

HMO Colorado/Anthem Blue Cross and Blue Shield Colorado Higher Education Insurance Benefits Alliance Effective January 1, 2011

PART A: TYPE OF COVERAGE

	BlueAdvantage HMO/Point-of-Service (POS) Plan	PRIME PPO Health Plan	Custom Plus (Traditional)
TYPE OF PLAN	Point of Service	Preferred Provider Plan	Medical Expense Policy
OUT-OF-NETWORK CARE COVERED?¹	Yes, but patient pays more for out-of-network care.	Yes, but patient pays more for out-of-network care	Yes, policy makes no distinction between in and out-of-network care.
AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado	Plan is available throughout Colorado	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFIT

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	BlueAdvantage HMO/Point-of-Service (POS)		PRIME PPO Health Plan		Custom Plus (Traditional)
	In-Network (HMO)	Out-of-Network (POS)	In Network	Out-of Network	
Deductible Type²	Calendar Year				
ANNUAL DEDUCTIBLE^{2a} a) Individual^{2b} b) Family^{2c} Some covered services have a maximum benefit of days, visits or dollar amounts. When the deductible is applied to a covered service which has a maximum number of days or visits, those maximum benefits will be reduced by the amount applied toward the deductible, whether or not the covered service is paid.	No Deductible No Deductible	\$500 \$1,000 aggregate	\$350 \$700 aggregate	\$840 \$1,680 aggregate	\$600 \$1,200

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Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

	BlueAdvantage HMO/Point-of-Service (POS)		PRIME PPO Health Plan		Custom Plus (Traditional)
	In-Network (HMO)	Out-of-Network (POS)	In Network	Out-of Network	
OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family The deductible is NOT included in the out-of-pocket maximum. Some covered services have a maximum numbers of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied. The difference between billed charges and the maximum allowed amount for non-participating providers does not count toward the out-of-pocket annual maximum. Even once the out-of-pocket annual maximum is satisfied, the member will still be responsible for paying the difference between the maximum allowed amount and the non-participating providers billed charges.	\$2,000 \$4,000 aggregate Copayments for inpatient hospital, outpatient/ambulatory surgery and other outpatient services except emergency room copayments apply to the out-of-pocket annual maximum. All other copayments including but not limited to PCP or specialties copayments are still required after the out-of-pocket annual maximum is met.	\$2,500 \$5,000 aggregate	\$750 \$1,500 aggregate	\$2,000 \$4,000 aggregate	\$2,000 aggregate \$4,000 aggregate
LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most covered services. Infertility diagnostic services have a lifetime maximum payment of \$2,000 per member. Bariatric surgery has a per occurrence maximum payment of \$15,000 per member for services received from a designated facility (and \$1,500 per member from a facility that is not a designated facility) with a total per occurrence maximum that shall not exceed \$15,000 per member for designated and non-designated facilities combined.				
COVERED PROVIDERS	HMO Colorado Managed Care Network.	All providers licensed or certified to provide covered benefits.			
WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?	Yes	Yes	Yes	Not applicable	Not applicable.
MEDICAL OFFICE VISIT^{S4} a) Primary Care Providers b) Specialists	\$15 per visit copayment \$15 per visit copayment	Covered person pays 30% after deductible Covered person pays 30% after deductible	Covered person pays 15% after deductible Covered person pays 15% after deductible	Covered person pays 35% after deductible Covered person pays 35% after deductible	Covered person pays 20% after deductible Covered person pays 20% after deductible

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	In-Network (HMO)	Out-of-Network (POS)	In Network	Out-of Network	
<p>PREVENTIVE CARE</p> <p>a) Children's services</p> <p>b) Adult's services Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits.</p>	No copayment (100% covered)	Up to age 13, covered person pays \$30 copayment per visit. Copayment includes services provided as preventive care.	Up to age 13, covered person pays no deductible or coinsurance.	Up to age 13, covered person pays no deductible or coinsurance.	Up to age 13, covered person pays no deductible or coinsurance.
	No copayment (100% covered)	\$30 copayment per visit. Copayment includes services provided as preventive care. For covered colonoscopy facility services, covered person pays \$500 copayment.	Covered person pays no deductible or coinsurance. Routine preventive colonoscopies are covered at no deductible or coinsurance (100% covered).	Covered person pays no deductible or coinsurance. For covered colonoscopy facility services, covered person pays \$500 copayment.	Covered person pays no deductible or coinsurance.
<p>MATERNITY</p> <p>a) Prenatal care</p> <p>b) Delivery & inpatient well baby care⁵</p>	One time \$15 copayment for first prenatal care visit office visit and delivery from the physician.	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible
	\$400 per admission copayment for facility services	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible
INPATIENT HOSPITAL	\$400 per admission copayment	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible
OUTPATIENT AMBULATORY SURGERY	\$75 per procedure copayment	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible
<p>DIAGNOSTICS</p> <p>a) Laboratory & x-ray</p> <p>b) MRI, nuclear medicine, and other high-tech services</p>	\$15 per visit copayment (waived if part of a medical office visit)	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible
	\$100 copayment per procedure for MRI/MRA/CT/PET scans	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible
EMERGENCY CARE	\$100 copayment per emergency room visit. Copayment waived if admitted to hospital.	Out-of-network care is paid as in-network	Covered person pays 15% after deductible	Out-of-network care is paid as in-network	Covered person pays 20% after deductible

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	In-Network (HMO)	Out-of-Network (POS)	In Network	Out-of Network	
AMBULANCE	\$100 per trip copayment (waived if admitted)	Out-of-network care is paid as in-network	Covered person pays 15% after deductible	Out-of-network care is paid as in-network	Covered person pays 20% after deductible (Covered person pays up to \$2,000 for ground and \$5,000 for air per trip)
URGENT, NON-ROUTINE, AFTER HOURS CARE	\$50 per urgent care visit copayment. Urgent care may be received from your PCP or from an urgent care center.	\$50 per urgent care visit copayment Urgent care may be received from your PCP or from an urgent care center.	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible
BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	Coverage is no less extensive than the coverage provided for any other physical illness.				
OTHER MENTAL HEALTH CARE					
a) Inpatient care	\$400 per admission copayment	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible.
b) Outpatient care	For outpatient facility services covered person pays no copayment (100% covered); for outpatient office visits and professional services \$15 copayment per visit for PCP or specialists.	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible.
ALCOHOL AND SUBSTANCE ABUSE					
a) Inpatient care	\$400 per admission copayment	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible.
b) Outpatient care	For outpatient facility services covered person pays no copayment (100% covered); for outpatient office visits and professional services \$15 copayment per visit for PCP or specialists.	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible.

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	In-Network (HMO)	Out-of-Network (POS)	In Network	Out-of Network	
PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient Limited to 30 non-acute inpatient days per calendar year in and out of network combined. b) Outpatient From birth until the sixth birthday benefits are provided as required by applicable law.	\$400 copayment per admission. \$15 copayment per visit. Limited to 30 visits per calendar year each for physical, occupational and speech therapy in and out-of-network combined	Covered person pays 30% after deductible. Covered person pays 30% after deductible. Limited to 30 visits per calendar year each for physical, occupational and speech therapy in and out-of-network combined.	Covered person pays 15% after deductible Covered person pays 15% after deductible. Limited to 60 visits per calendar year combined for physical, speech and occupational therapies in and out-of-network combined.	Covered person pays 35% after deductible Covered person pays 35% after deductible Limited to 60 visits per calendar year combined for physical, speech and occupational therapies in and out-of-network combined.	Covered person pays 20% after deductible Covered person pays 20% after deductible
DURABLE MEDICAL EQUIPMENT	No copayment (100% covered).	Covered person pays 30% after deductible.	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible.
OXYGEN	No copayment (100% covered).	Covered person pays 30% after deductible.	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible
ORGAN TRANSPLANT Transportation and lodging services are limited to a maximum benefit of \$10,000; unrelated donor searches are limited to a maximum benefit of \$30,000	\$400 per admission copayment for inpatient services \$15 per office visit copayment	Covered by HMO Colorado when preauthorized and delivered at a Center of Excellence. Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 20% after deductible. See Certificate for details.
HOME HEALTH CARE	No copayment (100% covered)	Covered person pays 30% after deductible	No coinsurance (100% covered) Limited to 60 visits per year combined in and out-of-network.	Covered person pays 35% after deductible. Limited to 60 visits per year combined in and out-of-network.	Covered person pays 20% after deductible, pre-authorization required (up to 60 visits per year)
HOSPICE CARE	No copayment (100% covered)	Covered person pays 30% after deductible	No coinsurance (100% covered)	Covered person pays 35% after deductible	Covered person pays 20% after deductible (up to 30 inpatient days per year and up to \$91 per day for up to 91 outpatient days per year)

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	In-Network (HMO)	Out-of-Network (POS)	In Network	Out-of Network	
SKILLED NURSING FACILITY CARE When covered, limited to 60 days per calendar year combined in and out of network.	No copayment (100% covered).	Covered person pays 30% after deductible.	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Not covered
DENTAL CARE	Not covered	Not covered	Not covered	Not covered	Not covered
VISION CARE	Not covered	Not covered	Not covered		Not covered
CHIROPRACTIC CARE For POS and Prime, limited to 20 visits per calendar year combined with out-of-network coverage for chiropractic care, in-network coverage for massage therapy and in-network coverage with acupuncture care. No physician referral required.	\$15 per visit copayment .	Covered person pays 30% after deductible.	Covered person pays 15% after deductible.	Covered person pays 35% after deductible	Covered person pays 20% after deductible. Limited to 12 visits per calendar year.
Massage Therapy/ Acupuncture Care When covered, Limited to 20 visits per calendar year combined with in and out-of-network coverage for chiropractic care and in-network coverage for acupuncture care and massage therapy.	\$15 copayment per visit.	Not covered	Covered person pays 15% after deductible.	Not covered	Not Covered
HEARING AIDS Benefits are covered up to age 18 and are supplied every 5 years, except as required by law.	No copayment (100% covered).	No copayment (100% covered).	Covered person pays 15% after deductible.	Covered person pays 35% after deductible.	Covered person pays 20% after deductible.
SECOND OPINIONS	When a member desires another professional opinion, they may obtain a second opinion.				
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 analysis services for in- and out-of-network services combined: <ul style="list-style-type: none"> • From birth to age eight (up to member's ninth birthday): \$34,000 in and out-of-network combined • Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 in and out-of-network combined 				
SIGNIFICANT ADDITIONAL COVERED SERVICES	BlueCares for You Program	Point of Service Rider For services covered under this rider, a member is not required to get a PCP referral. A member may also choose to receive covered services from a provider who is not in the HMO Colorado network.	Accident Benefits Rider Additional accident benefits are allowed for the treatment of accident-related injuries up to \$500 not subject to deductible and coinsurance. Services after \$500 are subject to deductible and coinsurance requirements.		Accident Benefits Rider Additional accident benefits are allowed for the treatment of accident-related injuries up to \$500 not subject to deductible and coinsurance. Services after \$500 are subject to deductible and coinsurance requirements.

	BlueAdvantage HMO/Point-of-Service (POS) and PRIME PPO Health Plan		Custom Plus (Traditional)
	In-Network (HMO and PPO)	Out-of-Network (POS, Participating and Non-Participating)	
<p>PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions⁶</p> <p>a) Inpatient care</p> <p>b) Outpatient care</p> <p>c) Prescription Mail Service</p>	<p>Included with the inpatient hospital benefit</p> <p>Retail Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$30 copayment, tier 3 \$45 copayment, tier 4 30% coinsurance, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 retail pharmacy drugs, the maximum copayment per prescription is \$100 per 30-day supply.</p> <p>Specialty Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$30 copayment, tier 3 \$45 copayment, tier 4 30% coinsurance, per prescription from our Specialty Pharmacy up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum copayment per prescription is \$100 per 30-day supply from our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy. Specialty pharmacy drugs are only available through The Pharmacy Benefit Manager (PBM).</p> <p>Mail-Order Pharmacy Drugs - Tier 1 \$30 copayment, tier 2 \$60 copayment, tier 3 \$90 copayment, tier 4 30% coinsurance, per prescription through the mail-order service up to a 90-day supply. For the tier 4 mail-order drugs, the maximum copayment per prescription is \$100 per 30-day supply or \$200 per 90-day supply. Specialty pharmacy drugs are only available through the Pharmacy Benefit Manager (PBM).</p> <p>The following applies to b) and c) above: Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem,.</p> <p>Asthma and diabetic prescription drugs and supplies received from a retail pharmacy or mail-order pharmacy are covered under the tier 1 copayment.</p> <p>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 brand-name drug, in addition to your tier 1 generic copayment. The cost difference between the generic and brand-name drug does not contribute the out-of-pocket annual maximum. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. HMO Colorado reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, call customer service at 800-542-9402.</p>	<p>Included with the inpatient hospital benefit</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>	<p>Included with the inpatient hospital benefit</p> <p>Covered person pays 20% after deductible</p> <p>Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem.</p> <p>Not covered</p>

PART C: LIMITATIONS AND EXCLUSIONS

	BlueAdvantage HMO/Point-of-Service (POS)	PRIME PPO Health Plan	Custom Plus (Traditional)
Period during which pre-existing conditions are not covered ¹⁰	Not applicable. Plan does not impose limitation periods for pre-existing conditions. For late enrollees, individual must wait until next open enrollment.	6 months for new members without prior creditable health insurance. See policy for details.	6 months for new members without prior creditable health insurance. See policy for details.
EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No	No
How does the policy define a "pre-existing condition?"	Not applicable. Plan does not exclude coverage for pre-existing conditions.	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.	
What treatments and conditions are excluded under this policy?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.		

PART D: USING THE PLAN

	BlueAdvantage HMO/Point-of-Service (POS)	PRIME PPO Health Plan	Custom Plus (Traditional)
Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No		
Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield. If the provider is in-network , the physician who schedules the procedure or hospital care is responsible for obtaining the pre-certification.		
If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	Yes, unless the provider participates with HMO Colorado or Anthem Blue Cross and Blue Shield or is a PPO Provider		
What is the main customer service number?	800-542-9402		
Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202		
Does the plan have a binding arbitration clause?	Yes		
Whom do I write/ call if I have a complaint or want to file a grievance? ¹¹	HMO Colorado Complaints and Appeals 700 Broadway CAT0430 Denver, CO 80273 800-542-9402	Anthem BCBS Complaints and Appeals 700 Broadway CAT0430 Denver, CO 80273 800-542-9402	
To assist in filing a grievance, indicate the form number of this Large Group policy.	Policy form #'s 98898_GF	Policy form #94593_GF	Policy form #94594_GF

¹ "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay 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 "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or Per Confinement".

^{2a} "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible should vary by policy. Expenses that are subject to deductible may be noted in boxes 8 through 31.

^{2b} "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for the allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

^{2c} "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "\$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

³ "Out-of-pocket maximum" Means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.

⁴ Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

⁵ Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together: there are not separate copayments.

⁶ Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

⁷ "Emergency care" means all services delivered in an emergency care facility which is 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.

⁸ Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

⁹ "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

¹⁰ Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

¹¹ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Cancer Screenings

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below.

Pap Tests

All plans provide coverage under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the plan's provisions for preventive care service. Payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

All plans provide coverage under the preventive care benefits for one routine screening or diagnostic mammogram per year regardless of age (or in accordance with the frequency determined by your provider) for women. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care and is normally not subject to the deductible or coinsurance.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide coverage under the preventive care benefits for one routine prostate cancer screening per year regardless of age (or in accordance with the frequency determined by your provider) for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive exam and laboratory services and is normally not subject to the deductible or coinsurance.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Payment for preventive colorectal cancer screenings are not subject to the deductible or coinsurance.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Colorado Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Colorado Health Benefit Plan Description Form.