Anthem.

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
BluePreferred PPO Plan for the University of Colorado

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Nationally

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the 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.

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE[2]	Benefit Year	Benefit Year
4a. ANNUAL DEDUCTIBLE[2]		
a) Individual[2b]	$850	$1,700
b) Family[2c]	$2,250 aggregate	$4,500 aggregate
5. OUT-OF-POCKET ANNUAL MAXIMUM[3]		
a) Individual	$4,000, includes per-confinement inpatient and outpatient surgery copayments. Excludes all other copayments and copayments and coinsurance for outpatient other mental-health care	Unlimited
b) Family	$12,000 aggregate, includes per-confinement inpatient and outpatient surgery copayments. Excludes all other copayments and copayments and coinsurance for outpatient other mental-health care	Unlimited
c) Is deductible included in the out-of-pocket maximum?	No	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.

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

	IN-NETWORK	OUT-OF-NETWORK
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[4]		
a) Primary Care Providers	$20 copayment per visit, 40% after deductible for all other services (e.g., laboratory and x-ray services, office surgical services).	50% after deductible
b) Specialists	$20 copayment per visit, 40% after deductible for all other services (e.g., laboratory and x-ray services, office surgical services).	50% after deductible
9. PREVENTIVE CARE		
a) Children's services	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).	Up to age 13, 50% not subject to deductible.
b) Adult's services	$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).	50% after deductible except for mammogram and prostate screening, which are not subject to deductible or coinsurance.
c) Colorectal screening services (not subject to deductible)[4a, 4b]	$15 copayment per visit. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.	50% not subject to deductible. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.
10. MATERNITY		
a) Prenatal care	20% after deductible	50% after deductible
b) Delivery & inpatient well baby care[5]	$500 per admission copayment, then 20% after deductible	$500 per admission copayment, then 50% after deductible

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions[6] a) Inpatient care	$500 per admission copayment, then 50% after deductible.	$500 per admission copayment, then 50% after deductible
b) Outpatient care	**Retail Pharmacy Drugs** - 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.	Not covered
c) Prescription Mail Service	**Mail-Order Pharmacy Drugs** - 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. **The following applies to b) and c) above:** 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. 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 www.anthem.com/universityofcolorado.	Not covered
12. INPATIENT HOSPITAL	$500 per admission copayment, then 20% after deductible	$500 per admission copayment, then 50% after deductible
13. OUTPATIENT/AMBULATORY SURGERY	$500 per visit copayment, then 40% after deductible	$500 per visit copayment, then 50% after deductible
14. DIAGNOSTICS a) Laboratory & x-ray	40% after deductible	50% after deductible
b) MRI, nuclear medicine, and other high-tech services	40% after deductible	50% after deductible
15. EMERGENCY CARE[7,8]	40% after deductible	40% after in-network deductible
16. AMBULANCE	20% after deductible	20% after in-network deductible

	IN-NETWORK	OUT-OF-NETWORK
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$20 copayment per visit, 40% after deductible for all other services (e.g., laboratory and x-ray services).	50% after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	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.
19. OTHER MENTAL HEALTH CARE		
a) Inpatient care	$500 per admission copayment, then 50% after deductible. Limited to 45 full or 90 partial days per benefit 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 benefit year in- and out-of-network combined for other mental-health care except as listed below.
b) Outpatient care	50% after deductible. Limited to 20 visits with a minimum of $1,000 in benefits per benefit year in- and out-of-network combined for other mental-health care except as listed below.	50% after deductible. Limited to 20 visits with a minimum of $1,000 in benefits per benefit 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.	
20. ALCOHOL & SUBSTANCE ABUSE	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.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY		
a) Inpatient	$500 per admission copayment, then 20% after deductible. Limited to 30 non-acute inpatient days per benefit year in- and out-of-network combined.	$500 per admission copayment, then 50% after deductible. Limited to 30 non-acute inpatient days per benefit year in- and out-of-network combined.
b) Outpatient	40% after deductible. Limited to a maximum-benefit of $2,000 per benefit year for physical therapy, and a maximum-benefit of $2,000 per benefit year for occupational and speech therapy in- and out-of-network combined or no less than 20 visits for each for physical, occupational and speech therapy for children up to age 6 years of age for therapies related to congenital defects or birth abnormalities in- and out-of-network combined.	50% after deductible. Limited to a maximum-benefit of $2,000 per benefit year for physical therapy, and a maximum-benefit of $2,000 per benefit year for occupational and speech therapy in- and out-of-network combined or no less than 20 visits for each for physical, occupational and speech therapy for children up to age 6 years of age for therapies related to congenital defects or birth abnormalities in- and out-of-network combined.
22. DURABLE MEDICAL EQUIPMENT	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 benefit 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 benefit year in- and out-of-network combined.

	IN-NETWORK	OUT-OF-NETWORK
23. OXYGEN	20% after deductible	50% after deductible
24. ORGAN TRANSPLANTS	$500 per admission copayment, then 20% after deductible.	Not covered
25. HOME HEALTH CARE	20% after deductible. Limited to 60 visits per benefit year combined in- and out-of-network.	50% after deductible. Limited to 60 visits per benefit year combined in- and out-of-network.
26. HOSPICE CARE **a) Inpatient** **b) Outpatient**	 $500 per admission copayment, then 20% after deductible. 20% after deductible	 $500 per admission copayment, then 50% after deductible. 50% after deductible
27. SKILLED NURSING FACILITY CARE	$500 per admission copayment, then 20% after deductible. Limited to 100 days per benefit year in- and out-of-network combined.	$500 per admission copayment, then 50% after deductible. Limited to 100 days per benefit year in- and out-of-network combined.
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	40% after deductible. Limited to a maximum-benefit of $500 per benefit year in- and out-of-network combined.	50% after deductible. Limited to a maximum-benefit of $500 per benefit year in- and out-of-network combined.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Members who desire another professional opinion, may obtain a second surgical opinion. **Hearing Aids for Children**[12] 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**[12] 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.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. [10]	None
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable; Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. 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.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization.	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.

	IN-NETWORK	OUT-OF-NETWORK
39. What is the main customer service number?	800-735-6072	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 800-735-6072	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s 07-00031 Group – Large	
43. Does the plan have a binding arbitration clause?	Yes	Yes

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

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

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

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

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified 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.

[3] "Out-of-pocket maximum" Means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the 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.

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

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

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

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

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

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

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

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

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

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

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