

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Lumenos® Health Savings Account (HSA-Compatible) Plan for the University of Colorado

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plan-High Deductible Health Plan
2. OUT-OF-NETWORK CARE COVERED? ¹	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Nationally

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the benefit booklet, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., the plan may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual benefit booklet to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE ²	Benefit Year	Benefit Year
4a. ANNUAL DEDUCTIBLE ^{2a}		
a) Single ^{2b}	\$1,500	\$3,000
b) Non-single ^{2c}	\$3,000	\$6,000
	If more than employee-only coverage applies, the entire family deductible must be met before the plan will pay benefits for any individual within the family. May not be combined with out-of-network deductible.	If more than employee-only coverage applies, the entire family deductible must be met before the plan will pay benefits for any individual within the family. May not be combined with in-network deductible.
5. OUT-OF-POCKET ANNUAL MAXIMUM ³		
a) Individual	\$3,000	\$6,000
b) Family	\$6,000	\$12,000
	If more than employee-only coverage applies, the family out-of-pocket maximum must be met.	If more than employee-only coverage applies, the family out-of-pocket maximum must be met.
c) Is deductible included in the out-of-pocket maximum?	Yes	Yes

An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. © Registered marks Blue Cross and Blue Shield Association

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

	IN-NETWORK	OUT-OF-NETWORK
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$2,000,000 per member for most covered services, in- and out-of-network combined. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in- and out-of-network combined. Bariatric surgery has a lifetime maximum benefit of \$7,500 per member for services received from a designated facility; total lifetime maximum benefit shall not exceed \$7,500 per member in- and out-of-network combined.	\$2,000,000 per member for most covered services, in- and out-of-network combined. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in- and out-of-network combined. Bariatric surgery has a lifetime maximum benefit of \$1,500 per member for services received from a facility that is not a designated facility; total lifetime maximum benefit shall not exceed \$7,500 per member in- and out-of-network combined.
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO provider network. Visit our website at www.anthem.com/universityofcolorado for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS ⁴		
a) Primary Care Providers	15% after deductible	35% after deductible
b) Specialists	15% after deductible	35% after deductible
9. PREVENTIVE CARE		
a) Children services	Up to age 13, covered person pays no coinsurance (100% covered), not subject to deductible.	Up to age 13, 35% not subject to deductible.
b) Adult services	Age 13 and above, covered person pays no coinsurance (100% covered), not subject to deductible.	Age 13 and above, mammogram and prostate screenings: 35% not subject to deductible. Age 13 and above, all other covered services: 35% after deductible.
c) Colorectal screening services (not subject to deductible) ^{4a, 4b}	Covered person pays no coinsurance (100% covered), not subject to deductible. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.	35% not subject to deductible. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.
10. MATERNITY		
a) Prenatal care	15% after deductible	35% after deductible
b) Delivery & inpatient well baby care ⁵	15% after deductible	35% after deductible

<p>11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions⁶</p> <p>a) Inpatient care</p> <p>b) Outpatient care</p> <p>c) Prescription Mail Service Mail Order Pharmacy Location University of Colorado Hospital Mail Order Prescription Service 12065 E. 16th, Mail Stop A014 Aurora, Co 80045 Phone (720) 848-1432 Fax (720) 848-1433</p>	<p>15% after deductible</p> <p>20% after deductible for up to a 30 day supply.</p> <p>Mail-Order Pharmacy Drugs: 20% after deductible for up to a 90 day supply. Only orders placed through the University of Colorado Hospital Mail Order Prescription Service will be covered.</p> <p>For drugs on our approved list, call customer service at 800-735-6072 or visit our website at www.anthem.com/universityofcolorado.</p>	<p>35% after deductible</p> <p>20% after in-network deductible for up to a 30 day supply.</p> <p>No benefit for mail-order drugs</p>
<p>12. INPATIENT HOSPITAL</p>	<p>15% after deductible</p>	<p>35% after deductible</p>
<p>13. OUTPATIENT/AMBULATORY SURGERY</p>	<p>15% after deductible</p>	<p>35% after deductible</p>
<p>14. LABORATORY AND X-RAY</p>	<p>15% after deductible</p>	<p>35% after deductible</p>
<p>15. EMERGENCY CARE^{7,8}</p>	<p>15% after deductible</p>	<p>15% after in-network deductible</p>
<p>16. AMBULANCE</p>	<p>15% after deductible</p>	<p>15% after in-network deductible</p>
<p>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</p>	<p>15% after deductible</p>	<p>35% after in-network deductible</p>
<p>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹</p>	<p>15% after deductible</p>	<p>35% after deductible.</p>
<p>19. OTHER MENTAL HEALTH CARE</p> <p>a) Inpatient care</p> <p>b) Outpatient care</p>	<p>15% after deductible.</p> <p>15% after deductible.</p>	<p>35% after deductible.</p> <p>35% after deductible.</p>
<p>20. ALCOHOL & SUBSTANCE ABUSE</p> <p>c) Inpatient care</p> <p>d) Outpatient care</p>	<p>15% after deductible.</p> <p>15% after deductible.</p>	<p>35% after deductible.</p> <p>35% after deductible.</p>
<p>21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY</p> <p>a) Inpatient</p> <p>b) Outpatient</p>	<p>15% after deductible. Limited to 30 non-acute inpatient days per benefit year in- and out-of-network combined.</p> <p>15% after deductible. Limited to a maximum benefit of \$2,000 per benefit year for physical therapy, and a maximum benefit of \$2,000 per benefit year for occupational and speech therapy in- and out-of-network combined or no less than 20 visits for each for physical, occupational and speech therapy for children up to age 6 years of age for therapies related to congenital defects or</p>	<p>35% after deductible. Limited to 30 non-acute inpatient days per benefit year in- and out-of-network combined.</p> <p>35% after deductible. Limited to a maximum benefit of \$2,000 per benefit year for physical therapy, and a maximum benefit of \$2,000 per benefit year for occupational and speech therapy in- and out-of-network combined or no less than 20 visits for each for physical, occupational and speech therapy for children up to age 6 years of age for therapies related to congenital defects or</p>

	IN-NETWORK	OUT-OF-NETWORK
	birth abnormalities in- and out-of-network combined.	birth abnormalities in- and out-of-network combined.
22. DURABLE MEDICAL EQUIPMENT	15% after deductible. Limited to a maximum benefit of \$5,000 per benefit year. The \$5,000 maximum benefit is combined in- and out-of-network. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum benefit of \$5,000.	35% after deductible. Limited to a maximum benefit of \$5,000 per benefit year. The \$5,000 maximum benefit is combined in- and out-of-network. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum benefit of \$5,000.
23. OXYGEN	15% after deductible	35% after deductible
24. ORGAN TRANSPLANTS	15% after deductible	Not covered
25. HOME HEALTH CARE	15% after deductible. Limited to 100 visits per benefit year combined in- and out-of-network.	35% after deductible. Limited to 100 visits per benefit year combined in- and out-of-network.
26. HOSPICE CARE	15% after deductible	35% after deductible
27. SKILLED NURSING FACILITY CARE	15% after deductible. Limited to 100 days per benefit year in- and out-of-network combined.	35% after deductible. Limited to 100 days per benefit year in- and out-of-network combined.
28. DENTAL CARE	Not Covered	Not Covered
29. VISION CARE	Not Covered	Not Covered
30. CHIROPRACTIC CARE	15% after deductible	35% after deductible
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	<p>Members who desire another professional opinion may obtain a second surgical opinion.</p> <p>Treatment of Autism Spectrum Disorders Member cost shares and benefit level determined by type of service provided.</p> <p>The following annual maximums, based on benefit year, are effective for applied analysis services [for in- and out-of-network services combined]:</p> <ul style="list-style-type: none"> • Birth to age eight (up to member's ninth birthday): \$34,000 (in and out-of-network combined) • Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 (in and out-of-network combined) <p>Hearing Aids for Children¹² Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law.</p>	<p>Members who desire another professional opinion may obtain a second surgical opinion.</p> <p>Treatment of Autism Spectrum Disorders Member cost shares and benefit level determined by type of service provided.</p> <p>The following annual maximums, based on benefit year, are effective for applied analysis services [for in- and out-of-network services combined]:</p> <ul style="list-style-type: none"> • Birth to age eight (up to member's ninth birthday): \$34,000 (in and out-of-network combined) • Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 (in and out-of-network combined) <p>Hearing Aids for Children¹² Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law.</p>

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	None (No pre-existing)
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable; Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by plan. A list of exclusions is available immediately upon request from your third party administrator. Review them to see if a service or treatment you may need is excluded from the plan.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization.	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
39. What is the main customer service number?	800-735-6072	
40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 800-735-6072	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s 07-00030 Large Group	
43. Does the plan have a binding arbitration clause?	No	

¹ "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

² "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the plan's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or Per Confinement".

^{2a} "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by plan. Expenses that are subject to deductible should be noted in boxes 8 through 31.

^{2b} “Individual” means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for the allowable covered expenses before the plan will cover those expenses. “Single” means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

^{2c} “Family” is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., “\$3,000 per family”) or specified as the number of individual deductibles that must be met (e.g., “3 deductibles per family”). “Non-single” is the deductible amount that must be met by one or more family members covered by an HSA-qualified health plan before any covered expenses are paid.

³ “Out-of-pocket maximum” means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the benefit booklet for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by plan. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

⁴ Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

^{4a} Coverage shall be provided for asymptomatic, average risk adults who are 50 years of age or older and covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn’s disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

^{4b} Benefits provided for the following tests as determined by the provider to detect adenomatous polyps or colorectal cancer: modalities that are currently included in an “A” recommendation or a “B” recommendation of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services.

⁵ Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together: there are not separate copayments.

⁶ Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

⁷ “Emergency care” means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

⁸ Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

⁹ “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

¹⁰ Waiver of pre-existing condition exclusions. State law requires plans to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your third party administrator for details.

¹¹ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

¹² Hearing aids for dependent children under the age of 18 are covered. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review.