2016—Medical Comparison Guide

This and the following pages contain a limited description of the benefit coverage available through this group plan. Coverage is governed at all times by the complete terms of the Master Group Insurance Policy issued to Colorado State University (CSU). Great care is taken to assure the accuracy of this guide, but in the event of any discrepancies between the information in this guide and in such other documents, Anthem's coverage certificate will govern (Green, Gold, POS, Ram-HDHP). Anthem's coverage certificate is available online at www.hrs.colostate.edu/benefits/fap.html.

Topic	Point-of-Service PPO Plan		Gold Plan	Green Plan	Ram Plan-HDHP
	PPO Participating Providers (In-Network)	Non-PPO Participating Providers (Out-of-Network)	Participating and Non-participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers
1. ANNUAL DEDUCTIBLE a) Individual	None	$500	$750, plus a separate deductible for outpatient retail and specialty prescription drugs of $150.	$1,000, plus a separate deductible for outpatient retail and specialty prescription drugs of $150.	$1,500
b) Family	None	$1,000 for all family members. No one family member may meet more than $500 of the $1,000 family deductible.	$1,500, plus a separate deductible for outpatient retail and specialty prescription drugs of $300. No one family member may meet more than $750 of the $1,500 family deductible. For prescription drugs no one family member may meet more than $150 of the $300 family deductible.	$2,000, plus a separate deductible for outpatient retail and specialty prescription drugs of $300. No one family member may meet more than $1,000 of the $2,000 family deductible. For prescription drugs no one family member may meet more than $150 of the $300 family deductible.	$3,000 If you select family membership, no individual deductible applies and the family deductible must be met.
2. COINSURANCE/ COPAYMENTS	**Coinsurance:** Refer to the below benefits for specific details. Coinsurance is required up to the out-of-pocket annual maximum. **Copayments:** Refer to the below benefits for specific details.	**Coinsurance:** You pay 30% or 10% after deductible. Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below. **Copayments:** Does not apply	**Coinsurance:** You pay 20% after deductible. Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below . **Copayments:** Does not apply.	**Coinsurance:** You pay 20% after deductible. Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below. **Copayments:** Does not apply.	**Coinsurance:** You pay 20% after deductible. Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below. **Copayments:** Does not apply.
Coinsurance options reflect the amount You will pay. The difference between what you pay and 100% is the amount the Plan pays for PPO (participating) providers. For non-participating providers you also pay the difference between Anthem's Maximum allowed amount and the amount billed by the non-participating provider.					

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3. OUT-OF-POCKET ANNUAL MAXIMUM[2] **a) Individual**	• $1,250 in coinsurance, *plus* • Copayments	• $3,000 in coinsurance, *plus* • Deductible, *plus* • Copayments, *plus* • Charges for non-participating providers that are above Anthem's maximum allowed amount.	• $4,500 includes coinsurance and deductible for pharmacy and medical • Plus—charges for non-participating providers that are above Anthem's maximum allowed amount.	• $5,000 in coinsurance, *plus* • Deductible, *plus* • $1,000 in coinsurance for retail and specialty outpatient prescription drugs, *plus* • Charges for non-participating providers that are above Anthem's maximum allowed amount.	• $6,550 includes deductible and coinsurance • Plus—charges for non-participating providers that are above Anthem's maximum allowed amount.
b) Family	• $2,500 in coinsurance, *plus* • Copayments. No one family member may meet more than $1,250 of the $2,500 family out-of-pocket annual maximum.	• $6,000 in coinsurance, *plus* • Deductible, *plus* • Copayments, *plus* • Charges for non-participating providers that are above Anthem's maximum allowed amount. No one family member may meet more than $3,000 of the $6,000 family out-of-pocket annual maximum.	• $9,000 includes coinsurance and deductible for pharmacy and medical • Plus—charges for non-participating providers that are above Anthem's maximum allowed amount. No one family member may meet more than $4,500 of the $9,000 family out-of-pocket annual maximum.	• $10,000 in coinsurance, *plus* • Deductible, *plus* • $2,000 in coinsurance for retail and specialty outpatient prescription drugs, *plus* • Charges for non-participating providers that are above Anthem's maximum allowed amount. No one family member may meet more than $5,000 of the $10,000 family out-of-pocket annual maximum. For prescription drugs no one family member may meet more than $1,000 of the $2,000 family out-of-pocket annual maximum.	• $13,100 includes deductible and coinsurance • Plus—charges for non-participating providers that are above Anthem's maximum allowed amount. No one family member may meet more than $6,550 of the $13,100 family out-of-pocket annual maximum.
4. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL	No lifetime maximum.	No lifetime maximum.	No lifetime maximum.	No lifetime maximum.	No lifetime maximum.
5. ROUTINE MEDICAL OFFICE VISITS	Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services. Copayment does not apply if an office visit is not billed.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible

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6. PREVENTIVE CARE **a) Well baby services, (0 up to 12 months)**	Covered in full	You pay 30% after deductible	**Participating Provider:** Covered in full not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible	**Participating Provider:** Covered in full not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible	**Participating Provider:** Covered in full not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible;
	includes routine physicals, associated laboratory, X-rays and immunizations.				
b) Children's services	Covered in full	You pay 30% after deductible	**Participating Provider:** Covered in full not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible	**Participating Provider:** Covered in full not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible	**Participating Provider:** Covered in full not subject to deductible . **Non-Participating Provider:** You pay 20% not subject to deductible
	12 months through age 12, includes routine physicals, routine associated laboratory and X-ray and immunizations				
c) Adults' services	Covered in full	Not covered	**Participating Provider:** Covered in full, not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible;	**Participating Provider:** Covered in full, not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible;	**Participating Provider:** Covered in full, not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible;
	includes associated laboratory and X-ray, mammogram screening, preventive colorectal cancer screenings and immunizations				
7. MATERNITY **a) Prenatal care**	Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services. Copayment does not apply if an office visit is not billed.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
b) Delivery & inpatient well baby care	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible

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8. PRESCRIPTION DRUGS **IMPORTANT NOTES**	**Copayments for retail pharmacy and specialty pharmacy for each 34-day supply:** Tier 1 - $10 copayment Tier 2 - $20 copayment Tier 3 - $40 copayment **Copayments for mail order service (90-day supply maximum):** Tier 1 - $20 copayment Tier 2 - $40 copayment Tier 3 - $80 copayment **Note**: • 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 expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and the brand-name drug, in addition to your tier 1 copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength and effectiveness. Anthem reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, contact Customer Service at (800) 542-9402 or access our website at www.anthem.com.	Not covered	You pay 20% after separate deductible for outpatient retail or specialty prescription drugs of $150 per member or $300 per family. Deductibles for prescription drugs apply toward meeting annual out-of-pocket maximums	You pay 20% after separate deductible for outpatient retail or specialty prescription drugs of $150 per member or $300 per family up to separate out-of-pocket annual maximum for outpatient retail or specialty prescription drugs of $1,000 per member or $2,000 per family. Deductibles for prescription drugs apply toward meeting annual out-of-pocket maximums	You pay 20% after deductible

- **Specialty Pharmacy:** Participating pharmacy (34-day supply). Specialty pharmacy drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a retail pharmacy or through the mail order service. Benefits are only provided when you receive services from a specialty pharmacy as determined by Anthem for those specialty pharmacy drugs included on Anthem's specialty drug list.
- **Smoking Cessation Prescription Drugs:** Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem.
- **Birth Control:** Certain oral, injection and contraceptive devices obtained by a physician's prescription are covered at 100%.
- Prescription drugs are covered only when received from a participating pharmacy (34 to 90-day supply), participating specialty pharmacy (34-day supply) or participating mail order service.
- Retail Pharmacy: Participating Pharmacy (34–day supply).

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9. INPATIENT HOSPITAL **IMPORTANT NOTES**	You pay 10% after $125 per admission copayment Pre-certification from Anthem BCBS must be received **before a hospital admission or within 5 days** after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%.	You pay 30% after deductible Pre-certification from Anthem BCBS must be received **before a hospital admission or within 5 days** after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%. If you use a non-participating provider, you are responsible for making sure this pre-certification has been obtained.	You pay 20% after deductible Pre-certification from Anthem BCBS must be received **before a hospital admission or within 5 days** after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%. If you use a non-participating provider, you are responsible for making sure this pre-certification has been obtained.	You pay 20% after deductible Pre-certification from Anthem BCBS must be received **before a hospital admission or within 5 days** after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%. If you use a non-participating provider, you are responsible for making sure this pre-certification has been obtained.	You pay 20% after deductible Pre-certification from Anthem BCBS must be received **before a hospital admission or within 5 days** after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%. If you use a non-participating provider, you are responsible for making sure this pre-certification has been obtained.
10. OUTPATIENT/ AMBULATORY SURGERY	You pay 10% after you pay $125 per admission copayment. This includes colonoscopies with a medical diagnosis.	You pay 30% after deductible. This includes colonoscopies with a preventive or medical diagnosis.	You pay 20% after deductible. This includes colonoscopies with a medical diagnosis.	You pay 20% after deductible. This includes colonoscopies with a medical diagnosis.	You pay 20% after deductible. This includes colonoscopies with a medical diagnosis.
11. LABORATORY AND X-RAY	You pay 10%	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
12. EMERGENCY CARE[3]	You pay 10% after $60 copayment per emergency room visit, applied to inpatient hospital copayment if admitted.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible

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13. AMBULANCE **a) Ground**	You pay 10% after $60 per trip copayment	You pay 10% after $60 per trip copayment	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
b) Air	You pay 10% after $125 per trip copayment	You pay 10% after $125 per trip copayment	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
14. URGENT, NON-ROUTINE, AFTER HOURS CARE **a) Inpatient care**	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
b) Outpatient care	Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services. Copayment does not apply if an office visit if not billed.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
15. MENTAL HEALTH CARE **a) Inpatient care**	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
b) Outpatient care	You pay 10% after $15 per office visit copayment.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
c) Important Note	Copayments for other mental health care do not count towards meeting your out-of-pocket annual maximum.				
	Contact the behavioral health administrator at (800) 424-4014 for information on how to locate a provider and your benefits.				

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16. ALCOHOL & SUBSTANCE ABUSE **a) Inpatient Care**	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
b) Outpatient Care	You pay 10% after $15 per office visit copayment Copayments for other alcohol and substance abuse care does not go towards meeting your out-of-pocket annual maximum.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
c) Important Note	Contact the behavioral health administrator at (800) 424-4014 for information on how to locate a provider and/or your benefits.				
17. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **a) Inpatient**	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
b) Outpatient	You pay 10% after $15 per office visit copayment (See Benefit Booklet for definitions, limitations, and exclusions).	You pay 30% after deductible (See Benefit Booklet for definitions, limitations, and exclusions).	You pay 20% after deductible (See Benefit Booklet for definitions, limitations, and exclusions).	You pay 20% after deductible (See Benefit Booklet for definitions, limitations, and exclusions).	You pay 20% after deductible (See Benefit Booklet for definitions, limitations, and exclusions).
18. DURABLE MEDICAL EQUIPMENT	You pay 10%	Not covered	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible

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19. OXYGEN	You pay 10%	Not covered	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
20. ORGAN TRANSPLANTS[4]	You pay 10% after $125 per admission copayment (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell). **Precertification required.**	Not covered	You pay 20% after deductible (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell). **Precertification required.**	You pay 20% after deductible (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell). **Precertification required.**	You pay 20% after deductible (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell). **Precertification required.**
21. HOME HEALTH CARE	Covered in full after you pay $15 per visit copayment (up to 100 visits per calendar year).	Not covered	Covered in full (up to 100 visits per calendar year combined in and out-of-network).	Covered in full (up to 100 visits per calendar year combined in and out-of-network).	You pay 20% after deductible (up to 100 visits per calendar year combined in and out-of-network).
22. HOSPICE CARE	Covered in full.	You pay 30% after deductible.	Covered in full.	Covered in full.	You pay 20% after deductible
23. SKILLED NURSING FACILITY CARE	You pay 10% after $125 per admission copayment (up to 100 days per calendar year in and out-of-network combined) copayment waived if admitted directly to skilled nursing facility from an inpatient acute facility).	You pay 30% after deductible (up to 100 days per calendar year in and out-of-network combined).	You pay 20% after deductible (up to 100 days per calendar year combined in and out-of-network).	You pay 20% after deductible (up to 100 days per calendar year combined in and out-of-network).	You pay 20% after deductible (up to 100 days per calendar year combined in and out-of-network).
24. VISION CARE	Covered in full after you pay $15 per office visit copayment (limited to one exam per calendar year, eyeglass hardware not covered).	Not covered	You pay 20% after deductible (limited to one exam per calendar year combined in and out-of-network, eyeglass hardware not covered).	You pay 20% after deductible (limited to one exam per calendar year combined in and out-of-network, eyeglass hardware not covered).	You pay 20% after deductible (limited to one exam per calendar year combined in and out-of-network, eyeglass hardware not covered).
25. RETAIL HEALTH CLINIC VISITS	Covered in full after you pay$15 per office visit copayment and 10% for laboratory and x-ray services	Not Covered	You pay 20% after deductible for participating providers; not covered for non-participating providers.	You pay 20% after deductible for participating providers; not covered for non-participating providers.	You pay 20% after deductible for participating providers; not covered for non-participating providers.

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26. CHIROPRACTIC CARE	Covered in full after you pay $15 per visit copayment (up to 20 visits per calendar year) and 10% for laboratory and x-ray services. Copayment does not apply if an office visit if not billed.	Not covered	You pay 20% after deductible (up to 20 visits per calendar year combined in and out-of-network).	You pay 20% after deductible (up to 20 visits per calendar year combined in and out-of-network).	You pay 20% after deductible (up to 20 visits per calendar year combined in and out-of-network).
27. SIGNIFICANT ADDITIONAL COVERED SERVICES	**Treatment of Autism Spectrum Disorders** Benefit level determined by type of service provided. The following annual maximums based on calendar year, are effective for applied behavior analysis services for In and Out-of-Network services combined. We may exceed these maximums if required by law: From birth to age eight (up to Member's ninth birthday): 550 sessions of 25 minutes for each session In and Out-of-Network combined Age nine to age eighteen (up to Member's nineteenth birthday): 185 sessions of 25 minutes for each session In and Out-of-Network combined When a member desires another professional opinion, they may obtain a second surgical opinion.				
28. COVERED PROVIDERS	• Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list or refer to www.anthem.com or www.bcbs.com for providers outside the state of Colorado. • Non-contracted providers licensed or certified to provide covered benefits. (*You may incur higher out of pocket expenses with non-contracted providers.*)				

EXCLUDED EXPENSES: Charges not covered include (partial list): Glasses & other vision hardware: hearing aids; cosmetic surgery except for injury or birth defects: purely custodial care; dental work except if done within 1 year of an accidental injury to sound natural teeth if an accident occurred while insured; surgery or treatment of Temporomandibular Joint Disorders; charges in excess of reasonable and customary; services considered experimental in nature; charges in connection with impregnation or fertilization; treatment of weak, strained, flat, unstable or unbalanced feet. Sexual Dysfunction: this plan does not pay for prescription drugs for treatment of sexual dysfunction, including but not limited to Viagra.

[1] "Network" refers to a specified group of physicians, hospital, medical clinics and other medical care providers that your Plan may require you to use in order to get any coverage at all under the Plan, or that the Plan may encourage you to use because it pays 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] "Out-of-pocket maximum" The maximum amount you will have to pay for allowable covered expenses under a medical Plan, which may or may not include the deductible or copayments, depending on the contract for that Plan.

[3] "Emergency care" means services delivered by 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.

[4] "Transplants" will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.