



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.anthem.com/cuhealthplan>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (800) 735-6072 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,500</b> /single or <b>\$3,000</b> /family for <a href="#">In-Network Providers</a> . <b>\$3,000</b> /single or <b>\$6,000</b> /family for <a href="#">Out-of-Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> for <a href="#">In-Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$3,000</b> /single or <b>\$6,000</b> /family for <a href="#">In-Network Providers</a> . <b>\$6,000</b> /single or <b>\$12,000</b> /family for <a href="#">Out-of-Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Pre-Authorization Penalties, <a href="#">Premiums</a> , <a href="#">Balance-Billing</a> charges, and Health Care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, PPO. See <a href="http://www.anthem.com/cuhealthplan">www.anthem.com/cuhealthplan</a> or call (800) 735-6072 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
	<a href="#">Specialist</a> visit	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	\$0 /visit	35% <a href="#">coinsurance</a> after deductible	There may be other levels of cost share that are contingent on how services are provided. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> under Anthem's Preferred Formulary is available at <a href="http://www.anthem.com/cuhealthplan">www.anthem.com/cuhealthplan</a>	Tier 1 - Typically Generic	20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply at Anthem Retail Pharmacies and up to a 90-day supply at UCHealth Retail Pharmacies or UCH Mail Order	20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply	<b>Specialty RX:</b> Per fill, a maximum of up to 30 days of Specialty medication.  <b>Maintenance medication:</b> Per fill, a maximum of up to 30 days of maintenance medication may be purchased at a retail pharmacy. If using mail order for up to a 90-day supply, UCH Mail Order Prescription Service must be used for maintenance medications to be covered.
	Tier 2 - Typically Preferred Brand	20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply at Anthem Retail Pharmacies and up to a 90-day supply at UCHealth Retail Pharmacies or UCH Mail Order	20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply	<b>Diabetic Medication &amp; Supplies:</b> Members diagnosed with diabetes may be eligible to have diabetic medication & supplies (needles, syringes, lancets,

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Tier 3 - Typically Non-Preferred Brand	20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply at Anthem Retail Pharmacies and up to a 90-day supply at UCHealth Retail Pharmacies or UCH Mail Order	20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply	test strips) obtained at in network pharmacies with no applicable copayment (100% covered). Please contact member services for additional information.  Mail Order Pharmacy Location: University of Colorado Hospital Mail Order Prescription Service 12605 E. 16 <sup>th</sup> Avenue, Mail Stop A014 Aurora, CO 80045 Phone (720) 848-1432 Fax (720) 848-1433
	Tier 4 - Typically <a href="#">Specialty Drugs</a>	20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply at Anthem Retail Pharmacies, UCHealth Retail Pharmacies or UCH Mail Order	20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply	Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket costs. You may request, or your Provider may order, the Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic and Brand Name Drug, in addition to your tier Copayment. The cost difference between the Generic and Brand Name Drug does not contribute to the Out-of-Pocket Annual Maximum. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. The Plan reserves the right, at its discretion, to remove certain higher cost Generic Drugs from this coverage.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.

For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	15% <a href="#">coinsurance</a> after deductible	Covered as <a href="#">In-Network</a>	There may be other levels of cost share that are contingent on how services are provided.
	<a href="#">Emergency medical transportation</a>	15% <a href="#">coinsurance</a> after deductible	Covered as <a href="#">In-Network</a>	-----none-----
	<a href="#">Urgent care</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fees	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 15% <a href="#">coinsurance</a> after deductible; Other Outpatient 15% <a href="#">coinsurance</a> after deductible	Office Visit 35% <a href="#">coinsurance</a> after deductible; Other Outpatient 35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
	Inpatient services	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
If you are pregnant	Office visits	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) For inpatient admission, failure to obtain pre-authorization may result in reduced or no coverage.
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	100 visits/calendar year combined for <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> . Failure to obtain pre-authorization may result in reduced or no coverage.
	<a href="#">Rehabilitation services</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Outpatient coverage of physical, occupational and speech therapies is limited to 40 visits each per plan year combined <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> . All rehabilitation and
	<a href="#">Habilitation services</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				habilitation visits count toward your rehabilitation visit limit.
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per plan year combined <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> .
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a> after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage. Includes 1 wig following cancer treatment.
	<a href="#">Hospice services</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-----none-----
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	-----none-----

#### Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Long-term care</li> </ul>                     | <ul style="list-style-type: none"> <li>• Dental care (adult)</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul>  | <ul style="list-style-type: none"> <li>• Routine foot care unless you have been diagnosed with diabetes</li> </ul> | <ul style="list-style-type: none"> <li>• Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.</li> <li>• Routine vision exam</li> </ul> |

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture (20 visit maximum)
- Most coverage provided outside the United States [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery
- Hearing Aids (limits apply)
- Chiropractic care (20 visit maximum)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————



About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,840
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In this example, Peg would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,000

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">PCP coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

This EXAMPLE event includes services like:  
[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$7,460
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In this example, Joe would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$894
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,394

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,010
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In this example, Mia would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$77
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,577

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

**(TTY/TDD: 711)**

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 735-6072

**Amharic** (አማርኛ) የሚገናኝ ስልክ በዓለም አቀፍ ደረጃ በየዓመቱ በሚያስፈልጉበት ሁኔታ በተለያዩ ቦታዎች ላይ የሚገኙ ስልኮችን ያጠቃልላል፡፡  
የስልክ ቁጥር (800) 735-6072 ይጻፉ፡፡

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 735-6072 (800).

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 735-6072:

**Bassa (Bàsɔ̀ Wùdù):** M̃ dyi dyi-diè-d̃è b̃é b̃é d̃é bá c̃éè-d̃é ñà k̃e dyí ní, ɔ̀ mò ñi dyí-b̃é d̃èin-d̃é b̃é m̃ k̃e gbo-kpá-kpá k̃e b̃ǎ kp̃ǎ d̃é m̃ b̃í d̃í-wù d̃ùun b̃ó pí dyi. B̃é m̃ k̃e wu d̃u-z̃i in-nỹò d̃ò gbo wù d̃ù k̃e, d̃á (800) 735-6072.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 735-6072 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 735-6072 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (800) 735-6072。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wər alēu bē gēer yic yin ne thoŋ du ke cin wēu tāauē ke piny. Te kər yin ba jam wēnē ran ye thok geryic, ke yin cəl (800) 735-6072.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 735-6072.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 735-6072 (800) تماس بگیرید.



**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 735-6072.

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