment period, you must show proof of your other coverage. Coverage will begin on the date the insurance company receives the enrollment form. Coverage will not be back-dated or pro-rated.

- Undergraduate students taking less than nine (9) credit hours and graduate students taking less than six (6) credit hours and graduate students that are not in a degree seeking program are not eligible to participate in the UNC Student Health Insurance Plan. They may, however contact Academic HealthPlans at 1-855-825-3985, who will assist then in finding individual coverage.

- Summer Enrollment: Students enrolling for summer classes may purchase the Student Health Insurance, provided you meet the above criteria. Students need to complete an enrollment form during the open enrollment period. No back-dating or pro-rating of the coverage will be done. Coverage will begin on the date the insurance company approves the enrollment.

  Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased unless he or she withdraws due to an Injury or Sickness and the absence is an approved medical leave. The Company maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If the Company discovers the eligibility requirements have not been met, its only obligation is refund of cost. Please contact the Student Health Insurance Office at (970) 351-1915 for details.

If you no longer meet the eligibility requirements contact Academic HealthPlans at 1-855-825-3985 prior to your termination date.

Eligible Dependents

An Insured student's Dependents (spouse, including domestic partner and children) are eligible to participate in this Plan. Dependent enrollment must take place at the time of student enrollment with the exception of newborn or adopted children or a Qualifying Event. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student.

Dependent means: 1) An Insured Student's lawful spouse or Civil Union Partner; 2) An Insured Student's dependent biological or adopted child or stepchild under age 26; and 3) An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is: a) primarily dependent upon the Insured Student for support and maintenance; and b) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap. Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan. Contact UNC Student Health Insurance Office for Dependent Enrollment information.

Eligible Dependents Continued

Newly Born Children

A newly born child of an Insured Person will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. To continue coverage beyond this initial 31-day period, the Insured Person must: 1) Notify Us of the birth; and 2) Pay any additional premium.

Qualifying Event: Eligible students who have a change in status and lose coverage under another Health Care Plan are eligible to enroll for coverage under the Policy provided, within 31 days of the qualifying event, students should send a copy of the Certificate of Creditable Coverage, the completed Qualifying Events Form and the letter of ineligibility to Academic HealthPlans. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment or legal separation. The premium will be the same as it would have been at the beginning of the semester or quarter, whichever applies. However, the effective date will be the later of the date the student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends. You may download a form from ***unco.myahpcare.com***.

You are entitled to the benefits described in this brochure, if you have enrolled for this insurance and paid the required cost.

Effective and Termination Dates

Includes Plan Cost

The Policy on file at the school becomes effective at 12:01 a.m. at the University's address on the later of the following dates:

- The effective date of the Policy, August 17, 2018; or
- The day after the date premium is received by the Company or its authorized representative.

Semester coverage and cost is as follows:

Effective and Termination Dates	Fall Semester	Spring/Summer Session	Summer Session Only
	08/17/18 to 01/01/19	01/01/19 to 08/17/19	05/06/19 to 08/17/19
Student Only	$ 1,265*	$ 1,265*	$ 649*
Spouse	$ 1,265*	$ 1,265*	$ 649*
Child(ren)	$ 2,530*	$ 2,530*	$ 1,297*

*The billed amount includes administrative fees, non-insured services and certain federal, health care fees/assessments.

Intercollegiate Sports Coverage	Fall Semester	Spring/Summer Session
	08/01/18 to 01/01/19	01/01/19 to 08/01/19
Student Only	$ 835	$ 835

NOTES: Please note when calculating total cost, the cost for student, spouse, child(ren), and spouse & child(ren) is listed individually. When selecting coverage for yourself or for yourself and Dependents, please select the correct cost amounts to add together for payment. Payment of spring semester cost automatically includes coverage for summer session. The student cost includes a $75 administrative fee retained by the University.

Dependent Open Enrollment Periods *The open enrollment periods during which students may enroll eligible spouses and/or dependents, is as follows:*		
	From	Through
Fall	05/10/18	10/06/18
Spring/Summer	12/15/18	02/15/19
Summer	04/12/19	05/10/19

The coverage provided with respect to the Insured Person shall terminate *08/17/2019* at 12:01 a.m. on the earliest of the following dates:

1) The date the Policy terminates for all insured persons; or
2) The end of the period of coverage for which premium has been paid; or
3) The date an Insured Person ceases to be eligible for the insurance; or
4) The date an Insured Person enters military service.

You must meet the eligibility requirements listed herein each time for automatic enrollment of insurance coverage. To avoid

Effective and Termination Dates Continued

a lapse in coverage, your premium must be received within 31 days after the coverage expiration date. This process will be done via the hard waiver system at the University of Northern Colorado. It is the student's responsibility to pay the premium via the student bill. It is also the students responsibility to be sure the premium charge has posted to the student bill to ensure coverage. **Refunds of premium are allowed only upon entry into the Armed Forces, and the Company receives proof of active duty. Otherwise all premiums received by the Company will be considered fully earned and nonrefundable.**

The Policy issued to the University is a Non-Renewable, One-Year Term Policy. However, if you still maintain the required eligibility you may purchase the plan the next year. It is the Insured Person's responsibility to enroll for coverage each year in order to maintain continuity of coverage. If you no longer meet the eligibility requirements contact Academic HealthPlans at 1-855-825-3985 prior to your termination date.

Coverage Period Notice

Coverage Periods are established by the University and subject to change from one policy year to the next. In the event that a coverage period overlaps, the prior coverage period will terminate as of the effective date of the new coverage period. In no case will an eligible member be covered under two coverage periods within the same group.

Waiver Procedure

Students preferring to waive the UNC Student Health Insurance Plan and cost from their tuition/fees billing, must be enrolled in a comparable health insurance plan and are REQUIRED to complete the on-line waiver found on the financial tab in URSA NO LATER THAN THE 10th DAY OF CLASS. The waiver will be in effect until Fall Semester of the next academic year ONLY, at which time the waiver process must be repeated. To be considered comparable insurance, the insurance policy must be in effect by the waiver deadline for the current semester.

The other insurance must also meet one of these two criteria: (1) be a Company-sponsored plan through work, parent or spouse; or (2) coverage through the U.S. government or a foreign government.

If the other insurance does not meet one of these two criteria mentioned above, then it must meet all criteria required in the Affordable Care Act.

Schedule of Benefits

***Preventive Services:**

Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of PPO Allowance when services are provided through a Network Provider.

Non-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 50% of the Usual and Reasonable charge.

The following services shall be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

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 with respect to the Insured Person involved.
3. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Schedule of Benefits Continued

* Please visit healthcare.gov/preventive-care-benefits/ for more information.

Maximum Benefit *(per Insured Person, per Policy Year)*	**Unlimited**	
Deductible *(per Insured Person, per Policy Year) (Not Applicable to Preventive Services)*	**Network Provider**	**Non-Network Provider**
	$500	**$1,000**
Individual Out-of-Pocket Expense Limit* *(per Insured Person, per Policy Year)*	**$6,350**	
Family Out-of-Pocket Expense Limit* *(per Family, per Policy Year)*	**$12,700**	
	Network Provider	**Non-Network Provider**
Coinsurance *(Not Applicable to Preventive Services)*	**80%** **of PPO Allowance for Covered Medical Expenses**	**50%** **of Usual and Reasonable (U&R) for Covered Medical Expenses**

**The Out-of-Pocket Expense Limit provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. Expenses that are not eligible or amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. However, the Insured Person's Coinsurance amounts, Deductibles, and Copayments will apply toward the Out-of-Pocket Expense Limit.*

Benefit Payment for Network Providers and Non-Network Providers: The Policy provides benefits based on the type of health care provider selected. The Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

Preferred Provider Organization: To locate a Network Provider in your area, consult your Cigna Provider Directory. You may go to ***unco.myahpcare.com.*** **Local Hospital Provider:** North Colorado Medical Center, Greeley, CO

At Pharmacies Contracting With the HealthSmart RX®

You must go to a pharmacy contracting with the HealthSmart RX® in order to access this program. Present your insurance ID card to the pharmacy to identify yourself as a participant in this plan. Eligibility status will be online at the pharmacy. You can locate a participating pharmacy online at ***unco.myahpcare.com*****.**

Services at the University Health Services (UHS)

At the Student Health Center on campus only: Students insured with the UNC Student Health Insurance Program pay a $20 copayment (not subject to deductible) for a regular visit and additional benefits at the University Health Services are covered at 100%. If services or tests need to be sent outside of the Health Services clinic, coverage will be at 80% of the maximum allowable after the $500 per policy year deductible has been satisfied. Wellness exams performed at the University Health Services are subject to one exam per policy year.

If you reside more than 20 miles away from University Health Services or have been referred to another Cigna provider from University Health Services, covered expenses incurred at a Cigna Network Provider will be paid at 80% of the maximum allowable after the $500 deductible has been met.

University Health Services (UHS) Referral

This is a supplemental plan. Where available, the student must first use the resources of the UHS where treatment will be administered or a referral issued. Expenses incurred for medical treatment rendered outside of the UHS for which no prior approval or referral is obtained may be excluded from coverage. A referral issued by the UHS must accompany the claim when submitted. If the student does receive a referral and uses a provider outside of University Health Servcies, it is subject to the $500 deductible and covered benefits paid at 80% if in network and 50% if out of network.

A UHS referral for outside care is not necessary ONLY under the following conditions: 1) For a Emergency Medical Condition. The student must return to the UHS for necessary follow-up care; 2) When the UHS is closed; 3) For medical care received when the student is more than 20 miles from campus; 4) For medical care obtained when a student is no longer able to use the UHS due to a change in student status. 5) For maternity care; 6) When service is rendered at another facility during break or vacation period. **A UHS referral is NOT required at the Counseling Center.**

The Covered Medical Expense for an issued Policy will be: 1) Those listed in the Covered Medical Expenses Provision; 2) According to the following Schedule of Benefits; and 3) Determined by whether or not the service or treatment is provided by a Network Provider.

Inpatient	Network Provider	Non-Network Provider
Hospital Intensive Care Unit Expense, in lieu of normal Hospital Room & Board Expenses	80% of PPO Allowance	50% of U&R
Hospital Miscellaneous Expenses, for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	80% of PPO Allowance	50% of U&R
Hospital Room and Board Expense	80% of PPO Allowance	50% of U&R
Inpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	80% of PPO Allowance	50% of U&R
Mental Health Disorder Inpatient Services	Same as any other Covered Sickness	
Physician Visits while confined, includes a specialist. Visit limited to one per day of Confinement	80% of PPO Allowance	50% of U&R
Preadmission Testing	80% of PPO Allowance	50% of U&R
Registered Nurse Services, for private duty nursing while confined	80% of PPO Allowance	50% of U&R
Substance Used Disorder Inpatient Services	Same as any other Covered Sickness	

Outpatient	Network Provider	Non-Network Provider
Diagnostic X-ray Services	80% of PPO Allowance	50% of U&R
Emergency Services Expenses, $150 Copayment per visit	80% of PPO Allowance	80% of PPO Allowance
Home Health Care Expenses, up to 28 hours per week	80% of PPO Allowance	50% of U&R
Hospice Care Coverage	80% of PPO Allowance	50% of U&R
In-Office Physician's Fees, including specialist, licensed registered nurse and licensed physician assistant	80% of PPO Allowance	50% of U&R
Laboratory Procedures (Outpatient)	80% of PPO Allowance	50% of U&R
Mental Health Disorder Outpatient Services	Same as any other Covered Sickness	
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of PPO Allowance	50% of U&R

Outpatient	Network Provider	Non-Network Provider
Outpatient Prescription Drugs **Prescription Drug Deductible $100** All prescriptions are limited to 30 day retail supply, Includes diabetic supplies. Copayments apply to Out-of-Pocket Maximum. *The University Health Services is not a participating pharmacy.*	***At pharmacies contracting with HealthSmart Rx®*** 100% of PPO Allowance after a Tier 1 Generic Copayment: $20 Tier 2 Preferred Brand Copayment: $50 Tier 3 Brand Copayment: $70	***At pharmacies contracting with HealthSmart Rx®*** 50% of U&R after a Tier 1 Generic Copayment: $20 Tier 2 Preferred Brand Copayment: $50 Tier 3 Brand Copayment: $70
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	80% of PPO Allowance	50% of U&R
Outpatient Surgery Miscellaneous, excluding not-scheduled surgery – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	80% of PPO Allowance	50% of U&R
Shots and Injections, unless considered Preventive Services or otherwise covered under the Prescription Drug Benefit	80% of PPO Allowance	50% of U&R
Skilled Nursing Facility Benefit, up to 100 days per Policy Year	80% of PPO Allowance	50% of U&R
Substance Used Disorder Outpatient Services	Same as any other Covered Sickness	
Urgent Care Centers or Facilities	80% of PPO Allowance	50% of U&R

Other	Network Provider	Non-Network Provider
Accidental Injury Dental Treatment	80% of PPO Allowance	50% of U&R
Allergy Testing	80% of PPO Allowance	50% of U&R
Ambulance Services	70% of PPO Allowance	70% of U&R
Bariatric Surgery	80% of PPO Allowance	50% of U&R
Chemotherapy and Radiation Therapy	80% of PPO Allowance	50% of U&R
Chiropractic Care Benefit	80% of PPO Allowance	50% of U&R
Consultant Physician Services, when requested by the attending physician	80% of PPO Allowance	50% of U&R
Dialysis	80% of PPO Allowance	50% of U&R
Durable Medical Equipment	80% of PPO Allowance	50% of U&R
Infertility Treatment	80% of PPO Allowance	50% of U&R
Infusion Therapy	80% of PPO Allowance	50% of U&R
Maternity Benefit	Same as any other Covered Sickness	

Other	Network Provider	Non-Network Provider
Pediatric Dental Care Benefits limited to two visits in a 12 month period	100% of PPO Allowance for Preventive Services	50% of U&R
Basic Restorative	50% of U&R	50% of U&R
Oral Surgery	50% of U&R	50% of U&R
Endodontics	50% of U&R	50% of U&R
Pediatric Vision Care Benefit, limited to one exam per Policy Year and one pair of prescribed lenses and frames or contact lenses	100% of PPO Allowance for Preventive Services	50% of U&R for Preventive Services
Physical, Occupational & Speech Therapy	80% of PPO Allowance	50% of U&R
Reconstructive Surgery	80% of PPO Allowance	50% of U&R
Routine Adult Eye Exam Benefit	100% of PPO Allowance for Preventive Services	50% of U&R
Routine Newborn Care	Same as any other Covered Sickness	
Sickness Dental Expense, $500 Maximum per Policy Year	80% of PPO Allowance	50% of U&R
Sports Accident Expense, $5,000 maximum per Injury, incurred as a result of the play or practice of Intercollegiate sports. *Additional cost required*	80% of PPO Allowance	50% of U&R
Student Health Center/Infirmary Expense	**Office Visits** 100% of U&R for Covered Medical Expenses, subject to Copayment of $20, Deductible waived.	
Transplants	80% of PPO Allowance	50% of U&R
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of PPO Allowance	50% of U&R

Mandated Benefits	Network Provider	Non-Network Provider
Autism Spectrum Disorders Benefit, Insured Dependent Children Under Age 19	Same as any other Covered Sickness up to the benefit maximums described in the Benefit	
Cervical Cancer Vaccination Benefit	Same as any other Preventive Service	
Child Health Supervision Services Benefit	Same as any other Covered Sickness	
Cleft Lip and Cleft Palate	Same as any other Covered Sickness	
Clinical Trials Benefit	Same as any other Covered Sickness	
Diabetes Benefit	Same as any other Covered Sickness	
Early Intervention Services Benefit (Deductible Waived), maximum 45 visits per Policy Year	This benefit is not subject to a Deductible; Same as any other Covered Sickness	
Hearing Aids for Minors Benefit	Same as any other Covered Sickness	
Hospitalization and General Anesthesia for Dental Procedures for Dependent Children Benefit	Same as any other Covered Sickness	

Mandated Benefits	Network Provider	Non-Network Provider
Inherited Enzymatic Disorders Benefit, Medical Foods payable on the same basis as other Prescription Drugs	Same as any other Covered Sickness except that Medical Foods payable on same basis as other Prescription Drugs	
Oral Anticancer Medication Benefit	Same as any other Covered Sickness	
Prosthetic Devices Benefit	Same as any other Covered Sickness	
Therapies for Congenital Defects and Birth Abnormalities Benefit, Insured Dependent Children Age 3-6	Same as any other Covered Sickness	

Extension of Benefits

Coverage under the Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended if an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to a minimum of 90 days from the Termination Date while such confinement continues.

Continuous Coverage: Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under the Policy: 1) When premium payment is received either in Our Home Office or by Our Agent or the Plan Administrator; and 2) Premium is received within the Enrollment Period specified in this Insurance Information.

This is regardless of any breaks in calendar days between consecutive periods of insurance.

Coordination of Benefits

If a Insured Person is also covered under one or more other Plans, the benefits payable under the Policy will be coordinated with the benefits payable under all other Plans under which an individual is covered so that the total benefits paid will not exceed 100% of the Covered Expenses incurred.

Pre-Certification Process

You must adhere to the Pre-certification process. Failure to comply with the Pre-certification requirements may result in a Pre-certification penalty. You are responsible for notifying the claims administrator at the phone number found on your ID card to begin the Pre-certification process. For inpatient benefits or surgery, the call must be made at leave 5 working days before Hospital Confinement or surgery.

The following inpatient benefits require Pre-certification:

1. All inpatient admissions to a Hospital, Skilled Nursing Facility, facility established primarily for the Treatment of Substance Use Disorder, or residential Treatment facility. The expected length of stay should be included in the notification.
2. All inpatient maternity care after the initial 48/96 hours.

Pre-certification is not required for Medical Emergency or Urgent Care; Hospital Confinement for maternity care; or Obstetric or gynecological care when provided by a Network Provider; or Outpatient treatment

Pre-certification does not guarantee that Benefits will be paid. Your Physician will be notified of Our decision.

Failure by the claims administrator to make a determination within the time periods stated in the policy will be deemed an Adverse Determination subject to an appeal.

The Insured Person should contact his or her Physician with question about any Precertification status.

Definitions

Accident means a sudden, unforeseeable external event that causes Injury to an Insured Person. The Accident must occur while coverage is in effect for the Insured Person.

Ambulance Service means transportation to a Hospital by a licensed Ambulance Service.

Anesthetist means a Physician or nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Brand Name Drugs means drugs for which the drug manufacturer's trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.

Coinsurance means the ratio by which We and the Insured Person share in the payment of Usual and Reasonable expenses for treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits.

Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Copayment means the amount of Usual and Reasonable expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.

Covered Injury means a bodily injury that is: 1) Sustained by an Insured Person while he/she is insured under the Policy or the School's prior policies; and 2) Caused by an accident directly and independently of all other causes. Coverage under the School's policies must have remained continuously in force: 1) From the date of Injury; and 2) Until the date services or supplies are received, for them to be considered as a Covered Medical Expense under the Policy.

Covered Medical Expense means those charges for any treatment, service or supplies that are: 1) Not in excess of the Usual and Reasonable charges therefore; 2) Not in excess of the charges that would have been made in the absence of this insurance; and 3) Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which: 1) causes a loss while the Policy is in force; and 2) which results in Covered Medical Expenses.

Deductible means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Policy. The amount of the Deductible and the frequency (annual or per occurrence) will be shown in the Schedule of Benefits.

Dependent means:

1. An Insured Student's lawful spouse or Civil Union Partner;
2. An Insured Student's dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is:
    a. primarily dependent upon the Insured Student for support and maintenance; and
    b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when a Insured Student enrolls a new disabled child under the plan.

Elective Surgery or Elective Treatment means surgery or medical treatment that is: 1) not necessitated by a pathological or traumatic change in the function or structure of any part of the body; and 2) which occurs after the Insured Person's effective date of coverage. **Elective Treatment** includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, infertility, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. Elective Surgery includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Definitions Continued

Eligible Student means a student who meets all enrollment requirements of the School named as the Policyholder in the Insurance Information Schedule.

Emergency Medical Condition means a medical condition which:

1. manifests itself by acute symptoms of sufficient severity (including severe pain); and
2. causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention might result in:
    a. lacing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

Essential Health Benefits mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:

1) Ambulatory patient services;
2) Emergency services;
3) Hospitalization;
4) Maternity and newborn care;
5) Mental health and substance use disorder services, including behavioral health treatment;
6) Prescription drugs;
7) Rehabilitative and habilitative services and devices;
8) Laboratory services;
9) Preventive and wellness services and chronic disease management; and
10) Pediatric services, including oral and vision care.

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Brand, and Preferred Brand Drugs.

Generic Drugs means a drug that is identical or bioequivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.

Home Country means the Insured Student's country of citizenship. If the Insured Student has dual citizenship, his or her Home Country is the country of the passport he or she used to enter the United States. The Insured Student's Home Country is considered the Home Country for any dependent of an Insured Student while insured under the Policy.

Hospital means an institution that:

1. Operates as a Hospital pursuant to law;
2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
3. Provides 24-hour nursing service by Registered Nurses on duty or call;
4. Has a staff of one or more Physicians available at all times; and
5. Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis.

Hospital does not include the following:

1. Convalescent homes or convalescent, rest or nursing facilities;
2. Facilities primarily affording custodial, educational, or rehabilitory care; or
3. Facilities for the aged, drug addicts or alcoholics.

Hospital Confined or Hospital Confinement means a stay of eighteen (18) or more consecutive hours as a resident bed patient in a Hospital.

Immediate Family Member means the Insured Person and his or her spouse/Civil Union Partner or the parent, child, brother or sister of the Insured Person or his or her spouse/Civil Union Partner.

Insured Person means an Insured Student or dependent of an Insured Student while insured under the Policy.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under the Policy.

Loss means medical expense caused by an Injury or Sickness which is covered by the Policy.

Medically Necessary means medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice. The Insured Person's health care provider determines if the medical treatment provided is medically necessary.

Network Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Non-Network Providers have not agreed to any pre-arranged fee schedules.

Out-of-pocket Expense Limit means the amount of Usual and Reasonable expenses that an Insured Person is responsible for paying.

Physician means a:

1. Doctor of Medicine (M.D.); or
2. Doctor of Osteopathy (D.O.); or
3. Doctor of Dentistry (D.M.D. or D.D.S.); or
4. Doctor of Chiropractic (D.C.); or
5. Doctor of Optometry (O.D.); or
6. Doctor of Podiatry (D.P.M.);

who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered.

A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician.

The term Physician does not mean any person who is an Immediate Family Member.

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

Preferred Brand Drug means a formulary drug that is within a select subset of therapeutic classes, which make up the formulary drug list.

School or College means the college or university attended by the Insured Student.

Skilled Nursing Facility means an institution that provides skilled nursing care under the supervision of a Physician, provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.), and maintains a daily record of each patient. Skilled nursing facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Student Health Center or Student Infirmary means an on campus facility that provides:

1. Medical care and treatment to Sick or Injury students; and
2. Nursing services.

A Student Health Center or Student Infirmary does not include:

1. Medical, diagnostic and treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or
2. Inpatient care.

Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

Usual and Reasonable means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a: 1) Like service by a provider with similar training or experience; or 2) Supply that is identical or substantially equivalent.

We, Us, or Our means National Guardian Life Insurance Company or its authorized agent.

Exclusions and Limitations

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

The Policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Policy and as shown in the Schedule of Benefits.

- services or supplies not necessary for the medical care of the Insured Person's Injury or Sickness.
- services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except as specifically provided in the Schedule of Benefits.
- expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as required for repair caused by a Covered Injury.
- expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- any expenses in excess of Usual and Reasonable charges.
- loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Schedule of Benefits.
- loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
- Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
- expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
  - For the purposes of this provision, **Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
  - For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.
- an Insured Person's:
  - committing or attempting to commit a felony,
  - being engaged in an illegal occupation, or
  - participation in a riot.

Academic Emergency Services

The following services are not part of the plan underwritten by National Guardian Life Insurance Company.

To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans has included Academic Emergency Services benefits in your student health plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small.

The following services and benefits are available to you 24 hours a day, 7 days a week:

Medical Assistance: Pre-travel information; doctor, dentist or ophthalmologist referrals; medical monitoring to ensure adequate care; 24/7 Nurse Help Line; prescription assistance or medicine dispatch.

Emergency Medical Evacuation and Repatriation: Unlimited benefit for evacuation from inadequate facility to closest adequate facility, repatriation home for continued care or recovery and repatriation of deceased remains.

Accidental Death and Dismemberment: $25,000 benefit (Student Only)

Emergency Family Assistance: Benefits for visit of a family member or friend if hospitalized for 7 or more days, return of children if left unattended, bereavement reunion, emergency return home in the event a participant's family member suffers life threatening illness or death and return of participant's personal belongings in the event of evacuation or death.

Travel, Legal and Security Assistance: Pre-travel destination information or security advice; assistance locating lost luggage; passport replacement assistance; emergency travel arrangements; translation assistance; interpreter referral; legal consultation and referral; emergency message forwarding.

Preparing for your time away from home is easy, simply visit

the Academic Emergency Services portal:

aes.myahpcare.com

To obtain additional pre-travel information or advice, or in the event of a medical, travel or security crisis, call Academic Emergency Services immediately.

1-855-873-3555 call toll free from the US

+ 1-410-453-6354 call collect from anywhere

Email: assistance@ahpcare.com

This provides you with a brief outline of the services available to you. Terms, conditions, limitations and exclusions apply. All services must be arranged and paid for through the AES service provider, UnitedHealthcare Global. There is no claim process for reimbursement of self-paid expenses unless specifically described in the service plan.

Academic Emergency Services (AES) is a global emergency services product. These services are provided by a separate and independent company from AES or Academic HealthPlans. AES provides medical, security and natural disaster evacuation services, repatriation of remains, emergency medical and travel assistance, travel information and other services for Academic HealthPlans.

CareNet 24 –Hour Nurse Advice Line

The CareNet 24/7 Nurse Advice Line provides a convenient, easy, and confidential way to get medical care advice. RNs are available to help answer questions concerning a diagnosis or medical treatment, to assist with healthcare questions and to help you figure out the best course of action for a non-emergency health concern: Do you need immediate medical care? Should you see your provider? Or will self-care help you? With this service, you have round-the-clock access to experienced healthcare professionals that are ready to assist! CareNet Nurse Advice Line 1-877-924-7758. *(CareNet 24-hour Nurse Advice Line is not affiliated with National Guardian Life Insurance Company)*

When You Have a Claim

- Save all itemized bills, including those being accumulated to satisfy the Deductible. An itemized bill from a Doctor or Hospital must include: a) the name, address and tax identification number of the health care provider; b) the name of the patient receiving services or supplies; c) the date(s) services or supplies were provided; d) each charge, service, supply; e) a description of the services or supplies, and f) diagnosis or illness.
- Submit All Claims to: Electronic Payer ID# 62308, Cigna Healthcare, PO Box 188061, Chattanooga, TN 37422-8061
- For Claims Inquiries, assistance with filing a claim or have other questions regarding your Policy, contact:
  HealthSmart
  Medical Providers Call: 1-844-221-0959
  All Other Calls: 1-855-825-3985
  Email: akronclaims@healthsmart.com
  EDI #: 62308
  Group #: SA626G8

Appeals Procedures

For purposes of this Section, the following definitions apply:

Adverse Determination means a determination by Us or Our designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a Covered Medical Expense has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated. Denials of coverage based on a determination that a service recommended or requested health care or treatment is experimental also are Adverse Determination and must comply with procedures for reviewing coverage denials based on an determination that a recommended or requested health care service or treatment is experimental.

Prospective Review means utilization review conducted prior to an admission or course of treatment.

Retrospective Review means a review of Medical necessity conducted after services have been provided to an Insured Person but does not include the review of the claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Internal Review Procedure:

1) In the event of an Adverse Determination, We will notify the Insured Person immediately in writing of Our decision and the reason for the Adverse Determination. The notice will include a description of any additional information that might be necessary for reconsideration of the claim and the notice will also describe the right to appeal. The Insured Person also had the right to contact the Commissioner of Insurance or his or her office at any time.
2) A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Determination. The Insured Person does not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative may: a) review all documents related to the claim and submit written comments and issues related to the denial; and b)submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

We will provide the Insured Person with the contact person who is coordinating the first level review within 3 days of the date of receipt of the grievance.

After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent either in writing or electronically to the Insured Person within 30 days for a Prospective Review request or 60 days for a Retrospective Review request after receipt of the notice requesting the first level review.

We shall provide free of charge to the Insured Person, or the Insured Person's authorized representative, any new or additional evidence, relied upon or generated by Us, or at Our direction, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the Insured Person, or the Insured Person's authorized representative, a reasonable opportunity to respond prior to the date.

Before the We issue or provide notice of a final Adverse Determination that is based on new or additional rationale, We shall provide the new or additional rationale to the Insured Person, or the Insured Person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final Adverse Determination is to be provided to permit the Insured Person, or the Insured Person 's authorized representative a reasonable opportunity to respond prior to the date.

Appeals Procedures Continued

In the case of an Adverse Determination involving utilization review, We will designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed to determine Adverse Determination. The clinical peer(s) shall not have been involved in the initial adverse determination. We shall ensure that the individuals reviewing the Adverse Determination have appropriate expertise.

Expedited reviews of grievances involving an Adverse Determination

We shall provide expedited review of a grievance involving an Adverse Determination with respect to concurrent review urgent care requests 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. The Insured Person or the Insured Person's authorized representative shall request an expedited review orally or in writing. We will appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the Adverse Determination. The clinical peer or peers shall not have been involved in making the initial Adverse Determination. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the Insured Person or, if applicable, the Insured Person's authorized representative and Us by telephone, facsimile or the most expeditious method available. An expedited review decision shall be made and the Insured Person or, if applicable, the Insured Person's authorized representative shall be notified of the decision within seventy two (72) hours after the receipt of the request for the expedited review. If the expedited review is of a grievance involving an Adverse Determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the Insured Person until the Insured Person has been notified of the determination.

If the Insured Person Disagrees with Our Internal Review Determination

In the event that the Insured Person disagrees with Our internal review determination, the Insured Person or his or her authorized representative may:

a. File a complaint with the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202-4910. You can call us at 303-894-7490, email your questions to insurance@dora.state.co.us or fill out the on-line Request Assistance form; or
b. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

The Insured Person also has the right to bring a civil action in a court of competent jurisdiction. Note that he or she may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the state Insurance Commissioner.

External Review Procedure:

1) An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If an Insured Person has an Adverse Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply.

We shall notify the Insured Person in writing of the Insured Person's right to request an external review at the time the We send written notice of: a) An Adverse Determination upon completion of the Our utilization review process described above; or b) A final Adverse Determination.

An external review may be requested within 60 days after the Insured Person receives Our adverse benefit determination. The request needs to be accompanied by a signed authorization by the Insured Person to release their medical records as necessary to conduct the external review.

2) An external review may be requested by the Insured Person or an authorized representative of the Insured Person.

3) The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.

4) We will review the request and if it is: a) Complete we will initiate the external review and notify the Insured Person of: i) The name and contact information for the assigned independent review organization or the Commissioner of Insurance, as applicable for the purpose of submitting additional information; and ii) A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or the Commissioner of Insurance to consider when conducting the external review. However, this doesn't apply to expedited request or external reviews that involve an experimental or investigational treatment. b) If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.

Appeals Procedures Continued

5) We will not afford the Insured Person an external review if: a) The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or b) The Insured Person has failed to exhaust Our internal review process; or c) The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us. If We deny a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, We will notify the Insured Person in writing: a) The reason for the denial; and b) That the denial may be appealed to the Commissioner of Insurance.
6) For an expedited review: the Insured Person may make a request for an expedited external review after receiving an adverse benefit determination if: a) The Insured's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person if treated after the time frame of an expedited internal review. b) The Insured Person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person , or would jeopardize the Insured Person's ability to regain maximum function, if treated after the time frame of a standard external review. or c) The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received Emergency Services, but has not yet been discharged from a facility.
7) An Insured Person shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by Us, the insurer.
8) At the request of the independent review organization, the Insured Person, provider, health care facility rendering health care services to the Insured Person, or Us shall provide any additional information the independent review organization requests to complete the review.
9) If the independent review organization does not receive any requested information necessary to complete the review they are not required to make a decision. They shall notify the Insured Person and Us that a decision is not being made. The notice may be made in writing, orally, or by electronic means.
10) We may elect to cover the service requested and terminate the review. We shall notify the Insured Person and all other parties involved with the decision by mail, or with the consent or approval of the Insured Person, by electronic means.
11) In the case of an expedited review, the independent review organization shall issue a written decision within seventy-two (72) hours after being assigned an expedited external review. In all other cases, written decision shall be issued no later than thirty (30) days after the filing of the request for review to the Insured Person, the insurer and the Insured Person's provider or the health care facility if they requested the review. The written decision shall include a description of the Insured Person's condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.
12) We shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the Insured Person's policy or certificate.

External Review of Denial of Experimental or Investigative Treatment

Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or final Adverse Determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or the Insured Person's authorized representative may file a request for external review with the Commissioner of Insurance.

An Insured Person or the Insured Person's authorized representative may make an oral request for an external review of the Adverse Determination or final Adverse Determination if the Insured Person's treating Physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

Upon receipt of a request for an expedited external review, the Commissioner of Insurance immediately shall assign an independent review organization to conduct the review. Upon receipt of a request for external review, the Commissioner of Insurance immediately shall notify and send a copy of the request to Us. For an expedited external review request, at the time We receive the notice, We or Our designee utilization review organization shall provide or transmit all necessary documents and information considered in making the Adverse Determination or final Adverse Determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious manner.

Right of Recovery

If the amount of the payments made by Our Agent or We is more than it should have paid under the COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Privacy Disclosure

Under HIPAA's Privacy Rule, we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You will receive a copy of the NGL HIPAA Privacy Notice upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605 or call 1-855-825-3985. You may also view and download a copy from the website at: ***unco.myahpcare.com*.**

Policy Notice

This information provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued in the state in which the Policy was delivered. Complete details may be found in the Policy on file at your school's office. The Policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

Summary of Benefits and Coverage

The Affordable Care Act requires all health insurers to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a description of the benefits and health coverage offered by a particular health plan. The SBC is intended to provide clear, consistent descriptions that may make it easier for people to understand their health insurance coverage.

The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in your insurance Policy to obtain an SBC for your Policy, please go to ***unco.myahpcare.com.***

Your good health is your best wealth.

PLAN UNDERWRITTEN BY:

National Guardian Life Insurance Company

The 2018-2019 Student Health Insurance Plan is underwritten by National Guardian Life Insurance Company, NBH-280 (2014) CO.

National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, AKA The Guardian or Guardian Life

PLAN MANAGED BY:

Academic HealthPlans, Inc.
P.O. Box 1605
Colleyville, TX 76034-1605
Phone: 1-817-809-4700
Fax: 1-855-858-1964
ahpcare.com

CLAIMS ADMINISTERED BY:

Cigna Healthcare
PO Box 188061
Chattanooga, TN 37422-8061
(EDI #62308)

Claims Inquiries Please Contact
Medical Providers call: 1-844-221-0959
All Other calls: 1-855-825-3985
Email: akronclaims@healthsmart.com

TO LOCATE A NETWORK PROVIDER:

Cigna PPO
mycigna.com
Academic HealthPlans, Inc.
1-855-825-3985
unco.myahpcare.com

PHARMACY BENEFITS MANAGEMENT SERVICES PROVIDED BY:

HealthSmart Rx®
1-844-221-0959

National Guardian Life Insurance Company

ahp | Academic HealthPlans℠

HealthSmart™

FOR MORE INFORMATION, CONTACT:

UNC Student Health Insurance Office
Cassidy Hall-Campus Box 46
Greeley, Colorado 80639

970-351-1915 (office)
970-351-4726 (fax)

unco.edu/ship

ahp | Academic HealthPlans℠

UNC | UNIVERSITY OF NORTHERN COLORADO

UNC Student Health Insurance Office

Cassidy Hall-Campus Box 46 | Greeley, Colorado 80639 | 970-351-1915 (office) | 970-351-3234 (fax) | unco.edu/ship