2026 - 2027

Anthem

Helping keep you at your personal best



University of Denver

Student Health Insurance Plan

www.du.edu/hcc

Anthem

Health & Counseling Center
UNIVERSITY OF DENVER

121363XXMENXXX Rev. 03/2026



Benefits at a glance

This is a brief description of your student health plan underwritten by Anthem Blue Cross and Blue Shield (Anthem). If you would like more details about your coverage and costs, you can find additional information online at **www.du.edu/hcc**

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Welcome to the DU Student Health Insurance Plan from Anthem Student Advantage

As the new year begins, it's important to feel secure and confident with your healthcare. This booklet explains what's covered under the Anthem Student Advantage plan, how much it costs, and the best ways to access care.

What you need to know about Anthem Student Advantage

Who is eligible?

- All DU students in an on-campus degree seeking program (except those in completely online or certificate programs*) are eligible to enroll in SHIP.
- Students registered for one or more credit hours, will be automatically enrolled in SHIP unless they submit a SHIP waiver along with proof of adequate alternate coverage.

Coverage is only available for students

Spouse, domestic partner, or dependent children under the age of 26 are not eligible for coverage.



Coverage periods and rates

Costs and dates of coverage

With the DU Student Health Insurance Plan from Anthem Student Advantage, you don't have to worry about paying a monthly premium. Payment is due each period.

Law / Semester	Coverage Starts Date	Coverage End Date	Premium	Open Enrollment Begins:	Enroll or Request a Waiver By:
FALL	8/1/2026	12/31/2026	$2200	8/1/2026	9/4/2026
SPRING	1/1/2027	7/31/2027	$2200	11/3/2026	1/22/2027
SUMMER	5/17/2027	7/31/2027	$916.65	*	6/18/2027

Quarter	Coverage Starts Date	Coverage End Date	Premium	Open Enrollment Begins:	Enroll or Request a Waiver By:
FALL	9/1/2026	3/31/2027	$2200	8/1/2026	9/25/2026
Winter	1/1/2027	3/31/2027	$1100	*	1/22/2027
SPRING	4/1/2027	8/31/2027	$2200	3/1/2027	4/16/2027
SUMMER	6/14/2027	8/31/2027	$916.65	*	7/2/2027

*Contact the DU HCC to receive the off-term enrollment information: insurance@hcc.du.edu

Coverage will become effective at 12:01 a.m., and will end at 11:59 p.m. on the dates shown above.

Keep in touch with your benefits information

DU Health & Counseling Center

Address: 2240 Buchtel Blvd S, Denver, CO 80210

Phone: 303-871-2205

Website: https://du.edu/hcc

Email: insurance@hcc.du.edu

Hours: Monday 8 am to 5 pm; Tuesday 9 am to 5 pm; Wednesday through Friday 8 am to 5 pm.

*When the DU HCC is closed, please call the HCC to access on call providers for medical and mental health issues.

Customer Service and coverage

Enrollment & Waiver should be accessed through the MyDU student portal https://studentaffairs.du.edu/health-counseling-center/insurance-plans-fees/SHIP-waiver

Anthem Blue Cross and Blue Shield Member Services: 844-412-0752

Eligibility, enrollment and benefits

DU Health & Counseling Center

Address: 2240 Buchtel Blvd S, Denver, CO 80210

Phone: 303-871-2205

Website: https://du.edu/hcc

Email: insurance@hcc.du.edu

Your Student Health Center services

Your plan gives you access to the following services at your Student Health Center to help you be well – physically and mentally.

Visit us on campus and online: insurance@du.edu

General medical services

- Urgent/After Hours Care
- Psychiatric Treatment
- Women's Health
- LGBTQIA+Health
- Lab Tests
- Immunizations
- Allergy Injections

Health Promotion

- Well-Being
- Mental Health
- Alcohol & Other Drugs
- Healthy Masculinities
- Interpersonal Violence Prevention
- Sexual Health
- Thrive Peer Educators

Mental Health Services

- Inclusive & Specialty Services
- Group Therapy & Workshops
- Graduate & Postgraduate Training
- Community Mental & Behavioral Health Resources

Survivor Advocacy

- **Medical Services**
  Our medical facility is a fully AAAHC accredited primary care medical team located on campus with board certified physicians, physician assistants, nurses, and medical assistants.

- **Health Promotion**
  The Department of Health Promotion cultivates a thriving DU community through education, engagement, and sociocultural change. Health Promotion provides outreach, workshops, and resources to help DU students make success-oriented decisions related to alcohol and other drugs, mental health, gender violence, sexual health, and other aspects of wellbeing. The Health Promotion team Includes professional health educators, graduate fellows, and undergraduate peer educators.

- **Counseling Services**
  Counseling Services Is here to support your transition to DU and other transitions in your life, as well as support your development and emotional health. Students have access to different types of services with licensed psychologists, licensed mental health practitioners and other trained professionals; including individual, couples and group therapy.

- **The Center For Advocacy, Prevention, and Empowerment (CAPE)**
  CAPE supports survivor healing by providing advocacy and support for those Impacted by sexual assault, relationship violence, stalking, and sexual harassment. All services are confidential and free of charge.

Easy access to care

Access the care you need, when you need it, and in the way that works best for you.



Sydney Health app

With the Sydney Health[1] app through Anthem Student Advantage, you have instant access to:

- Your member ID card.
- The Find a Doctor tool.
- More information about your plan benefits.
- Health tips that are tailored to you.
- LiveHealth Online and 24/7 NurseLine.
- Student support specialists (through click-to-chat or by phone).

Access the Sydney Health app

Go to the App Store℠ or Google Play™ and search for the Sydney Health app to download it today.



Emotional Well-being Resources

Access to online support that can help you live your happiest, healthiest life, via Learn to Live

- Download the **Sydney℠ Health** app, choose **Menu**, and select **My Health Dashboard**. Go to Featured Programs and choose **Emotional Well-being Resources**.
- Log in to **anthem.com**, go to My Health Dashboard tab, choose **Featured Programs**, and select **View All**.

Learn effective ways to identify and manage:

- Anxiety
- Depression
- Sleep Issues
- Panic
- Social Anxiety
- Stress
- Drug and Alcohol Use
- Worry



Provider Finder

You can find the right doctor or facility close to where you are by visiting:

- **www.anthem.com**
- Sydney Health app

Important tips:

- When you need health care, please access the DU Health and Counseling Center first for treatment options.
- When additional care is needed, use the Anthem provider finder to locate a Network Provider near you. This can help you save on out-of-pocket costs.
- Anthem Blue Cross Blue Shield provides open access to network providers without a need for a referral.
- Networks may change, so make sure you contact the provider before getting care to confirm they are in the network.

1 Sydney Health is a service mark of CareMarket, Inc.

2 Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Anthem

Your benefits go with you

With the BlueCard PPO and Blue Cross Blue Shield Global Core programs



If you're away from home and you need care right away, as an Anthem member, you have access to care across the country through the BlueCard® preferred provider organization (PPO) program. This includes 1.7 million doctors and hospitals — more than any other insurer.[1]

How to access care across the U.S.:

Call 911 or go to the nearest hospital in an emergency.[2]

Log in to anthem.com and use the Find a Doctor tool to search for a doctor or hospital in the BlueCard PPO program.

Use the Sydney℠ Health app to search for a BlueCard PPO program doctor or hospital. Get turn-by-turn directions to the nearest doctor, urgent care center, or emergency room.

Call Member Services at the number on your health plan ID card.

When you're outside the U.S., the Blue Cross Blue Shield Global® Core program gives you access to preferred doctors and hospitals in nearly 190 countries and territories around the world.[3]

Need care outside the U.S.? You can:

Go straight to the nearest hospital in an emergency.

Go to bcbsglobalcore.com to search for a doctor or hospital.

Use the Blue Cross Blue Shield Global Core app to find a doctor or hospital.

Call the Blue Cross Blue Shield Global Core Service Center 24/7 at **800-810-2583 (BLUE)** or call collect at **804-673-1177**. They can help you set up a doctor visit or hospital stay.

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Download the Blue Cross Blue Shield Global Core app today

With it, you can:

- Search for a doctor or hospital.[4]
- Submit claims.
- Get translations for medical terms — including symptoms and phrases — and even use an audio feature to play the translation.[4]
- Find a drug's generic name and local brand name, and check whether it's available.
- Learn how to find and contact a U.S. embassy.

Download on the App Store

GET IT ON Google Play

Unless it's an emergency, call the Global Core Service Center before getting care outside the U.S. Global Core will work with the doctor and Anthem to approve and accept a Guarantee of Payment (GOP). If you get care from a doctor or hospital that has not accepted a GOP, you will need to:

1. Pay the full cost of your care upfront.
2. Download an international claim form at bcbsglobalcore.com or request a form by calling Member Services at the number on your ID card.
3. Fill out the claim form and send it with the original bills to the Blue Cross Blue Shield Global Core Service Center. You can submit them through the mobile app, email, or postal mail.



Traveling? Here's what you need to know:

- Before leaving the country, ask Member Services if your international benefits are different.
- Ask for approval before getting care. This is "preapproval" and helps you find care covered by your plan. To see if you need preapproval, call Member Services at the number on your ID card.
- Save money by seeing a BlueCard program doctor or hospital. You only pay your usual out-of-pocket amounts (such as deductible, your percentage of costs, or copay). If you go to a doctor or hospital outside the program, you'll need to pay the entire bill upfront.
- Show your Anthem ID card so the doctor or hospital can check your benefits and send us a claim for processing.

Remember to carry your ID card

The "PPO-in-a-suitcase" symbol shows you can get care from BlueCard PPO program doctors and hospitals.

PPO

Anthem

1 Blue Cross Blue Shield Association: *The Blue Cross Blue Shield System* (accessed May 20, 2024): bcbs.com.
2 You or a family member need to call the Member Services number on your ID card within 24 hours (48 hours for members in Indiana) after going to the hospital or as soon as you can.
3 GeoBlue: *More than 25 years as a leader in international healthcare* (accessed May 20, 2024): about.geo-blue.com.
4 Using the Blue Cross Blue Shield Global Core app itself does not require an internet connection. However, using GPS for mapping or downloading an audio translation does require an internet connection. See bcbsglobalcore.com/home/mobileapp/#features.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem HealthChoice Assurance, Inc., and Anthem HealthChoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI) underwrites or administers PPO and indemnity policies and underwrites the out-of-network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Medical Evacuation and Repatriation Services

Anthem has you covered with GeoBlue

GeoBlue's 24/7/365 Global Service Center is available to support members experiencing medical emergencies. GeoBlue coordinates emergency services through strategic resources located around the world.

Members in need of life-saving medical intervention are treated at the nearest appropriate medical facility

What to do in the event of a medical emergency

- Call Collect: **+1-833-511-4763** within the United States
- If you're outside of the United States, call collect: **+1-484-808-5225**.
- GeoBlue's medical assistance team will contact your treating physician and closely monitor your case to determine if a medical evacuation is necessary.

When you call GeoBlue, please be prepared to provide the following information:

1. The insured person's name
2. The ID number located on the front of your Anthem Blue Cross Blue Shield Medical ID card
3. The program name and your school name as shown below:
   - Anthem MERE Companion
   - University of Denver
4. Detailed information regarding the nature of the emergency
5. If applicable, the name and contact details for the treating physician and/or hospital
6. The insured person's specific location in the country. Utilize GPS if available.

Your GeoBlue benefits for the 2025-2026 school year

Use of benefits must be coordinated and approved by GeoBlue.

Emergency medical evacuation	Actual Cost of the Evacuation & Repatriation
Repatriation of remains	Actual Cost of the Repatriation of Mortal remains
Emergency family travel arrangements	Maximum benefit up to $5,000 each coverage year
Accidental death and dismemberment	Maximum benefit up to $10,000 per covered person

GeoBlue

1 GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association. Coverage is not available in all states. Some restrictions apply.

2 Telemedicine services are provided by Teladoc Health, directly to members. GeoBlue assumes no liability and accepts no responsibility for information provided by Teladoc Health and the performance of the services by Teladoc Health. Support and information provided through this service does not confirm that any related treatment or additional support is covered under a member's health plan.

3 These medical expenses are limited and are subject to limitations and exclusions. See full certificate of insurance for a full description of services and coverage of what is and isn't covered.

4 The Political, Military and Natural Disaster Evacuation Services (PEND) are provided through Crisis24, an independent third party, non-affiliated service provider. Crisis24 does not supply Blue Cross or Blue Shield products or other benefits, and is therefore solely responsible for PEND and other collateral services it provides. GeoBlue makes no warranty, express or implied, and accepts no responsibility resulting from the provision or use of Crisis24 PEND or other Crisis24 services.

Your summary of benefits

Anthem Blue Cross and Blue Shield

Student Health Insurance Plan:
University of Denver

Your network:
Blue Classic - 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 and applies to services provided outside of the CSU Health Network. 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. Plan benefits are pending approval with the state and subject to change.

Medical

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible		
Per Member Per Plan Year The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.	$500	$1,500
Out-of-Pocket Limit		
The Out-of-Pocket Limit includes all applicable Deductibles, Coinsurance, and Copayments, including Prescription Drugs Coinsurance/Copayments, you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.	$2,000	$7,500
Acupuncture/Nerve Pathway Therapy	See "Therapy Services".	
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services	15% Coinsurance after Deductible	
Ambulance Services (Ground)	15% Coinsurance after Deductible	
For emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider. Note: All scheduled ground ambulance services for non-emergency transfers, except transfers from one acute facility to another, must be approved through precertification. Please see the section "How to Access your Services and Obtain Approval of Benefits" in the Plan document for details.		
Autism Services **Includes Applied Behavioral Analysis Services**	Benefits are based on the setting in which Covered Services are received.	
The limits for physical, occupational, and speech therapy will not apply to children between age 3 and 6 with Autism Spectrum Disorders, if part of a Member's Autism Treatment Plan, and determined Medically Necessary by Anthem.		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Behavioral Health Services	See "Mental Health, Alcohol and Substance Abuse Services".	
Cardiac Rehabilitation	See "Therapy Services".	
Chemotherapy	See "Therapy Services".	
Chiropractic Care	See "Therapy Services".	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Education, and Supplies **Screenings for gestational diabetes are covered under "Preventive Care."**	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services".	
Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies (Received from a Supplier)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Prosthetics	15% Coinsurance after Deductible	40% Coinsurance after Deductible
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office orProsthetics outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		
Initial and replacement hearing aids will be supplied every 5 years. New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.	15% Coinsurance after Deductible	15% Coinsurance after Deductible
Emergency Room Services		
Emergency Room Facility Charge	$300 Copayment per visit and 15% Coinsurance. Deductible does not apply. Copay waived if admitted.	
Emergency Room Doctor Charge	15% Coinsurance after deductible is met.	
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	15% Coinsurance after deductible is met.	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	15% Coinsurance after deductible is met.	
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" and "Therapy Services" in the Plan document	
Home Care		
• Home Care Visits • Skilled Nursing Facility • Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Services (Precertification Required)		
Facility Room & Board Charge: • Hospital / Acute Care Facility • Skilled Nursing Facility • Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	15% Coinsurance after Deductible	40% Coinsurance after Deductible

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Services for: • General Medical Care / Evaluation and Management (E&M) • Surgery • Bariatric Surgery	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Services for:		
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	Coverage is based on the setting in which Covered Services are received.	
Inpatient Services (Delivery)	See "Inpatient Services."	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Infertility	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Massage Therapy	See "Therapy Services".	
Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services		
• Inpatient Facility Services • Residential Treatment Center Services • Inpatient Doctor Services	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Facility Services	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Doctor Services	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Office Visits (Including Online Visits and Intensive In-Home Behavioral Health Programs)	$25 copay per visit. (No deductible)	$25 copay and 40% Coinsurance. Deductible does not apply
Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section in the Plan document for details.		
Occupational Therapy	See "Therapy Services".	
Office Visits		
Primary Care Physician / Provider (PCP)	$25 Copay Deductible does not apply	$25 Copay and 40% Coinsurance Deductible does not apply
Specialty Care Physician / Provider (SCP)	$25 Copay Deductible does not apply	$25 Copay and 40% Coinsurance Deductible does not apply
Retail Health Clinic Visit	$25 Copay Deductible does not apply	$25 Copay and 40% Coinsurance Deductible does not apply
Counseling – Includes Family Planning and Nutritional Counseling (Other than Eating Disorders)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Nutritional Counseling for Eating Disorders	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Testing	$25 Copay Deductible does not apply	$25 Copay and 40% Coinsurance Deductible does not apply
Allergy Shots / Injections (other than allergy serum)	15% Coinsurance after Deductible	$25 Copay and 40% Coinsurance Deductible does not apply
Preferred Diagnostic Labs (i.e., reference labs)	15% Coinsurance after Deductible	40% Coinsurance after Deductible

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Diagnostic Lab (non-preventive)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic X-ray (non-preventive)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Tests (non-preventive; including hearing and EKG)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Office Surgery	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapy Services:		
Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	$20 Copay and 15% Coinsurance Deducible does not apply	$20 Copay and 40% Coinsurance after Deductible is met
Acupuncture/Nerve Pathway Therapy & Massage Therapy	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical, Speech, & Occupational Therapy	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Dialysis / Hemodialysis	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiation / Chemotherapy / Non-Preventive Infusion & Injection	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac Rehabilitation & Pulmonary Therapy	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	$25 copay per visit and 40% Coinsurance. No Deductible.	$25 copay per visit and 40% Coinsurance. No Deductible.
Orthotics	See “Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies”.	
Outpatient Facility Services		
Facility Surgery Charge	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Surgery Charges	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Lab	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic X-ray	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapy:		
Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	$20 Copay and 15% Coinsurance Deducible does not apply	$20 Copay and 15% Coinsurance Deducible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Physical, Speech, & Occupational Therapy	$20 copay per visit, then 15% coinsurance. No Deductible.	$20 copay per visit, then 15% coinsurance. No Deductible.
Radiation / Chemotherapy / Non-Preventive Infusion & Injection	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Dialysis / Hemodialysis	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac Rehabilitation & Pulmonary Therapy	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Prescription Drugs Administered in an Outpatient Facility	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy	See "Therapy Services".	
Preventive Care **Preventive care from an Out-of-Network Provider is not subject to the Maximum Allowed Amount.**	No Copayment, Deductible or Coinsurance	40% Coinsurance after Deductible
Prosthetics	See "Prosthetics" under "Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies".	
Pulmonary Therapy	See "Therapy Services".	
Radiation Therapy	See "Therapy Services".	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" for details on Benefits.	
Respiratory Therapy	See "Therapy Services".	
Skilled Nursing Facility	See "Inpatient Services".	
Speech Therapy	See "Therapy Services".	
Surgery	Benefits are based on the setting in which Covered Services are received.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Physical Therapy (Rehabilitative)	Unlimited vists	
Physical Therapy (Habilitative)	Unlimited vists	
Occupational Therapy (Rehabilitative)	Unlimited vists	
Occupational Therapy (Habilitative)	Unlimited vists	
Speech Therapy (Rehabilitative)	Unlimited For cleft palate or cleft lip conditions, Medically Necessary speech therapy is not limited, but those visits lower the number of speech therapy visits available to treat other problems.	
Speech Therapy (Habilitative)	Unlimited Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from injury, trauma, stroke, surgery, cancer, or vocal nodules.	
Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	Review of medical necessity will be performed after 20 visits per injury or sickness	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Cardiac Rehabilitation	Unlimited visits	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Gender Affirming Care **Precertification required**	Benefits are based on the setting in which Covered Services are received.	
Transplant Services **Precertification required**	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services".	
Urgent Care Services (Office Visits)		
Urgent Care Office Visit Charge	$50 Copayment per visit plus 15% Coinsurance Deductible does not apply	$50 Copayment per visit plus 40% Coinsurance Deductible does not apply
Allergy Shots / Injections (other than allergy serum)	$25 Copayment per visit plus 15% Coinsurance Deductible does not apply	$25 Copayment per visit plus 40% Coinsurance Deductible does not apply
Preferred Diagnostic Labs (i.e., reference labs)	$25 Copayment per visit plus 15% Coinsurance Deductible does not apply	$25 Copayment per visit plus 40% Coinsurance Deductible does not apply
Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	$25 Copayment per visit plus 15% Coinsurance Deductible does not apply	$25 Copayment per visit plus 40% Coinsurance Deductible does not apply
Advanced Diagnostic Imaging (including MRIs, CAT scans)	$25 Copayment per visit plus 15% Coinsurance Deductible does not apply	$25 Copayment per visit plus 40% Coinsurance Deductible does not apply
Office Surgery	$25 Copayment per visit plus 15% Coinsurance Deductible does not apply	$25 Copayment per visit plus 40% Coinsurance Deductible does not apply
Prescription Drugs Administered in the Office (includes allergy serum)	$25 Copayment per visit plus 15% Coinsurance Deductible does not apply	$25 Copayment per visit plus 40% Coinsurance Deductible does not apply
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services		
To best understand your benefits, you may call our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. We suggest you do this before you have an evaluation and/or work-up for a transplant, so that we can assist you in maximizing your benefits. To learn more or to find out which Hospitals are In-Network Transplant Providers, you may contact the Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. In addition, you or your Provider must call our Transplant Department for Precertification prior to the transplant, whether this is performed in an Inpatient or Outpatient setting. **The requirements described below do not apply to the following:** • Cornea and kidney transplants, which are covered as any other surgery; and • Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service. Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received.		

Covered Medical Benefits	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
Transplant Benefit Period	**In-Network Transplant Provider**	**Out-of-Network Transplant Provider**
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	**In-Network Transplant Provider**	**Out-of-Network Transplant Provider**
Precertification required	During the Transplant Benefit Period, 20% Coinsurance after Deductible Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	During the Transplant Benefit Period, 40% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	15% Coinsurance after Deductible	40% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	Not covered	Not covered
Transportation and Lodging Limit	Not appliable	
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Donor Search Limit	Covered, as approved by Anthem, up to $30,000 per transplant. In- and Out-of-Network combined	
Live Donor Health Services	15% Coinsurance after Deductible	40% Coinsurance after Deductible
Donor Health Service Limit	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure, for up to six weeks from the date of procurement.	



Pharmacy

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
At least one product in all 18 approved methods of contraception is covered under this policy without cost sharing as required by Federal and state law. Otherwise, each Prescription Drug will be subject to a cost share (e.g., Copayment/Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Prescription Drug Co-Payment Per Member Retail Co-Payment	**$500 RX deductible** $20 Retail and $20 Mail copay* for Tier 1 (typically generic) $50 Retail $100 Mail copay* for Tier 2 (typically preferred brand) $100 Retail and $160 Mail copay for Tier 3 (typically non-preferred brand) *RX deductible must be met before copay will apply	
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days (90 Dayss permitted at participating pharmacies subject to 3X the 30 days supply)	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy	30 days* *See additional information in the "Specialty Drug Copayments / Coinsurance" section below.	

Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. For certain higher cost generic drugs, we reserve the right, in our sole discretion, to make an exception and not require you to pay the difference in cost between the Generic and Brand Name Drug.

Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

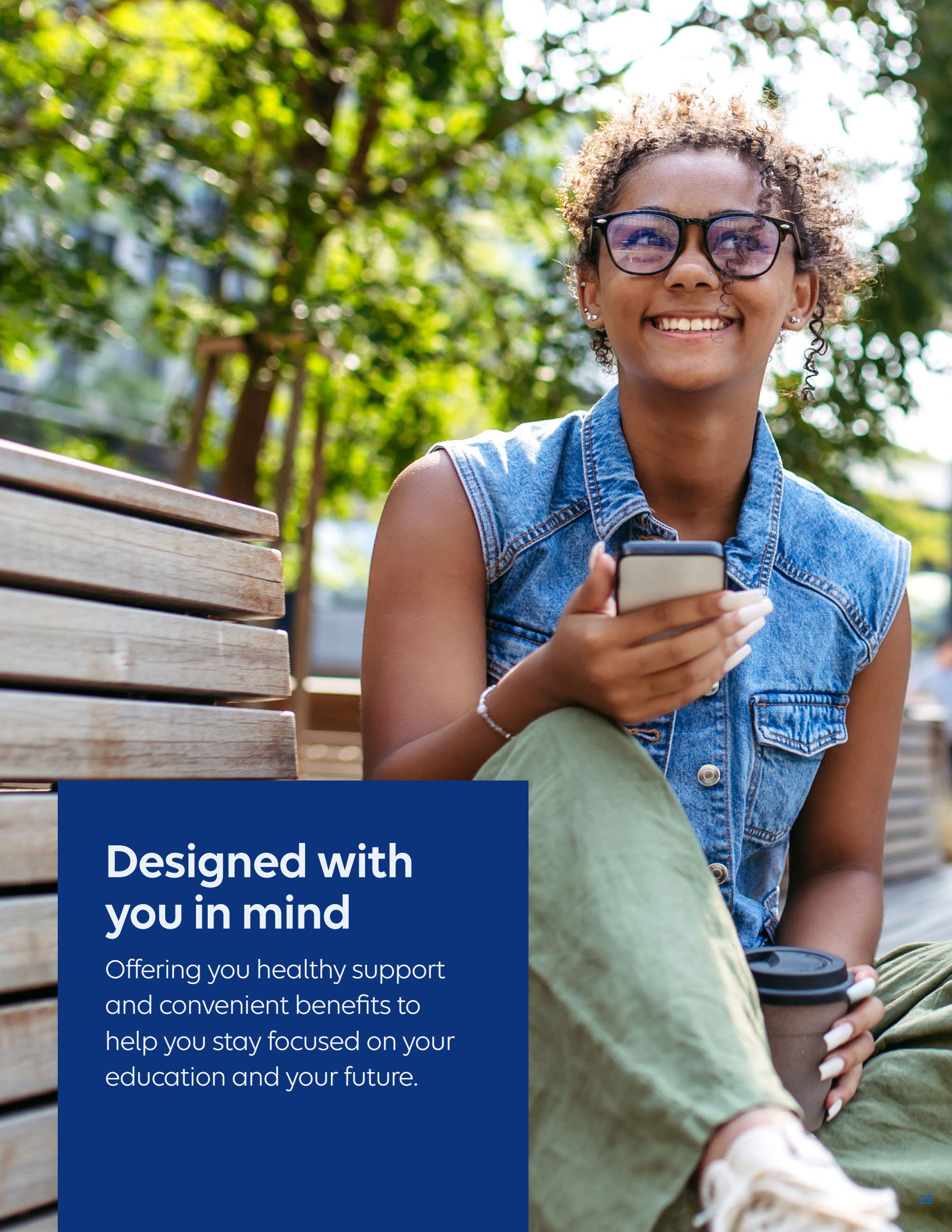
Pediatric Vision Limited to covered persons under the age of 19.

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for student's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Children's Vision Essential Health Benefits **Limited to covered persons under the age of 19.**		
Vision exam Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.	No charge	Reimbursed Up to $30
Frames Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.	No charge	Reimbursed Up to $45
Lenses Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.		
Single vision lenses	$0 copay	Reimbursed Up to $25
Bifocal lenses	$0 copay	Reimbursed Up to $40
Trifocal lenses	$0 copay	Reimbursed Up to $55
Elective contact lenses Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.	No charge	Reimbursedup to $60
Non-Elective Contact Lenses Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.	No charge	Reimbursedup to $210
Adult Vision (age 19 and older) **Adult Vision Coverage**		
Limited to certain vision screenings required by Federal law and covered under the "Preventive Care" benefit.	See "Preventive Care" benefit	See "Preventive Care" benefit



Pediatric Dental Limited to covered persons under the age of 19.

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Dental Essential Health Benefits (up to age 19)		
Diagnostic and Preventive Services (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 Sevices	50% coinsurance. Deductible does not apply	50% coinsurance. Deductible does not apply
Cosmetic Orthodontic Services	Not covered	Not covered
Adult Dental	Not covered	Not covered



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Access help in your language

If you have questions about this document, you have the right to help and information in your language at no cost. To talk to an interpreter, call **855-330-1098**.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف (TTY/TDD: 711) الخاصة بك للمساعدة

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Navajo

Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog

May karapatan kayong makakuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

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If you have questions, we're here to help.

Call 844-412-0752 or visit us at www.du.edu/hcc

Anthem

Health & Counseling Center
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