

Student Health Insurance Plan

(Mandatory With Right of Waiver)

Network Plan - 80% in-network,
60% out-of-network, \$100 annual deductible

Designed For The Students Of

RmCAD[®]

Rocky Mountain College of Art + Design

Denver, Colorado

2009 - 2010

Policy Number:

CUH201682

Group Number:

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TO THE STUDENTS OF ROCKY MOUNTAIN COLLEGE OF ART + DESIGN

Rocky Mountain College of Art + Design is pleased to sponsor this Health Insurance Plan.

If you do not have personal or family injury or sickness insurance coverage now, please read this brochure carefully. You should consider the advantages as they relate to your personal needs as well as coverage while attending Rocky Mountain College of Art + Design.

All students enrolled in 9 or more credit hours must carry health insurance coverage. Unless a health insurance waiver form and accompanying proof of current external insurance coverage is provided annually, students enrolled for 9 or more credit hours will be automatically enrolled in the College sponsored plan. **IMPORTANT! THIS COVERAGE COORDINATES WITH ANY OTHER INSURANCE YOU MAY HAVE.** You must submit a new health insurance waiver form annually if you do not wish to be added to the College's health insurance plan. The priority waiver deadline for the Fall term is August 1, 2009 and is subject to the refund policy set forth by the College. The priority waiver deadline for the Spring term is January 1, 2010 and is subject to the refund policy set forth by the College. Waivers are valid for one academic year only (fall term through the following summer term). Health insurance waiver forms are available through the Dean of Students.

Even if you already have health insurance, please read about this special low-cost insurance plan anyway. It might be of additional help to you.

Please contact the Dean of Students if you have any questions.

ELIGIBILITY

All students carrying 9 credit hours or more who do not waive coverage under this plan will be insured for the period for which premium has been paid, including interim vacations. Coverage begins on August 28, 2009 or the date of enrollment in the plan, whichever is later.

Students must actively attend classes for at least the first 31 days beginning with the first day for which coverage is purchased. The Company maintains the right to investigate student status and attendance records to verify that Policy eligibility requirements have been met. If the Company discovers that the Policy eligibility requirements have not been met, coverage will be terminated. Eligibility requirements must be met each time a premium is paid (start of both the fall and spring academic terms) to continue coverage.

Newborn children are covered for Injury or Sickness from birth until 31 days old. After 31 days since birth have passed, the newborn no longer has coverage under this plan.

SUMMER SESSION COVERAGE

Summer Session Coverage Available – If you were covered during the previous Spring term your coverage will continue during the summer months, regardless of your enrollment in summer classes, and without any additional premium cost. If you were not covered during the Spring term, but are enrolled in 9 or more credit hours for the Summer term and do not have a waiver on file with the College, you will be added to this plan and billed through the College for the premium.

EFFECTIVE DATES AND RATES

Annual: 8/28/09-8/27/10

Student: \$1,819

Fall: 8/28/09-1/10/2010

Student: \$910

Spring/Summer: 1/11/2010-8/27/2010

Student: \$910

EFFECTIVE DATE AND TERMINATION DATE

An eligible student's coverage becomes effective on the first day of the term or in the event of a qualifying event, the date of the qualifying event if the application and full premium is received within 31 days of the qualifying event or if not, the date the application and full premium are received by the College, whichever is later. Coverage terminates the earlier of: the last day of the period for which premium is paid; or the date the Covered Person enters full time military service. Upon request, the Company will refund the unearned pro rata premium for persons entering full-time military service.

EXTENSION OF BENEFITS AFTER TERMINATION

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the 60 day period following such termination of insurance.

COORDINATION OF BENEFITS PROVISION

Benefits under this insurance will be coordinated with benefits under other group insurance that the Covered Person may have so that no more than 100% of expenses incurred will be paid by all insurance combined.

DEFINITIONS

Covered Charge or Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification. Whenever the Policy provides for reimbursement for any service that may be lawfully performed by a person licensed in Colorado for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, podiatry, reimbursement under the Policy shall not be denied when such service is rendered by a person so licensed. This shall also

(Definitions continued)

include registered professional nurses and licensed clinical social workers.

Injury means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student while insured under this Plan.

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

Loss means medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan, and other expenses as specifically covered.

Medical Emergency means the unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective or routine care.

Medically Necessary means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Insured Person or provider;
- (b) it is not the appropriate treatment for the Insured Person's diagnosis or symptoms;
- (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Reasonable and Customary Expenses means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

Sickness means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us and Our means the Combined Insurance Company of America.

You, Your or Yours means the Insured Student.

PREFERRED PROVIDER NETWORK

Utilizing the PHCS Preferred Provider Network will decrease your out of pocket costs under this Accident and Sickness Insurance Plan. The PHCS Network consists of hospitals, physicians and other health care providers, which are organized into a network for the purpose of delivering quality health care at a preferred fee. In order to use the services of a participating provider you must present your Combined Insurance Company of America Medical Identification Card. An Insured Person may contact PHCS at 1-800-672-2140, toll free number available Monday through Friday, 8:00 a.m. to

8:00 p.m. Pacific Time to receive information on participants in their area, or visit their web site at www.multiplan.com.

PRE-EXISTING CONDITIONS LIMITATION

“**Pre-existing Condition**” is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months prior to the Effective Date of the Insured Person’s coverage under this Policy.

The Pre-existing Condition Waiting Period is six (6) months. If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a six (6) consecutive month period has passed from the Insured Student’s effective date, and (b) We will pay only for Loss or expense incurred after such six (6) consecutive month period. The Pre-existing Condition Waiting Period shall not apply to a child that is adopted or placed for adoption before attaining eighteen (18) years of age or to pregnancy.

We shall waive the Pre-existing Condition Waiting Period for that period of time an Insured Person was previously covered by Creditable Coverage if such Creditable Coverage was continuous to a date not more than ninety (90) days prior to the Effective Date of the Insured Person’s coverage under this Policy.

Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage of more than ninety (90) days, the Pre-existing Condition Waiting Period will have to be satisfied again.

“**Creditable Coverage**” includes any of, or a combination of, the following: (a) a group health plan; (b) a health insurance plan or health maintenance organization (HMO) plan; (c) an individual health insurance policy; (d) COBRA continuation of coverage; (e) a health benefit plan under Chapter 55, Title 10, United States Code pertaining to members of the uniformed services of the United States; (f) Medicare or Medicaid; (g) a medical care program of the Indian Health Service or of a tribal organization; (h) a state health benefits risk pool; (i) a health plan offered under FEHBP (Chapter 89 of Title 5, United States Code); (j) a health plan under Section 5(e) of the Peace Corps Act; or (k) a public health plan.

EXCLUSIONS

1. For services or supplies rendered by a close relative of the Insured Person. By “close relative” We mean an Insured Person’s spouse, children, parents, brothers and sisters;
2. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
3. Preventative medicines, serums, immunizations, or vaccines, except as specifically provided, refer to page 8;
4. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;
5. Injury due to participation in a riot;

(Exclusions continued)

6. Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law;
7. Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor;
8. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
9. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part;
10. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;
11. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasik or other vision procedures except as required for repair caused by a covered Injury;
12. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports;
13. Care and/or treatment in skilled nursing facility, except as specifically provided;
14. Organ transplants; except as specifically provided;
15. Hospice services, except as specifically provided;
16. Pre-existing Conditions as defined in this Policy;
17. Nonprescription drugs or medicines;
18. Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;
19. Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;
20. Services incurred prior to the Insured Person’s Effective Date or during Hospital Confinement in one or more facilities, which began prior to the Insured Person’s Effective Date;
21. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain;
22. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;
23. Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community. Also services and supplies in connection with Experimental or Investigational Care for the terminally ill;
24. Charges for treatment of any Injury or Sickness due to an Insured Person’s commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;

(Exclusions continued)

25. Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;
26. For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;
27. Expense covered by any other valid and collectible medical, health or accident insurance;
28. Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; calluses; bunions, except open cutting operations; routine care of toenails, except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet; and any tarsalgia, metatarsalgia. Expenses incurred for the care and treatment of Injury or infection, or disease are not excluded;
29. Screening examinations, including X-ray examinations made without film, except as specifically provided;
30. Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination, and services or supplies for inducing conception;
31. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
32. Inpatient charges for physical therapy or diagnostic services if physical therapy and diagnostic services are available on an outpatient basis;
33. Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;
34. Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;
35. Marriage, family, and group counseling;
36. Well baby care, including routine exams and immunizations, except as specifically provided;
37. Routine periodical physical examinations, except as specifically provided, refer to page 8;
38. Expenses incurred for allergy testing and allergy treatment;
39. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
40. Expenses for any service or supply not specified in this Policy as a covered service;
41. An amount of a charge in excess of the Reasonable and Customary Expense;
42. Elective Treatment or elective surgery, except as specifically provided;
43. Services not Medically Necessary;
44. Expenses for emergency room treatment for an Injury or Sickness not a Medical Emergency as defined in this Policy, including emergency "follow-up" visits;
45. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile;
46. Suicide, attempted suicide, or intentionally self-inflicted injury, whether sane or insane;
47. Expense incurred for: tubal ligation; vasectomy; breast

(Exclusions continued)

- implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; and learning disabilities or disorders;
48. Expenses incurred for Attention Deficit Disorder;
49. Voluntary or elective abortion;
50. Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs except as noted, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery;
51. Illegal drugs;
52. Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit; pre-natal vitamins, except as specifically provided;
53. Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;
54. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;
55. Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;
56. Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Plan, provided they are obtained within four months of the date of the Injury;
57. Expense for hair replacement, wigs or wig maintenance;
58. Any treatment, service or supply in excess of the maximum benefit specified in this Policy;
59. Care, treatment or supplies furnished by a program or agency funded by any government;
60. Nicotine addiction.

WELLNESS BENEFIT

The following wellness benefits are paid at 80% of PPO Allowance for in-network providers or 60% of Reasonable & Customary Charges for out-of-network providers up to a maximum of \$500.

Well-Adult Care

- Immunizations
 - Influenza Vaccination (flu shot) once per plan year
 - Pneumococcal Vaccination (Pneumovax) one dose for persons 65 and over
 - Three doses of HPV Vaccine
 - Two doses of MMR for Students who were not previously Inoculated
 - One dose of Meningococcal Immunization
- Screenings
 - Cholesterol screening including triglycerides, LDL, HDL or lipid panel once every five years beginning at age 20
 - Mammogram annually starting at age 40
 - Pap smear and routine pelvic exam once each plan year beginning at age 18
- One annual routine physical

24-HOUR NURSE ADVICE LINE

Students may utilize the Nurse Advice Line anytime they need confidential medical advice. On Call International provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in the Student Accident and Sickness Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives Insured students access to a toll-free nurse information line 24-hours a day, 7 days a week. To access a wealth of useful health care information, contact the Nurse Advice Line.

Contact On Call International toll free from U.S. and Canada at 1-800-850-4556 or call collect worldwide: 1-603-898-9159.

REPATRIATION OF REMAINS EXPENSE

If you die while insured under this policy, We will pay the actual expenses incurred for preparation and transportation to your home country (in accordance with the applicable international requirements) the remains of the deceased's body, but not to exceed \$10,000 in the aggregate. This benefit is payable in addition to any other benefit of this policy.

Repatriation of Remains Expense must be approved in advance by the Company.

MEDICAL EVACUATION EXPENSE

When as a result of a Covered Accident or Sickness, you are hospitalized for five (5) days, or more, We will pay, upon the recommendation and approval of the attending Physician, for your evacuation to your natural country, or to a facility operated pursuant to the law for the care and treatment of injured or ill persons, the actual expense incurred, but not to exceed \$15,000 in the aggregate. This benefit is payable in addition to any other benefit of this policy.

Emergency Medical Evacuation must be approved in advance by the Company.

TRAVEL ASSISTANCE SERVICES

Included in this health insurance program is access to a 24-hour worldwide assistance network for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance.

The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency Physicians in the United States.
3. Urgent message relay between family, friends, personal physician, school, and insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations and repatriations.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact On Call International for any of these services:
Toll Free from U.S. and Canada: 1-800-850-4556
Call Collect Worldwide: 1-603-898-9159
www.oncallinternational.com

SCHEDULE OF BENEFITS

Benefits will be paid up to the Maximum Benefit for each service as described below.

	In Network	Out of Network
Lifetime Maximum	\$250,000	\$250,000
Annual Deductible	\$100	\$100
Out of Pocket Maximum (after the deductible, excluding copays)	\$10,000	\$10,000
COVERED MEDICAL EXPENSES:		
Hospital Room & Board/Hospital In-patient Miscellaneous (Including nursing care, the cost of pre-admission testing, the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Intensive Care	80% of PPO Allowance	60% of Reasonable & Customary Charges
Day Surgery Miscellaneous (Including the cost of the operating room; laboratory tests, x-ray examinations, anesthesia; drugs or medicines, and supplies)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Surgery - Inpatient & Outpatient (When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50 percent of the Covered Percentage of the Covered Charge for these procedures.)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Assistant Surgeon	80% of PPO Allowance	60% of Reasonable & Customary Charges
Anesthetist	80% of PPO Allowance	60% of Reasonable & Customary Charges
Doctor's Visits (Benefits are limited to one visit per day and do not apply when related to surgery.)	100% after \$30 copay	100% after \$30 copay
Doctor's Visits-Inpatient (Benefits are limited to one visit per day and do not apply when related to surgery.)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Urgent Care	80% of PPO Allowance	60% of Reasonable & Customary Charges
Consultant Doctor Fees - Inpatient & Outpatient (when requested and approved by the attending Doctor)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Physiotherapy - Inpatient & Outpatient	80% of PPO Allowance	60% of Reasonable & Customary Charges
Registered Nurse's Services (Private duty nursing care)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Emergency Room	80% of PPO Allowance	60% of Reasonable & Customary Charges
Ambulance	80% of PPO Allowance	60% of Reasonable & Customary Charges
X-Ray & Laboratory - Inpatient & Outpatient	80% of PPO Allowance	60% of Reasonable & Customary Charges
Tests & Procedures (Diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Braces & Appliances	80% of PPO Allowance	60% of Reasonable & Customary Charges
Prescription Drugs (Out-patient)	Generic \$10, Brand \$20, Formulary \$20	
Dental Treatment (Made necessary by Injury to Sound, Natural Teeth)	\$200 per tooth	\$200 per tooth
Maternity & Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Mental or Nervous Disorders (In-patient)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Mental or Nervous Disorders (Out-Patient)	50% of PPO Allowance otherwise payable, if any, up to a maximum of \$5,000 per Policy Year	50% of Reasonable & Customary Charges otherwise payable, if any, up to a maximum of \$5,000 per Policy Year
Mental or Nervous Disorders (Biologically Based)	Paid as any other Sickness	Paid as any other Sickness
Alcoholism (In-Patient)	80% of PPO Allowance	60% of Reasonable & Customary Charges
Alcoholism (Out-Patient)	50% of PPO Allowance up to a maximum of \$500 per Policy Year	50% of PPO Allowance up to a maximum of \$500 per Policy Year
Wellness Benefit (\$500 maximum benefit, see page 8 for more details)	80% of PPO Allowance	60% of Reasonable & Customary Charges

PRESCRIPTION DRUG BENEFIT

The outpatient prescription drug program is available through the Express Scripts Pharmacy Network. The Express Scripts Pharmacy Network includes national pharmacy chains such as CVS, Brooks Pharmacy, Rite Aid, and Walgreens as well as local independent pharmacies. After a \$10.00 co-payment for a 30-day supply of a generic drug and a \$20.00 co-payment for a 30-day supply of a brand name drug, and a \$20.00 co-payment for formulary drug, a prescription will be reimbursed at 100% up to a maximum of \$3,000.00 per policy year. Insured Persons use their student health insurance ID card to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving the ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained at www.summitamerica-ins.com). To locate a participating Express Scripts Pharmacy, please call 1-877-868-9060 or visit their website at www.Express-Scripts.com.

Mail Service Prescription Drug Program

Medications that are taken for a chronic condition can be filled for up to a 90-day supply using Express Scripts' Mail Service Prescription Drug Program. Using the Mail Service Prescription Drug Program, a 90-day supply of a medication can be filled with a co-payment that is 2 times the co-payment of a 30-day supply.

When you use the Mail Service Prescription Drug Program you will need to complete an "Express Scripts By Mail" Order Form and mail it directly to Express Scripts along with your doctor's signed prescription form. After submitting your initial prescription, additional prescriptions can be filled by going online to www.Express-Scripts.com.

DISCOUNT DENTAL, PHARMACY AND VISION CARD

The Discount Dental, Pharmacy and Vision Card is a discount medical plan that provides discounts at certain healthcare providers for medical services. For provider locations or to obtain plan information, please visit www.locateproviders.com or call Member Services at 800-800-7616. The Discount Medical Plan does not make payments directly to the providers for medical services. The plan member is obligated to pay for all health services provided but will receive a discount from those providers who have contracted with the discount plan organization, New Benefits, Ltd. 14240 Proton Rd., Dallas, TX 75244. New Benefits will provide a fulfillment kit which will be mailed to each member containing the Discount Card and information booklet.

MANDATED BENEFITS

Mental and Nervous Conditions Expense Benefit

If an Insured Person requires treatment for a Mental or Nervous Condition, We will pay for such treatment on the same basis as any other Sickness, as follows:

Benefits for Inpatient Hospital Confinement and Partial Hospitalization:

We will pay the Covered Percentage of the Covered Charges incurred for inpatient or partial hospitalization in a Hospital or psychiatric hospital licensed by the Colorado Department of Public Health and Environment for Medically Necessary treatment of mental or nervous conditions. Benefits are limited in any 12 month period to:

- (a) 45 days for inpatient care; or
- (b) 90 days for partial hospitalization.

Each two days of partial hospitalization care will reduce by one day the 45 days available for inpatient care. Each day of inpatient care will reduce by two days the 90 days available for partial hospitalization. Each day of inpatient care in a Hospital or psychiatric hospital or each two days of partial hospitalization will reduce by one day the available days for treatment of alcoholism.

Benefits for Outpatient Services:

We will pay the Covered Percentage of the Covered Charges incurred for outpatient services for treatment of mental or nervous conditions furnished by: (a) a comprehensive health care service corporation; (b) a Hospital; or (c) a community mental health center; or (d) other mental health clinic approved by the Department of Human Services to furnish mental health services; or (e) a registered professional nurse within the scope of his license; (f) a licensed clinical social worker within the scope of his license; or (g) or under the supervision of a Physician, licensed psychologist or a LPC practicing within the scope of their license. All such services must be provided under the direct supervision of a physician or licensed psychologist. The Insured Person's patient records must show that the attending physician or licensed psychologist either saw the Insured Person or had a written summary of consultations or a personal consultation with the therapist at least once every 90 days.

Mental or Nervous Conditions: This term means those conditions listed in the standard nomenclature of the American Psychiatric Association, but does not include autism.

Partial Hospitalization: means continuous treatment for at least 3 hours, but not more than 12 hours in any 24 hour period.

(Mandated Benefits continued)

Alcoholism and Drug Abuse Expense Benefit

We will pay the Covered Percentage of Covered Charges incurred by an Insured Person for the Medically Necessary treatment of alcoholism and drug abuse.

Benefits for such treatment will be paid as they would for any other Sickness, subject to the following limits for each Insured Person:

(a) Inpatient care provided by a Hospital or any other public or private facility or portion thereof providing services especially for the treatment of alcoholism or drug abuse which is licensed by the Department of Health to provide such services shall not exceed 45 days per Insured Person in any Policy Year. Each day of confinement as an inpatient shall reduce by one day the days payable under the Policy for treatment of mental and nervous disorders.

(b) Outpatient care made by a Hospital or any other public or private facility or portion thereof providing services especially for the treatment of alcoholism or drug abuse which is licensed by the Department of Human Services to provide such services, or any mental health facility approved as such by the Department of Human Services, shall not exceed \$500 per Insured Person in any Policy Year.

Benefits will not be payable under this benefit unless the Insured Person has completed the full continuum of care, including detoxification and rehabilitation. What We pay is shown in the Plan of Insurance.

Alcoholism: This term means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse: This term means a condition which is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Maternity and Newborn Child Expense Benefit

We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital. If 48 hours or 96 hours following a delivery falls after 8 p.m., coverage will continue until 8 a.m. the following morning.

Coverage for a Hospital stay for a newborn following a normal vaginal delivery will not be limited to less than 48 hours and following a cesarean section will not be limited to less than 96 hours. If 48 hours or 96 hours following a delivery falls after 8 p.m., coverage will continue until 8 a.m. the following morning. These lengths of stay do not apply in any case in

(Mandated Benefits continued)

which the decision to discharge the newborn prior to the minimum length of stay is made by the attending Doctor in agreement with the mother of the newborn. This provision does not require an Insured Person to give birth in a Hospital or to stay in a Hospital for a fixed period of time after the birth of her child.

For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child who have a shorter Hospital stay, We will pay for one home visit scheduled within 24 hours after Hospital discharge; and an additional home visit if prescribed by an attending provider.

Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

Covered Charges also include Doctor prescribed pre-natal vitamins.

Covered Charges include Medically Necessary treatment of a newborn child born with cleft lip and/or palate as follows:

- (a) Oral and facial surgery, surgical management, and follow up care by plastic surgeons and oral surgeons;
- (b) Prosthetic treatment such as obturators, speech appliances and feeding appliances;
- (c) Medically necessary prosthodontic treatment;
- (d) Otolaryngology treatment;
- (e) Audiological assessments and treatment;

Covered Charges also include Medically Necessary treatment physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities for newborn children up to five years of age who are covered under the Policy. Visits for such therapy will be limited to the greater of:

- (a) the number of visits provided under the policy for such therapy, if any; or
- (b) 20 therapy visits per Policy Year each for physical therapy, occupational therapy and speech therapy.

Visits will be distributed as medically appropriate throughout the year without regard to whether: (a) the condition is acute or chronic and (b) the purpose of the therapy is to maintain or to improve functional capacity.

We cover such charges the same way We treat Covered Charges for any other Sickness.

(Mandated Benefits continued)

Mammographic Examination Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for mammographic exams, not to exceed \$65.37*. The charges must be incurred while the Insured Person is insured for these benefits.

Benefits will be paid for mammographic exam charges incurred for the following:

One baseline Mammogram for a woman thirty-five years of age and under forty years of age;

One Mammogram every two years for a woman forty years of age and under fifty years of age, but once a year for a woman with risk factors to breast cancer as determined by a Doctor;

One Mammogram every year for a woman fifty years of age to sixty-five years of age.

We cover such charges the same way We treat Covered Charges for any other Sickness, except that this benefit is not subject to any Deductible provision.

Mammogram means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.

*This amount will be updated each September to reflect the most recent annual national Consumer Price Index-Urban (CPI-U) Published by the U.S. Bureau of Labor and Statistics.

Cytologic Screening (Pap Smear) Expense Benefit

We cover charges for Expenses incurred for an annual Cytologic Screening (Pap Smear) or more frequently when recommended by a Doctor, nurse practitioner, or a certified nurse midwife. Such benefits will include the examination, laboratory fee, and the Doctors interpretation of the laboratory results. We cover such charges the same way We treat Covered Charges for any other Sickness.

Cytologic Screening: This term means a pap test to detect cervical cancer through the simple microscope examination of cells scraped from the surface of the cervix.

Ambulance Expense Benefit

When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury

(Mandated Benefits continued)

or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

Consultant Expense Benefit

If by reason of Injury or Sickness, an Insured Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Doctor for the purpose of confirming or determining a diagnosis, We will pay the Covered Percentage of the Covered Charges incurred.

Licensed Nurse Expense Benefit

If by reason of Injury or Sickness, an Insured Person requires the service of a licensed nurse or licensed practical nurse during a Hospital Confinement, We will pay the Covered Percentage of the Covered Charges incurred subject to the Deductible shown in the Plan of Insurance.

Pre-Admission Tests Expense Benefit

Notwithstanding any provision in the Policy to the contrary, We will pay benefits for Covered Charges made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to the Insured Person's admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within seven days of pre-surgical tests; and (d) the Insured Person is physically present at the Hospital for the tests.

No benefit shall be payable under this provision in excess of either: (1) the benefits that would have been provided under this Policy had the Insured Person received those tests while confined in the Hospital as a resident bed-patient; or (2) the Miscellaneous Hospital Expense Maximum shown in the Plan of Insurance for the Miscellaneous Hospital Expense Benefit.

If, by reason of similar benefit provisions elsewhere contained, the Policy provides for reimbursement for the same charges, no benefits shall be payable under these provisions, except to the extent by which the amount of benefit produced under those provisions for a given charge exceeds the amount of benefits produced for that same charge under this provision.

This provision shall apply with respect to the Insured Person only to the extent that the Insured Person is insured under this Policy for Hospital Expense Benefits.

Prosthetic Appliance and Orthotic Device Expense Benefit

If, by reason of Injury or Sickness, an Insured Person requires the use of a Prosthetic Appliance or Orthotic Device, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for the purchase, initial fitting, and needed adjustment of such appliances or devices, as shown in the Plan of Insurance.

Covered Charges are limited to the most appropriate model that adequately meets the medical needs of the Insured Person as determined by the Insured Person's treating Doctor.

(Mandated Benefits continued)

Repairs and replacement of Prosthetic Appliances or Orthotic Devices are also covered unless necessitated by misuse or loss.

Prosthetic Appliance means a device, or artificial appliance, that: (1) maintains or replaces the body part of an Insured Person whose covered Injury or Sickness has required the removal of that body part; and (2) is prescribed by the Insured Person's Doctor who documents the necessity for the item.

Orthotic Device means a mechanical device, such as braces (but not dental) or shoes, that: (1) is directly related to the treatment of an Injury or Sickness; and (2) is prescribed by the Insured Person's Doctor who documents the necessity for the item.

Biologically Based Mental Illness Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for treatment of biologically based mental illness, including:

- (a) Schizophrenia;
- (b) Schizoaffective disorder;
- (c) bipolar affective disorder;
- (d) major depressive disorder;
- (e) specific obsessive-compulsive disorder; and
- (f) panic disorder.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Prostate Cancer Screening Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for an annual screening for the early detection of prostate cancer in men who are covered under the policy according to the following guidelines:

- (a) for men over age 50, one screening each year; and
- (b) for men 40 to 50 years of age who are at increased risk of developing prostate cancer as determined by the man's Doctor, one screening each year.

Benefits are limited to the lesser of:

- (a) \$65 per prostate screening; or
- (b) the actual charge for such screening.

The screening must be performed by a qualified medical professional. This includes a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner or physician assistant. The screening will consist, at a minimum, of the following tests: (a) a prostate-specific antigen (PSA) blood test; (b) digital rectal examination.

We cover such charges the same way We treat Covered Charges for any other Sickness, except that this benefit is not subject to any Deductible provision.

(Mandated Benefits continued)

Child Health Supervision Services Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for child health supervision services (preventive services and immunizations) for Dependent children up to 31 days of age who are covered under the Policy as follows:

One newborn home visit during first week of life if the newborn is released from the Hospital less than 48 hours after delivery, 5 Well-Child Visits, 1 PKU, Immunizations as recommended by the American Academy of Pediatrics.

Well Child Visit means a visit to a Doctor that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment.

Child health supervision services rendered during a periodic review is covered only to the extent such services are provided during the course of one visit by or under the supervision of a single physician, physician's assistant or registered nurse.

We cover such charges the same way We treat Covered Charges for any other Sickness, except that this benefit is not subject to any Deductible or Maximum Benefit provision.

Inherited Metabolic Disease Expense Benefit Rider

We will pay the Covered Percentage of the Covered Charges incurred for amino acid modified preparations, Low Protein Modified Food products and formulas for therapeutic treatment of an Insured Person with Inherited Metabolic Disease if:

- (a) The Medical Food or Low Protein Modified Food products are prescribed as Medically Necessary for Inherited Metabolic Disease; and
- (b) The products are administered under the direction of a Doctor.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

"Inherited Metabolic Disease" means a disease caused by an inherited abnormality of body chemistry, and includes the following diagnosed conditions: phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia.

"Low Protein Modified Food Product" means a food product that is specifically formulated to have less than one gram of protein per service and intended to be used under the direction of a Doctor for the dietary treatment of an inherited metabolic disease.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles

(Mandated Benefits continued)

and formulated to be consumed or administered entirely under the direction of a Doctor.

Diabetes Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for equipment, supplies and outpatient diabetes self-management training and education for treatment of an Insured Person who has been diagnosed as having diabetes. This includes medical nutrition therapy. Prescribed diabetes outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. We cover such charges the same way We treat Covered Charges for any other Sickness.

Cervical Cancer Vaccine Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for the full cost of cervical cancer vaccination for all females up to age 20 for whom a vaccination is recommended by the advisory committee on immunization practices of the United States Department of Health and Human Services.

Colorectal Cancer Screening

Requirement is for one screening per year for the early detection of colorectal cancer in Insured Persons who are covered under the policy according to the following guidelines:

- (a) for Insured Persons over age 50, and
- (b) for Insured Persons who are at increased risk of developing colorectal cancer as determined by the Insured Persons's Doctor.

APPEAL PROCEDURE

If a claim is wholly or partially denied, a written notice will be sent to the Insured Person containing the reason for the denial. The notice will include a reference to the provision in the Plan description and a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal, along with any additional information or comments may be sent within six (6) months after notice of denial. In preparing the appeal, the Insured Person, or his representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an extension for further review will be granted, but not for longer than 60 additional days.

HIPAA PRIVACY RULE

Under HIPAA's Privacy Rule the Insurer is required to provide you with notice of the Insurer's legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your insurance identification card. If, at anytime, you wish to request a copy of Combined Life Insurance Company of New York's Privacy Notice, write to 5050 Broadway, Chicago, IL 60640 Attn: HIPAA Privacy Office, call 1-800-951-6206, select HIPAA or on-line at <http://www.combinedinsurance.com/customer-center/hipaa-insurance.html>.

CLAIM PROCEDURE

In the event of Injury or Sickness, the student should:

1. Report to a Physician or Hospital.
2. Obtain a claim form from the College or at www.summitamerica-ins.com. Please submit one claim form per policy year. Mail the completed claim form and all medical bills and copies of your other insurance carrier's Explanation of Benefits Statements to the address below.
3. Claims must be filed with all other insurance carrier(s) prior to filing under this plan.
4. File a claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.
5. Claim status can be checked online at www.summitamerica-ins.com.

Submit All Claims and Claims Inquiries to:

SUMMIT AMERICA INSURANCE SERVICES, L.C.

7400 College Blvd., Suite 100

Overland Park, KS 66210

www.summitamerica-ins.com

Call (877) 246-6997

Or e-mail claims related questions to:

claims@summitamerica-ins.com

Sales/Marketing Services:

Summit America Insurance Services

800-775-8089

Underwritten by:

Combined Insurance Company of America

Policy Number: CUH201682

**THIS PLAN WILL COMPLY WITH ALL
COLORADO INSURANCE REGULATIONS.**

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the College contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits. Any discrepancy between this brochure and the policy will be governed by the policy.