



**Colorado Health Benefit Plan Description Form
UA Net Plan for the University of Colorado**

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	UA Net Plan
2. OUT-OF-NETWORK CARE COVERED? ¹	Only for emergency
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

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 copayments options reflect the amount the covered person will pay.

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. DEDUCTIBLE TYPE ²	Benefit Year
4a. ANNUAL DEDUCTIBLE ^{2a}	
a) Individual ^{2b}	No deductible
b) Family ^{2c}	No deductible
5. OUT-OF-POCKET MAXIMUM ³	
a) Individual	Unlimited
b) Family	Unlimited
c) Is deductible included in the out-of-pocket maximum?	Not applicable
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most covered services. Infertility diagnostic services have a lifetime maximum payment of \$2,000 per member. Major organ transplants have a lifetime maximum benefit of \$1,000,000 per transplant per member.
7A. COVERED PROVIDERS	UA Network Managed Care Network. This is a limited provider network. See provider directory at www.anthem.com/universityofcolorado for complete list of current providers.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes

HMO Colorado is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered marks Blue Cross and Blue Shield Association

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

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8. MEDICAL OFFICE VISITS ⁴ a) Primary Care Providers b) Specialists	\$30 copayment per visit \$40 copayment per visit
9. PREVENTIVE CARE a) Children's services b) Adults' services c) Colorectal screening services ^{4a, 4b}	\$15 copayment per visit \$15 copayment per visit \$15 copayment per visit. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	\$15 copayment, one copayment per pregnancy \$250 copayment per day up to a maximum of \$1,000 in copayments per admission

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<p>11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions⁶</p> <p>a) Inpatient care</p> <p>b) Outpatient care University of Colorado Hospital (UCH) Retail Pharmacy Locations Atrium Pharmacy 12065 E 16th, Room 1054, MS A027 Aurora, CO 80045 Phone (720) 848-4083 Fax (720) 848-4084</p> <p>Anschutz Outpatient Pavilion (AOP) Pharmacy 1635 Aurora Court, RM 1012, MS F702 Aurora, CO 80045 Phone (720) 848-1020 Fax (720) 848-1040</p> <p>Garfield Pharmacy at Lowry 8011 E Lowry Blvd., STE 110, MS B01, Denver, CO 80230 Phone (720) 848-9590 Fax (720) 848-9593</p> <p>Anthem Participating Retail Pharmacy Locations</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>Included with the inpatient hospital copayment (see line 12)</p> <p>Tier 1 generic prescription \$12.50 copayment for 30-day supply and \$25 for 90 day supply, tier 2 brand-name prescription \$30 copayment for 30- day supply and \$60 for 90-day supply. Copayments apply to retail purchases at UCH pharmacies.</p> <p>Tier 1 generic prescription \$15 copayment, Tier 2 brand-name prescription \$35 copayment, Tier 3 non-formulary prescription not covered, per prescription at a Anthem participating pharmacy up to a 30-day supply</p> <p>After a maximum of 90 days, maintenance medications must be ordered through the University of Colorado Hospital Mail Order Prescription Service to be covered.</p> <p>Tier 1 generic prescription \$25 copayment, tier 2 brand-name prescription \$60 copayment, per prescription through the mail-order service up to a 90-day supply. Only orders placed through the University of Colorado Hospital Mail Order Prescription Service will be covered.</p>
<p>12. INPATIENT HOSPITAL</p>	<p>\$250 copayment per day up to a maximum of \$1,000 in copayments per admission</p>
<p>13. OUTPATIENT/AMBULATORY SURGERY</p>	<p>\$250 copayment per visit</p>
<p>14. LABORATORY AND X-RAY</p> <p>a) Laboratory & x-ray</p> <p>b) MRI, nuclear medicine, and other high-tech services</p>	<p>No copayment (100% covered)</p> <p>\$100 copayment per procedure for MRI/MRA/CT/PET scans</p>
<p>15. EMERGENCY CARE ^{7,8}</p>	<p>\$150 copayment per emergency room visit. Copayment is waived if admitted. Care is covered in-network or out-of-network.</p>

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16. AMBULANCE	No copayment (100% covered). Care is covered in-network or out-of-network.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$150 copayment for urgent care received in an emergency room. \$30 copayment per urgent care visit at all other locations. Urgent care may be received from your PCP or from an urgent care center. Care is covered in-network or out-of-network.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE ⁹	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	\$250 copayment per day up to a maximum of \$1,000 in copayments per admission \$30 copayment per office visit for PCP \$40 copayment per office visit for specialist
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient care b) Outpatient care	\$250 copayment per day up to a maximum of \$1,000 in copayments per admission \$30 copayment per office visit for PCP \$40 copayment per office visit for specialist
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a) Inpatient b) Outpatient	\$250 copayment per day up to a maximum of \$1,000 in copayments per admission. Limited to 30 non-acute inpatient days per benefit year. \$30 copayment per visit. Limited to a maximum of 20 visits per certain acute conditions for physical, occupational and speech therapy. For children born with congenital defects or birth abnormalities up to age 6, 20 visits each of physical, occupational and speech therapy per benefit year.
22. DURABLE MEDICAL EQUIPMENT	No copayment (100% covered). Limited to a maximum benefit of \$4,000 per benefit year; combined with oxygen (see line 23). Prosthetic appliances 20% copayment, services are not subject to the maximum benefit. Orthopedic braces and podiatric shoe inserts are limited to a separate combined \$500 maximum benefit per benefit year. Surgical bras are limited to a separate combined \$500 maximum benefit per benefit year. Colostomy/ostomy supplies are limited to a separate combined \$3,000 maximum benefit per benefit year.
23. OXYGEN	No copayment (100% covered). Limited to a maximum benefit of \$4,000 per benefit year; combined with durable medical equipment (see line 22).
24. ORGAN TRANSPLANTS	\$250 copayment per day up to a maximum of \$1,000 in copayments per admission
25. HOME HEALTH CARE	No copayment (100% covered)
26. HOSPICE CARE	No copayment (100% covered)
27. SKILLED NURSING FACILITY CARE	No copayment (100%) covered. Limited to 100 days per benefit year.
28. DENTAL CARE	Not covered
29. VISION CARE	\$30 copayment per eye exam. Limited to a maximum of one visit every 12 months. Coverage is not provided for hardware. Additional information on the vision benefits included in this plan can be found on the separate BlueView Vision Summary Description.

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30. CHIROPRACTIC CARE	\$30 copayment per visit. Limited to 20 visits per benefit year.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	<p>Members who desire another professional opinion may obtain a second 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:</p> <ul style="list-style-type: none"> • Birth to age eight (up to member's ninth birthday): \$34,000 • Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 <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>Allergy Services \$10 copayment per visit for allergy injections including the allergy serum. Allergy testing is subject to the medical office visit copayment.</p> <p>Home Injectables \$75 copayment of injectables for home use</p> <p>Cardiac Rehabilitation \$40 copayment per visit for cardiac rehabilitation. Limited to 10 visits per benefit year.</p>

PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	Not applicable; Plan does not impose limitation periods for pre-existing conditions.
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. 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 policy.

PART D: USING THE PLAN

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who scheduled the procedure or hospital care is responsible for obtaining the preauthorization.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
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	HMO Colorado, 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 07-00027 Group – Large
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.