

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

**PART A: TYPE OF COVERAGE**

<b>1. TYPE OF PLAN</b>	Preferred provider plan
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	Yes, but the patient pays more for out-of-network care
<b>3. AREAS OF WHERE PLAN IS AVAILABLE</b>	Plan is available throughout the United States

**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 Benefits 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., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual Benefits Booklet to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

4. DEDUCTIBLE TYPE <sup>2</sup>	IN-NETWORK	OUT-OF-NETWORK
	Benefit Year	Benefit Year
<b>4a. ANNUAL DEDUCTIBLE<sup>2a</sup></b>		
<b>a) Single<sup>2b</sup></b>	\$1,500 single	\$3,000 single
<b>b) Non-single<sup>2c</sup></b>	\$3,000 non-single	\$6,000 non-single
	<p>If you select family membership, no single deductible applies and the non-single deductible must be met before Anthem provides benefits. The non-single deductible amount is met as follows: when one family member has satisfied the non-single deductible, that family member and all other family members are eligible for benefits. When no family member meets the non-single deductible, but the family members collectively meet the entire non-single deductible, then all family members will be eligible for benefits.</p> <p>Some covered services have a maximum benefit of days, visits or dollar amounts. When the deductible is applied to a covered service which has a maximum number of days or visits, those maximum benefits will be reduced by the amount applied toward the deductible, whether or not the covered service is paid.</p>	<p>If you select family membership, no single deductible applies and the non-single deductible must be met before Anthem provides benefits. The non-single deductible amount is met as follows: when one family member has satisfied the non-single deductible, that family member and all other family members are eligible for benefits. When no family member meets the non-single deductible, but the family members collectively meet the entire non-single deductible, then all family members will be eligible for benefits.</p> <p>Some covered services have a maximum benefit of days, visits or dollar amounts. When the deductible is applied to a covered service which has a maximum number of days or visits, those maximum benefits will be reduced by the amount applied toward the deductible, whether or not the covered service is paid.</p>

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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.

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<p><b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></b></p> <p><b>a) Individual</b></p> <p><b>b) Family</b></p> <p><b>c) Is deductible included in the out-of-pocket maximum?</b></p>	<p>\$3,000 per individual, includes deductible and coinsurance.</p> <p>\$6,000 per individual or family, includes deductible and coinsurance.</p> <p>If you select family membership, no individual out-of-pocket annual maximum applies and the family out-of-pocket annual maximum must be met before Anthem provides benefits. The family out-of-pocket annual maximum amount is met as follows: when one individual has satisfied the family out-of-pocket maximum, that family member and all other family members are eligible for benefits. When no family member meets the family out-of-pocket maximum, but the family members collectively meet the entire family out-of-pocket maximum, then all family members will be eligible for benefits.</p> <p>Yes</p> <p>Some covered services have a maximum numbers of days, visits or dollar amounts. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.</p>	<p>\$6,000 per individual, includes deductible and coinsurance.</p> <p>\$12,000 per individual or family, includes deductible and coinsurance.</p> <p>If you select family membership, no individual out-of-pocket annual maximum applies and the family out-of-pocket annual maximum must be met before Anthem provides benefits. The family out-of-pocket annual maximum amount is met as follows: when one individual has satisfied the family out-of-pocket maximum, that family member and all other family members are eligible for benefits. When no family member meets the family out-of-pocket maximum, but the family members collectively meet the entire family out-of-pocket maximum, then all family members will be eligible for benefits.</p> <p>Yes</p> <p>Some covered services have a maximum numbers of days, visits or dollar amounts. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.</p> <p>The difference between billed charges and the maximum allowed amount for non-participating providers does not count toward the out-of-pocket annual maximum. Even once the out-of-pocket annual maximum is satisfied, the member will still be responsible for paying the difference between the maximum allowed amount and the non-participating providers billed charges.</p>
<p><b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b></p>	<p>No lifetime maximum for most covered services. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in and out-of-network combined. Bariatric surgery has a per occurrence maximum benefit of \$7,500 per member for services received from a designated facility; total per occurrence maximum benefit shall not exceed \$7,500 per member in- and out-of-network combined.</p>	<p>No lifetime maximum for most covered services. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in and out-of-network combined. Bariatric surgery has a per occurrence maximum benefit of \$1,500 per member for services received from a designated facility; total per occurrence maximum benefit shall not exceed \$7,500 per member in- and out-of-network combined.</p>

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>7A. COVERED PROVIDERS</b>	Anthem Blue Cross and Blue Shield PPO provider network. Visit our website at <a href="http://www.anthem.com/universityofcolorado">www.anthem.com/universityofcolorado</a> for a complete list of current providers	All providers licensed or certified to provide covered benefits.
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Yes	Yes
<b>8. MEDICAL OFFICE VISITS<sup>4</sup></b>		
<b>a) Primary Care Providers</b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.
<b>b) Specialists</b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.
<b>9. PREVENTIVE CARE</b>		
<b>a) Children services</b>	Up to age 13, Covered person pays no coinsurance (100% covered), not subject to deductible.	Up to age 13, covered person pays 35% coinsurance not subject to deductible.
<b>b) Adult services</b>	Age 13 and above, Covered person pays no coinsurance (100% covered), not subject to deductible.  For non-preventive colonoscopies and sigmoidoscopies benefits are described under line 13 below.  Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits; and are not subject to coinsurance or deductible.	Age 13 and above, mammogram, preventive colonoscopies and sigmoidoscopies and prostate screenings, covered person pays 35% not subject to deductible.  Age 13 and above, for all other covered preventive services covered person pays 35% after deductible.  Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits.
<b>10. MATERNITY</b>		
<b>a) Prenatal care</b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.
<b>b) Delivery &amp; inpatient well baby care<sup>5</sup></b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.
<b>11. PRESCRIPTION DRUGS</b>		
<b>Level of coverage and restrictions on prescriptions<sup>6</sup></b>		
<b>a) Inpatient care</b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.
<b>b) Outpatient care</b>	<b>Retail Pharmacy Drugs:</b> Covered person pays 20% coinsurance after deductible for up to a 30 day supply.  <b>Specialty Pharmacy Drugs:</b> Covered person pays 20% coinsurance after deductible per 30-day supply from our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy.	<b>Retail Pharmacy Drugs:</b> Covered person pays 20% coinsurance after in-network deductible for up to a 30 day supply.  Not covered

	IN-NETWORK	OUT-OF-NETWORK
<p><b>c) Prescription Mail Service</b></p> <p><b>Mail Order Pharmacy Location</b>  University of Colorado Hospital Mail  Order Prescription Service  12605 E. 16<sup>th</sup> Ave.  Mail Stop A014  Aurora, Co 80045  Phone (720) 848-1432  Fax (720) 848-1433</p>	<p><b>Mail-Order Pharmacy Drugs:</b>  Covered person pays 20% coinsurance after deductible for up to a 90 day supply. Specialty pharmacy drugs are not available through the mail-order service.</p> <p><b>Only orders placed through the University of Colorado Hospital Mail Order Prescription Service will be covered.</b></p> <p>Prescription Drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. For drugs on our approved list, call customer service at 800-735-6072 or visit our website at <a href="http://www.anthem.com/universityofcolorado">www.anthem.com/universityofcolorado</a></p>	<p>Not covered</p>
<b>12. INPATIENT HOSPITAL</b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.
<b>13. OUTPATIENT / AMBULATORY SURGERY</b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.
<b>14. LABORATORY AND X-RAY</b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.
<b>15. EMERGENCY CARE<sup>7,8</sup></b>	Covered person pays 15% coinsurance after deductible.	Out-of-network care is paid as in-network.
<b>16. AMBULANCE</b>	Covered person pays 15% coinsurance after deductible.	Out-of-network care is paid as in-network.
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after in-network deductible.
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
<b>19. OTHER MENTAL HEALTH CARE</b> a) Inpatient care  b) Outpatient care	Covered person pays 15% coinsurance after deductible.  Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.  Covered person pays 35% coinsurance after deductible.
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE</b> a) Inpatient care  b) Outpatient care	Covered person pays 15% coinsurance after deductible.  Covered person pays 15% coinsurance after deductible.	Covered person pays 35% coinsurance after deductible.  Covered person pays 35% coinsurance after deductible.



	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
	<p><b>Treatment of Autism Spectrum Disorders</b> Benefit level determined by type of service provided.</p> <p>The following annual maximums, based on benefit year, are effective for applied behavior analysis services for in- and out-of-network services combined:</p> <ul style="list-style-type: none"> <li>• From birth to age eight (up to member's ninth birthday): \$34,000 in and out-of-network combined</li> <li>• Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 in and out-of-network combined</li> </ul>	<p><b>Treatment of Autism Spectrum Disorders</b> Benefit level determined by type of service provided.</p> <p>The following annual maximums, based on benefit year, are effective for applied behavior analysis services for in- and out-of-network services combined:</p> <ul style="list-style-type: none"> <li>• From birth to age eight (up to member's ninth birthday): \$34,000 in and out-of-network combined</li> <li>• Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 in and out-of-network combined</li> </ul>

**PART C: LIMITATIONS AND EXCLUSIONS**

<b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.</b> <sup>10</sup>	Not applicable; plan does not exclude coverage for pre-existing conditions.
<b>33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the Benefits Booklet?</b>	No
<b>34. HOW DOES THE BENEFITS BOOKLET DEFINE A "PRE-EXISTING CONDITION"?</b>	Not applicable; plan does not exclude coverage for pre-existing conditions.
<b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS BENEFITS BOOKLET?</b>	Exclusions vary by Benefits Booklet. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the Benefits Booklet.

**PART D: USING THE PLAN**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	No	No
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	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.
<b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
<b>39. What is the main customer service number?</b>	800-735-6072	
<b>40. Whom do I write/call if I have a complaint or want to file a grievance?</b> <sup>11</sup>	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 800-735-6072	
<b>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</b>	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	

<b>42. To assist in filing a grievance, indicate the form number of this Benefits Booklet; whether it is individual, small group, or large group; and if it is a short-term Benefits Booklet.</b>	Benefits Booklet form # COSGCDH Group – Large
<b>43. Does the plan have a binding arbitration clause?</b>	No

<sup>1</sup> “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).

<sup>2</sup> “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 Benefits Booklet’s anniversary date) or if the deductible is based on other requirements such as a “Per Accident or Injury” or Per Confinement”.

<sup>2a</sup> “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 Benefits Booklet. Expenses that are subject to deductible should be noted in boxes 8 through 31.

<sup>2b</sup> “Individual” means the deductible amount you and each individual covered by a non-HSA qualified Benefits Booklet will have to pay for the allowable covered expenses before the carrier 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.

<sup>2c</sup> “Family” is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified Benefits Booklet 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 plan before any covered expenses are paid.

<sup>3</sup> “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 contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by Benefits Booklet. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

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

<sup>5</sup> 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.

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

<sup>7</sup> “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.

<sup>8</sup> 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.

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

<sup>10</sup> Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

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