

FY10 HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 750		
	In-Network	Out-of-Network
<p>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 Plan, 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 Pre-Treatment Authorization or use of specified providers or facilities). Consult the actual Summary Plan Description to determine the exact terms and conditions of coverage. Coinsurance % reflects the amount the Plan will pay.</p>		
Part A: Type of Coverage		
1. Type of Plan	Preferred Provider Organization- Open Access Network	
2. Out-of-Network Care Covered? ¹	Yes, but patient pays more for out-of-network care.	
3. Areas of Colorado where Plan is Available	Plan is available nationally.	
Part B: Summary of Benefits		
4. Plan Year Deductible	\$750	\$1,500
a) Individual	\$1,500	\$3,000
b) Family	The in-network deductible may not be used to satisfy the out-of-network deductible.	The out-of-network deductible may not be used to satisfy the in-network deductible.
5. Plan Year Out-of-Pocket maximum (includes deductible, if any) ²	\$3,000	\$6,000
a) Individual	\$6,000	\$12,000
b) Family	The in-network out-of-pocket maximum may not be used to satisfy the out-of-network out-of-pocket maximum.	The out-of-network out-of-pocket maximum may not be used to satisfy the in-network out-of-pocket maximum.
6. Lifetime Maximum	No lifetime maximum with the following exception: surgical treatment of morbid obesity, if Medically Necessary, is covered up to a lifetime maximum of \$7,500	
7. Covered Providers	Great-West Healthcare Open Access Network, Pharmacy Services provided by Express Scripts® by arrangement with Great-West Healthcare.	All providers licensed or certified to provide covered benefits.
8. Medical Professional Services	80% after deductible	60% after deductible
9. Office Visits	80% after deductible	60% after deductible
10. Scheduled Preventive Care:		
a) Children	90% not subject to deductible	70% not subject to deductible
b) Adults	90% not subject to deductible (Routine PSA blood test and digital rectal exam payable at 100%)	70% not subject to deductible (Routine PSA blood test and digital rectal exam payable at 100%)
11. Maternity		
a) Prenatal care	80% after deductible	60% after deductible
b) Delivery & Inpatient well baby care	80% after deductible	60% after deductible
c) Delivery Professional services	80% after deductible	60% after deductible
12. Prescription Drugs		
Level of coverage and restrictions on prescriptions	a), b) and c) subject to \$150 per member Rx deductible before copay applies (waived for all generic drugs).	
a) Retail Copays	\$10	Not Covered
- Generic	\$25	
- Preferred	\$50	
- Non-Preferred	(30 day supply)	
b) Mail Order Copays	\$25	Not Covered
- Generic	\$62.50	
- Preferred	\$125	
- Non-Preferred	(90 day supply)	
c) Self-admin. Injectables disp. thru Pharmacy	Plan pays 70%. Member share not to exceed \$300 per 34-day supply or \$750 per 90-day supply	Not Covered
d) Injectables admin. in office or OP facility	70% after deductible (Plan Year deductible – see #4 above.)	Not Covered
<p>The Prescription Drug Program has been designed to encourage the use of generic medications. If a generic drug is available, but the preferred drug is dispensed (whether by your request or upon a physician specifying "Dispense As Written,") you are required to pay the applicable preferred copayment PLUS the difference in cost between the generic and preferred drug. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as preferred drugs.</p>		

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13. Inpatient Hospital	80% after deductible	60% after deductible
14. Outpatient / Ambulatory Surgery	80% after deductible	60% after deductible
15. Other services		
a) Laboratory	80% after deductible	60% after deductible
b) X-ray	80% after deductible	60% after deductible
c) MRI / PET / CAT scans	80% after deductible	60% after deductible
<i>b) & c) subject to Pre-Treatment Authorization</i>	80% after deductible	60% after deductible
16. Emergency Care	80% after deductible	60% after deductible
17. Ambulance		
a) Ground	80% after in-network deductible, maximum benefit \$1,000 per trip.	
b) Air	80% after in-network deductible, maximum benefit \$10,000 per trip.	
18. Urgent Care	80% after deductible	60% after deductible
"Urgent Care" means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a member's health.		
19. Biologically Based Mental Health³ Care and Mental Disorders Care	80% after deductible	60% after deductible
20. Other Mental Health	Maximum 45 full/90 partial days inpatient services and 30 visits for outpatient services per Plan Year.	
a) Inpatient care	80% after deductible	60% after deductible
b) Outpatient care	80% after deductible	60% after deductible
21. Substance Abuse		
a) Inpatient Rehab	80% after deductible	60% after deductible
b) Outpatient	80% after deductible	60% after deductible
22. Early Intervention Services	Plan pays applicable percentage based on the type of service performed, not subject to deductible, copays or other Benefit specific maximums, up to \$5,725 per Plan year	Plan pays applicable percentage based on the type of service performed, not subject to deductible, copays or other Benefit specific maximums, up to \$5,725 per Plan year
23. Physical, Occupational & Speech Therapy		
a) Inpatient	80% after deductible	60% after deductible
b) Outpatient	80% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.	60% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.
24. Durable Medical Equipment		
a) Inpatient	80% after deductible	60% after deductible
b) Outpatient including supplies	80% after deductible, maximum of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to \$5,000 max and do not reduce the \$5,000 max.)	60% after deductible, maximum of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to \$5,000 max and do not reduce the \$5,000 max.)
25. Medical Supplies	80% after deductible	60% after deductible
26. Oxygen		
a) Inpatient	Included in Hospital	Included in Hospital
b) Outpatient	80% after deductible	60% after deductible
27. Transplants	80% after deductible	Not Applicable (Transplants must be in-network.)
28. Home Health Care <i>(Subject to Pre-Treatment Authorization)</i>	80% after deductible 100 visits per Plan Year. Maximum includes in and out-of-network visits.	60% after deductible 100 visits per Plan Year. Maximum includes in and out-of-network visits.
29. Hospice		
a) Inpatient	80% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.	60% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.
b) Outpatient	80% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.	60% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.

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30. Skilled Nursing Facility Care	80% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.	60% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.
31. Dental Care	Not covered	Not covered
32. Vision Care	AVESIS Network only NOT COVERED UNDER MEDICAL PLAN See page 114 of the Summary Plan Description for details on this benefit.	AVESIS Network only NOT COVERED UNDER MEDICAL PLAN See page 114 of the Summary Plan Description for details on this benefit.
33. Chiropractic Care and Acupuncture	80% after deductible, maximum benefit \$750 per Plan Year per benefit. Maximum applies to both in and out-of-network visits.	60% after deductible, maximum benefit \$750 per Plan Year per benefit. Maximum applies to both in and out-of-network visits.
34. Significant Additional Covered Services a) Hearing Aids exams, hearing aids and their fittings b) Infertility	100% after deductible, limited to \$500 every 3 years. Maximum applies to both in and out-of-network. 80% after deductible, maximum benefit \$2,500 per Plan Year. Limit applies to both in and out-of-network.	100% after deductible, limited to \$500 every 3 years. Maximum applies to both in and out-of-network. 60% after deductible, maximum benefit \$2,500 per Plan Year. Limit applies to both in and out-of-network.
Part C: Limitations and Exclusions		
35. Period during which Pre-Existing Conditions are not Covered.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.	
36. What Treatments & Conditions are excluded Under this Policy?	See Summary Plan Description for list of exclusions.	
Part D: Using the Plan		
37. Does the enrollee have to obtain a referral for specialty care in most or all cases?	No	
38. Is Pre-Treatment Authorization required for surgical procedures and hospital care (except in an emergency)?	Yes. See Summary Plan Description for list of procedures.	
39. If the provider charges more for a covered service than the Plan normally pays, does the enrollee have to pay the difference?	No	Yes
40. What is the main customer service number?	1-888-ST8-OFCO (1-888-788-6326)	
41. Whom do I write/call if I have a complaint or want to file a grievance?	Call the Great-West Customer Service Department at (1-888-788-6326)	
42.. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Submit Appeals form to: Great-West Healthcare Attention: Appeals/Grievances 8525 E. Orchard Road, 4T3 Greenwood Village, Colorado 80111	
43. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Number: 179528 Self-Funded Large Group	
44. Does the Plan have a binding arbitration clause?	No	

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Part E: Costs

45. What is the cost of this Plan?
- a) Employee Only
 - b) Employee + Child(ren)
 - c) Employee + Spouse
 - d) Family

Rates are available on the Benefits website
www.colorado.gov/dpa/dhr/benefits.

¹Network 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 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).

²Out-of-pocket maximum. 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 copay, depending on the contract for that Plan. Mental Health Expenses do not apply to the out-of-pocket (does not include Biologically based Mental Health or Mental Disorders).

³Emergency Care means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Urgent care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a member's health.

⁴Biologically based Mental Health means schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder. Mental Disorders means: post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder and anorexia nervosa and bulimia nervosa (to the extent those diagnoses are treated on an out-patient, day treatment and in-patient basis, exclusive of residential treatment).