This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/cuhealthplan or by calling 1-800-735-6072.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Plan Year Deductible: July 1st, 2016 – June 30th, 2017 For in-network: **$750** Individual **$1,500** Family Aggregate Does not apply to preventive care and services subject to a copayment.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,850** Individual **$13,700** Family Aggregate	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com/cuhealthplan or call 1-800-735-6072 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $30) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copayment/visit	Not covered	• $10 Copayment/visit for allergy injections.
	Specialist visit	$50 Copayment/visit	Not covered	——————none——————
	Other practitioner office visit	$40 Copayment/visit	Not covered	Chiropractic and acupuncture care are limited to a combined maximum of 20 visits per plan year.
	Preventive care/screening/ immunization	No Copayment (100% covered)	Not covered	Preventive services are not subject to deductible. For a detailed list of covered preventive services, please visit: www.anthem.com/cuhealthplan
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance after deductible	10% Coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	10% Coinsurance after deductible	10% Coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage under Anthem's Preferred Formulary** is available at www.anthem.com/cuhealthplan	Tier 1 Generic drugs	• **Anthem and UCHealth Retail Pharmacy Locations**: $15/prescription for up to a 30-day supply • **UCH Mail order**: $30/prescription for up to a 90-day supply	Not covered	**Specialty RX:** Per fill, a maximum of up to 30 days of Specialty medication. **Maintenance medication:** 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. **Diabetic Medication & Supplies:** Members diagnosed with diabetes may be eligible to have diabetic medication & supplies (needles, syringes, lancets, 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. 16th Avenue, Mail Stop A014
	Tier 2 Preferred brand drugs	• **Anthem and UCHealth Retail Pharmacy Locations**: $35/prescription for up to a 30-day supply • **UCH Mail order**: $70/prescription for up to a 90-day supply	Not covered	
	Tier 3 Non-preferred brand drugs	• **Anthem and UCHealth Retail Pharmacy Locations**: $50/prescription for up to a 30-day supply • **UCH Mail order**: $100/prescription for up to a 90-day supply	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Tier 4 Specialty Orals and Injectable drugs	• **Anthem and UCHealth Retail Pharmacy Locations**: $75/prescription for up to a 30-day supply • **UCH Mail order**: $75/prescription for up to a 30-day supply	Not covered	Aurora, CO 80045 Phone (720) 848-1432 Fax (720) 848-1433 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Physician/surgeon fees	10% Coinsurance after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$150 Copayment/visit	$150 Copayment/ visit	Copayment waived if admitted to hospital.
	Emergency medical transportation	10% Coinsurance after deductible	10% Coinsurance after deductible	——————none——————
	Urgent care	$40 Copayment/visit	$40 Copayment/ visit	$150 Copayment for urgent care received in an emergency room.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fee	10% Coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 Copayment/office visit; 10% Coinsurance after deductible for outpatient facility	Not covered	In-network: copayment applies to office visits and professional services; services provided as part of an office visit or professional service may be subject to the deductible. Failure to obtain pre-authorization may result in reduced or no coverage.
	Mental/Behavioral health inpatient services	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Substance use disorder outpatient services	$40 Copayment/office visit; 10% Coinsurance after deductible for outpatient facility	Not covered	In-network: copayment applies to office visits and professional services; services provided as part of an office visit or professional service may be subject to the deductible. Failure to obtain pre-authorization may result in reduced or no coverage.
	Substance use disorder inpatient services	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
If you are pregnant	Prenatal and postnatal care	$25 Copayment for first prenatal care office visit	Not covered	Copayment includes physicians' prenatal care services and deliveries.
	Delivery and all inpatient services	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Rehabilitation services	Inpatient: 10% Coinsurance after deductible; Outpatient: $40 Copayment per visit	Not covered	Outpatient coverage of physical, occupational and speech therapies is limited to 40 visits each per plan year. $50 Copayment/visit for cardiac rehabilitation up to a maximum of 36 visits per plan year.
	Habilitation services	Inpatient: 10% Coinsurance after deductible; Outpatient: $40 Copayment per visit	Not covered	Outpatient coverage of physical, occupational and speech therapies is limited to 40 visits each per plan year. $50 Copayment/visit for cardiac rehabilitation up to a maximum of 36 visits per plan year.All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	10% Coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per plan year.
	Durable medical equipment	10% Coinsurance after deductible	10% Coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage. Includes 1 wig following cancer treatment.
	Hospice service	10% Coinsurance after deductible	Not covered	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	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine foot care
- Routine vision exam
- Weight loss programs (unless in conjunction with approved bariatric surgery plan)

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture care (limits apply)
- Bariatric Surgery
- Chiropractic care (limits apply)
- Hearing aids (limits apply)
- Non-emergency care when traveling outside the U.S

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your Human Resources Department. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Appeals:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway, CAT CO0104-0430
Denver, CO 80273

Grievances:

Anthem Quality Management
700 Broadway, Mail Code MC0532
Denver, CO 80273

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,310
- **Patient pays** $1,230

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$300
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$750
Copays	$55
Coinsurance	$425
Limits or exclusions	$0
Total	**$1,230**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,260
- **Patient pays** $1,140

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$750
Copays	$325
Coinsurance	$65
Limits or exclusions	$0
Total	**$1,140**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.