

# UNIVERSITY PHYSICIANS, INC.

YOUR HEALTH

YOUR CHOICES

## 2009-10 BENEFITS GUIDE

MEDICAL

DENTAL

UPI-FLEX

LIFE

DISABILITY

CARRIER CONTACT

Visit the University Physicians, Inc. (UPI) website at [www.upicolo.org/benefits](http://www.upicolo.org/benefits) for more information. HR is also available to review these materials and plans with you, and to answer your specific questions.



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**This document is a guide.** It only briefly describes the employee benefits available for UPI employees. Complete information on benefits eligibility, costs, and coverage may be obtained from University Physicians, Inc. (UPI) or online at [www.upicolo.org/benefits](http://www.upicolo.org/benefits). If there are any differences between the information contained in this guide and the master plan documents, the plan documents, UPI policies and procedures, and any applicable federal and state laws will govern. The benefits described in this guide may be changed, modified, or eliminated at any time.

# CONTENTS

- 10 Helpful Hints** ..... 2
- Enrollment Deadlines and Defaults**..... 3
- Eligibility and Coverage Dates** ..... 4
- Medicare Part D**
  - Creditable Coverage Notice ..... 7
- Medical**
  - Types of Plans..... 10
  - Plan Options..... 11
  - Educated Decisions Worksheet ..... 13
  - Plan Summaries and Comparisons ..... 14
- Dental**
  - Types of Plans and Options..... 38
  - Plan Summaries and Comparisons ..... 40
- UPI-Flex**
  - Overview ..... 41
  - To Flex or Not to Flex?..... 43
- Life Plan Options**..... 45
- Disability Overview**..... 47
- Carrier Contact Information** ..... Inside Back Cover



## 10 HELPFUL HINTS

To successfully enroll in your benefits package, follow these helpful hints:

- 1 **Review this guide.** It provides an overview of the benefits plans available to you.
- 2 **Attend an orientation.** The orientation provides a review of UPI's benefits programs and an opportunity to ask questions.
  - During open enrollment, review the Open Enrollment website for a calendar of information sessions.
- 3 **Use the Educated Decisions Worksheet.** The Educated Decisions Worksheet on page 13 provides a basic cost analysis to help you choose the most cost-effective plan for your needs. It is an important step in being an informed consumer.
- 4 **Consider the advantages of UPI-Flex Options.** The Premium Only Plan, Health Care Flexible Spending Account, and Dependent Care Flexible Spending Account provide opportunities to save money.
- 5 **Select a primary care physician (PCP).** If you are enrolling in HMO Colorado, UA Net HMO, or Kaiser Permanente HMO in the Colorado Springs/Pueblo area, you must choose a primary care physician.
- 6 **Waive coverage if you do not want coverage.** If you do not want medical and dental coverage, check the "Waive Medical Coverage" and "Waive Dental Coverage" options in sections 1 and 2 of the Benefits Enrollment/Change Form.
- 7 **Understand Dependent Eligibility.** You are allowed to enroll eligible dependents **only**. For detailed information, review page 4 of this guide.
- 8 **Get more help if you need it.** It is available. HR provides the resources and services to answer your specific questions and help you make educated benefits decisions.
- 9 **Confirm your intended elections.** Once you have completed the Benefits Enrollment/Change Form, take the time to verify that you have completed your elections correctly. After enrollment, HR will mail you a Benefits Confirmation Statement showing your benefits elections. Contact HR immediately if you have questions or concerns about your enrollment.
- 10 **Be on time.** You must complete and submit your Benefits Enrollment/Change Form to the HR office—13611 E. Colfax Avenue, Aurora, CO 80045—within the required time frames.

# ENROLLMENT DEADLINES AND DEFAULTS

HR encourages you to review all materials, attend information sessions, and ask questions if necessary, to ensure that you make the best possible decisions about your benefits.

UPI's benefits plan year runs from July 1, 2009, through June 30, 2010.

## Deadlines

**New Employees**—Must enroll within 31 days following date of hire.

**Qualifying Life Events**—HR must receive a Benefits Enrollment/Change Form with the proper supporting documentation\* within 31 days following the date of the *qualifying life event*.

**Open Enrollment**—As specified each year (refer to the Open Enrollment website).

After the initial 31-day enrollment period, open enrollment is the **ONLY TIME** during the plan year when **YOU CAN MAKE CHANGES** to your UPI benefits plans, **UNLESS** you experience a *qualifying life event* as defined by applicable federal and/or state laws or the master plan documents.

## Defaults

**New Employees**—If you **TAKE NO ACTION** to enroll or waive your coverage, the following defaults apply:

- Medical—Lumenos, employee-only coverage
- Dental—Exclusive Panel Option (EPO), employee-only coverage

**Open Enrollment**—As specified each year (refer to the Open Enrollment website).

**NOTE:** Filling in your enrollment form incorrectly, forgetting to enroll, or being unable to continue paying your premium are **NOT** *qualifying life events*. You must notify HR of a *qualifying life event* within 31 days of the event to change your benefits coverage. **THIS INCLUDES THE BIRTH OR ADOPTION OF A CHILD EVEN IF YOU ALREADY HAVE FAMILY COVERAGE.** If you do not notify HR within the time specified, you will **NOT** be able to add or remove a dependent or make any other coverage changes until the next open enrollment period, with benefits coverage effective the following July 1.

\*Contact HR or refer to the UPI website for details regarding proper documentation.

## ELIGIBILITY AND COVERAGE DATES

Individuals must be paid on UPI's monthly pay cycle and be appointed to a permanent 50 percent or greater benefits-eligible position in order to be eligible for UPI's group benefits plans.

### Eligible Dependents for UPI Benefits

You may enroll your eligible dependents in certain UPI benefits plans as described in this guide. Your dependent(s) may be eligible to participate in a UPI plan as a "dependent" but may not meet the definition of a *federal tax dependent* for federal income tax purposes (see the "Definition of a Federal Tax Dependent" box on the opposite page). If your dependent(s) meet the IRS definition of a *federal tax dependent* they are considered *qualified dependents*. If your dependent(s) do not meet the IRS definition of a federal tax dependent they are considered *nonqualified dependents*. When you enroll a *nonqualified dependent\*\** in a UPI plan, there are tax consequences (imputed income) that will be calculated into your taxable income. For details, go to [www.upicolo.org/benefits](http://www.upicolo.org/benefits).

When enrolling your dependents you must first determine if they are eligible dependents. Eligible dependents include **only** the following:

- Your spouse, common-law spouse\*, or same gender domestic partner (SGDP)\*.
- Your, your spouse's, or your SGDP's unmarried children including legally adopted children, children placed with you for adoption, and stepchildren. Each child must be either a
  - dependent child, as defined under Internal Revenue Code, through the end of the month in which they turn age 24 (qualified dependent);
  - dependent child of any age who is dependent on you because of a permanent physical or mental disability (qualified dependent);
  - dependent child age 19 through the end of the month in which they turn age 24 who is not considered a tax dependent under Internal Revenue code (nonqualified dependent\*\*); or
  - dependent child age 24 through the end of the month they turn age 25 (nonqualified dependent\*\*).

When you have confirmed your dependents' eligibility and are ready to enroll them in a UPI plan, you must indicate on the Benefits Enrollment/Change Form whether each individual qualifies as a *federal tax dependent*. If you do not identify your dependent as a *federal tax dependent*, they will be identified as a non-federal tax (nonqualified\*\*) dependent.

\*There are specific documents required by HR to enroll your common-law spouse or SGDP. Contact HR or refer to the UPI website for details.

\*\*Nonqualified dependent(s) must be unmarried, have the same legal residence as the parent, or be financially dependent on the parent.

## Definition of a Federal Tax Dependent

An individual is a taxpayer's "dependent" for federal income tax purposes—that is, a federal tax dependent—if he or she meets one of the definitions below:

- 1) A "qualifying child" is an individual: (a) who is a child (including an adopted child or an eligible foster child—i.e., one who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of court), stepchild, sibling, or step-sibling (or descendant of any of these); and (b) who has the same principal place of residence as the taxpayer for more than one-half of the calendar year; and (c) who (other than in the case of total disability) has not yet attained age 19 by the end of the calendar year (age 24 if a full-time student for at least five months); and (d) who receives more than one-half of his or her support from you.
- 2) A "qualifying relative" is an individual: (a) who is not your qualifying child or the qualifying child of any other taxpayer; (b) who is related to you, or who is not related to you but has the same principal place of residence as you for more than one-half of the calendar year and is a member of your household; and (c) who receives more than one-half of his or her support from you.

## Eligible Dependents Who Are Not Federal Tax Dependents

If you have any dependents who are not federal tax dependents (nonqualified), please consider the following information carefully:

- Dependents who do not qualify as federal tax dependents **ARE NOT** eligible for UPI-Flex plans.
- Dependents who do not qualify as federal tax dependents **ARE** eligible for UPI medical, dental, and optional life plans, but you will incur imputed income when enrolling such a dependent in these plans. See [www.upicolo.org/benefits](http://www.upicolo.org/benefits) for more information.

## Individuals Who Are Not Eligible for UPI Benefits

Individuals who are **NOT** eligible for UPI benefits include, but are not limited to, the employee's or spouse's:

- parents, grandparents, great-grandparents
- siblings, nieces and nephews, aunts and uncles, cousins
- grandchildren, great-grandchildren
- ex-spouses
- renters, boarders, tenants, employees
- any other individuals **not** listed in the Eligible Dependents section above

*Note:* UPI conducts audits regularly to verify the eligibility of dependents.

## When Your Coverage Begins

- If your date of eligibility is the first day of the month, your medical and dental coverage will begin on that date.
- If your date of eligibility is any other date, medical and dental coverage will begin the first day of the following month.
- The effective date for other benefits options depends on the benefit elected and when your Benefits Enrollment/Change Form is received by HR. Please refer to the Benefits Enrollment/Change Form.
- Elections made for open enrollment will be effective on July 1 each year.

## Premium Payments

- Premium payments are deducted on each monthly paycheck.
- When enrollment forms are received by the 10th of the month in which the coverage is to be effective, premium deductions will be taken from that month's paycheck.
- When enrollment forms are received after the 10th of the month, the required premium deductions will be taken from the next month's paycheck and may result in a double deduction from your paycheck in order to "catch up" on the premiums owed.
- Employees who do not receive a paycheck (e.g., employees on leave without pay) or who do not have their premiums automatically deducted are responsible for submitting their own premium payments by the first of the month.

## Qualifying Life Events

- Your benefits plan elections are in effect throughout the plan year (July 1 through June 30).
- The effective date of most changes to medical/dental will be the first of the month **following** your *qualifying life event*.
- The effective date of changes to other benefits depends on the benefits elected and when HR receives the Benefits Enrollment/Change Form.

**NOTE:** Review the *qualifying life events* information on the UPI website at [www.upicolo.org/benefits](http://www.upicolo.org/benefits) for a list of eligible *qualifying life events*, information regarding proper documentation, and if applicable, refund information.

## When Your Coverage Ends

- Coverage ends the last day of the month in which you terminate employment.
- Coverage will end if you fail to make a premium payment by the due date (for example, if you are on leave without pay and your premium is not being automatically deducted).

# MEDICARE PART D

## CREDITABLE COVERAGE NOTICE\*

### **Important Notice from the University of Colorado About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the University of Colorado and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The University of Colorado has determined that the prescription drug coverage offered by the Anthem Blue Cross Blue Shield HMO Colorado, UA Net HMO, BluePreferred PPO, Lumenos and Medicare Primary plans, and the Kaiser Permanente HMO plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "Creditable Coverage."

**Because your existing University of Colorado coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31. For some individuals this means you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may be required to pay a higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition if you lose, or decide to leave, employer sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your University of Colorado medical coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your University of Colorado medical plan which includes prescription drug coverage, be aware that you and your

\*This notice is required by the Centers for Medicare and Medicaid Services (CMS) regarding Medicare Part D prescription coverage.

dependents may not be able to get this coverage back. You should also know that if you drop or lose your coverage with the University of Colorado and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1 percent of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium may consistently be at least 19 percent higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

**For more information about this notice or your current prescription drug coverage:**

Contact Payroll & Benefit Services at 303-735-6500. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through University of Colorado changes. You also may request a copy.

**For more information about your options under Medicare prescription drug coverage:**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

**For more information about Medicare prescription drug coverage:**

- Visit [www.medicare.gov](http://www.medicare.gov).
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).**

Date:	July 1, 2009
Name of Entity/Sender:	University of Colorado
Contact:	Office of Payroll & Benefit Services
Address:	3100 Marine Street, 6th Floor Boulder, CO 80309-0575
Phone Number:	303-735-6500

## MEDICARE PART D AND UNIVERSITY OF COLORADO

<b>MEDICARE PART D</b>			
Member pays \$295 deductible	Member pays 25% of next \$2,405  Medicare pays 75% of next \$2,405	Member pays 100% of next \$3,453.75	Member pays 5% of costs over \$6,153.75  Medicare pays 95% of costs over \$6,153.75
<b>\$0</b>	<b>\$295</b>	<b>\$2,700</b>	<b>\$6,153.75</b>
<b>DRUG EXPENSES</b>			

<b>UNIVERSITY PRESCRIPTION DRUG PLANS</b>			
<b>INSURANCE CARRIER</b>	<b>MEMBER PAYS</b>	<b>MEMBER PAYS</b>	<b>CARRIER PAYS</b>
HMO Colorado UA Net HMO	No deductible	Member pays \$15/\$35 copay—retail \$30/\$70 copay—mail order	Carrier pays 100% after copay
Kaiser Permanente HMO	No deductible	Member pays \$15/\$35 copay—retail \$30/\$70 copay—mail order	Carrier pays 100% after copay
Lumenos	\$1,500/\$3,000 Deductible	Member pays 20% up to \$3,000/\$6,000, then member pays 0% for balance of plan year— retail and mail order	Carrier pays 80% up to \$3,000/\$6,000, then carrier pays 100% for balance of plan year
BluePreferred PPO	No deductible	Member pays \$15/\$40/\$60 copay—retail \$30/\$80/\$120 copay—mail order	Carrier pays 100% after copay
Medicare Primary Retail	\$240 deductible	Member pays 20% up to \$2,400/\$7,200, then member pays 0% for the balance of plan year	Carrier pays 80% up to \$2,400/\$7,200, then carrier pays 100% for balance of plan year
Medicare Primary Mail Order	\$150 deductible	Member pays \$25/\$50/\$100 copay	Carrier pays 100% after deductible or copay

## TYPES OF MEDICAL PLANS

You are strongly encouraged to review all available options before making your selection. All plans have a large network of doctors, a prescription drug benefit, and many other positive features. However, each type of plan has different features that should be carefully considered when trying to best meet your needs and the needs of your eligible dependents. For evidence of coverage, limitations and exclusions, formularies, or to find a provider, go to the UPI website at [www.upicolo.org/benefits](http://www.upicolo.org/benefits).

### Health Maintenance Organization (HMO)

- In-network coverage only except in cases of an emergency.
- Members must reside in the HMO service area.
- Members must select a Primary Care Physician (PCP), otherwise one will be assigned.
- Members must pay a copay for covered services provided by the in-network doctors.
- Closed prescription drug formulary.
- Most specialist visits with the UA Net HMO require a referral from your PCP. Specialist visits with HMO Colorado do not require a referral from your PCP; however, you must see a specialist in the HMO Colorado network.

### Preferred Provider Organization (PPO)

- National network of providers.
- Deductibles apply.
- Coinsurance coverage once the deductible is met.
- In-network preventive services are not subject to a deductible.
- May qualify for a Health Savings Account (HSA). See plan detail for a description of an HSA.
- Open prescription drug formulary.
- PCP and referrals to specialists are not required.

### Waive Coverage Option

If you want to waive medical coverage for the plan year, you must select the "Waive Medical Coverage" box on the Benefits Enrollment/Change Form. Once you waive coverage, you will not be allowed to enroll until the next scheduled open enrollment or within 31 days of a *qualifying life event* as defined by applicable federal and/or state laws or the master plan documents.

# MEDICAL PLAN OPTIONS

For more coverage information see the Medical Plan Summaries and Comparisons beginning on page 14.

## HMO Colorado

HMO Colorado is an open access HMO, meaning you do NOT need to get a referral to seek specialty care. HMO Colorado offers in-network coverage only except in cases of an emergency.

HMO Colorado is NOT available to employees who live in a specific portion of the UA Net HMO service area—an area defined by Denver Metro zip codes. You will find the UA Net HMO service area zip codes listed on the UPI website. If you live in one of the UA Net HMO service area zip codes, you **cannot** enroll in HMO Colorado.

## UA Net HMO

UA Net HMO is a statewide limited network HMO which offers access to the providers and hospitals affiliated with the University of Colorado School of Medicine and the University of Colorado Hospital, including a limited number of community physicians associated with the University of Colorado School of Medicine (“UA Network”). All members must select a UA Net primary care physician (PCP) from the UA Net HMO Provider Directory. Specialty care can only be accessed through a PCP referral, and this plan offers in-network coverage only except in cases of an emergency.

## Kaiser Permanente HMO

A PCP is not required for members in the Denver/Boulder area. However, Kaiser Permanente recommends its members select and partner with a PCP.

In the Colorado Springs and Pueblo area, members are required to select a PCP. See the UPI website for a list of available Kaiser Permanente PCPs in this area.

## Lumenos

Lumenos is a Health Savings Account (HSA) qualified plan which has national and international coverage. Under this plan the family deductible must be satisfied before benefits are paid for any individual family member. If a member goes out-of-network, coverage is for allowable benefit charges only. Under this plan, in-network deductible and out-of-pocket maximum do not apply toward out-of-network deductible and out-of-pocket maximum, and vice versa.

Note: If you enroll in an HMO and you move outside of the HMO service area, you will be required to change plans. HR will provide a 31-day notice allowing you to select another plan option. Your new plan option will be effective the first of the month following your notice. If you take no action, you will be enrolled into UPI's default plan.

## BluePreferred PPO

BluePreferred PPO offers a national network of providers and is available in Colorado and throughout the United States through the BlueCard Network. Plan members can refer themselves to doctors of their choice, including specialists, both in- and out-of-network. There is a \$500 confinement fee on this plan which does not apply toward the plan year deductible, but does apply to the out-of-pocket maximum.

<b>BLUEPREFERRED PPO PLAN COVERAGE BASED ON WHERE SERVICES APPEAR IN THE TIERS*</b>		
<b>TIER I</b>	<b>TIER II</b>	<b>TIER III</b>
Plan pays 100% after \$20 copay for preventive care and office visits	Plan pays 80% for essential and catastrophic services after \$850 deductible and a separate \$500 confinement fee	Plan pays 60% for scheduled/routine services and outpatient diagnostic services after the \$850 deductible
<b>Preventive—No Diagnosis</b> <ul style="list-style-type: none"> <li>● Routine</li> <li>● Immunizations</li> <li>● Diagnostic</li> <li>● Well woman</li> <li>● Prostate exams</li> </ul>	<b>Inpatient Hospital</b> <ul style="list-style-type: none"> <li>● Chemotherapy</li> <li>● Cardiac</li> <li>● Radiation</li> <li>● Ambulance</li> <li>● ER (admitted)</li> </ul>	<b>Outpatient</b> <ul style="list-style-type: none"> <li>● Office surgeries (separate \$500 confinement fee applies)</li> <li>● Physical therapy</li> <li>● ER (released)</li> </ul>
<i>Example:</i> Joe has a sore throat and sees his in-network physician for an exam. Upon examination, Joe's physician orders lab tests		
Office Visit (In-network)	➔	Tier I—\$20 Copay
Lab Test (In-network)	➔	Tier III—Plan pays 60% after \$850 deductible is met

\*In-network coverage

### What is a Health Savings Account (HSA)?

An HSA offers you the ability to set aside funds in a bank account to help offset health related expenses and receive a credit on your annual income tax return. Any remaining balance can be carried forward and used in upcoming years. You must directly contact a financial institution in order to establish an HSA account. If you are interested in establishing an HSA, HR encourages you to consult with your financial or tax advisor.

#### To establish and contribute to an HSA, you

- must be covered by a qualified High-Deductible Health Plan (HDHP);
- cannot be covered by any other health plan;
- cannot be claimed as a dependent on another person's tax return;
- cannot be in both an HSA and the UPI Flex Health Care Flexible Spending Account program; and
- cannot be entitled to Medicare.

Go to [www.opm.gov/hsa](http://www.opm.gov/hsa) for more information.

# EDUCATED DECISIONS WORKSHEET

This worksheet is intended to give you an overview of what your total premium plus out-of-pocket costs would be for your top three medical plan choices.

	PLAN	PLAN	PLAN
<b>PLANS:</b> (Fill in plan names)			

**What is your coverage level ?**     Employee Only     Employee+Children     Employee+Spouse/SGDP     Family

**What is your plan-year premium cost for your coverage level?**

Multiply by 12 the monthly employee premium cost for your coverage level.	PLAN-YEAR COST	PLAN-YEAR COST	PLAN-YEAR COST
	\$	\$	\$

**Do you have deductibles to meet first?** If yes, check the box and fill in the annual amount.

<input type="checkbox"/> Individual	\$	\$	\$
<input type="checkbox"/> Family	\$	\$	\$

**What type of routine office visits will you need during the plan year?**

Multiply your copay/coinsurance by the number of office visits per plan year.	PLAN-YEAR COST	PLAN-YEAR COST	PLAN-YEAR COST
Routine office visit	\$	\$	\$
Routine well baby care	\$	\$	\$
Routine wellness care	\$	\$	\$
Specialist visit	\$	\$	\$
Hospital/delivery	\$	\$	\$
Other	\$	\$	\$

**Are you or your dependents taking routine maintenance drugs?**

Multiply your copay/coinsurance by the number of months needed to take drug (maximum of 12 months).	PLAN-YEAR COST	PLAN-YEAR COST	PLAN-YEAR COST
Self (employee)	\$	\$	\$
Dependents	\$	\$	\$

**What if you have emergency room visits this year?** Multiply the ER cost by the number of visits.

ER/Urgent care cost	\$	\$	\$
<b>Total premium + estimated out-of-pocket expenses</b>	\$	\$	\$

**Are you participating in any of the UPI-Flex plans to get the tax advantage?**     Yes     No

For more information, review the UPI-Flex section in the online Benefits Guide.

- If you enroll in the POP plan, that enrollment will continue from plan year to plan year.
- If you want to participate in one of the Flexible Spending Accounts, you must re-enroll at every open enrollment.

# HMOs

<b>UA Net HMO</b>	<b>Kaiser Permanente HMO</b>
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**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 policy, 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 policy to determine the exact terms and conditions of coverage. Coinsurance and copayments options reflect the amount the covered person will pay.

**Part A: Type of Coverage**

<b>1. Type of Plan</b>	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
<b>2. Out-of-Network Care Covered?<sup>1</sup></b>	Only for emergency care.	Only for emergency care.
<b>3. Areas of Colorado where Plan is Available</b>	Plan is available throughout Colorado.	Plan is available only in the following areas: Denver and Boulder Counties and portions of Adams, Arapahoe, Broomfield, Clear Creek, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld Counties as determined by zip code.  Colorado Springs: portions of Douglas, El Paso, Fremont, Park, Pueblo and Teller Counties as determined by zip code

**Part B: Summary of Benefits**

	In-network Through UA Net Providers Only (Out-of-network care is not covered except as noted)	In-network Only (Out-of-network care is not covered except as noted)
<b>4. Deductible Type<sup>2</sup></b>	Plan year	
<b>4a. Deductible<sup>2a</sup></b> <b>a. Single<sup>2b</sup></b> <b>b. Non-Single<sup>2c</sup></b>	No deductibles No deductibles	No deductibles No deductibles
<b>5. Out-of-Pocket Maximum per plan year<sup>3</sup></b> <b>a. Individual</b> <b>b. Family</b> <b>c. Is deductible included in the out-of-pocket maximum?</b>	Unlimited Unlimited Not applicable	a. \$4,000 per Individual per plan year b. \$10,000 per family per plan year c. Not applicable  For families, the individual family members are responsible for meeting the family out-of-pocket maximum, only up to the individual out-of-pocket maximum amount.
<b>6. Lifetime or Benefit Maximum Paid by the Plan for All Care</b>	No lifetime maximum for most covered service. 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.	Lifetime Maximum No lifetime maximum The lifetime maximum represents the combined benefit maximum for all covered services. Benefit Maximum(s) Transplant lifetime maximum \$1,000,000 per individual \$25,000 bone marrow donor search per individual The \$25,000 bone marrow donor search does not apply toward the transplant lifetime maximum or the lifetime maximum.
<b>7a. Covered Providers</b>	UA Network Managed Care Network. This is a limited provider network. See provider directory at <a href="http://www.anthem.com/universityofcolorado">www.anthem.com/universityofcolorado</a> for complete list of current providers.	Colorado Permanente Medical Group, P.C. See provider directory for a complete list of current providers.  Colorado Springs: Kaiser Permanente affiliated network of primary care and specialty physicians See provider directory for a complete list of current providers.
<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

# HMOs

## HMO Colorado

**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 policy, 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 policy to determine the exact terms and conditions of coverage. Coinsurance and copayments options reflect the amount the covered person will pay.

### Part A: Type of Coverage

<b>1. Type of Plan</b>	Health Maintenance Organization (HMO)
<b>2. Out-of-Network Care Covered?</b> <sup>1</sup>	Only for emergency care.
<b>3. Areas of Colorado where Plan is Available</b>	Plan is available throughout all Colorado zip codes except for those zip codes listed at <a href="http://www.anthem.com/universityofcolorado">www.anthem.com/universityofcolorado</a> .

### Part B: Summary of Benefits

	<b>In-network Only</b> (Out-of-network care is not covered except as noted)
<b>4. Deductible Table</b> <sup>2</sup>	Plan year
<b>4a. Deductible</b> <sup>2a</sup> <b>a. Single</b> <sup>2b</sup> <b>b. Non-Single</b> <sup>2c</sup>	No deductibles No deductibles
<b>5. Out-of-Pocket Maximum per plan year</b> <sup>3</sup> <b>a. Individual</b> <b>b. Family</b> <b>c. Is deductible included in the out-of-pocket maximum?</b>	Unlimited Unlimited Not applicable
<b>6. Lifetime or Benefit Maximum Paid by the Plan for All Care</b>	No lifetime maximum for most covered service. Infertility diagnostic services have a lifetime maximum payment of \$2,000 per member. Bariatric surgery has a lifetime maximum payment of \$7,500 per member for services received from a designated facility or a lifetime maximum benefit of \$1,500 from a facility that is not a designated facility. Major organ transplants have a lifetime maximum benefit of \$1,000,000 per transplant per member.
<b>7a. Covered Providers</b>	HMO Colorado managed care network. See provider directory at <a href="http://www.anthem.com/universityofcolorado">www.anthem.com/universityofcolorado</a> for complete list of current providers.
<b>7b. With respect to network plans, are all the providers listed in 7a accessible to me through my primary care physician?</b>	Yes

# HMOs

	UA Net HMO	Kaiser Permanente HMO
<b>8. Medical Office Visits<sup>4</sup></b> a. Primary Care Provider b. Specialists	\$30 per visit copayment \$40 per visit copayment	Do not apply toward out-of-pocket maximum a. \$30 copayment each primary care office visit b. \$40 copayment each specialist care office visit  Line 13 may apply for procedures performed during an office visit
<b>9. Preventive Care</b> a. Children services b. Adult services c. Colorectal screening services <sup>4a, 4b</sup>	\$15 per visit copayment \$15 per visit copayment \$15 copayment per visit. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below	Does not apply toward out-of-pocket maximum a. \$15 copayment each visit b. \$15 copayment each visit
<b>10. Maternity</b> a. Prenatal care  b. Delivery & Inpatient well baby care <sup>5</sup>	\$15 copayment, one copayment per pregnancy  \$250 copayment per day up to a maximum of \$1,000 in copayments per admission	a. No charge (100% covered). Does not apply toward out-of-pocket maximum b. \$250 copayment per day up to a maximum of \$1,000 in copayments per admission. Applies toward out-of-pocket maximum
<b>11. Prescription Drugs</b> Level of coverage and restrictions on prescriptions <sup>6</sup>  a. Inpatient care  b. Outpatient care  c. Prescription Mail Service	Included with the inpatient hospital copayment (see line 12)  Tier 1 generic prescription \$15 copayment, tier 2 brand-name prescription \$35 copayment, tier 3 non-formulary prescription <b>not</b> covered, per prescription at a participating pharmacy up to a 30-day supply.  Tier 1 generic prescription \$30 copayment, tier 2 brand-name prescription \$70 copayment, tier 3 non-formulary prescriptions <b>not</b> covered, per prescription through the mail-order service up to a 90-day supply.  In addition to the cost sharing described above, if you purchase a tier 2 brand-name prescription when there is a FDA rated equivalent tier 1 generic prescription drug available, you are responsible for the tier 2 brand-name copayment and you will pay the cost difference between the brand-name prescription drug and the tier 1 generic prescription drug. 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> .	Do not apply toward out-of-pocket maximum  b. \$15 Generic/\$35 Brand – up to a 30-day supply/ 20% coinsurance for specialty drugs, including self-administered injectables, up to a maximum of \$75 per drug dispensed.  c. Mail-order drugs available for up to a 90-day supply for two copayments.
<b>12. Inpatient Hospital</b>	\$250 copayment per day up to a maximum of \$1,000 in copayments per admission	Applies toward out-of-pocket maximum \$250 copayment each day up to a maximum of \$1,000 per admission
<b>13. Outpatient/Ambulatory Surgery</b>	\$250 copayment per visit	Applies toward out-of-pocket maximum \$250 copayment each visit for outpatient surgery performed in any setting other than inpatient
<b>14. Diagnostics</b> a. Laboratory & X-ray  b. MRI, nuclear medicine, and other high-tech services	No copayment (100% covered)  \$100 copayment per procedure for MRI/MRA/CT/PET scans	Do not apply toward out-of-pocket maximum a. Diagnostic Lab and X-ray – No Charge (100% covered) Therapeutic X-ray – \$40 Copayment each visit b. MRI/CT/PET (Special Procedures) - \$100 copayment per procedure

# HMOs

HMO Colorado	
<p><b>8. Medical Office Visits<sup>4</sup></b>                      a. Primary Care Provider                      b. Specialists</p>	<p>\$30 per visit copayment                      \$40 per visit copayment</p>
<p><b>9. Preventive Care</b>                      a. Children services                      b. Adult services                      c. Colorectal screening services<sup>4a, 4b</sup></p>	<p>\$15 per visit copayment                      \$15 per visit copayment                      \$15 copayment per visit. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below</p>
<p><b>10. Maternity</b>                      a. Prenatal care                      b. Delivery &amp; Inpatient well baby care<sup>5</sup></p>	<p>\$15 copayment, one copayment per pregnancy                      \$250 copayment per day up to a maximum of \$1,000 in copayments per admission</p>
<p><b>11. Prescription Drugs</b>                      Level of coverage and restrictions on prescriptions<sup>6</sup></p> <p>a. Inpatient care</p> <p>b. Outpatient care</p> <p>c. Prescription Mail Service</p>	<p>Included with the inpatient hospital copayment (see line 12)</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 participating pharmacy up to a 30-day supply.</p> <p>Tier 1 generic prescription \$30 copayment, tier 2 brand-name prescription \$70 copayment, tier 3 non-formulary prescriptions not covered, per prescription through the mail-order service up to a 90-day supply.</p> <p>In addition to the cost sharing described above, if you purchase a tier 2 brand-name prescription when there is a FDA rated equivalent tier 1 generic prescription drug available, you are responsible for the tier 2 brand-name copayment and you will pay the cost difference between the brand-name prescription drug and the tier 1 generic prescription drug. 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><b>12. Inpatient Hospital</b></p>	<p>\$250 copayment per day up to a maximum of \$1,000 in copayments per admission</p>
<p><b>13. Outpatient/Ambulatory Surgery</b></p>	<p>\$250 copayment per visit</p>
<p><b>14. Diagnostics</b>                      a. Laboratory &amp; X-ray                      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>

# HMOs

	UA Net HMO	Kaiser Permanente HMO
<b>15. Emergency Care<sup>7,8</sup></b>	\$150 copayment per emergency room visit. Copayment is waived if admitted. Care is covered in-network or out-of-network.	Does not apply toward out-of-pocket maximum \$150 copayment each visit at a Kaiser Permanente designated plan or non-plan emergency room, waived if admitted as an inpatient Line 14b procedures (special procedures) performed while receiving emergency services will generate a separate copayment per procedure in addition to the emergency services copayment. The copayment(s) for special procedures is (are) waived if admitted as an inpatient.
<b>16. Ambulance</b>	No copayment (100% covered). Care is covered in-network or out-of-network.	Coinsurance only applies toward out-of-pocket maximum  No Charge (100% covered)
<b>17. Urgent, Non-routine, After Hours Care</b>	\$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.	a. <u>Urgent care</u> <sup>7</sup> – Does not apply toward out-of-pocket maximum \$150 copayment each visit at a Kaiser Permanente designated plan emergency room inside the service area or a non-plan emergency room outside the service area, waived if admitted as an inpatient b. <u>Non-routine care</u> – Does not apply toward out-of-pocket maximum \$30 copayment each visit at a Kaiser Permanente plan facility inside the service area or a non-plan facility outside the service area during office hours c. <u>After-hours care</u> – Does not apply toward out-of-pocket maximum \$30 copayment each after-hours visit at a Kaiser Permanente designated after-hours plan facility inside the service area
<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> <b>a. Inpatient care</b>  <b>b. Outpatient care</b>	<p>\$250 copayment per full day or \$125 copayment per partial day up to a maximum of \$1,000 in copayments per admission. Limited to 45 full or 90 partial days per plan year for other mental health care except as listed below.</p> <p>\$30 copayment per visit for visits 1-20, \$50 copayment per visit thereafter except for those mental disorders as listed below.</p> <p>The following other mental disorders received on an inpatient or outpatient basis are covered no less extensively than the coverage provided for any other physical illness: posttraumatic stress disorder, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder and general anxiety disorder. Anorexia nervosa and bulimia nervosa, to the extent those diagnoses are treated on an outpatient, day treatment, and inpatient basis (residential treatment is excluded), are covered no less extensively than the coverage provided for any other physical illness.</p>	a. <u>Inpatient</u> * – Does not apply toward out-of-pocket maximum \$250 copayment each day/\$125 copayment each partial day – up to a maximum of \$1,000 per admission – up to 45 full days/90 partial days per plan year b. <u>Outpatient</u> * – Coinsurance only applies toward out-of-pocket maximum  \$30 copayment each visit for visits 1-20; \$50 copayment for each visit thereafter per plan year. Group visits will be charged at half the copayment of an individual visit, rounded down to the nearest dollar. Two (2) group visits will count as one individual visit.  * For mental disorders, as defined by state law, day limitations as set forth above, do not apply.

# HMOs

<b>HMO Colorado</b>	
<b>15. Emergency Care<sup>7,8</sup></b>	\$150 copayment per emergency room visit. Copayment is waived if admitted. Care is covered in-network or out-of-network
<b>16. Ambulance</b>	No copayment (100% covered). Care is covered in-network or out-of-network.
<b>17. Urgent, Non-routine, After Hours Care</b>	\$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
<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.
<b>19. Other Mental Health Care</b> <b>a. Inpatient care</b>  <b>b. Outpatient care</b>	<p>\$250 copayment per full day or \$125 copayment per partial day up to a maximum of \$1,000 in copayments per admission. Limited to 45 full or 90 partial days per plan year for other mental health care except as listed below.</p> <p>\$30 copayment per visit for visits 1-20, \$50 copayment per visit thereafter except for those mental disorders as listed below.</p> <p>The following other mental disorders received on an inpatient or outpatient basis are covered no less extensively than the coverage provided for any other physical illness: posttraumatic stress disorder, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder and general anxiety disorder. Anorexia nervosa and bulimia nervosa, to the extent those diagnoses are treated on an outpatient, day treatment, and inpatient basis (residential treatment is excluded), are covered no less extensively than the coverage provided for any other physical illness.</p>

# HMOs

	UA Net HMO	Kaiser Permanente HMO
<b>20. Alcohol/Substance Abuse</b>	Coverage is no less extensive than the coverage provided for any other physical illness.	<p>a. <u>Inpatient Medical Detoxification</u> – Applies toward out-of-pocket maximum \$250 copayment each day up to a maximum of \$1,000 per admission Detoxification is limited to removing toxic substance from the body</p> <p><u>Inpatient Residential Rehabilitation</u> – Does not apply toward out-of-pocket maximum \$250 copayment each day/\$125 copayment each partial day – up to a maximum of \$1,000 per admission.</p> <p>b. <u>Outpatient Chemical Dependency</u> – coinsurance only applies toward out-of-pocket maximum \$30 copayment each visit. Group visits will be charged at half the copayment of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.</p>
<b>21. Physical, Occupational &amp; Speech Therapy</b> <b>a. Inpatient</b>  <b>b. Outpatient</b>	<p>\$250 copayment per day up to a maximum of \$1,000 in copayments per admission. Limited to 30 non-acute inpatient days per plan year.</p> <p>\$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 plan year.</p>	<p>For conditions subject to significant improvement within two (2) months</p> <p>Inpatient* – Applies toward out-of-pocket maximum \$250 copayment each day up to a maximum of \$1,000 per admission</p> <p>Outpatient* – Does not apply toward out-of-pocket maximum \$30 copayment each visit for up to 20 visits per year for each type of therapy (i.e. physical, occupational and speech therapy)</p> <p>*Therapy for congenital defects and birth abnormalities is covered for children from age 3 to age 6 for both acute and chronic conditions. For children ages 0-3 services may be available as part of early intervention services as defined by state law.</p>
<b>22. Durable Medical Equipment</b>	No copayment (100% covered). Limited to a maximum benefit of \$4,000 per plan 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 plan year. Surgical bras are limited to a separate combined \$500 maximum benefit per plan year. Colostomy/ostomy supplies are limited to a separate combined \$3,000 maximum benefit per plan year.	<p>Does not apply toward out-of-pocket maximum</p> <p>No charge (100% covered)/up to \$4,000 annual maximum benefit paid by health plan per plan year. Prosthetic arms and legs covered at 20% coinsurance with no annual maximum benefit. See policy for types and circumstances of coverage.</p>
<b>23. Oxygen</b>	No copayment (100% covered). Limited to a maximum benefit of \$4,000 per plan year; combined with durable medical equipment (see line 22).	<p>Does not apply toward out-of-pocket maximum</p> <p>No charge (100% covered).</p>
<b>24. Organ Transplants</b>	\$250 copayment per day up to a maximum of \$1,000 in copayments per admission	<p>a. Inpatient – see box 12, inpatient hospital</p> <p>b. Outpatient – see applicable benefit in this health plan description form Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver.</p>
<b>25. Home Health Care</b>	No copayment (100% covered)	<p>Does not apply toward out-of-pocket maximum</p> <p>No charge (100% covered) for prescribed medically necessary part-time home health services. Not covered outside the service area.</p>
<b>26. Hospice</b>	No copayment (100% covered)	<p>Inpatient only applies toward out-of-pocket maximum</p> <p>No charge (100% covered) for hospice care. Not covered outside the service area.</p>



# HMOs

	UA Net HMO	Kaiser Permanente HMO
<b>27. Skilled Nursing Facility Care</b>	No copayment (100%) covered. Limited to 100 days per plan year.	Does not apply toward out-of-pocket maximum No charge (100% covered) for up to 100 days per plan year for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the service area.
<b>28. Dental Care</b>	Not covered	Not covered
<b>29. Vision Care</b>	\$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 Anthem Vision Summary Description.	Does not apply toward out-of-pocket maximum \$30 copayment per vision exam performed by an optometrist. Hardware not covered.
<b>30. Chiropractic Care</b>	\$30 copayment per visit. Limited to 20 visits per plan year.	Does not apply toward out-of-pocket maximum \$30 copayment each visit up to 20 visits per plan year
<b>31. Significant Additional Covered Services</b>	Members who desire another professional opinion may obtain a second opinion.  Hearing Aids for Children <sup>12</sup> 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.  \$10 copayment per visit for allergy injections including the allergy serum. Allergy testing is subject to the medical office visit copayment. \$75 copayment of injectables for home use \$40 copayment per visit for cardiac rehabilitation. Limited to 10 visits per plan year.	Travel clinic for pre-travel, health risk assessments, immunizations and prescriptions; mail-order pharmacy; health education classes including smoking cessation, stress management, women's health and diet and nutrition; special services hospice program for persons who have not yet chosen hospice care; limited coverage for dependent students attending an accredited college or vocational school outside any Kaiser Permanente service area.
<b>Part C: Limitations and Exclusions</b>		
<b>32. Period During which Pre-existing Conditions are not Covered<sup>10</sup></b>	Not applicable. Plan does not impose limitation periods for pre-existing conditions.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
<b>33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	No	No
<b>34. How Does the Policy Define a "Pre-existing Condition"?</b>	Not applicable. Plan does not exclude coverage for pre-existing conditions.	Not applicable. Plan does not exclude coverage for pre-existing conditions.
<b>35. What Treatments &amp; Conditions are Excluded Under this Policy?</b>	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent or plan. It is important to review them to see if a service or treatment you may need is excluded from the policy.	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.
<b>Part D: Using the Plan</b>		
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	Yes	No
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	Yes, the physician who scheduled the procedure or hospital care is responsible for obtaining the preauthorization.	Yes
<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	No
<b>39. What is the main customer service number?</b>	800-735-6072	Denver/Boulder: 800-632-9700 Colorado Springs: 888-681-7878

# HMOs

<b>HMO Colorado</b>	
<b>27. Skilled Nursing Facility Care</b>	No copayment (100% covered). Limited to 100 days per plan year.
<b>28. Dental Care</b>	Not covered
<b>29. Vision Care</b>	\$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 Anthem Vision Summary Description.
<b>30. Chiropractic Care</b>	\$30 copayment per visit. Limited to 20 visits per plan year.
<b>31. Significant Additional Covered Services</b>	<p>Members who desire another professional opinion may obtain a second opinion.</p> <p>Hearing Aids for Children<sup>12</sup> 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>\$10 copayment per visit for allergy injections including the allergy serum. Allergy testing is subject to the medical office visit copayment.</p> <p>\$75 copayment of injectables for home use \$40 copayment per visit for cardiac rehabilitation. Limited to 10 visits per plan year.</p>
<b>Part C: Limitations and Exclusions</b>	
<b>32. Period During which Pre-existing Conditions are not Covered<sup>10</sup></b>	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
<b>33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	No
<b>34. How Does the Policy Define a "Pre-existing Condition"?</b>	Not applicable. Plan does not exclude coverage for pre-existing conditions.
<b>35. What Treatments &amp; Conditions are Excluded Under this Policy?</b>	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent or plan. It is important to review them to see if a service or treatment you may need is excluded from the policy.
<b>Part D: Using the Plan</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
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	Yes, the physician who scheduled the procedure or hospital care is responsible for obtaining the preauthorization.
<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
<b>39. What is the main customer service number?</b>	800-735-6072

# HMOs

UA Net HMO		Kaiser Permanente HMO
<b>40. Whom do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></b>	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 800-735-6072	Customer Service Center 2500 S. Havana St. Aurora, CO 80014 303-338-3800
<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	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 policy; whether it is individual, small group, or large group; and if it is a short-term policy.</b>	Policy form #'s 07-00027 Group – Large	Not applicable
<b>43. Does the plan have a binding arbitration clause?</b>	Yes	Yes
<b>Part E: Cost</b>		
<b>44. What is the cost of this plan?</b> a. Employee Only b. Employee + Child(ren) c. Employee + Spouse/SGDP d. Family	Coverage levels and total plan cost are provided separately and can also be found online at <a href="http://www.upicolo.org/benefits">www.upicolo.org/benefits</a> .	Coverage levels and total plan cost are provided separately and can also be found online at <a href="http://www.upicolo.org/benefits">www.upicolo.org/benefits</a> .
<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> “DeductibleType” indicates whether the deductible period is “CalendarYear” (January 1 through December 31) or “Plan Year” (i.e., based on a plan year beginning on the policy’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 plan year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. 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 policy 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 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 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 policy. 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>4a</sup> 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. (Applies to Anthem only.)		
<sup>4b</sup> 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. (Applies to Anthem only.)		

# HMOs

<b>HMO Colorado</b>	
<b>40. Whom do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></b>	HMO Colorado, 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 policy; whether it is individual, small group, or large group; and if it is a short-term policy.</b>	Policy form #'s 07-00027 Group – Large
<b>43. Does the plan have a binding arbitration clause?</b>	Yes
<b>Part E: Cost</b>	
<b>44. What is the cost of this plan?</b> a. Employee Only b. Employee + Child(ren) c. Employee + Spouse/SGDP d. Family	Coverage levels and total plan cost are provided separately and can also be found online at <a href="http://www.upicolo.org/benefits">www.upicolo.org/benefits</a> .
<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.	
<sup>12</sup> 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 (e.g., 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. (Applies to Anthem only.)	

# PPOS

## Anthem Blue Cross and Blue Shield Lumenos Health Savings Account Plan

**In-network**

**Out-of-network**

**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 policy, 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 policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

**Part A: Type of Coverage**

<b>1. Type of Plan</b>	Preferred Provider Plan-High Deductible Health 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 where Plan is Available</b>	Nationally

**Part B: Summary of Benefits**

<b>4. Deductible Type<sup>2</sup></b>	Plan year	Plan year
<b>4a. Annual Deductible<sup>2a</sup></b> a. Single <sup>2b</sup> b. Non-Single <sup>2c</sup>	\$1,500 \$3,000 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.	\$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 in-network deductible.
<b>5. Out-of-Pocket maximum per plan-year<sup>3</sup></b>  a. Individual b. Family  c. Is deductible included in the out-of-pocket maximum?	\$3,000 \$6,000 If more than employee-only coverage applies, the family out-of-pocket maximum must be met. Yes	\$6,000 \$12,000 If more than employee-only coverage applies, the family out-of-pocket maximum must be met. Yes
<b>6. Lifetime or Benefit Maximum Paid by the Plan for All Care</b>	\$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.
<b>7a. Covered Providers</b>	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for 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> a. Primary Care Providers b. Specialists	15% after deductible 15% after deductible	35% after deductible 35% after deductible
<b>9. Preventive Care</b> a. Children Services  b. Adult Services  c. Colorectal screening services (not subject to deductible) <sup>4a, 4b</sup>	Up to age 13, covered person pays no coinsurance (100% covered) not subject to deductible  Age 13 and above, covered person pays no coinsurance (100% covered) not subject to deductible  Covered person pays no coinsurance (100% covered), not subject to deductible. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.	Up to age 13, 35% 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. 35% not subject to deductible. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.

# PPOS

## Anthem Blue Cross and Blue Shield Lumenos Health Savings Account Plan

	In-network	Out-of-network
<b>10. Maternity</b> a. Prenatal Care b. Delivery & Inpatient Well Baby Care <sup>5</sup>	15% after deductible 15% after deductible	35% after deductible 35% after deductible
<b>11. Prescription Drugs</b> Level of coverage and restrictions on prescriptions <sup>6</sup> a. Inpatient care b. Outpatient care c. Prescription Mail Service	15% after deductible 20% after deductible for up to a 30-day supply  20% after deductible for up to a 90-day supply  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> .	35% after deductible 20% after in-network deductible for up to a 30-day supply No benefit for mail-order drugs
<b>12. Inpatient Hospital</b>	15% after deductible	35% after deductible
<b>13. Outpatient/Ambulatory Surgery</b>	15% after deductible	35% after deductible
<b>14. Diagnostics Laboratory &amp; X-ray</b>	15% after deductible	35% after deductible
<b>15. Emergency Care<sup>7,8</sup></b>	15% after deductible	15% after in-network deductible
<b>16. Ambulance</b>	15% after deductible	15% after in-network deductible
<b>17. Urgent, Non-routine, After Hours Care</b>	15% after deductible	35% 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	15% after deductible. Limited to 45 full or 90 partial days per plan year combined in- and out-of-network for other mental-health care except as listed below.  15% after deductible. Limited to 30 visits with a minimum of \$1,000 in benefits per plan year combined in- and out-of-network for other mental-health care except as listed below.  For other mental disorders of posttraumatic stress disorder, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder and general anxiety disorder, coverage is no less extensive than the coverage provided for any other physical illness. Anorexia nervosa and bulimia nervosa, to the extent those diagnoses are treated on an outpatient, day treatment, and inpatient basis (residential treatment is excluded), are covered no less extensively than the coverage provided for any other physical illness.	35% after deductible. Limited to 45 full or 90 partial days per plan year combined in- and out-of-network for other mental-health care except as listed below.  35% after deductible. Limited to 30 visits with a minimum of \$1,000 in benefits per plan year combined in- and out-of-network for other mental-health care except as listed below.
<b>20. Alcohol &amp; Substance Abuse</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>21. Physical, Occupational &amp; Speech Therapy</b> a. Inpatient  b. Outpatient	15% after deductible. Limited to 30 non-acute inpatient days per plan year in- and out-of-network combined. 15% after deductible. Limited to a maximum-benefit of \$2,000 per plan year for physical therapy in- and out-of-network combined, and a maximum-benefit of \$2,000 per plan 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 birth abnormalities in- and out-of-network combined.	35% after deductible. Limited to 30 non-acute inpatient days per plan year in- and out-of-network combined. 35% after deductible. Limited to a maximum-benefit of \$2,000 per plan year for physical therapy in- and out-of-network combined, and a maximum-benefit of \$2,000 per plan 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 birth abnormalities in- and out-of-network combined.

# PPOS

## Anthem Blue Cross and Blue Shield Lumenos Health Savings Account Plan

	In-network	Out-of-network
<b>22. Durable Medical Equipment</b>	15% after deductible. Limited to a maximum-benefit of \$5,000 per plan 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 plan 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.
<b>23. Oxygen</b>	15% after deductible	35% after deductible
<b>24. Organ Transplants</b>	15% after deductible	Not Covered
<b>25. Home Health Care</b>	15% after deductible. Limited to 100 visits per plan year combined in- and out-of-network.	35% after deductible. Limited to 100 visits per plan year combined in- and out-of-network.
<b>26. Hospice Care</b> <b>a. Inpatient</b>	15% after deductible	35% after deductible
<b>b. Outpatient</b>	15% after deductible	35% after deductible
<b>27. Skilled Nursing Facility Care</b>	15% after deductible. Limited to 100 days per plan year in- and out-of-network combined.	35% after deductible. Limited to 100 days per plan year in- and out-of-network combined.
<b>28. Dental Care</b>	Not Covered	Not Covered
<b>29. Vision Care</b>	Not Covered	Not Covered
<b>30. Chiropractic Care</b>	15% after deductible	35% after deductible
<b>31. Significant Additional Covered Services</b>	Members who desire another professional opinion may obtain a second surgical opinion.  Hearing Aids for Children <sup>12</sup> 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.	Members who desire another professional opinion may obtain a second surgical opinion.  Hearing Aids for Children <sup>12</sup> 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.
<b>Part C: Limitations and Exclusions</b>		
<b>32. Period During which Pre-Existing Conditions are not Covered<sup>10</sup></b>	None (No pre-existing)	
<b>33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	No	
<b>34. How Does the Policy Define a "Pre-existing Condition"?</b>	Not applicable. Plan does not exclude coverage for pre-existing conditions.	
<b>35. What Treatments &amp; Conditions are Excluded Under this Policy?</b>	Exclusions vary by policy. A 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 policy.	
<b>Part D: Using the Plan</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	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
<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.

# PPOS

## Anthem Blue Cross and Blue Shield Lumenos Health Savings Account Plan

<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?<sup>11</sup></b>	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 number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.</b>	Policy form #'s 07-00030 Large Group
<b>43. Does the plan have a binding arbitration clause?</b>	Yes
<b>Part E: Cost</b>	
<b>44. What is the cost of this plan?</b> <b>a. Employee Only</b> <b>b. Employee + Child(ren)</b> <b>c. Employee + Spouse/SGDP</b> <b>d. Family</b>	Coverage levels and total plan cost are provided separately and can also be found online at <a href="http://www.upicolo.org/benefits">www.upicolo.org/benefits</a> .

<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 "Plan Year" (i.e., based on a plan year beginning on the policy'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 plan year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. 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 policy 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 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 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 policy. 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>4a</sup> 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.

<sup>4b</sup> 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.

<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.

# PPOS

## Anthem Blue Cross and Blue Shield Lumenos Health Savings Account Plan

<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.

<sup>12</sup> 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 (e.g., 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.

# PPOS

## Anthem Blue Cross and Blue Shield BluePreferred PPO Plan

In-network

Out-of-network

**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 policy, 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 policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

### Part A: Type of Coverage

1. Type of Plan	Preferred provider plan
2. Out-of-Network Care Covered? <sup>1</sup>	Yes, but the patient pays more for out-of-network care
3. Areas where Plan is Available	Nationally

### Part B: Summary of Benefits

4. Deductible Type <sup>2</sup>	Plan year	Plan year
4a. Annual Deductible <sup>2a</sup> a. Single <sup>2b</sup> b. Non-Single <sup>2c</sup>	\$850 \$2,250 aggregate	\$1,700 \$4,500 aggregate
5. Out-of-Pocket maximum per plan-year <sup>3</sup> a. Individual  b. Family  c. Is deductible included in the out-of-pocket maximum?	\$4,000, includes per-confinement inpatient and outpatient surgery copayments. Excludes all other copayments and coinsurance for outpatient other mental-health care.  \$12,000 aggregate, includes per-confinement inpatient and outpatient surgery copayments. Excludes all other copayments and coinsurance for outpatient other mental-health care.  No	Unlimited  Unlimited  Not applicable
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. Major organ transplants have a lifetime-maximum benefit of \$1,000,000 per transplant per member.	\$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. See provider directory 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 <sup>4</sup> a. Primary Care Providers  b. Specialists	\$20 copayment per visit, 40% after deductible for all other services (e.g., laboratory and x-ray services, office surgical services).  \$20 copayment per visit, 40% after deductible for all other services (e.g., laboratory and x-ray services, office surgical services).	50% after deductible  50% after deductible

# PPOS

## Anthem Blue Cross and Blue Shield BluePreferred PPO Plan

	In-network	Out-of-network
<b>9. Preventive Care</b> <b>a. Children Services</b>  <b>b. Adult Services</b>  <b>c. Colorectal screening services (not subject to deductible)<sup>4a, 4b</sup></b>	<p>Up to age 13, \$20 copayment per visit, no deductible or coinsurance (100% covered) for all other services (e.g. laboratory and x-ray services).</p> <p>\$20 copayment per office visit for routine exam, no deductible or coinsurance (100% covered) for all other services (e.g. laboratory and x-ray services).</p> <p>\$15 copayment per visit. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.</p>	<p>Up to age 13, 50% not subject to deductible.</p> <p>50% after deductible except for mammogram and prostate screening, which are not subject to deductible or coinsurance.</p> <p>50% not subject to deductible. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.</p>
<b>10. Maternity</b> <b>a. Prenatal Care</b>  <b>b. Delivery &amp; Inpatient Well Baby Care<sup>5</sup></b>	<p>20% after deductible</p> <p>\$500 per admission copayment, then 20% after deductible</p>	<p>50% after deductible</p> <p>\$500 per admission copayment, then 50% after deductible</p>
<b>11. Prescription Drugs</b> <b>Level of coverage and restrictions on prescriptions<sup>6</sup></b>  <b>a. Inpatient care</b>  <b>b. Outpatient care</b>  <b>c. Prescription Mail Service</b>	<p>\$500 per admission copayment, then 50% after deductible.</p> <p><b>Retail Pharmacy Drugs</b> - Tier 1 generic prescription \$15 copayment, tier 2 brand-name prescription \$40 copayment, tier 3 non-formulary prescription \$60 copayment, per prescription at a participating pharmacy up to a 30-day supply.</p> <p><b>Mail-Order Pharmacy Drugs</b> - Tier 1 generic prescription \$30 copayment, tier 2 brand-name prescription \$80 copayment, tier 3 non-formulary prescription \$120 copayment, per prescription at a participating pharmacy up to a 90-day supply.</p> <p><b>The following applies to b. and c. above:</b> Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem, up to \$250 per member per calendar year, \$500 per lifetime.</p> <p>In addition to the cost sharing described above, if you purchase a tier 2 brand-name prescription drug when there is a FDA rated equivalent tier 1 generic prescription drug available, you are responsible for the tier 2 brand-name copayment and you will pay the cost difference between the brand-name prescription drug and the tier 1 generic prescription drug. 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>\$500 per admission copayment, then 50% after deductible</p> <p>Not covered</p> <p>Not covered</p>
<b>12. Inpatient Hospital</b>	\$500 per admission copayment, then 20% after deductible	\$500 per admission copayment, then 50% after deductible
<b>13. Outpatient/Ambulatory Surgery</b>	\$500 per visit copayment, then 40% after deductible	\$500 per visit copayment, then 50% after deductible
<b>14. Diagnostics</b> <b>a. Laboratory &amp; X-ray</b>  <b>b. MRI, nuclear medicine, and other high-tech services</b>	<p>40% after deductible</p> <p>40% after deductible</p>	<p>50% after deductible</p> <p>50% after deductible</p>
<b>15. Emergency Care<sup>7,8</sup></b>	40% after deductible	40% after in-network deductible
<b>16. Ambulance</b>	20% after deductible	20% after in-network deductible.

# PPOS

## Anthem Blue Cross and Blue Shield BluePreferred PPO Plan

	In-network	Out-of-network
<b>17. Urgent, Non-routine, After Hours Care</b>	\$20 copayment per visit, 40% after deductible for all other services (e.g., laboratory and x-ray services).	50% after 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> <b>a. Inpatient care</b>	\$500 per admission copayment, then 50% after deductible. Limited to 45 full or 90 partial days per plan year in- and out-of-network combined for other mental-health care except as listed below.	\$500 per admission copayment, then 50% after deductible. Limited to 45 full or 90 partial days per plan year in- and out-of-network combined for other mental-health care except as listed below.
<b>b. Outpatient care</b>	50% after deductible. Limited to 20 visits with a minimum of \$1,000 in benefits per plan year in- and out-of-network combined for other mental-health care except as listed below.  For other mental disorders of posttraumatic stress disorder, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder and general anxiety disorder, coverage is no less extensive than the coverage provided for any other physical illness. Anorexia nervosa and bulimia nervosa, to the extent those diagnoses are treated on an outpatient, day treatment, and inpatient basis (residential treatment is excluded), are covered no less extensively than the coverage provided for any other physical illness.	50% after deductible. Limited to 20 visits with a minimum of \$1,000 in benefits per plan year in- and out-of-network combined for other mental-health care except as listed below.
<b>20. Alcohol &amp; Substance Abuse</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>21. Physical, Occupational &amp; Speech Therapy</b> <b>a. Inpatient</b>	\$500 per admission copayment, then 20% after deductible. Limited to 30 non-acute inpatient days per plan year in- and out-of-network combined.	\$500 per admission copayment, then 50% after deductible. Limited to 30 non-acute inpatient days per plan year in- and out-of-network combined.
<b>b. Outpatient</b>	40% after deductible. Limited to a maximum-benefit of \$2,000 per plan year for physical therapy, and a maximum-benefit of \$2,000 per plan 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 birth abnormalities in- and out-of-network combined.	50% after deductible. Limited to a maximum-benefit of \$2,000 per plan year for physical therapy, and a maximum-benefit of \$2,000 per plan 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 birth abnormalities in- and out-of-network combined.
<b>22. Durable Medical Equipment</b>	20% after deductible for life sustaining durable medical equipment including prosthetic devices. Covered person pays 40% after deductible for non-life sustaining durable medical equipment limited to a maximum-benefit of \$2,500 per plan year in- and out-of-network combined.	50% after deductible for life sustaining durable medical equipment including prosthetic devices. Covered person pays 50% after deductible for non-life sustaining durable medical equipment limited to a maximum-benefit of \$2,500 per plan year in- and out-of-network combined.
<b>23. Oxygen</b>	20% after deductible	50% after deductible
<b>24. Organ Transplants</b>	\$500 per admission copayment, then 20% after deductible.	Not covered
<b>25. Home Health Care</b>	20% after deductible. Limited to 60 visits per plan year combined in- and out-of-network.	50% after deductible. Limited to 60 visits per plan year combined in- and out-of-network.
<b>26. Hospice Care</b> <b>a. Inpatient</b>	\$500 per admission copayment, then 20% after deductible.	\$500 per admission copayment, then 50% after deductible.
<b>b. Outpatient</b>	20% after deductible	50% after deductible
<b>27. Skilled Nursing Facility Care</b>	\$500 per admission copayment, then 20% after deductible. Limited to 100 days per plan year in- and out-of-network combined.	\$500 per admission copayment, then 50% after deductible. Limited to 100 days per plan year in- and out-of-network combined.
<b>28. Dental Care</b>	Not covered	Not covered

# PPOS

## Anthem Blue Cross and Blue Shield BluePreferred PPO Plan

	In-network	Out-of-network
<b>29. Vision Care</b>	Not covered	Not covered
<b>30. Chiropractic Care</b>	40% after deductible. Limited to a maximum-benefit of \$500 per plan year in- and out-of-network combined.	50% after deductible. Limited to a maximum-benefit of \$500 per plan year in- and out-of-network combined.
<b>31. Significant Additional Covered Services</b>	Members who desire another professional opinion may obtain a second surgical opinion.  Hearing Aids for Children <sup>12</sup> 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.	Members who desire another professional opinion may obtain a second surgical opinion.  Hearing Aids for Children <sup>12</sup> 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.
<b>Part C: Limitations and Exclusions</b>		
<b>32. Period During which Pre-Existing Conditions are not Covered<sup>10</sup></b>	None (No pre-existing)	
<b>33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	No	
<b>34. How Does the Policy Define a "Pre-existing Condition"?</b>	Not applicable. Plan does not exclude coverage for pre-existing conditions.	
<b>35. What Treatments &amp; Conditions are Excluded Under this Policy?</b>	Exclusions vary by policy. A 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 policy.	
<b>Part D: Using the Plan</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	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
<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?<sup>11</sup></b>	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 number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.</b>	Policy form #'s 07-00031 Large Group	
<b>43. Does the plan have a binding arbitration clause?</b>	Yes	

# PPOS

## Anthem Blue Cross and Blue Shield BluePreferred PPO Plan

In-network

Out-of-network

**Part E: Cost**

- 44. What is the cost of this plan?**  
**a. Employee Only**  
**b. Employee + Child(ren)**  
**c. Employee + Spouse/SGDP**  
**d. Family**

Coverage levels and total plan cost are provided separately and can also be found online at [www.upicolo.org/benefits](http://www.upicolo.org/benefits).

- <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 "Plan Year" (i.e., based on a plan year beginning on the policy'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 plan year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. 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 policy 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 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 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 policy. 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>4a</sup> 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.
- <sup>4b</sup> 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.
- <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.
- <sup>12</sup> 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 (e.g., 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.

# CANCER SCREENING GUIDELINES

## Anthem

### Pap Tests

All plans provide coverage under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the plan's provisions for laboratory services or preventive care service. Payment for the related office visit is based on the plan's preventive care provisions. Under most plans Pap tests received out-of-network are not covered since under most plans coverage for preventive care is not covered out-of-network.

### Mammogram Screenings

All plans provide coverage under the preventive care benefits for one routine screening or diagnostic mammogram per year regardless of age (or in accordance with the frequency determined by your provider) for women. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care and is normally not subject to the deductible or coinsurance.

### Prostate Cancer Screenings

All plans provide coverage under the preventive care benefits for one routine prostate cancer screening per year regardless of age (or in accordance with the frequency determined by your provider) for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive exam and laboratory services and is normally not subject to the deductible or coinsurance.

### Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Our plans do not provide coverage for preventive colorectal cancer screenings involving DNA analysis. Under most plans colorectal cancer screenings received out-of-network are not covered since under most plans coverage for preventive care is not covered out-of-network.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Colorado Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Colorado Health Benefit Plan Description Form.

## Kaiser Permanente (Charges may apply)

SCREENING	(FREQUENCY SUBJECT TO PHYSICIAN RECOMMENDATION)	KAISER PERMANENTE RECOMMENDATION
<b>Breast Cancer</b>		
Clinical breast exam	Annually	As jointly determined by physician and patient
Mammogram	Available annually for all women beginning at age 40 or earlier based upon patient risk	At least every 2 years, particularly after age 50
Genetic testing for inherited susceptibility for breast cancer	Available upon referral of a Kaiser Permanente provider	For those women who meet the following criteria: Patients with a 10% or greater risk of inherited gene defect
<b>Colon and Rectal Cancer</b>		
Fecal occult blood test (FIT)	Annually after age 50	Annually beginning at age 50 through age 75 (if not screened with colonoscopy)
Flexible sigmoidoscopy	On an individual basis	Not a routine recommendation
Barium enema	On an individual basis	Not a routine recommendation
Colonoscopy	Every 10 years, more frequently for high risk patients	Every 10 years beginning at age 50 through age 75. High risk patients may start at an earlier age and may be screened more frequently.
<b>Cervical Cancer</b>		
Pap test	Annually	Every 2 years, starting 3 years after becoming sexually active or at age 21; more frequently if high risk. For ages 65 and older, not recommended if long history of normal PAP smears and not high risk.
<b>Prostate Cancer</b>		
Digital rectal exam	Annually	As jointly determined by physician and patient
Serum prostatic specific antigen (PSA)	Annually	As jointly determined by physician and patient. Not recommended for those over 75.

**You have**

**31 days**

**from your date of hire or a qualifying life event  
to enroll or make changes.**

**Submit your completed forms to  
HR by fax, mail, or in person.**



**University Physicians, Inc.**

13611 E. Colfax Avenue

Aurora, CO 80045-5701

Phone: 303-493-7607

Fax: 303-493-7601

E-mail: [benefits.admin@upicolo.org](mailto:benefits.admin@upicolo.org)

**[www.upicolo.org/benefits](http://www.upicolo.org/benefits)**

## TYPES OF DENTAL PLANS AND OPTIONS

If you select a medical plan, you must also select a dental plan. At a minimum you are required to enroll in one of the dental plans, employee-only coverage. Both plans are administered by Delta Dental. If you waive medical coverage, you have the option to either waive or enroll in dental coverage.

For services exceeding \$400, have your dentist submit a treatment plan to Delta Dental prior to receiving any services. This will assist you with managing your out-of-pocket costs.

Your dependent children may be added to your current plan by submitting the Benefits Enrollment/Change Form either:

- within 31 days of their date of birth for an immediate effective date,
- within 31 days of their third birthday, or
- during the next annual open enrollment period.

### **Exclusive Panel Option (EPO)**

- Members must live in Colorado.
- Benefits are paid **ONLY** when members use a dentist in the Delta Dental PPO provider network.
- Verify that your dentist is in the network prior to each appointment by calling Delta Dental.
- Members must pay a copay for most services.
- You may change dentists at any time as long as the dentist is a Delta Dental PPO dentist.
- Employee-only monthly premium is paid in full by UPI.
- Claims are submitted by provider.
- Children orthodontics to age 19 is a covered benefit.
- Adult orthodontics is a covered benefit.
- No international coverage.

## Delta Dental PPO

- In- and out-of-network coverage is available.
- You have a lower out-of-pocket cost when using an in-network provider.
- You may change dentists at any time.
- Deductible applies per plan year per member (except for preventive and diagnostic).
- Plan pays percentage of covered cost based on provider used (in-network or out-of-network).
- Plan provides international coverage.
- Members may be required to submit claims.
- Only children up to age 19 have orthodontic coverage.

### Waive Coverage Option

If you want to waive dental coverage for the plan year you must select the “Waive Dental Coverage” box on the Benefits Enrollment/Change Form. Once you waive coverage, you will not be allowed to enroll until the next scheduled open enrollment or within 31 days of a *qualifying life event* as defined by applicable federal and/or state laws or the master plan documents.

# DENTAL PLAN OPTIONS

## DELTA DENTAL SUMMARY OF BENEFITS

DENTAL BENEFITS <i>(Administered by Delta Dental)</i>	EXCLUSIVE PANEL OPTION (EPO)	DELTA DENTAL PPO		
		<i>In-network coverage (PPO Dentists)</i>	<i>In-network coverage (Premier Dentists)</i>	<i>Out-of-network coverage (Non-participating Dentists)</i>
Provider Selection	<ul style="list-style-type: none"> <li>• Dentist agrees to accept scheduled fees</li> <li>• Claim forms are filed by dental office</li> </ul>	<ul style="list-style-type: none"> <li>• Dentist agrees to accept scheduled fees</li> <li>• Claim forms are filed by dental office</li> </ul>	<ul style="list-style-type: none"> <li>• Dentist agrees to accept scheduled fees</li> <li>• Claim forms are filed by dental office</li> </ul>	<ul style="list-style-type: none"> <li>• Benefits are based on Delta's allowed charges</li> <li>• You pay any excess charges above Delta's allowed charges</li> <li>• You are responsible for filing claim forms</li> </ul>
Plan-Year Deductible	None	\$50 per member per plan year—deductible does not apply to diagnostic and preventive services	\$75 per member per plan year—deductible does not apply to diagnostic and preventive services	\$75 per member per plan year—deductible does not apply to diagnostic and preventive services
Plan-Year Maximum	\$2,000/person	\$2,000/person	\$2,000/person	\$2,000/person
Preventive (cleanings, fluoride, sealants) and Diagnostic (X-rays, oral examinations)	No copays for initial/periodic oral exam. Up to two cleanings in a plan year.	100%—up to two cleanings in a plan year	100%—up to two cleanings in a plan year.	100% of Delta's allowed charges
Basic Restorative (fillings)	\$32 to \$97 copay, depending on procedure	80% after deductible	60% after deductible	After deductible, 60% of allowed charges
Endodontics (root canal therapy)	\$223 to \$373 copay, depending on procedure	70% after deductible	50% after deductible	After deductible, 50% of allowed charges
Periodontics (treatment of the gums)	\$117 to \$334 copay, depending on procedure	70% after deductible	50% after deductible	After deductible, 50% of allowed charges
Oral Surgery (extractions)	\$39 to \$151 copay, depending on procedure	70% after deductible	50% after deductible	After deductible, 50% of allowed charges
Prosthodontics (crowns, bridges, dentures)	\$22 to \$569 copay, depending on procedure	50% after deductible	40% after deductible	After deductible, 40% of allowed charges
Implants as part of a major restoration	Not covered	50% after deductible	40% after deductible	After deductible, 40% of allowed charges
Orthodontics (children to age 19)	\$4,000 lifetime maximum based on EPO copay schedule	50% to \$1,500 lifetime maximum per child	50% to \$1,500 lifetime maximum per child	40% of allowed charges, up to \$1,500 lifetime maximum per child (deductible does not apply)
Orthodontics (adults)	\$4,000 lifetime maximum based on EPO copay schedule	Not a covered benefit	Not a covered benefit	Not a covered benefit
Emergency Services	\$31 copay	Covered with appropriate coinsurance	Covered with appropriate coinsurance	Covered with appropriate coinsurance

# UPI-FLEX OVERVIEW

UPI-Flex is an Internal Revenue Code (IRC) Section 125 flexible benefits plan that offers three different options, which may be elected separately or in combination to help lower your taxable income.

## Premium Only Plan (POP)

- Once you elect to participate in the POP, your enrollment will continue from plan year to plan year. Changes to your POP election may be made **only during open enrollment**.
- The POP allows your monthly medical and dental insurance premiums to be deducted from your paycheck before taxes are calculated.
- If you have children or relatives who do not qualify as federal tax dependents, their premiums are not eligible for the POP.
- HR requires proper documentation for SGDPs and their dependents in order to deduct the relevant portions of their premium pre-tax.
- If you have any children or relatives enrolled who do not qualify as federal tax dependents, you will incur imputed income.

## Health Care Flexible Spending Account (HCFSA)

- You **must** re-elect the HCFSA every plan year to continue participation.
- The HCFSA allows you to contribute, pre-tax, a minimum of \$10 per month up to \$6,000 each plan year to cover certain eligible out-of-pocket medical, dental and vision expenses not covered or reimbursed by insurance and incurred by you or your federal tax dependents.
- You cannot make contributions to both an HCFSA and a Health Savings Account (HSA).
- You can incur eligible expenses for your account until September 15, 2010.
- You may file a claim for reimbursement until November 15, 2010.
- Enrollment in a UPI medical/dental plan is not required for you and/or your federal tax dependents to participate in the HCFSA.
- You may submit eligible healthcare expenses under this plan for yourself and your federal tax dependents.
- Expenses qualify for the HCFSA when they are incurred, not when they are paid.
- Over-the-counter (OTC) medications and drugs are covered, but they must be used to treat an existing or imminent medical condition. You cannot claim OTC items used for general good health. Additional claim documentation may be required.
- You may not use this account to reimburse insurance premiums.

*continued on next page*

## Dependent Care Flexible Spending Account (DCFSA)

- You **MUST** re-elect the DCFSA every plan year to continue participation.
- You may contribute, pre-tax, a minimum of \$10 per month and up to \$5,000 (\$2,500 if you are married and file your taxes separately) to pay for the cost of caring for your federal tax dependents so you (and your spouse if you are married) can work.
- This is NOT for your dependent spouse's or children's healthcare expenses.
- Your contribution is for the **plan year**. However, for tax purposes you are responsible for keeping track of your total **calendar-year contributions**, including any contributions made by your spouse.
- You can incur eligible expenses for your account until September 15, 2010.
- You may file a claim for reimbursement until November 15, 2010.
- Contact HR if you need assistance calculating your calendar-year maximum and plan-year maximum.
- Federal tax dependents, for the purpose of the DCFSA, include any qualifying child or relative who is under the age of 13, your spouse, and older dependents who are mentally or physically incapable of self-care and who live in your home at least eight hours each day.
- If you are divorced, the dependent must be your son or daughter for whom you have more than 50 percent physical custody.
- Dependent daycare expenses are incurred when the day care is provided. You must receive the dependent daycare services before you file a claim for those services.
- Qualifying providers can provide care in your home or outside your home. Care provided outside your home and in a facility caring for more than five individuals must be licensed by the state.
- Expenses may not be paid to your spouse, to any of your children who are under the age of 19 at the end of the year in which the expenses are incurred, or to any other individuals for whom you or your spouse are entitled to a personal tax exemption as a dependent.

ASI administers the Healthcare Flexible Spending Account (HCFSA) and Dependent Care Flexible Spending Account (DCFSA). For more details on qualified expenses and how these accounts work, please refer to the ASI website at [www.asiflex.com](http://www.asiflex.com).

## TO FLEX OR NOT TO FLEX?

Because flex accounts provide tax advantages, the federal government imposes strict rules and limitations on enrolling, making changes, or using these accounts. You should consult your tax advisor or the IRS for guidance on how UPI-Flex options might affect your personal tax status. Please carefully consider the following in making your decision whether to flex or not, and if you do, how much you should contribute.

### Effective Date

- Flexible Spending Account (FSA) elections will be effective the first day of the month following receipt of the Benefits Enrollment/Change Form by HR.

### Tax Considerations

- UPI-Flex dollars are deducted from your paycheck pre-tax, meaning before federal, state, FICA (Social Security), and Medicare taxes are paid. Your taxable income is reduced by the amount you contribute.
- Participating in UPI-Flex reduces the salary on which annual contributions to Social Security are calculated, which may result in a reduction of the Social Security benefits received at retirement.
- Reimbursements from your DCFSA may reduce or eliminate dependent care tax credits on your federal income tax return. For most people, DCFSA reimbursements provide a greater benefit, but everyone's tax situation is different, so it is best to compare tax savings on an individual basis.
- HR requires proper documentation for SGDPs and their dependents in order to deduct the relevant portions of their premium pre-tax.
- Dependents ages 19 to 25 must qualify as federal tax dependents to participate.

### Changing Your Flex Contribution During the Plan Year

- Your elections under these plans **ARE IRREVOCABLE** during the plan year except as specified by IRC rules.
- Contact HR for information if you go on leave without pay.

### Separate Choices and Accounts

- The POP, HCFSA, and DCFSA are three separate choices. You may **NOT** use your HCFSA contributions to reimburse yourself for dependent daycare expenses or vice versa, even if you have excess contributions in one account and a shortage in the other.

### Using Contributions

- Your spending accounts **CAN ONLY BE USED** to reimburse eligible expenses incurred during the effective period of the plan year for which you enroll. You **CANNOT** roll over any amount not used in your account.
- You have until November 15, 2010, to submit any eligible expenses incurred within the plan year for reimbursement.

## **Unused Balances**

- It is important that you review your previous year's expenses and carefully plan your election amount for each account.
- If you do not incur eligible expenses equal to your contributions, the IRC requires that the unused portion of your account balance be forfeited.

## **Terminating Participation**

- Your participation will end when you terminate employment with UPI. This means you will no longer be able to make contributions to the plan, unless you elect the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
- Expenses incurred while you are not a participant—for example, on leave without pay (LWOP)—will not qualify for reimbursement unless you are on approved Family Medical Leave Act (FMLA) leave.
- If you return to work within 30 days during the same plan year, your participation will be reinstated. You will have the option of reinstating your coverage at the same plan-year level you had prior to your termination, or reinstating your coverage at the same monthly amount with a reduced plan-year amount. Contact HR when you return to work.
- Should you choose the same plan-year amount, your per-pay-period contributions will be adjusted so that your total contributions for the plan year will equal your annual coverage amount.
- If you return to work after 31 days during the same plan year, you may make a new election for the remainder of the plan year.
- If you terminate participation in the plan prior to the end of the plan year, you are not eligible to submit expenses for reimbursement after your termination date, regardless of the balance in your account.

## **COBRA**

- To the extent required by COBRA, a participant or his/her federal tax dependent may elect to continue the coverage elected under the Health Care Flexible Spending Account (HCFSA).
- Please refer to the UPI website for the UPI-Flex Summary Plan Description (SPD) detailing COBRA continuation of coverage rights.

# LIFE PLAN OPTIONS

University Physicians, Inc. offers three life insurance plan options to benefits-eligible employees and two optional life insurance plans for eligible dependents. All the plans are administered by Standard Insurance Company.

## Basic Term Life/AD&D Insurance Plan

All eligible employees are automatically enrolled in UPI-paid Basic Term Life Insurance plan. This plan also includes an Accidental Death and Dismemberment (AD&D) benefit.

## Optional Term Life/AD&D Insurance Plan

**Employee Optional Term Life Insurance**—You may purchase additional life insurance through the Optional Term Life/AD&D Insurance Plan in increments of \$1,000, up to \$500,000. AD&D coverage is equal to the Optional Term Life amount.

**Spouse/SGDP Optional Term Life Insurance**—You may purchase additional life insurance for your spouse/SGDP in increments of \$1,000, not to exceed the amount of your own optional life insurance.

**Dependent Optional Life Insurance**—You may purchase an additional life insurance policy for your eligible dependent children for either \$5,000 or \$10,000, as long as it does not exceed the amount of your own optional term life insurance.

### Rate Discount

If you and/or your spouse/SGDP are non-tobacco users, meaning that you have not used tobacco products within the past 12 months, you are eligible for a discounted rate in the Optional Term Life/AD&D Insurance Plan. Complete the appropriate section on the Benefits Enrollment/Change Form to receive the discounted rate. If your status changes from a non-tobacco user to a tobacco user, you must notify HR immediately.

### Imputed Income on Life Insurance

According to IRC regulations (IRC section 79), life insurance coverage in excess of \$50,000 may be subject to federal taxes based on a graduated rate table provided by the IRS. The amount of life insurance coverage in excess of \$50,000 is multiplied by a premium rate based on an employee's age at the end of the calendar year, which results in a monthly amount of "imputed" income. This imputed income, reduced by the amount the employee paid toward the insurance, is taxable as a benefit and is, therefore, added to the employee's applicable wage base for federal income tax, Social Security tax, and Medicare tax purposes. Imputed income will be calculated on employees' life plans (basic and optional) and on their spouse's/SGDP's optional life insurance, as applicable. The \$50,000 exclusion for employees does not apply to their spouse's/SGDP's optional life insurance.

Although the taxable portion of the group life insurance benefit is subject to federal income tax and is recorded on an employee's W-2 annually, UPI is *not required to withhold* income tax from an employee's paycheck. UPI is *required to withhold* Social Security and Medicare taxes on the life insurance benefit each month. For most employees, this usually equates to a very small sum of money.

**During your initial 31-day eligibility period**, you have a one-time opportunity to enroll yourself in coverage up to the guaranteed issue (GI) amount of three times your annual salary, plus you may enroll your spouse/SGDP up to the GI amount of \$50,000, without providing a medical history statement.

**After the initial 31-day eligibility period**, you will not be allowed to enroll until the next scheduled open enrollment or within 31 days of a *qualifying life event* (as defined by applicable federal and/or state laws or the master plan documents). If you experience a *qualifying life event*, you may only enroll yourself and/or your spouse/SGDP for up to a maximum of \$10,000, not to exceed the GI amount, without providing a medical history statement.

### **Voluntary Accidental Death and Dismemberment Insurance (Voluntary AD&D) Plan**

You may elect coverage for yourself—and up to an equal amount for your spouse/SGDP—in multiples of \$10,000 up to 10 times your annual salary or \$250,000, whichever is less. Dependent children may be covered for \$5,000. If you do not enroll during your initial 31-day eligibility period, you will not be allowed to enroll until the next scheduled open enrollment or within 31 days of a *qualifying life event* (as defined by applicable federal and/or state laws or the master plan documents).

#### **Beneficiary Designations for Life and Voluntary AD&D Plans**

- Primary beneficiaries receive the benefit in the event of your death. If you name more than one primary beneficiary, you must indicate the percentage assigned to each and make sure the total in this category equals 100 percent.
- Contingent beneficiaries receive the benefit only if your primary beneficiary(ies) is deceased. If naming more than one contingent beneficiary(ies), please indicate the percentage assigned to each and make sure the total equals 100 percent.
- For spouse/SGDP and dependent Optional Life/AD&D and Voluntary AD&D coverage, the beneficiary is automatically you, the UPI employee.
- Changes to beneficiary designations require you to complete the Benefits Enrollment/Change Form. The effective date of beneficiary changes is the date you signed the form.

### **Termination of UPI Employment**

If you are enrolled in one or more of the term life insurance plans and your employment terminates for any reason, contact HR immediately to receive information on your rights for conversion or portability of the policy.

# DISABILITY OVERVIEW

Disability coverage pays a portion of your pre-disability income when it is medically necessary for you to be off work. Review the chart below summarizing your disability benefits. For complete details, go to the Summary Plan Descriptions (SPD) located on the UPI website at [www.upicolo.org/benefits](http://www.upicolo.org/benefits).

## DISABILITY PROGRAMS

	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Amount of Coverage	Your choice of \$100 up to \$850 maximum weekly benefit, based on earnings equal to or less than your annual salary. May not exceed your annual salary amount.	60% of pre-disability earnings, not to exceed \$5,500 per month, less income from other sources (e.g., Social Security). Monthly benefit includes a 15% contribution to an individual TIAA-CREF retirement annuity.
Cost	See Rate Sheet	UPI-paid.
Enrollment Process	If the Benefits Enrollment/Change Form is completed and submitted to HR within the first 31 days of eligibility, medical history is not required. If enrolling outside of the initial 31-day eligibility period, completion of the medical history statement is required.	Enrollment is automatic after becoming benefits-eligible.
Effective Date	The date you apply if it is within 31 days of eligibility. Otherwise, the date Standard Insurance Company approves our application. If electing the maximum weekly benefit for your salary, you may increase your coverage level within 31 days of a salary increase that puts you into the next coverage level.	First day of the month after becoming benefits-eligible.
Benefit Claim Process	Contact HR within 30 days of disability.	Contact HR 3–4 months following disability.
Benefit Waiting Period	29 days from the date of disability or exhaustion of sick leave, whichever is later.	6 months from the date of disability or exhaustion of sick leave, whichever is later.
Maximum Benefit Period	22 weeks	If disabled prior to age 60, benefit pays to age 65. For age 60 or higher, see plan certificate.
Benefit Taxability	Benefits are not taxable.	Benefits are considered taxable income.
Coverage Termination	Coverage ends on termination date. No conversion option available.	Coverage ends on termination date. Contact Standard Insurance Company for conversion option.

Administered by Standard Insurance Company.

# NOTES

## Carrier Contact List for University Physicians, Inc.

CARRIER NAME	POLICY/GROUP NO.	TOLL-FREE/ LOCAL PHONE NO.	WEB ADDRESS
<b>Medical</b>			
Anthem HMO Colorado UA Net HMO Lumenos BluePreferred PPO	195333	1-800-735-6072	www.anthem.com/ universityofcolorado
Kaiser Permanente	1057	Denver/Boulder 1-800-632-9700/303-338-3800 Colorado Springs 1-888-681-7878	http://my.kp.org/ university of colorado
<b>Dental</b>			
Exclusive Panel Option (EPO)	6457	1-800-610-0201/303-741-9305	www.deltadentalco.com
Delta Dental PPO	1650	1-800-610-0201/303-741-9305	www.deltadentalco.com
<b>Life Insurance</b>			
Standard Insurance Company— Basic & Optional Life	399101	1-800-628-8600	www.standard.com
Standard Insurance Company—Voluntary AD&D	399101	1-800-628-8600	www.standard.com
PERA—UnumProvident		1-866-277-1649	www.copera.org
<b>UPI-Flex</b>			
ASI	16	1-800-659-3035	www.asiflex.com
<b>Tax-Deferred Savings Plan—403(b)</b>			
TIAA-CREF		1-800-842-2776	www.tiaa-cref.org
<b>Other Important Contact Information</b>			
Social Security Administration		1-800-772-1213	www.ssa.gov
Medicare		1-800-633-4227	www.medicare.gov
COBRA Administration		1-877-627-1877/303-735-6500	www.cu.edu/pbs



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