

PRE-EXISTING CONDITION LIMITATION

The Insurer does not pay benefits for loss due to a Pre-Existing Condition during the first 6 months of coverage. Pre-Existing Conditions will be covered after the Covered Person's coverage has been in force for 6 months. However, the Pre-Existing Condition Limitation is amended to include a credit for the time a Covered Person was covered by Creditable Coverage that was in effect not more than 90 days before the Covered Person's effective date under the policy. In addition, the Pre-Existing Condition limitation shall not be applied to a child that is adopted or placed for adoption before attaining age 18, or relating to pregnancy and does not apply to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit.

PREVENTATIVE HEALTH SERVICES

Provided at the Health Center at Auraria only. Benefits include one comprehensive physical per Policy Year and one HIV/syphilis test per year (includes pre/post test counseling). For men the benefit covers the office visit charge and may include a gonorrhea/chlamydia test, a hemoglobin, and urine test, as indicated. For men over 50 a hemocult and PSA test is included. For women, an annual examination includes the office visit charge and a Pap Smear. A Gonorrhea/Chlamydia test, a hemoglobin and a urine test may be done as indicated. For women over age 50 a hemocult test is included.

WHAT IS NOT COVERED?

Unless specifically provided for elsewhere under the Policy, the Policy does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. Expenses incurred in excess of Reasonable Expenses.
2. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health, except at the Health Center at Auraria.
3. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury.
4. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
5. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
6. For diagnostic investigation or medical treatment for infertility, fertility, or birth control.
7. Voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Physician. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.
8. Organ or tissue transplant.
9. Participating in an illegal occupation or committing or attempting to commit a felony.
10. For treatment, services, supplies, or Confinement in a Hospital owned or operated by a national government or its agencies. (This does not apply to charges the law requires the Covered Person to pay.)
11. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
12. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
13. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia.

14. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
15. Diagnosis and treatment of acne and sebaceous cyst.
16. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority; riot; or civil commotion
17. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight
18. Loss arising from:
 - a. participating in any intercollegiate/interscholastic or professional sport, contest or competition;
 - b. participating in any intramural sport competition, contest or competition;
 - c. participating in any club sport competition, contest or competition;
 - d. participating in any professional sport, contest or competition;
 - e. skin/scuba diving, sky diving, hang gliding or bungee jumping
19. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

WHO IS THE PPO NETWORK AND HOW DO I FIND PROVIDERS?

The PPO network is Aetna. To find providers, either go to the official company website at hthstudents.com, or access the network directly at www.aetna.com.

CLAIMS SUBMISSION

Claims are to be submitted to HTH Worldwide, PO Box 30259, Tampa, FL 33630, USA. See the hthstudents.com.

CLAIMS AND BENEFIT QUESTIONS

If you have questions on your benefits or claims, call HTH at 1-888-350-2002. They will need the certificate number that is printed on your ID card to answer claims and benefits questions.

WHAT ARE THE DATES AND COSTS FOR THIS PLAN?

The following are the dates for coverage under this plan:

Semester	Beginning	Through
Fall	08-01-2008	12-31-2008
Spring/Summer	01-01-2009	07-31-2009
Summer	05-15-2009	07-31-2009

(New Students)

The following is premium for coverage under this plan:

Semester	Participant	Add for Spouse	Add for One Child	Add for Child(ren)
Fall	\$645	\$2,210	\$900	\$1,725
Spring/Summer	\$903	\$3,094	\$1,260	\$2,415
Summer	\$335	\$1,117	\$463	\$875

(New Students)

This pamphlet contains a brief summary of the features and benefits for insured participants covered under Policy No. HM-2104-08. This policy complies with state mandated benefits for Colorado and therefore, Participants may be entitled to additional benefits. Please see the Certificate of Insurance on file with the school for more information. Any provisions of this certificate that may be in conflict with the laws of the state where the purchaser is located will be administered to conform with the requirements of that state's laws, including mandated benefits. If there is a difference between this program description and the certificate wording, the certificate controls.

UNIVERSITY OF COLORADO AT DENVER



Inbound International Plan 2008-2009

Blanket Student Accident and
Sickness Insurance

Administered by:

HTH Worldwide

1.888.350.2002
hthstudents.com

Questions on Enrollment
and Eligibility? Call:

UCDHSC, Downtown Denver Campus,
Student Insurance Office, 303-556-6273,
Tivoli Room 303

or

ECI at toll-free 866-780-3824,
direct 719-836-3824, fax 719-836-3825
or info@evansconsult.com

Underwritten by:



This blanket accident and sickness policy is
underwritten by the Highmark, Inc.
Insurance Company NAIC # 842-60314

WHO IS ELIGIBLE FOR COVERAGE?

All regular, full-time Eligible Participants and Eligible Dependents of the educational organization or institution who:

1. Are engaged in international educational activities; and 2. Are temporarily located outside his/her Home Country as a non-resident alien; and 3. Have not obtained permanent residency status.

International students with a visa status of F1, J1 and J2 will automatically be enrolled in the health insurance plan and the fee is added to the tuition account each semester. All other international students with a visa status of H1, H4, TN, R2 and PR who are taking 6 or more undergraduate credit hours or 3 or more graduate credit hours will be allowed to voluntarily enroll on the plan.

WHEN DOES COVERAGE START?

Coverage for an Eligible Participant and an Eligible Dependent starts at 12:00:01 a.m. on the latest of the following:

1. The effective date of the Policy; or 2. The Participating Organization's or Institution's Effective Date; 3. The effective date shown on the Insurance Identification Card, if any; 4. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

For dependents, coverage must begin when the Eligible Participant starts, or within 30 days of initial arrival in this country. Dependents cannot enroll at a later time, unless they are a Newborn.

Thereafter, the insurance is effective 24 hours a day, worldwide. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

WHEN DOES COVERAGE END?

Coverage for an Eligible Participant and an Eligible Dependent will automatically terminate on the earliest of the following dates:

1. The date the Policy terminates; 2. The Participating Organization's or Institution's Termination Date; 3. The date of which the Eligible Participant or the Eligible Dependent ceases to meet the Individual Eligibility Requirements; 4. The end of the term of coverage specified in the Eligible Participant's or Dependent's enrollment form, if any, including any requested extension; 5. The date the Eligible Participant or Eligible Dependent leaves the Country of Assignment for his/her or her Home Country; 6. The date the Eligible Participant or Eligible Dependent requests cancellation of coverage (the request must be in writing); or 7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.

WHAT TO DO IN THE EVENT OF AN EMERGENCY

All Eligible Participants are entitled to Global Assistance Services while traveling outside of the United States. In the event of an emergency, they should go immediately to the nearest physician or hospital without delay and then contact HTH Worldwide. HTH Worldwide will then take the appropriate action to assist and monitor the medical care until the situation is resolved. To contact HTH Worldwide in the event of an emergency, call 1.800.257.4823 or collect to +1.610.254.8771.

COORDINATION OF BENEFITS

The Insurer will reduce the amount payable under the Policy to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. The Policy is secondary coverage to all other policies. hthstudents.com. Once Eligible Participants receive their Medical Insurance ID card from HTH Worldwide, they should visit hthstudents.com, and using the certificate number on the front of the card, sign in to the site for comprehensive information and services relating to this plan. Participants can track claims, search for a doctor, view plan information, download claim forms and read health and security information.

WHAT IS COVERED BY THE PLAN?

Schedule of Benefits – Table 1

MEDICAL EXPENSES	Limits – Covered Person
Lifetime Maximum Benefit	\$500,000
Policy Year Maximum Benefits	\$150,000
Maximum Benefit per Injury or Sickness	\$150,000
Policy Year Out-of-Pocket Limit	\$2,500 per Policy Year
ACCIDENTAL, DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to \$10,000 for Participant; up to \$5,000 for Spouse; up to \$1,000 per Child(ren)
REPATRIATION OF REMAINS	Maximum Benefit up to \$15,000
MEDICAL EVACUATION	Maximum Lifetime Benefit up to \$50,000
BEDSIDE VISIT	Up to a maximum benefit of \$1,000

Schedule of Benefits – Table 2 – Medical Expenses

	In PPO Limits	Outside PPO Limits
Physician Office Visits*	100% of Reasonable Expenses after \$30 Copayment per visit	75% of Reasonable Expenses
Inpatient Hospital Services	100% of Reasonable Expenses after \$100 Copayment per visit	75% of Reasonable Expenses
Hospital and Physician Outpatient Services	100% of Reasonable Expenses after \$100 Copayment per visit	75% of Reasonable Expenses

*All Physician Visit Copayments for an Injury or Sickness are waived if treatment is received at Recognized Student Health Center or if the initial treatment for an Injury or Sickness is received at Recognized Student Health Center.

Schedule of Benefits – Medical Expense Benefits

Benefits listed below are subject to Table 1 Lifetime Maximums, Annual Maximums, Maximums per Injury and Sickness, Co-Insurance; and Table 2 Plan Type Limits

MEDICAL EXPENSES	Limits – Covered Person
Maternity Care for a Covered Pregnancy	Reasonable Expenses
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$10,000 Maximum per lifetime for a maximum period of 30 days per lifetime
Outpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$1,000 Maximum per lifetime
Outpatient back and spine treatment (including modalities)	Reasonable Expenses up to \$1,000 Maximum per Policy Year with a \$50 per visit Maximum and a Maximum of 3 visits per week
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses up to \$1,000 Maximum per Policy Year on an Inpatient basis. Reasonable Expenses up to \$50 Maximum per visit subject to a Maximum of 20 visits on an Outpatient basis. This benefit is per Policy Year
Therapeutic or Elective termination of pregnancy	Reasonable Expenses up to \$500 In PPO Maximum per Policy Year or up to \$400 Outside PPO Maximum per Policy Year
Routine nursery care of a newborn child of a covered pregnancy	Reasonable Expenses up to \$1,500 Maximum per Policy Year
Annual cervical cytology screening for women 18 and older	Reasonable Expenses
Low dose mammography screening, one baseline mammogram and one mammogram per year	Reasonable Expenses
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to \$500 per Policy Year maximum
Outpatient prescription drugs, including oral contraceptives and devices, filled at the Student Health Center	100% of actual charge after a \$20 Co-payment per 30 day supply per prescription
Outpatient prescription drugs, including oral contraceptives and devices, filled outside the Student Health Center	80% of actual charge
Medical treatment received in the Home Country, if NOT covered by Other Plan	100% of Reasonable Expenses up to \$1,000 lifetime maximum