



An Anthem Company

**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 and urgent care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	University of Colorado Subscribers: Plan is available throughout Colorado except for the listed <u>ZIP codes</u> University of Colorado Hospital/University Physicians, Inc. Subscribers: 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 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.

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. DEDUCTIBLE TYPE²	Benefit Year
4a. ANNUAL DEDUCTIBLE^{2a}	
a) Individual ^{2b}	\$250
b) Family ^{2c}	\$750 aggregate
5. OUT-OF-POCKET ANNUAL MAXIMUM³	
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 service. Infertility diagnostic services have a lifetime maximum payment of \$2,000 per member.
7A. COVERED PROVIDERS	UA Network Managed Care 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
8. MEDICAL OFFICE VISITS⁴	
a) Primary Care Providers	\$30 copayment per visit
b) Specialists	\$40 copayment per visit

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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.

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9. PREVENTIVE CARE

a) Children's services to age 13

Up to age 13, Covered person pays no coinsurance (100% covered), not subject to deductible.

b) Adults' services

Age 13 and above, Covered person pays no coinsurance (100% covered), not subject to deductible.

Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits.

For Coverage of non preventive colonoscopies and sigmoidoscopies, benefits are described under line 13 below.

10. MATERNITY

a) Prenatal care

\$15 copayment for the first prenatal care office visit/delivery from the physician

b) Delivery & inpatient well baby care⁵

Covered person pays no coinsurance (100% covered) after deductible.

11. PRESCRIPTION DRUGS

Level of coverage and restrictions on prescriptions⁶

a) Inpatient care

Included with the inpatient hospital benefit (see line 12).

b) Outpatient care

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.

University of Colorado Hospital (UCH)

Retail Pharmacy Locations

Atrium Pharmacy
12605 E 16th Avenue, Room 1054, MS A027
Aurora, CO 80045
Phone (720) 848-4083
Fax (720) 848-4084

The Apothecary at UMGP
350 N. Broadway, Suite 50
Boulder, CO 80305
Phone (303) 499-2879
Fax (303) 499-5308

Anschutz Outpatient Pavilion (AOP) Pharmacy
1635 Aurora Ct, Room 1012, MS F702
Aurora, CO 80045
Phone (720) 848-1020
Fax (720) 848-1040

Infectious Disease Group Practice (IDGP)
Pharmacy
1635 Aurora Ct. Room 7284; MS F702
Aurora, CO 80045
Phone (720) 848-4081
Fax (720) 848- 4082

Garfield Pharmacy at Lowry
8111 E Lowry Blvd, STE 110, MS B01
Denver, CO 80230
Phone (720) 848-9590
Fax (720) 848-9593

	<p align="center">IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)</p>
<p>The Apothecary at Wardenburg Health Center (CU Boulder Campus) Corner of 18th and Wardenburg Drive Boulder, CO 80309 Phone (303) 492 8553 Fax (303) 492-4874</p> <p>Anthem Participating Retail Pharmacy Locations</p> <p>c) Prescription Mail Service</p> <p>Mail Order Pharmacy Location</p> <p>University of Colorado Hospital Mail Order Prescription Service 12605 E. 16th Avenue, Mail Stop A014 Aurora, Co 80045 Phone (720) 848-1432 Fax (720) 848-1433</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 an 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.</p> <p>Only orders placed through the University of Colorado Hospital Mail Order Prescription Service will be covered.</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. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your generic copayment. The cost difference between the generic and brand-name drug does not contribute the out-of-pocket annual maximum. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. HMO Colorado reserves the right, at our discretion, to remove certain higher cost generic drugs from this Benefits Booklet. For drugs on our approved list, call customer service at 800-735-6072.</p>
<p>12. INPATIENT HOSPITAL</p>	<p>Covered person pays no coinsurance (100% covered) after deductible.</p>
<p>13. OUTPATIENT / AMBULATORY SURGERY</p>	<p>Covered person pays no coinsurance (100% covered) after deductible.</p>
<p>14. DIAGNOSTICS</p> <p>a) Laboratory & x-ray</p> <p>b) MRI, nuclear medicine, and other high-tech services</p>	<p>Covered person pays no coinsurance (100% covered) after deductible.</p> <p>Covered person pays no coinsurance (100% covered) after deductible.</p>
<p>15. EMERGENCY CARE^{7,8}</p>	<p>Covered person pays no coinsurance (100% covered) after deductible. Care is covered in-network or out-of-network.</p>
<p>16. AMBULANCE</p>	<p>Covered person pays no coinsurance (100% covered) after deductible. Care is covered in-network or out-of-network.</p>
<p>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</p>	<p>\$30 copayment per urgent care visit. Urgent care may be received from your PCP or from an urgent care center. Care is covered in-network or out-of-network.</p>
<p>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹</p>	<p>Coverage is no less extensive than the coverage provided for any other physical illness.</p>

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	Covered person pays no coinsurance (100% covered) after deductible. For outpatient facility services, covered person pays No copayment (100% covered) after deductible; for outpatient office visits and professional services \$30 copayment per visit.
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient care b) Outpatient care	Covered person pays no coinsurance (100% covered) after deductible. For outpatient facility services, covered person pays No copayment (100% covered) after deductible; for outpatient office visits and professional services \$30 copayment per visit.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a) Inpatient b) Outpatient	Covered person pays no coinsurance (100% covered) after deductible. Up 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	Covered person pays 20% not subject to deductible for Prosthetic Appliances. Covered person pays no coinsurance or copayment (100% covered) after deductible for all other durable medical equipment
23. OXYGEN	Covered person pays no coinsurance or copayment (100% covered) after deductible.
24. ORGAN TRANSPLANTS a) Inpatient b) Outpatient	Covered person pays no coinsurance (100% covered) after deductible. \$30 copayment per visit for PCP \$40 copayment per visit for specialist Transportation and lodging services are limited to a maximum benefit of \$10,000; unrelated donor searches are limited to a maximum benefit of \$30,000.
25. HOME HEALTH CARE	Covered person pays no coinsurance (100% covered) after deductible.
26. HOSPICE CARE	Covered person pays no coinsurance (100% covered) after deductible.
27. SKILLED NURSING FACILITY CARE	Covered person pays no coinsurance (100% covered) after deductible. Up to 100 days per benefit year.
28. DENTAL CARE	Not covered
29. VISION CARE	See Separate Blue View Vision Documents.
30. CHIROPRACTIC CARE	\$30 copayment per visit. Up to 20 visits per benefit year.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Members who desire another professional opinion may obtain a second opinion. Allergy Services \$10 copayment per visit for allergy injections including the allergy serum. Allergy testing is subject to the medical office visit copayment. Home Injectables \$75 copayment of injectables for home use Cardiac Rehabilitation \$40 copayment per visit for cardiac rehabilitation. Limited to 10 visits per benefit year.

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	<p>Hearing Aids 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>Treatment of Autism Spectrum Disorders 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:</p> <ul style="list-style-type: none"> ○ From 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

PART C: LIMITATIONS AND EXCLUSIONS

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 Benefits Booklet?	No
34. HOW DOES THE BENEFITS BOOKLET 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 BENEFITS BOOKLET?	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

	IN-NETWORK
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 Benefits Booklet; whether it is individual, small group, or large group; and if it is a short-term Benefits Booklet.	Benefits Booklet form #'s COLGBA 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 Benefits Booklet’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 Benefits Booklet. 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 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.

^{2c} “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.

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, 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.

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

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

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 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.

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