Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Student Advantage Health Insurance Plan

Your School: University of Denver – Domestic and International Student Health Plan

Your Network: Anthem PPO

Student Health and Counseling Center Benefits:
No Charge for Covered Medical Expenses
Deductible Waived

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$750 student	$1,500 student
Overall Out-of-Pocket Limit	$1,500 student	$7,500 student
All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at No charge per visit. Non-network not covered.*		
Primary Care (PCP) *virtual and office*	$25 copay per visit deductible does not apply	$25 copay per visit then 40% coinsurance deductible does not apply
Mental Health and Substance Abuse Care *virtual and office* *Non-Network Cost Shares applied to In-Network Out-of-Pocket Limit*	$25 copay per visit deductible does not apply	$25 copay per visit then 40% coinsurance deductible does not apply
Specialist Care *virtual and office*	$25 copay per visit deductible does not apply	$25 copay per visit then 40% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.*	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit deductible does not apply	$25 copay per visit then 40% coinsurance deductible does not apply
Chiropractic Services *Review of medical necessity will be performed after 20 visits per injury or Sickness.*	$20 copay per visit then 15% coinsurance deductible does not apply	$20 copay per visit then 40% coinsurance after deductible is met
Acupuncture	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	$25 copay per visit deductible does not apply	$25 copay per visit then 40% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	$25 copay per visit deductible does not apply	$25 copay per visit then 40% coinsurance after deductible is met
Surgery	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	Not covered
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services		
Lab		
Office	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Lab	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray		
Office	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging		
Office	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$25 copay per visit then 15% coinsurance. Deductible not required.	$25 copay per visit then 40% coinsurance. Deductible not required
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit, then 15% coinsurance. Deductible not required.	Covered as In-Network
Emergency Room Doctor and Other Services	15% coinsurance after deductible is met	Covered as In-Network
Emergency Room Mental Health and Substance Use Disorder Doctor and Other Services	15% coinsurance. Deductible not required.	Covered as In-Network
Emergency Ambulance	15% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	15% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services		
Hospital	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Doctor and other services	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *Review of medical necessity will be performed after 20 visits per injury or Sickness.*		
Office	$20 copay per visit then 15% coinsurance deductible does not apply	$20 copay per visit then 40% coinsurance deductible does not apply
Outpatient Hospital	$20 copay per visit then 15% coinsurance deductible does not apply	$20 copay per visit then 40% coinsurance deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Habilitation services *Review of medical necessity will be performed after 20 visits per injury or Sickness.*		
Office	$20 copay per visit then 15% coinsurance deductible does not apply	$20 copay per visit then 40% coinsurance deductible does not apply
Outpatient Hospital	$20 copay per visit then 15% coinsurance deductible does not apply	$20 copay per visit then 40% coinsurance deductible does not apply
Chemo/Radiation Therapy		
Office	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility)	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	15% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	15% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$250 student	Not applicable
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Not applicable
Prescription Drug Coverage **Network*: Base Network*** **Drug List: *Traditional Open***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$10 copay per prescription (retail) and $20 copay per prescription (home delivery)	Not covered
Tier 2 – Typically Preferred Brand	$50 copay per prescription (retail) and $100 copay per prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand	$80 copay per prescription (retail) and $160 copay per prescription (home delivery)	Not covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19) **Vision exam** *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $25*, Bifocal* Reimbursed Up to $40*, Trifocal* Reimbursed Up to $55*.*	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Limited to 2 visits per 12 months.*	No charge	No charge
Basic services	20% coinsurance deductible does not apply	20% coinsurance deductible does not apply
Major services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Adult Dental	Not covered	Not covered

Notes:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CO_SH_PPO.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call

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(TTY/TDD: 711)

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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՝ :

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Language Access Services:

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