

# STUDENT HEALTH INSURANCE PLAN

*Designed especially for the students of*



**2003 – 2004  
Plan Year**

Visit us on the web at  
[www.mscd.edu/student/resources/health](http://www.mscd.edu/student/resources/health)

**Includes Special 100% Reimbursed  
Health Center Benefits  
for Eligible Services**

Claims Administrator:  
AmeriBen Solutions

Insurance Carrier:  
The MEGA Life and Health Insurance Company

Form Number: 98-BR-CO (461)  
Policy Number: 2003-461-1

# TABLE OF CONTENTS

Introductory Letter	1
Waiver Policy	2
Student Health Insurance Plan	2
Confirmation of Coverage	3
Notification of Emergency Admission	3
Summary of Benefits Table	4-5
Summary of Psychiatric Benefits Table	6
Premium and Waiver Information	7-8
Eligibility	8
Dependent Coverage	9
Late Enrollment	9
Maximum Lifetime Benefit	10
General Plan Provisions	10
Health Care Management Program	10-11
Summary of Benefits	11
Prescription Drug Plans	12
Plan Year Deductibles	13
Subrogations	13
Continuation of Coverage	14
Out-of-Pocket Limit	14
Pre-Existing Conditions	14
Covered Medical Expenses	15-20
Assist America: Global Emergency	
Medical Assistance	20-21
Exclusions	21-23
Termination of Coverage	23
Coordination of Benefits	24
How To File A Claim	24-25
Disputed Claims	25
Proof of Loss Deadline	25-26
Extension of Benefits	26
Definitions	27-29
Claim Procedures	30
Insurance Company	30
Important Telephone Numbers	30
Important Notice	31

DEAR STUDENT:

Metropolitan State College of Denver, while primarily concerned with educational pursuits, is very aware of the varied needs of its urban student population, one of which is health. To meet these needs, Metropolitan State College of Denver offers a Student Health Program to serve the students in two broad areas – the Student Health Insurance Plan and the Health Center (HC). While these are separate entities, they have been designed to complement each other. Please review the significant plan benefits that are available to Insured Students who use the Health Center for their medical needs, by referring to the special benefits section on pages 4-5 of this brochure.

THE STUDENT HEALTH INSURANCE PLAN is designed to provide coverage for medical care, hospital and surgical expenses for either Injury or Sickness. All students (students enrolled for 10 credit hours or more in Fall and Spring and 8 credit hours for Summer Semester) are required to participate in the student health insurance plan unless they certify that they are currently covered by a comparable major medical health insurance plan. The waiver petition must be submitted by the deadline listed in the class schedule under the heading “Student Health Insurance.” **No refunds will occur after the waiver deadline date.** Although students with other comparable health insurance may waive participation, we strongly encourage careful evaluation of this particular plan as it can act as a valuable supplemental policy.

THE HEALTH CENTER AT AURARIA (HC) provides on-campus health care to any Metropolitan State College of Denver student enrolled for at least one credit hour. **Students do NOT need to participate in the Student Health Insurance Program to use the Health Center.** You will find that services provided by the Health Center are offered at a significantly reduced cost. Health Center services are comparable to those available at a family physician’s office.

**HEALTH CENTER AT AURARIA**  
**Plaza Building, Suite 150**  
**First Floor, West Entrance**  
**Insurance Phone: 303-556-3873**  
**Health Center Main Phone: 303-556-2525**

We wish you the very best in your academic, professional and personal endeavors. It is always a pleasure to be of service to you.

Sincerely,

Steve Monaco, Director  
 Health Center at Auraria

Sandra Dumanacas, Coordinator  
 Student Health Insurance

## WAIVER POLICY

Students eligible to waive participation in the Student Health Insurance Plan must submit an annual waiver of participation by the deadline listed below (note that deadlines change each semester). **No refunds will occur after the WAIVER deadline date.**

### Fall Term Coverage Dates:

August 18, 2003 through January 19, 2004

**Waiver Deadline:** September 12, 2003

### Spring Term Coverage Dates:

January 20, 2004 through May 31, 2004

**Waiver Deadline:** February 13, 2004

### Summer Term Coverage Dates:

June 1, 2004 through August 22, 2004

**Waiver Deadline:** June 18, 2004

Students may be ineligible if coverage has not been purchased for entire year.

## STUDENT HEALTH INSURANCE PLAN

This brochure is designed to acquaint students and other interested parties with the medical services available, cost of the plan and exclusions to the services offered. We ask that you read it carefully so that you will know the extent of medical services and insurance benefits you can expect.

The insurance plan is entirely supported by student premiums, no tuition or State appropriations are used to pay for these services.

The insurance becomes effective for a student and dependent(s) as provided in the policy and explained in this booklet.

The description in this brochure is generalized information. In all cases the contract with Mega Life and Health Insurance Company is the document that will prevail, in accordance with the "Blanket" policy regulations of the State of Colorado.

Claims should be submitted to Mountain Medical Affiliates (MMA) at 5889 S. Greenwood Plaza Bldg., Suite 200, Greenwood Village, Colorado 80111.

Correspondence concerning claims status, eligibility and benefits should be directed to AmeriBen Solutions, P.O. Box 7186, Boise, Idaho 83707, (800) 953-1801, reference the School's Group #0801031.

## CONFIRMATION OF COVERAGE FOR PARTICULAR SERVICES

It is the student's responsibility to confirm whether or not a particular service is covered under the plan. ***This confirmation must be done with AmeriBen Solutions.*** Health Center staff, including medical providers, are not adequately trained to provide confirmation of coverage for any services.

### ■ **Health Center at Auraria: (303) 556-2525**

Find out the availability of daily access, appointments and hours of the Health Center.

### **100% Reimbursement With NO Deductible Or Coinsurance (except for Prescriptions - see below)**

(This applies to eligible services; this option is not always available due to hours of operation and staffing)

### **Prescriptions**

Subject to \$15 co-pay per prescription up to a 30-day supply. Maintenance medications may be filled up to a 90-day supply. A co-pay of \$30 will apply per prescription for a 31-60 day supply. A co-pay of \$45 per prescription will apply for a 61-90 day supply.

Contraceptives are provided at the Health Center at Auraria only for students, spouses and dependents over 18. There is a copay of \$15 per prescription for contraceptives up to a maximum plan benefit of \$20/month (maximum benefit of \$240/year).

■ **Mountain Medical Affiliates (MMA) VADS Network:** Metro has a specially designed PPO VADS network through Mountain Medical Affiliates. Not all MMA providers are in the VADS network. To find which providers are included in the VADS network call one of the following numbers.

**Local Denver Number: 303-290-6451  
Toll-Free Number: 800-647-1856**

**80% Reimbursement**  
(after Deductible for eligible services)

■ **Mountain Medical Affiliates (MMA)**  
For pre-notification

**Local Denver Number: 303-770-4088  
Toll-Free Number: 800-942-4662**

## Notification of Emergency Admission:

**You must call Mountain Medical Affiliates at  
800-942-4662  
within 48 hours (two working days) of an  
emergency admission.**

**SUMMARY TABLE  
OUTLINING BASIC BENEFITS**

This chart summarizes co-payment amounts paid by the plan.

Note: The chart column entitled “Health Center at Auraria” applies to Insured Student and Dependents, Spouse (including domestic partner) and Children over 18 years of age.

Benefit Descriptions	Health Center at Auraria
Annual Deductible	N/A
Pre-Existing Condition Limitation	N/A
Well Care	100% with Limitations, No Deductible
Mammograms – Routine and Diagnostic	N/A
X-Ray Services and Laboratory Services	100% at Clinic, No Deductible. 80% at DMIC, No deductible. Plan Year Maximum does not apply.
Inpatient Hospital Services and Outpatient Surgery	N/A
Inpatient Mental / Nervous Disorders	See Page 16
Outpatient Mental / Nervous Disorders	See Page 16
Prescriptions	\$15 copay per prescription up to a 30-day supply; \$30 copay for 31-60 day supply; \$45 copay for 61-90 day supply (See “Confirmation of Coverage” Page 3)
Physical Therapy	N/A
Child Health Supervision and Immunization Services	N/A
All Other Covered Medical Expenses	100%; No Deductible

Benefit Descriptions	Health Center at Auraria
Annual Deductible	N/A
Dental Treatment for an Accidental Injury	N/A
Ambulance	80% after \$300 PPO Deductible
Durable Medical Equipment	N/A
Emergency Services	100%; No Deductible
Nutritional Counseling	100%; No Deductible
TMJ (Temporomandibular Joint Dysfunction)	N/A

If you reside, or are traveling outside the immediate Denver area, including overseas, you MUST contact the Insurance Office at the Health Center at Auraria PRIOR to receiving medical care or no benefits are payable, unless it's a medical emergency.

Mountain Medical Affiliates P.P.O. VADS Network	Additional Limitations and Explanations
Yes (\$300)	Does not apply to routine and diagnostic mammograms, child immunizations or prostate cancer screening by any provider.
Applies	
Not Covered	See Covered Medical Expenses Item #41, Page 19.
100%; No Deductible	Up to a Maximum of \$150 per Plan Year. Includes radiology readings.
80% after Deductible	Up to a plan year Maximum of \$2000, then payable at 50% for MMA PPO VADS network providers.
80% after Deductible	Anesthesia services will be paid at 80% if the surgery is at a PPO hospital or surgical center.
For Explanation of Benefits	
For Explanation of Benefits	
N/A	Separate \$200 Deductible when not filled at the Health Center. Copay; \$15 generic, \$40 brand and \$60 non-formulary up to 30 day supply per prescription when filled at participating pharmacy. See Page 12. Claims for Rx purchased outside the Health Center have a Plan Year Cap of \$1,500. Contraceptives are only covered at the Health Center.
80% after Deductible	
100%; No Deductible	See Covered Medical Expenses Item #43, Page 19.
80% after Deductible	Additional benefits are shown in the Covered Medical Expenses section of this brochure, beginning on page 15.

Any Provider	Additional Limitations and Explanations
\$300 (PPO Providers) \$500 (Out-of-Network)	\$300 Deductible within MMA PPO VADS Network providers. \$500 Deductible for Out-of-Network providers.
80% After Deductible	Treatment for Injury to sound, natural teeth occurring while insured.
80% After Deductible	Deductible applies for transportation from Health Center (C) to area hospital.
80% After Deductible	
80% After Deductible	Medical Emergency only; as defined.
80% After Deductible	Benefit applies for services rendered by any licensed provider.
80% After Deductible	Up to a Lifetime Maximum of \$2,500.

## PSYCHIATRIC AND ALCOHOL & SUBSTANCE ABUSE BENEFITS

**Biologically-based Mental Sickness:** Paid as any other sickness and not subject to 45 day inpatient limit and 30 visit or \$1,000 (whichever is greater) outpatient maximum.

**Mental or Nervous Disorders:** Inpatient benefits subject to 45 days per plan year maximum. Outpatient benefits subject to 30 visits per plan year maximum.

**Substance Abuse, Alcohol Abuse and Eating Disorders:** subject to \$10,000 aggregate lifetime maximum for inpatient/outpatient treatment. Inpatient benefits subject to 45 days per plan year maximum. Outpatient benefits subject to \$1,000 annual maximum.

	Inpatient	Outpatient
Health Center at Auraria	N/A	100%
MMA PPO VADS Network Providers	<p><u>With</u> HC Referral: 80% After Deductible</p> <p><u>Without</u> HC Referral: 80% After Deductible</p>	50% After Deductible
Out-Of-Network	No Coverage	No Coverage
Additional Limitations and Explanations	<p>See Covered Medical Expenses, Items 21, 22, 23 and 24, Pages 16 and 17.</p> <p>45-day limit except for Biologically-based Mental Sickness.</p>	<p>See Covered Medical Expenses, Items 21, 22, 23 and 24, Pages 16 and 17.</p> <p>30-visit limit except for Biologically-based Mental Sickness.</p>

## SPECIAL HEALTH CENTER BENEFITS

Please note that this section applies to **STUDENTS AND SPOUSES/DEPENDENTS OVER AGE 18 ONLY**. The Health Center is **NOT** a Medicare/ Medicaid Provider.

Necessary eligible medical expenses incurred for Sickness or Injury will be reimbursed at 100% (following the appropriate prescription co-pay.) for care provided at Health Center at Auraria. This includes limited well care, supplies, in-house testing and procedures. In addition, the Insured's Deductible, Coinsurance and pre-existing condition exclusion clause **will be waived** for services performed at the Health Center. No claim forms will be required. All other plan provisions will continue to apply to treatment rendered by the Health Center at Auraria.

## HEALTH INSURANCE REQUIREMENT for Full-Time Students

### Health Insurance Premium per Semester

Student (domestic & international) . . . . .	\$534
Additional for Spouse . . . . .	\$747
Additional for Child(ren) . . . . .	\$662
Additional for Spouse & Children . . . . .	\$1,409

Dependents can only purchase insurance if student is enrolled in this health plan.

### WAIVER INFORMATION

All students taking 10 credit hours or more in the Fall or Spring semester (or 8 credit hours in the Summer semester) are required to participate in the College sponsored health insurance program, unless proof can be provided that a student has comparable outside health insurance coverage that is currently valid.\* Proof must be submitted by the waiver deadline listed on page 2. **No refunds will occur after the waiver deadline date.**

**\*Individual insurance plans that are not required to meet State and Federal benefit mandates are not considered comparable and consequently will not be considered proof of comparable coverage.**

Students are **AUTOMATICALLY** billed for the Student Health Insurance on their tuition bill (under the heading of "insurance"). For those students who have outside coverage, it is their responsibility to complete a "waiver form" by the deadline listed on page 2 in order to have the insurance charge removed from their tuition bill.

**Waiver forms will not be accepted after the waiver deadline.**

## WAIVER INFORMATION (continued)

Students taking 10 credits in the Fall and Spring semesters, and 8 credits in the Summer semester, will be mailed a packet of insurance information. If, for any reason, you do not receive this packet, waiver forms are located in the back of the class schedule. Waiver forms and insurance brochures can also be obtained at either the Student Insurance Office located in the Health Center at Auraria (Plaza Building, Lower Level, Room 150) or the Student Accounts Office located in Central Classroom, Room 110. **Health Insurance waiver forms are only valid for one academic year.**

Continuing students are required to complete a new waiver form ANNUALLY prior to each Fall semester. Students with a break in their academic enrollment are required to complete a new waiver form when they re-enroll and every Fall semester thereafter.

## ELIGIBILITY

Students who have enrolled for a minimum of 10 credit hours for Fall and Spring semesters or 8 credit hours for Summer semester will be eligible for the college's insurance coverage. **Summer semester – Those students who are enrolled for Spring semester health insurance have the option of purchasing summer insurance coverage without attending classes provided they pay the premium at the Cashier's Office by the Summer waiver deadline of June 18, 2004. In order to be covered for a complete year (12 months), you must purchase coverage for all three semesters.**

Students graduating at the end of the Spring semester cannot purchase coverage for the Summer semester, but will be able to purchase Continuation of Coverage Insurance. Refer to page 14.

### **SPRING SEMESTER COVERAGE DOES NOT INCLUDE SUMMER SEMESTER COVERAGE.**

Once you have enrolled for the minimum required credit hours, coverage will be effective starting on the first day of the semester, and continuing through the last day before the next semester starts. **If you drop classes so that you fail to meet the minimum credit hour requirement before the waiver deadline listed on page 2, all insurance premiums will be refunded and you will not be covered by this insurance plan. You will be responsible for all incurred medical charges.** If you are enrolled in less than 6 credit hours in the last semester before you graduate, you can enroll on a voluntary basis. If you are enrolled in the Winterim Program, your eligibility start date is the start date of the session in which you are enrolled, and ends on the ending date for Spring Semester.

## Voluntary Insurance Program for Part-Time Students

Students taking 6 to 9 credit hours in the Fall or Spring semesters or 6 to 7 credit hours in the Summer semester are eligible for the voluntary Student Health Insurance program designed exclusively for part-time students. Students taking more or fewer credit hours than indicated above are NOT eligible for this voluntary program. For an application, contact the insurance office located in the Health Center, Plaza 150.

## DEPENDENT COVERAGE (Including Newborn Enrollment and Eligibility)

Eligible dependents include: your lawful spouse (or commonlaw spouse) as defined by applicable state law residing with the Insured Student, Domestic Partner, and dependent children. Dependent Children remain eligible until age 19.

If your insurance is in force, medical coverage for any newborn Children shall become effective at birth, and will continue in effect for 31 days from birth. To continue coverage beyond 31 days, you must enroll the Child for coverage within 31 days from birth and pay the semester premium (no prorating of premium) that may be due. Contact the Health Center at Auraria at 303-556-3873 to enroll the child.

## LATE ENROLLMENT

Eligible students will not be allowed to enroll in the plan after the applicable enrollment/waiver period unless proof is furnished that the eligible student became involuntarily ineligible for coverage under a group insurance policy during the 30 days immediately preceding the date of the request for late enrollment in the plan provided by Metropolitan State College of Denver. In such cases, the cost will be the same as it would have been at the beginning of the enrollment period, but the effective date will be the date the student enrolls and makes the required premium payment.

## MAXIMUM LIFETIME BENEFIT

Maximum Lifetime Benefit is \$300,000 per Insured Person. Maximum Lifetime Benefit is defined as any period of time a Covered Person is a participant in this plan or any other plan sponsored by Metropolitan State College of Denver and is inclusive and cumulative of any and all periods of coverage even if there were gaps in participation.

## GENERAL PLAN PROVISIONS

Coverage will be in effect 24 hours a day for emergency treatment. A Insured Person will be insured at home, school or when traveling outside the United States while insurance is in force.

## HEALTH CARE MANAGEMENT PROGRAM

Metropolitan State College of Denver has contracted with a professional health care management company to assist Insured Persons in determining whether or not proposed services are appropriate for reimbursement under the plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits or validate eligibility. The medical professionals who conduct the program focus their review on the appropriateness of hospital stays and proposed surgical procedures.

### Required Pre-Admission Notification

Insured Persons should call Mountain Medical Affiliates, at (800-942-4662), between 8:00 a.m. and 5:00 p.m. MST, Monday through Friday, before any elective admission to a hospital. Covered Persons must also call within 48 hours (2 working days) of any emergency admission. When calling, it will be necessary to provide the program with your name, the patient's name, the name of the Physician and hospital, the reason for the hospitalization and any other information needed to complete the review.

(continued)

## HEALTH CARE MANAGEMENT PROGRAM (continued)

### Special Case Management

Special Case Management is designed to help manage the care of patients who have catastrophic or extended care Sickness or Injury.

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

- ◆ Terminal Sicknesses
- ◆ Cancer
- ◆ AIDS
- ◆ Chronic Illnesses: Renal Failure, Cardiac Obstructive pulmonary disease, multiple sclerosis, cardiac conditions
- ◆ Accident victims requiring long-term rehabilitative therapy
- ◆ Newborns with high risk complications or multiple birth defects
- ◆ Diagnosis involving long-term IV therapy
- ◆ Sicknesses not responding to medical care
- ◆ Child and adolescent mental/nervous disorders

## SUMMARY OF BENEFITS

The following benefits will be paid when an Insured Person incurs a Covered Medical Expense while insured under the Plan. The expense must be due to a Sickness or Injury, be medically necessary, and authorized by a Physician. All benefits are subject to Usual and Customary guidelines, Deductibles, Coinsurance, plan maximums and limitations and exclusions. Usual and Customary allowances will be determined using the current survey of Ingenix with a 90th percentile reimbursement level.

## PRESCRIPTION DRUG PLAN EXPRESS SCRIPTS

Benefits are provided through Express Scripts, a point-of-service provider. Please call 800-206-4005 for questions regarding benefits or network participating pharmacies. **If an Insured Person incurs Rx claims within the first 6 weeks of the semester, the Covered Person must pay for the Rx and submit a claim to Express Scripts after the 6th week at:**

**Express Scripts, Inc.  
P.O. Box 66773,  
St. Louis, Missouri 63166-6773  
Attn: Claims Department**

After 6 weeks, the Covered Person may go to any network pharmacy and pay a \$15 copayment for generic, \$40 copayment for brand names or \$60 for non-formulary, for eligible prescription drugs up to a 30 day supply per prescription or refill and **up to a \$1500 maximum per year**. Maintenance medications may be filled up to a 90 day supply. A co-pay of \$30 generic, \$80 brand or \$120 non-formulary will apply per prescription for a 31-60 day supply. A co-pay of \$45 generic, \$120 brand, or \$180 non-formulary will apply per prescription for a 61-90 day supply. **A separate \$200 point-of-service Plan Year Deductible must be satisfied.**

After you have exhausted the \$1,500.00 annual maximum, prescriptions can be purchased at a network pharmacy at a discounted rate, but you will be responsible for payment on these prescriptions.

## PRESCRIPTION DRUG PLAN HEALTH CENTER AT AURARIA

Maintenance medications filled at the Health Center of Auraria may be filled up to a 90 day supply. A co-pay of \$15 will apply per prescription up to a 30 day supply. A co-pay of \$30 will apply per prescription for a 31-60 day supply. A co-pay of \$45 will apply per prescription for a 61-90 day supply. No Deductible applies for prescriptions filled at the Health Center.

## PLAN YEAR DEDUCTIBLES

### HEALTH CENTER AT AURARIA

For services performed at the Student Health Center, the Deductible **will be waived**.

### PRESCRIPTION DRUGS

**Separate:** \$200 for eligible Prescription Drug Expenses, per Covered Person, per Plan Year. Does not apply to prescriptions filled at Health Center.

### INDIVIDUAL

**In-Network:** \$300 of Covered Medical Expenses, per Insured Person, per Plan Year.

**Out-of-Network:** \$500 of Covered Medical Expenses, per Insured Person for emergency services and limited other benefits (see Schedule of Benefits), per Plan Year.

### FAMILY

**In-Network:** \$900

**Out-of-Network:** \$1,500 for emergency services and limited other benefits (see Schedule of Benefits) [when 3 covered family members each meet the Deductible in a Plan Year, the family Deductible is met.]

### CARRYOVER DEDUCTIBLE

Although a new Deductible will apply each Plan Year, expenses incurred during the last three months of a Plan Year which are applied to that Plan Year's Deductible will also be applied toward the Deductible for the next Plan Year and thus reduce or eliminate that Plan Year's Deductible. This does not include prescription drug deductible.

## SUBROGATION

If a Covered Person incurs Covered Medical Expenses for a Sickness or Injury that is caused by the act or omission of a third party, and if benefits are paid by the Policy, we reserve the right to have the Policy's benefits reimbursed from any payment made by the third party or its insurer. This right will only be to the extent of benefits that are paid by us for medical/dental expenses. The Insured Person shall furnish to us all information necessary to carry out the terms of this provision. This right will not apply to a recovery made from an insurance company under which The Covered Person is the insured person.

## CONTINUATION OF COVERAGE

Continuation of coverage is available to graduating seniors and their dependents, and may be purchased in increments of one month, with a six month maximum. You, and if applicable, your dependents, must have been enrolled in the semester immediately preceding graduation. Contact the Student Insurance Office at the Health Center at 303-556-3873 for a Continuation of Coverage enrollment form.

## OUT-OF-POCKET LIMIT

The In-Network and Emergency Services out-of-pocket limit is \$5,000 per Covered Person per Plan Year. The maximum out-of-pocket is the amount of Covered Medical Expenses an individual must pay for medical expenses during the Plan Year. When an out-of-pocket amount is satisfied, the plan will pay 100% of Covered Medical Expenses for the remainder of the Plan Year to the maximums of the plan.

Types of charges that do not apply toward the maximum out-of-pocket expense include the following: 1) prescription copayments and prescription annual deductible, 2) noncovered expenses such as expenses in excess of Usual and Customary allowances and charges not covered by the plan, and 3) charges in excess of maximum benefits payable under the plan.

## PRE-EXISTING CONDITIONS

Pre-Existing Conditions are covered at the earlier of:

- 1) the end of the three (3) month period following the Covered Person's effective date of coverage under the Policy during which no treatment was received for the Pre-existing Condition; or
- 2) the end of the six (6) month period following the Covered Person's effective date of coverage under the Policy.

The Pre-existing Condition Limitation will be reduced by the period of time a Covered Person was previously covered by Creditable Coverage if the Creditable Coverage was continuous to a date not more than 90 days prior to the effective date of the Covered Person's coverage under the Policy. Students and Dependents covered during the Spring Semester will not be considered to have had an interruption in coverage for the purposes of administering the Pre-existing Condition exclusion if they do not enroll in the Summer Semester. **NOTE:** The Pre-existing Condition Limitation shall not apply to covered expenses incurred at the Health Center, or pregnancy.

## COVERED MEDICAL EXPENSES

1. Room and Board Expense: 1) daily semi-private room rate when Hospital confined; 2) general nursing care provided and charged for by the Hospital and 3) for accommodations in an intensive care unit, the amount of daily room and board charge considered Covered Expense will not exceed an amount equal to twice the amount specified in (1) above.
2. Hospital Miscellaneous Expenses: 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
3. Surgery: Physician fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits.
4. Assistant Surgeon Fees: in connection with inpatient and outpatient surgery.
5. Anesthetist Services: in connection with inpatient and outpatient surgery.
6. Physician's Visits: outpatient and surgical.
7. Pre-admission Testing: limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit.
8. Denver Medical Imaging Center (DMIC) radiology charges will be payable at the MMA PPO VADS Network level of benefits with no Deductible.
9. Ambulance Services.
10. Charges by a home health care agency when such care is ordered by a Physician and the Covered Person is confined to his/her home. Such care shall be for part-time nursing, physical, occupational or speech therapy and shall be limited to 60 visits per person per Policy Year.
11. Hospice charges by a licensed agency for the care of terminally ill patients. Care must be ordered by a Physician and reviewed monthly.
12. Maternity: Same as any other Sickness.
13. Reconstructive surgery when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part, an Injury or for breast reconstruction following a total or partial mastectomy. Benefits for congenital birth defects are limited to children born after the insured's effective date and who are covered by the plan.

(continued)

## COVERED MEDICAL EXPENSES

(continued)

14. Human organ and tissue transplants that are medically necessary and appropriate. Experimental procedures are not covered.
15. Circumcision, for newborns only.
16. Surgical and nonsurgical treatment of temporomandibular joint dysfunction (TMJ) up to a Lifetime Maximum of \$2,500.
17. Podiatry treatment of metabolic or peripheral-vascular disease and medically necessary foot-care.
18. Physical therapy from a qualified practitioner, and occupational therapy, not including supplies.
19. Radiation therapy and chemotherapy.
20. Sleep disorders, if a result of a medical sickness.
21. Psychotherapy (Inpatient): Inpatient Benefits are based on confinement as an inpatient or partial hospitalization in a Hospital or psychiatric Hospital licensed by the Colorado Department of Health. partial Hospitalization, for the purposes of this benefit, means continuous treatment for at least three hours, but not more than 12 hours during a 24-hour period. The maximum number of days payable per 12-month period are 45 days for inpatient confinement and 90 days for partial hospitalization. The maximum amounts are specified in the Schedule of Benefits. For the purpose of computing the period for which benefits are payable, the following will apply:
  - 1) Two days of partial hospitalization shall reduce by one day the 45 days for inpatient care. One day of inpatient care shall reduce by two days the 90 days available for partial hospitalization.
  - 2) Each day of inpatient confinement under this benefit or each two days of partial hospitalization shall reduce by one day, the total days available for all Sickness for any one 12-month period.
  - 3) Each day of confinement as an inpatient in a Hospital or psychiatric Hospital, or each two days of partial hospitalization, shall reduce by one day, any days available for alcoholism coverage.
22. Psychotherapy (Outpatient) are for outpatient services furnished by 1) a comprehensive health care service corporation; or 2) a Hospital, a community mental health center; or 3) other mental health clinic approved by the Colorado Department of Human Services to provide such care; or 4) a registered professional nurse; or 5) a licensed clinical social worker, acting within the scope of license; or 6) furnished by or under the supervision of a licensed Physician or psychologist. Except as state below, all such services must be provided by or under the supervision of a licensed Physician or licensed psychologist; and records must show that the licensed Physician or psychologist, saw the patient or had a written summary of consultations or a personal consultation with the therapist at least once each 90 days.

(continued)

## COVERED MEDICAL EXPENSES

(continued)

- Covered services under this benefit, which can legally be furnished by a registered professional nurse or licensed clinical social worker, acting within the scope of his or her license, will not require the supervision of a Physician or psychologist. Reimbursement may be made directly to such provider. Limited to 30 visits annually per year.
23. Inpatient and outpatient treatment of substance abuse, alcohol abuse, and eating disorders; \$10,000 aggregate lifetime maximum for inpatient/outpatient treatment. **Inpatient:** up to 45 days treatment annually (plan year) for inpatient care at a hospital or a state licensed alcohol, psychiatric, chemical dependency, or residential treatment facility. No benefits are payable unless the full continuum of care, including detoxification and rehabilitation treatment plan have been completed. **Outpatient:** \$1,000 annual Plan Year aggregate maximum.
  24. Biologically-based Mental Sickness (schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder) are paid as any other Sickness and are not subject to the 45-day Inpatient limit and 30-visit Outpatient maximum as stated in Covered Medical Expenses, Item 21. Any inpatient benefit will be reduced by \$500 if you do not follow the requirements of the Health Care Management Program (See page 10).
  25. Attention Deficit Disorder, covered as a medical expense (not psychiatric).
  26. Dental treatment of Injury to sound natural teeth resulting from an accident occurring while insured. This includes replacement of teeth and any related x-rays.
  27. Speech therapy from a qualified practitioner to restore speech loss due to an Sickness or Injury.
  28. Treatment of diabetes including insulin, insulin syringes, insulin infusion pumps, and outpatient self-management training and education including medical nutrition therapy, and as mandated by Colorado law. Diabetic supplies are covered under the prescription drug plan.
  29. Dialysis.
  30. Hearing test, if for the diagnosis of an Sickness or Injury.
  31. Amniocentesis, only when medically necessary.
  32. Ultrasounds, only when medically necessary.
  33. Allergy testing, including allergy injections and serum.
  34. Magnetic Resonance Imaging (MRI), only when medically necessary.

(continued)

## COVERED MEDICAL EXPENSES

(continued)

35. Routine mammograms including radiology charges. Pays the lesser of \$150 or the actual charge, no deductible, for each routine low-dose mammography screening according to the following schedule: Baseline 35-40 years of age; once every two years for women from 40 years of age and under 50 years of age, or once annually if ordered by a Physician; and once annually for women from 50 to 65 years of age. If a participant has a family history of breast cancer, the baseline routine mammogram can be done after age 25.
36. Diagnostic mammograms. Not subject to the deductible.
37. Braces and Appliances: 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacement braces and appliances are covered if required because of a change in the Insured's physical condition. Braces and appliances include durable, medical equipment which is equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
38. Benefits will be paid for the Usual and Customary charges incurred for the purchase of prosthetic devices. Prosthetic and orthotic devices means:
  - 1) Devices that replace all or part of an internal body organ, including ostomy bags and supplies directly related to ostomy care, and replacement of such devices and supplies;
  - 2) One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens; and
  - 3) Leg, arm, back and neck braces, and artificial legs, arms and eyes, including replacements if required because of a change in the Insured's physical condition.Prosthetic device services include:
  - 1) Prosthetic devices (excluding dental devices and renal dialysis machine), that replace all or part of an internal body organ or external body member (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning external body member or internal body organ; and
  - 2) Services necessary to design the device, select the materials and components, measure, fit and align the device, and instruct the patient in its use.Orthotic device services include:
  - 1) Orthopedic devices that support or align movable parts of the body, prevent or correct deformities, or improve functioning; and
  - 2) Services necessary to design the device, select the materials and components, measure, fit and align the device, and instruct the patient in its use.

(continued)

## COVERED MEDICAL EXPENSES

(continued)

- The following are neither prosthetic nor orthotic devices:
- 1) Parenteral and enteral nutrients, supplies and equipment;
  - 2) Intraocular lenses;
  - 3) Medical supplies such as catheters, catheter supplies, ostomy bags and supplies related to ostomy care that are furnished by an HHA as part of home health services under Title 42, Chapter IV, Part 414, Sec. 409.40(e);
  - 4) Dental prostheses.
- Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy. Benefits are limited to the most appropriate model that adequately meets the medical needs of the Insured as determined by a Physician. Repairs and replacements of prosthetic devices are also covered, subject to copayments and Deductibles, unless necessitated by misuse or loss.
39. Blood and/or plasma and the equipment for its administration.
  40. Second Surgical opinions.
  41. Well Care Services are provided at the Health Center at Auraria for Students, spouse and dependents over 18. Benefits include one annual examination/routine physical per Plan Year and one HIV/Syphilis test per year (includes pre/post-test counseling). For men, a routine physical examination includes the office visit charge and a gonorrhea/chlamydia test, a hemoglobin, and urine test (Item 40 also applies according to age criteria). For women, an annual examination includes the office visit charge, pap smear, gonorrhea/chlamydia test; hemocult for women over age 50, a hemoglobin and a urine test.
  42. Prostate Cancer Screening – one screening per year for men over the age of 40 who are in high-risk categories as determined by the Covered Person's Physician. One screening per year for all men over the age of 50 years. Pay the lesser of \$70 per screening or the actual charge for such screening. Not subject to the Deductible.
  43. Child Health Supervision Services/Well-Child Care including immunizations up to age 13 as mandated by Colorado law. One newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery. Up to 1 year: 5 visits maximum and 1 PKU. Age 13 months to 3 years: 2 visit maximum. 3-7 years: 3 visit maximum. 7-13 years: 3 visit maximum. Not subject to the Deductible.
  44. Bereavement counseling provided by a Physician limited to a maximum benefit period of 3 months.
  45. Nutritional counseling.
  46. Congenital Birth Defects and Abnormalities as mandated by Colorado law.

(continued)

## COVERED MEDICAL EXPENSES

(continued)

47. General anesthesia and facility charges for dental procedures for Dependent children under certain conditions as mandated by Colorado law.
48. Medical foods prescriptions for inherited enzymatic disorders up to age 21 for men and 35 for women as mandated by Colorado law.
49. Contraceptives are provided at the Health Center at Auraria only for students, spouse and dependents over age 18. There is a copay of \$15 per prescription for oral contraceptives, devices or a Depovera shot up to a maximum plan benefit of \$20/month (maximum benefit of \$240/year).
50. Surgical breast reduction will be covered if medically necessary.

## ASSIST AMERICA: GLOBAL EMERGENCY MEDICAL ASSISTANCE

Through participation in the Metropolitan State College of Denver insurance plan, each Insured\* is eligible for global emergency medical assistance services when traveling 100 miles or more from his/her permanent home or campus address or abroad. Services are accessible 24 hours a day, 365 days a year and are provided by Assist America, Inc.

### Key Services include:

- ◆ Medical Consultation, Evaluation and Referrals
- ◆ Hospital Admission Guarantee
- ◆ Emergency Medical Evacuation
- ◆ Critical Care Monitoring
- ◆ Medically Supervised Repatriation
- ◆ Prescription Assistance
- ◆ Emergency Message Transmission
- ◆ Transportation to Join Patient
- ◆ Care for Minor Children
- ◆ Return of Mortal Remains
- ◆ Emergency Trauma Counseling
- ◆ Lost Luggage or Document Assistance
- ◆ Interpreter and Legal Referrals

(continued)

## ASSIST AMERICA: GLOBAL EMERGENCY MEDICAL ASSISTANCE (continued)

Please refer to [www.assistamerica.com](http://www.assistamerica.com) for service descriptions.

To access services please call:

(800) 872-1414 Toll-free within the United States  
(301) 656-4152 Collect outside the United States

Services are also accessible via e-mail at [medservices@assistamerica.com](mailto:medservices@assistamerica.com).

Assist America is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by Assist America. Claims for reimbursement for services not provided by Assist America will not be accepted.

\*Insured's spouse and dependent children may also be eligible for services.

## EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense caused by, contributed to, or resulting from:

1. Addiction and codependency – services and supplies related to nicotine addiction only;
2. Biofeedback – services and supplies related to biofeedback;
3. Cosmetic procedures, except cosmetic surgery required to correct an injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
4. Custodial Care services and supplies related to custodial care such as 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 also are not covered for domiciliary or custodial care;
5. Dental treatment, except for accidental injury to Sound, Natural Teeth;
6. Elective Surgery and Elective Treatment; elective abortion;
7. Injury sustained while (a) participating in any interscholastic, club, interscholastic, club, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

(continued)

## EXCLUSIONS AND LIMITATIONS

(continued)

8. Hearing examinations or hearing aids unless specifically provided for in the Prosthetic and Orthotic Devices Benefit; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
9. Immunizations services and supplies related to immunizations, except as specifically provided in a benefit section; preventive medicines or vaccines, except where required for treatment of a covered Injury or exposure to an Sickness.
10. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
11. Mental and behavioral problems – services and supplies for conditions related to learning disabilities, except as specifically provided in the policy;
12. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
13. Pre-existing Conditions, except as specifically stated in the Pre-Existing Condition provision;
14. Reproductive/Infertility services including but not limited to: birth control; except as specifically provided in the policy, family planning; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; premarital examinations; tubal ligation; vasectomy; sexual reassignment surgery;
15. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Illness; except as specifically provided in the Policy;
16. Services, supplies and/or treatment for acupuncture; alopecia;
17. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline or chartered aircraft only while participating in a school sponsored activity;
18. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices unless specifically provided for in the Prosthetic and Orthotic Devices Benefit, or gynecomastia; other than as specifically provided in the Policy;

(continued)

## EXCLUSIONS AND LIMITATIONS

(continued)

19. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
20. Vision services and supplies related to eye refractions or eye examinations, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses, and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or service except when due to a disease process;
21. 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); and
22. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

The following items are not covered under this policy, as they are deemed to be elective surgery, elective treatment, not a covered medical expense, or not a medical necessity: Spinal manipulation; adoption and surrogate expenses; charges made by a relative (related by blood, marriage, or domestic partner); non-medical expenses; medical expenses for which the insured is not obligated to pay; non-covered prescription drugs; experimental treatment; complications from a non-covered benefit; educational expenses; travel expenses for a physician or other medical provider; expenses related to personal comfort; removal of breast or other implants (covered only if initial implant was not for cosmetic purposes and removal is medically necessary); penile prosthetic implants; genetic counseling; massage therapy and rolfing; occupational therapy supplies; wigs or artificial hairpiece; morbid obesity; tiredness; vision therapy; and, dandruff.

## TERMINATION OF COVERAGE

The insurance for Insured Persons will continue through the last day before the next semester starts. In addition, if a full-time student decreases his/her credit hours to below full-time status prior to the insurance deadline, he/she will lose the insurance eligibility. If no beneficiary is designated or surviving at the Covered Person's death, AmeriBen Solutions and/or the Company may, at its option, make payment to the executor or administrator of your estate, or to your surviving spouse, mother, father, child or children.

## COORDINATION OF BENEFITS

The purpose of this medical insurance policy is to assist in the payment of medical bills. It is not intended that a Insured Person receive benefits greater than his/her total allowable expenses. *This plan will coordinate benefits with any other valid and collectible insurance.*

Benefits paid by the Master Policy will not exceed: 1) any applicable Policy maximums; and, 2) 100% of the compensable expenses incurred when combined with benefits paid by any Other Valid and Collectible Insurance.

### Medicare or Medicaid

If a Covered Person is eligible for Medicare or Medicaid benefits, this plan may (or may not) be primary to Medicare or Medicaid. This is determined by Medicare or Medicaid regulations, as applicable. **NOTE: THE HEALTH CENTER AT AURARIA IS NOT A MEDICARE OR MEDICAID PROVIDER.**

## HOW TO FILE A CLAIM

1. **Do Not Turn Claims into the Health Insurance Office on Campus or to AmeriBen Solutions.**
2. For charges incurred at the Health Center at Auraria, no claim form is required. Payment is required at the time of service for charges that are incurred at the Health Center that are not covered under the provision of the Plan.
3. If you or a covered dependent go to a P.P.O. Hospital or P.P.O. Physician the provider is obligated by contract to submit a claim for you.
4. Claim forms are available at the Student Insurance Office. Call **(303) 556-3873**.

Attach all related bills to a claim form and mail to (must include diagnostic [ICD9] and medical procedure CPT codes):

**Mountain Medical Affiliates (MMA)**  
**5889 S. Greenwood Plaza Building**  
**Suite 200**  
**Greenwood Village, CO 80111**  
**Metro Group #0801031**

The following can assist you when receiving service from a participating provider:

- a. Make certain the hospital or Physician is a participating network provider by calling the phone numbers listed on page 28.

(continued)

## HOW TO FILE A CLAIM (continued)

- b. Always present your insurance identification card to the hospital or physician's office at the time of service.
  - c. Do not pay the hospital or physician bill at the time of service. Allow the claim to be processed by AmeriBen Solutions before paying your portion.
  - d. If there are other questions, contact AmeriBen Solutions. See page 28 for a listing of important phone numbers.
5. Save all bills as evidence of your claim. Bills must be complete. Each bill should show:
- a. Patient's full name.
  - b. Date or dates the service was rendered or purchase was made.
  - c. Nature of the sickness or injury (ICD9 code).
  - d. Type of service or supply furnished (CPT procedure code).
  - e. Itemized charges.

## DISPUTED CLAIMS

If you have reason to believe a claim in part or whole has not been settled properly, or a claim has been improperly denied, the following process applies:

Contact **AMERIBEN SOLUTIONS (800-953-1801)** and ask for a second review within sixty (60) days after the claim payment date of the notice of denial of benefit. The claim will then be reviewed by another Benefit Administrator from AmeriBen Solutions.

*If the result of this review is not satisfactory:*

Contact **AmeriBen Solutions 800-953-1801**. Include the name of the student, Social Security number, and name of the patient, stating in clear and concise terms the reason(s) for disagreement with the handling of the claim. Health Center at Auraria, AmeriBen Solutions and The MEGA Life and Health Insurance Company will analyze all preceding efforts and will conduct their own review. The claimant shall be notified promptly of the findings, but not later than 120 days after the request for review, with copies of pertinent plan documents upon which any declination was based.

## PROOF OF LOSS DEADLINES

You have 90 days after the date of loss to furnish proof of loss to AmeriBen Solutions. If you do not furnish notice of proof within the time allotted, your claim will still be considered if you show that it was not reasonably possible to furnish the notice of proof and that the notice of proof (continued)

## PROOF OF LOSS DEADLINES

(continued)

was furnished as soon as reasonably possible. Except for absence of legal capacity, no claim for benefit will be accepted after one year from date treatment was completed.

AmeriBen Solutions and Metropolitan State College of Denver reserve the right and opportunity to examine the person whose injury or sickness is the basis of a claim as often as it may reasonably require during continuance of the claim.

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed. Nor shall action be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the Policy. If any time limitation of the Policy with respect to giving notice, filing proof of loss or commencing an action at law or in equity is less than permitted by the law of the state in which you reside at the time the Policy is issued, the limitation is hereby extended to agree with the minimum period permitted by such law.

## EXTENSION OF BENEFITS

Should a Covered Person be totally Disabled when coverage terminates under the policy, covered medical expenses will be payable up to the plan's maximum amount during the continuance of total Disability. However, all such payments cease on the earliest of the following: 1) When the Covered Person is no longer totally Disabled; 2) If the Covered Person becomes eligible for coverage under any other group insurance policy or under any group medical benefits or service plan; 3) At the end of the following 3 months after termination of insurance; or 4) Ninety (90) days after termination of the master group policy or major medical expense benefits under the policy.

The coverage provided under the policy ceases on the Termination Date. However, if an Insured incurs medical expenses within 30 days of the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, covered medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues:

- 1) When not Hospital Confined on the termination Date, not to exceed 90 days after the Termination Date; or
- 2) When Hospital Confined on the Termination Date, not to exceed 90 days after the Termination Date.

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

If the Insured is also an Insured under the succeeding policy issued to the Policyholder; this "Extension of benefits" provision will not apply.

## DEFINITIONS

**Coinsurance** means a provision of the insurance by which the Insured Person and the insurance carrier share in a specified ration (e.g. 80% / 20%, 100% / 0%) the payment of hospital or medical expenses resulting from an Sickness or Injury.

**Copayment** means a charge for Covered Medical Expense which must be paid by the Insured Person.

**Covered Medical Expenses** means reasonable charges which are: 1) not in excess of Usual and Customary charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

**Deductible** means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a Deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

**Domestic Partner** is defined on the "Affidavit of Domestic Partnership" which can be obtained at the Student Insurance Office located in the Health Center at Auraria, Plaza Building 150. Domestic Partners are eligible to enroll by completing the Affidavit of Domestic Partnership and submitting the executed Affidavit along with the appropriate payment.

**Dependent** means the spouse (husband or wife) of the Named Insured, and their dependent, unmarried children, adopted children and children in the custody of the Named Insured pursuant to an interim court of adoption, step children living with the Named Insured and children for which the named Insured is under court order to provide coverage. An adopted child shall be eligible for coverage on the same basis as other covered children. Coverage for a child the Named Insured adopts shall include the necessary care and treatment of medical conditions existing prior to the date of placement if adoption or placement occurs while the insurance is in effect for the Named Insured. Children shall cease to be dependent on the first to occur of:

- 1) The end of the month in which they marry; or,

(continued)

## DEFINITIONS (continued)

2) The end of the month in which they attain the age of nineteen (19) years.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

- 1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and,
- 2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

**Elective Surgery and Elective Treatment** means those health care services or supplies that do not meet the health care need for an Sickness or Injury. Elective Surgery or Elective Treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

**Injury** means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

**Insured Person** means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate dependent premium has been paid. The term "Insured" also means Insured Person.

**Preferred Provider Organization (P.P.O.)** The Mountain Medical affiliates (MMA) VADS network of hospitals and physicians are the P.P.O. medical providers. See the "Summary of Benefits" section.

(continued)

## DEFINITIONS (continued)

**Sickness** means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness.

**Physician** means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person's within the third degree by the laws of consanguinity or affinity.

**Plan Year** means a twelve (12) month period beginning each Fall semester and specifically defined by the College as the academic year.

**Pre-existing Condition** means any condition for which an Insured Person: 1) incurred charges; 2) received medical treatment; 3) consulted a health care professional; or 4) took Prescription Drugs within the 6 months immediately prior to the Insured's Effective Date under this policy. "Pre-existing Condition" does not include pregnancy.

**Usual and Customary Charges** means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

**Voluntary Participant** means Students who are taking 6 to 9 credit hours in the Fall or Spring semesters or 6 to 7 credit hours in the Summer semester are eligible to become Voluntary Participants. You must actively attend classes for at least the first 31 days of the period for which coverage is purchased, except in the case of medical withdrawal. If a participant was enrolled in the insurance plan during the previous Spring semester, he/she may enroll during the Summer not dependent on enrollment in classes.

## **CLAIM PROCEDURES**

**Send claims to:  
Mountain Medical Affiliates (MMA)  
5889 S. Greenwood Plaza Building, Suite 200  
Greenwood Village, CO 80111  
Group #0801031**

Claims will be handled by and further information can be obtained from the claims administrator, AmeriBen Solutions.

Claim forms are available at the Health Center at Auraria, (303) 556-3873.

## **CLAIMS, ELIGIBILITY AND BENEFITS QUESTIONS**

AmeriBen Solutions  
(800) 953-1801  
Group #0801031

## **PREFERRED PROVIDER ORGANIZATION**

Mountain Medical Affiliates (MMA) VADS Network  
Local Number for PPO Information 303-290-6451  
Toll-Free Number for PPO Information 800-647-1856

## **HEALTH CARE MANAGEMENT PROGRAM**

Mountain Medical Affiliates (MMA)  
For Pre-admission Notification  
Local Number 303-770-4088  
Toll-Free Number 800-942-4662

## **INSURANCE COMPANY**

The MEGA Life and Health Insurance Company  
Form Number: 98-BR-CO (461)  
Policy Number: 2003-461-1

## **IMPORTANT NOTICE**

Federal regulations now permit the time you are on the MSCD Student Health Insurance Plan to be counted as credit toward satisfying pre-existing condition clauses in future health insurance plans you may participate in after you leave the College.

These regulations provide that, when your College sponsored plan terminates (for example, your academic studies at MSCD are completed, or your eligibility under this plan ends, or you waive out of this plan with proof of outside insurance coverage), you are eligible to receive a certificate showing the amount of time you were covered under the College policy.

To obtain a certificate, please send a written request to MSCD Health Insurance Office, P.O. Box 173362, Campus Box 20, Denver, CO 80217-3362. Include your name, mailing address, social security number and telephone number. Specify whether the certificate is for you, or your dependents (give names and social security numbers of dependents for whom a certificate is requested).

## **PRIVACY POLICY**

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of The Mega Life and Health Insurance Company's privacy practices by calling them toll-free at 800-767-0700 or visiting them at [www.studentresources.net](http://www.studentresources.net).