

STATE OF COLORADO

INTRODUCTION

Your Employer has chosen the Benefits described in this Booklet for many reasons. The most important of these are to protect its most valuable assets -- its healthy and productive Employees -- and to provide Members with significant financial protection against the physical, emotional and economic strain that Illness or Injury can bring.

Please read this Booklet carefully to familiarize Yourself with the Benefits it describes and the procedures for filing claims. If You have any questions about Your coverage, please contact the Great-West Customer Service Department at **1-888-ST8-OFCO** or **1-888-788-6326**.

When used in the Plan, unless otherwise stated, the terms are as defined in:

1. the General Definitions section;
2. the specific Benefits sections.

Great-West Life & Annuity Insurance Company processes the benefits for this Plan under the name of Great-West Healthcare.

NOTE: *The STATE OF COLORADO reserves the right to add, modify, or discontinue the Benefit Plan as deemed necessary.*

TABLE OF CONTENTS

SECTION 1: MEDICAL PLAN

HEALTH PLAN DESCRIPTION FORMS – SUMMARIES OF BENEFITS	1-20
Open Access H Plan	1-5
Open Access 750 Plan	6-10
Open Access 1500 Plan	11-15
Open Access 3000 Plan	16-20
ABOUT YOUR MEDICAL COVERAGE	21-23
PROVIDERS	21
Network Providers	21
Non-Network Providers	21
COST SHARING REQUIREMENTS	22-23
Co-Payment	22
Deductible	22
Coinsurance	23
Maximum Lifetime Benefits	23
MANAGED CARE FEATURES	24-30
Process To Determine Whether Services Are Covered	24
Appropriate Place and Pre-Treatment Authorization	24-26
Concurrent Review	26-27
Retrospective Review	27
Benefits for Services of a Network Provider	27-28
Transitional Care Upon Termination of a Physician and/or Hospital from the Network	28
Out-of-Town Care	28
Great-West’s Medical Outreach Program	28-30
YOUR COVERAGE IN THE PLAN	31-42
Eligible Employees	31
Employee Responsibilities	31-32
Leaves of Absence	32
Reinstatement	32
Eligible Dependents	32
Dependent Definitions	32-33
Coverage for Newborns	34
When Coverage Begins for Eligible Employees and Eligible Dependents	34
Late Enrollees	34
What is Open Enrollment?	34
Eligible Events That May Allow Elections Changes	35
Qualified Change in Status Events	35-37
Change in Employee’s Legal Marital Status that affects Eligibility	35
Change in the Number of Employee’s Tax Dependents Eligible for Coverage	35-36
Change in Employment Status of Employee, Spouse, or Dependent That Affects Eligibility	36
Dependent Satisfies or Ceases to Satisfy Eligibility Requirements	36-37
Dependent’s Coverage under Children’s Basic Health Plan is Terminated	37
Change in Place of Residence of Employee, Spouse, or Dependent that affects Eligibility	37

TABLE OF CONTENTS - Continued

SECTION 1: MEDICAL PLAN

Significant Cost Changes	37
Cost Decrease	37
Cost Increase	37
Significant Curtailment of Coverage	38
Addition or Significant Improvement of Benefit Package Option	38
Change in Coverage Under Other Employer Cafeteria Plan	38
HIPAA Special Enrollment Rights	38-39
Special Enrollment for Loss of Other Health Coverage	38
Special Enrollment for Acquisition of New Dependent	39
COBRA Qualifying Events	39
Loss of Eligibility under a Spouse's or Dependent's Plan	39
Entry of a Qualified Medical Child Support Order (QMCSO)	39
Order that Requires Coverage For the Child Under Employee's Plan	39
Order that Requires Spouse, or Other Individual to Provide Coverage for the Child	39
Gain or Loss of Medicare or Medicaid Entitlement	39-40
Employee, Spouse or Dependent Becomes Entitled to Medicare or Medicaid	39
Employee, Spouse or Dependent Loses Medicare or Medicaid Entitlement	40
Family Medical Leave of Absence (FMLA)	40
Employee's Commencement of Unpaid FMLA Leave	40
Employee's Return From FMLA Leave	40
Military Leave under USERRA	40
Employee's Commencement of Unpaid Military Leave	40
Employee's Return From Military Leave	40
When Coverage Ends	41
Certificate of Creditable Coverage	41
Continuation of Coverage Under COBRA and USERRA	42
Extended Medical Care Benefits on Termination of Coverage	42
YOUR BENEFITS	43-73
Open Access H (Health Savings Account-Qualified High Deductible Health Plan) Option	43-45
Preventive Care Services	46-47
Family Planning	48
Maternity and Newborn Care	48-50
Diabetes Management	50
Physician's Office Services	50-51
Inpatient Facility Services	51-53
Outpatient Facility Services	53-54
Emergency Care and Urgent Care	54-56
Ambulance and Transportation Services	56-57
Outpatient Therapies	57-58
Early Intervention Services	58-59
Home Health Care/Home IV Therapy	59-60
Hospice Care	60-61
Clinical Trials	61-62
Transplant Services	62-64
Medical Supplies and Durable Medical Equipment	64-67
Reconstructive Services and Surgery	66
Enteral Nutrition Benefits	67
Dental Related Services	67-69
Biologically Based and Non-Biologically Based Mental Health Conditions and Mental Disorders	69-72

TABLE OF CONTENTS - Continued

SECTION 1: MEDICAL PLAN

PRESCRIPTION DRUG BENEFITS	73-78
How to Obtain Outpatient Prescription Drug Benefits	73
In-Network Retail Pharmacy.....	73
Out-of-Network Retail Pharmacy.....	74
Mail Service	74
Specialty Pharmacy Program.....	74-75
Ninety-day Retail Participating Provider Pharmacy Program	75
Prescription Drug Generic Option	75
Mandatory Generic Drug Replacement.....	75
Preferred Drug Option	76
Prior Authorization Program	76
Managed Drug Limit Program	76
Prior Authorization and Managed Drug Limit Lists.....	76
Unit Dose Limits	77
Prescription Drug Definitions	77
Prescription Drug Exclusions	78
Prescription Drug Claims.....	78
GENERAL EXCLUSIONS	79-83
Exclusions.....	79-83
Medical Assistance.....	83
ADMINISTRATIVE INFORMATION	84-86
Notice and Proof of Claim.....	84
Payment of Claims	84-85
Legal Actions	85
Assignment of Benefits.....	85
Physical Examinations.....	85
Incontestability and Misstatement	85
Refund to the Plan for Overpayment of Benefits.....	85-86
Right of Subrogation.....	86
COORDINATION OF BENEFITS	87-89
Medicare.....	89
COMPLAINTS, CLAIM DECISIONS AND APPEALS	90-93
Complaints.....	90
Claim Decisions.....	90
Appeals Procedure for Pre-Treatment Authorization, Concurrent Review or Retrospective Review	90-91
First Level Appeal.....	91
Standard First Level Appeal	91
Expedited First Level Appeal.....	91
Voluntary Second Level Appeal	92
External Appeal	92
Appeals Procedure for Claim Denials	93
GENERAL DEFINITIONS	94-104

TABLE OF CONTENTS - Continued

LEGAL COMPLIANCE AND IMPORTANT NOTICES	105-116
Authority of the Plan Administrator.....	105
The State’s Right.....	105
Funding and Compliance with Applicable Law.....	105
HIPAA Portability Rules.....	105
HIPAA Privacy & Security.....	106
Women’s Health and Cancer Rights Act.....	106
Newborns’ and Mothers’ Health Protection Act.....	106
COBRA Continuation Coverage Rights.....	107-111
USERRA Rights and Responsibilities.....	112-113
HIPAA Notice of Privacy Practices.....	114-116

* * * * *

SECTION 2: VISION PLAN

SUMMARY OF VISION BENEFITS	117-119
VISION CARE BENEFITS	117-118
LIMITATIONS AND EXCLUSIONS	118
SUBMITTING A CLAIM	118-119

FY09 HEALTH PLAN DESCRIPTION FORM – OA-H¹

Open Access H (HSA eligible)

	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?²	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		
a) Employee Only	\$1,500	\$3,000
b) Family	\$3,000 The family deductible must be satisfied before benefits are paid for any individual family member. The in-network deductible may not be used to satisfy the out-of-network deductible.	\$6,000 The family deductible must be satisfied before benefits are paid for any individual family member. The out-of-network deductible may not be used to satisfy the in-network deductible.
5. Plan Year³ Out-of-Pocket maximum (includes deductible, if any)		
a) Employee Only	\$3,000	\$6,000
b) Family	\$6,000 The family out-of-pocket maximum must be satisfied before benefits are paid at 100% for any individual family member. The in-network out-of-pocket maximum may not be used to satisfy the out-of-network out-of-pocket maximum.	\$12,000 The family out-of-pocket maximum must be satisfied before benefits are paid at 100% for any individual family member. 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	85% after deductible	65% after deductible
9. Office Visits	85% after deductible	65% 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	85% after deductible	65% after deductible
b) Delivery & Inpatient well baby care	85% after deductible	65% after deductible
c) Delivery professional services	85% after deductible	65% after deductible

HEALTH PLAN DESCRIPTION FORM – Open Access H¹

Open Access H (HSA eligible)

	In-Network	Out-of-Network
12. Prescription Drugs Level of coverage and restrictions on prescriptions a) Retail - Generic - Preferred - Non-Preferred b) Mail Order - Generic - Preferred - Non-Preferred c) Self-admin. Injectables disp. thru Pharmacy d) Injectables admin. in office or OP facility	85% after deductible (Plan Year deductible – see #4 above.) 85% after deductible (Plan Year deductible – see #4 above.) 85% after deductible (Plan Year deductible – see #4 above.) 70% after deductible (Plan Year deductible – see #4 above.)	65% after deductible (Plan Year deductible – see #4 above.) Not covered. (No mail order out-of-network benefit.) 65% after deductible (Plan Year deductible – see #4 above.) 70% after deductible (Plan Year deductible – see #4 above.)
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.		
13. Inpatient Hospital	85% after deductible	65% after deductible
14. Outpatient / Ambulatory Surgery	85% after deductible	65% after deductible
15. Other Services a) Laboratory b) X-ray* c) MRI / PET / CAT scans* *Subject to Pre-Treatment Authorization	85% after deductible 85% after deductible 85% after deductible	65% after deductible 65% after deductible 65% after deductible
16. Emergency Care⁴	85% after deductible	65% after deductible
Emergency 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.		
17. Ambulance a) Ground b) Air	85% after in-network deductible, maximum benefit \$1,000 per trip. 85% after in-network deductible, maximum benefit \$10,000 per trip.	
18. Urgent Care⁴	85% after deductible	65% after deductible
Urgent Care⁴ 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 Health and Mental Disorders Care⁵	85% after deductible	65% after deductible
20. Other Mental Health Care: a) Inpatient care b) Outpatient care	Maximum 45 full/90 partial days inpatient services and 30 visits for outpatient services per Plan Year. Number of inpatient days applies to both in and out-of network. 85% after deductible. 85% after deductible.	65% after deductible 65% after deductible

HEALTH PLAN DESCRIPTION FORM – Open Access H¹

Open Access H (HSA eligible)

	In-Network	Out-of-Network
21. Drug and Alcohol Disorders a) Inpatient Rehab b) Outpatient	85% after deductible. 85% after deductible.	65% after deductible 65% after deductible
22. Early Intervention Services	Plan pays applicable percentage based on the type of service performed, after deductible. (Not subject to any other Benefit specific maximums, up to \$5,725 per Plan Year.)	Plan pays applicable percentage based on the type of service performed, after deductible. (Not subject to any other Benefit specific maximums, up to \$5,725 per Plan Year.)
23. Physical, Occupational & Speech Therapy a) Inpatient b) Outpatient	85% after deductible 85% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.	65% after deductible 65% 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 b) Outpatient including supplies	85% after deductible 85% after deductible, maximum benefit of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to the \$5,000 maximum, and do not reduce the \$5,000 maximum.)	65% after deductible 65% after deductible, maximum benefit of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to the \$5,000 maximum, and do not reduce the \$5,000 maximum.)
25. Medical Supplies	85% after deductible	65% after deductible
26. Oxygen a) Inpatient b) Outpatient	Included in Hospital 85% after deductible	Included in Hospital 65% after deductible
27. Transplants	85% after deductible	Not Applicable. (Transplants must be in-network)
28. Home Health Care (Subject to Pre-Treatment Authorization)	85% after deductible, 100 visits per Plan Year. Maximum includes in and out-of-network visits.	65% after deductible, 100 visits per Plan Year. Maximum includes in and out-of-network visits.
29. Hospice a) Inpatient b) Outpatient	85% after deductible, 30 days per Plan Year. Number of days applies to both in and out-of-network. 85% after deductible, 91 days per Plan Year. Number of days applies to both in and out-of-network.	65% after deductible, 30 days per Plan Year. Number of days applies to both in and out-of-network. 65% after deductible, 91 days per Plan Year. Number of days applies to both in and out-of-network.
30. Skilled Nursing Facility Care	85% after deductible, 30 days per Plan Year. Number of days applies to both in and out-of-network.	65% 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	85% after deductible for exam only, no benefit for hardware.	65% after deductible for exam only, no benefit for hardware.
33. Chiropractic Care and Acupuncture	85% after deductible, maximum benefit \$750 per Plan Year, per benefit. Maximum applies to both in and out-of-network visits.	65% after deductible, maximum benefit \$750 per Plan Year, per benefit. Maximum applies to both in and out-of-network visits.

HEALTH PLAN DESCRIPTION FORM – Open Access H¹

Open Access H (HSA eligible)

	In-Network	Out-of-Network
34. Significant Additional Covered Services		
a) Hearing Aid exams, hearing aids and their fitting	85% after deductible, limited to \$500 every 3 years. Maximum applies to both in and out-of-network.	65% after deductible, limited to \$500 every 3 years. Maximum applies to both in and out-of-network.
b) Infertility	85% after deductible, maximum benefit \$2,500 per Plan Year. Limit applies to both in and out-of-network.	65% 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	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.	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-OFCC-(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/Grievance 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 is a short-term policy.	Policy Number: 179528 Self-funded large group.	

HEALTH PLAN DESCRIPTION FORM – Open Access H¹
Open Access H (HSA eligible)

44. Does the Plan have a binding arbitration clause?	<p align="center">No</p>
45. What is the cost of this Plan? a) Employee Only b) Employee + Child(ren) c) Employee + Spouse d) Family	<p align="center">Rates are available on the Benefits website www.colorado.gov/dpa/dhr/benefits.</p>

¹ Open Access H Plan is a HSA qualified High Deductible Health Plan (HDHP) as described by federal law.

² 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 pays more of your bill if you use network providers (i.e. go in-network) than if you don't (i.e. go out-of-network).

³ Out-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).

⁴ Emergency 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.

⁵ Biologically 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).

FY09 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		
a) Individual	\$750	\$1,500
b) Family	\$1,500	\$3,000
	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 ² Out-of-Pocket maximum (includes deductible, if any)		
a) Individual	\$3,000	\$6,000
b) Family	\$6,000	\$12,000
	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-network 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

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 750

	In-Network	Out-of-Network
12. Prescription Drugs Level of coverage and restrictions on prescriptions a) Retail Copays - Generic - Preferred - Non-Preferred b) Mail Order Copays - Generic - Preferred - Non-Preferred c) Self-admin. Injectables disp. thru Pharmacy d) Injectables admin. in office or OP facility	a) & b) & c) subject to \$150 per member Rx deductible before copays apply (waived for all Generic drugs). (30 day supply) \$10 \$25 \$50 (90 day supply) \$25 \$62.50 \$125 Plan pays 70%. Member share not to exceed \$300 per 34-day supply or \$750 per 90-day supply 70% after deductible (Plan Year deductible – see #4 above.)	Not Covered Not Covered Not Covered Not Covered
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.		
13. Inpatient Hospital	80% after deductible	60% after deductible
14. Outpatient / Ambulatory Surgery	80% after deductible	60% after deductible
15. Other Services a) Laboratory b) X-ray* c) MRI / PET / CAT scans* *Subject to Pre-Treatment Authorization	80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible
16. Emergency Care³	80% after deductible	60% after deductible
“Emergency 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.		
17. Ambulance a) Ground b) Air	80% after in-network deductible, maximum benefit \$1,000 per trip. 80% after in-network deductible, maximum benefit \$10,000 per trip.	
18. Urgent Care⁴	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 Health and Mental Disorders Care⁴	80% after deductible.	60% after deductible.
20. Other Mental Health Care:	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

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 750

	In-Network	Out-of-Network
21. Drug and Alcohol Disorders a) Inpatient Rehab b) Outpatient	80% after deductible 80% after deductible	60% 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 b) Outpatient	80% after deductible 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 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 b) Outpatient including supplies	80% after deductible 80% after deductible, maximum benefit of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to the \$5,000 maximum, and do not reduce the \$5,000 maximum.)	60% after deductible 60% after deductible, maximum benefit of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to the \$5,000 maximum, and do not reduce the \$5,000 maximum.)
25. Medical Supplies	80% after deductible	60% after deductible
26. Oxygen a) Inpatient b) Outpatient	Included in Hospital 80% after deductible	Included in Hospital 60% after deductible
27. Transplants	80% after deductible	Not Applicable. (Transplants must be in-network)
28. Home Health Care (Subject to Pre-Treatment Authorization)	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 b) Outpatient	80% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network. 80% after deductible 91 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. 60% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.
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 117 of the Summary Plan Description for details on this benefit.	AVESIS Network only. NOT COVERED UNDER MEDICAL PLAN. See page 117 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.

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 750

	In-Network	Out-of-Network
34. Significant Additional Covered Services		
a) Hearing Aid exams, hearing aids and their fitting	100% after deductible, limited to \$500 every 3 years. Maximum 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.
b) Infertility	80% after deductible, maximum benefit \$2,500 per Plan Year. Limit 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	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.	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-OFKO-(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/Grievance 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.	

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 750

<p>44. Does the Plan have a binding arbitration clause?</p>	<p align="center">No</p>
<p>45. What is the cost of this Plan? a) Employee Only b) Employee + Child(ren) c) Employee + Spouse d) Family</p>	<p align="center">Rates are available on the Benefits website www.colorado.gov/dpa/dhr/benefits.</p>

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 pays more of your bill if you use 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 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).

³ Emergency 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.

⁴ Biologically 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).

FY09 HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 1500

	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		
a) Individual	\$1,500	\$3,000
b) Family	\$3,000	\$6,000
	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 ² Out-of-Pocket maximum (includes deductible, if any)		
a) Individual	\$3,000	\$6,000
b) Family	\$6,000	\$12,000
	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-network 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

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 1500

	In-Network	Out-of-Network
12. Prescription Drugs Level of coverage and restrictions on prescriptions a) Retail Copays (30 day supply) - Generic \$10 - Preferred \$25 - Non-Preferred \$50 b) Mail Order Copays (90 day supply) - Generic \$25 - Preferred \$62.50 - Non-Preferred \$125 c) Self-admin. Injectables disp. thru Pharmacy d) Injectables admin. in office or OP facility	a) & b) & c) subject to \$150 per member Rx deductible before copays apply (waived for all Generic drugs). Plan pays 70%. Member share not to exceed \$300 per 34-day supply or \$750 per 90-day supply 70% after deductible (Plan Year deductible – see #4 above.)	Not Covered Not Covered Not Covered Not Covered
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.		
13. Inpatient Hospital	80% after deductible	60% after deductible
14. Outpatient / Ambulatory Surgery	80% after deductible	60% after deductible
15. Other Services a) Laboratory b) X-ray* c) MRI / PET / CAT scans* *Subject to Pre-Treatment Authorization	80% after deductible 80% after deductible 80% after deductible	60% after deductible 60% after deductible 60% after deductible
16. Emergency Care³	80% after deductible	60% after deductible
Emergency Care³ 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.		
17. Ambulance a) Ground b) Air	80% after in-network deductible, maximum benefit \$1,000 per trip. 80% after in-network deductible, maximum benefit \$10,000 per trip.	
18. Urgent Care⁴	80% after deductible	60% after deductible
Urgent Care⁴ 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 Health and Mental Disorders Care⁴	80% after deductible.	60% after deductible.
20. Other Mental Health Care:	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

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 1500

	In-Network	Out-of-Network
21. Drug and Alcohol Disorders a) Inpatient Rehab b) Outpatient	80% after deductible 80% after deductible	60% 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 b) Outpatient	80% after deductible 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 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 b) Outpatient including supplies	80% after deductible 80% after deductible, maximum benefit of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to the \$5,000 maximum, and do not reduce the \$5,000 maximum.)	60% after deductible 60% after deductible, maximum benefit of \$5,000 per Plan Year for in and out-of-network expenses combined (Prosthetic devices are not subject to the \$5,000 maximum, and do not reduce the \$5,000 maximum.)
25. Medical Supplies	80% after deductible	60% after deductible
26. Oxygen a) Inpatient b) Outpatient	Included in Hospital 80% after deductible	Included in Hospital 60% after deductible
27. Transplants	80% after deductible	Not Applicable. (Transplants must be in-network)
28. Home Health Care (Subject to Pre-Treatment Authorization)	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 b) Outpatient	80% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network. 80% after deductible 91 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. 60% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.
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 117 of the Summary Plan Description for details on this benefit.	AVESIS Network only. NOT COVERED UNDER MEDICAL PLAN. See page 117 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.

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 1500

	In-Network	Out-of-Network
34. Significant Additional Covered Services		
a) Hearing Aid exams, hearing aids and their fitting	100% after deductible, limited to \$500 every 3 years. Maximum 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.
b) Infertility	80% after deductible, maximum benefit \$2,500 per Plan Year. Limit 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	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.	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-OFKO-(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/Grievance 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 is a short-term policy.	Policy Number: 179528 Self-funded large group.	

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 1500

<p>44. Does the Plan have a binding arbitration clause?</p>	<p align="center">No</p>
<p>45. What is the cost of this Plan? a) Employee Only b) Employee + Child(ren) c) Employee + Spouse d) Family</p>	<p align="center">Rates are available on the Benefits website www.colorado.gov/dpa/dhr/benefits.</p>

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 pays more of your bill if you use 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 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).

³ Emergency 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.

⁴ Biologically 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).

FY09 HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 3000

	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		
a) Individual	\$3,000	\$6,000
b) Family	\$6,000	\$12,000
	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 ² Out-of-Pocket maximum (includes deductible, if any)		
a) Individual	\$5,000	\$10,000
b) Family	\$10,000	\$20,000
	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-network 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	75% after deductible	50% after deductible
9. Office Visits	75% after deductible	50% 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	75% after deductible	50% after deductible
b) Delivery & Inpatient well baby care	75% after deductible	50% after deductible
c) Delivery professional services	75% after deductible	50% after deductible

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 3000

	In-Network	Out-of-Network
12. Prescription Drugs Level of coverage and restrictions on prescriptions a) Retail Copays (30 day supply) - Generic \$10 - Preferred \$25 - Non-Preferred \$50 b) Mail Order Copays (90 day supply) - Generic \$25 - Preferred \$62.50 - Non-Preferred \$125 c) Self-admin. Injectables disp. thru Pharmacy d) Injectables admin. in office or OP facility	a) & b) & c) subject to \$150 per member Rx deductible before copays apply (waived for all Generic drugs). Plan pays 70%. Member share not to exceed \$300 per 34-day supply or \$750 per 90-day supply 70% after deductible (Plan Year deductible – see #4 above.)	Not Covered Not Covered Not Covered Not Covered
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.		
13. Inpatient Hospital	75% after deductible	50% after deductible
14. Outpatient / Ambulatory Surgery	75% after deductible	50% after deductible
15. Other Services a) Laboratory b) X-ray* c) MRI / PET / CAT scans* *Subject to Pre-Treatment Authorization	75% after deductible 75% after deductible 75% after deductible	50% after deductible 50% after deductible 50% after deductible
16. Emergency Care³	75% after deductible	50% after deductible
* Emergency Care³ 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.		
17. Ambulance a) Ground b) Air	75% after in-network deductible, maximum benefit \$1,000 per trip. 75% after in-network deductible, maximum benefit \$10,000 per trip.	
18. Urgent Care⁴	75% after deductible	50% after deductible
“ Urgent Care⁴ ” 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 Health and Mental Disorders Care⁴	75% after deductible.	50% after deductible.
20. Other Mental Health Care: a) Inpatient care b) Outpatient care	Maximum 45 full/90 partial days inpatient services and 30 visits for outpatient services per Plan Year. 75% after deductible. 75% after deductible.	50% after deductible 50% after deductible

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 3000

	In-Network	Out-of-Network
21. Drug and Alcohol Disorders a) Inpatient Rehab. b) Outpatient	75% after deductible. 75% after deductible.	50% after deductible 50% 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 b) Outpatient	75% after deductible 75% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.	50% after deductible 50% 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 b) Outpatient including supplies	75% after deductible 75% after deductible, maximum benefit of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to the \$5,000 maximum, and do not reduce the \$5,000 maximum.)	50% after deductible 50% after deductible, maximum benefit of \$5,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to the \$5,000 maximum, and do not reduce the \$5,000 maximum.)
25. Medical Supplies	75% after deductible	50% after deductible
26. Oxygen a) Inpatient b) Outpatient	Included in Hospital 75% after deductible	Included in Hospital 50% 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>	75% after deductible 100 visits per Plan Year. Maximum includes in and out-of-network visits.	50% after deductible 100 visits per Plan Year. Maximum includes in and out-of-network visits.
29. Hospice a) Inpatient b) Outpatient	75% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network. 75% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.	50% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network. 50% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.
30. Skilled Nursing Facility Care	75% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.	50% 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 117 of the Summary Plan Description for details on this benefit.	AVESIS Network only. NOT COVERED UNDER MEDICAL PLAN. See page 117 of the Summary Plan Description for details on this benefit.
33. Chiropractic Care and Acupuncture	75% after deductible, maximum benefit \$750 per Plan Year, per benefit. Maximum applies to both in and out-of-network visits.	50% after deductible, maximum benefit \$750 per Plan Year, per benefit. Maximum applies to both in and out-of-network visits.

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 3000

	In-Network	Out-of-Network
34. Significant Additional Covered Services		
a) Hearing Aid exams, hearing aids and their fitting	100% after deductible, limited to \$500 every 3 years. Maximum 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.
b) Infertility	75% after deductible, maximum benefit \$2,500 per Plan Year. Limit applies to both in and out-of-network.	50% 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	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.	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-OFKO-(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/Grievance 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 is a short-term policy.	Policy Number: 179528 Self-funded large group.	

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 3000

<p>44. Does the Plan have a binding arbitration clause?</p>	<p align="center">No</p>
<p>45. What is the cost of this Plan? a) Employee Only b) Employee + Child(ren) c) Employee + Spouse d) Family</p>	<p align="center">Rates are available on the Benefits website www.colorado.gov/dpa/dhr/benefits.</p>

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 pays more of your bill if you use 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 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).

³ Emergency 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.

⁴ Biologically 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).

ABOUT YOUR MEDICAL COVERAGE

About Your Medical Coverage

Your Employer has designed the Plan to include several different plan designs, as described in the *HEALTH PLAN DESCRIPTION FORMS*. All of these plan designs utilize the Open Access network and include both In-Network and Out-of-Network Benefits. In-Network Benefits are services provided to You by providers who are participants in the Great-West Healthcare network, as described under the heading **Network Providers** in this section. Out-of-Network Benefits are those provided to You by providers who are not participants in the Great-West Healthcare network.

The choice of plan designs offers great flexibility because You may choose how to use Your Benefits and how to control Your Out-of-Pocket Expenses. When You use In-Network Benefits, You receive the highest level of Benefits at the lowest cost. The *HEALTH PLAN DESCRIPTION FORMS* list payment levels for both In-Network and Out-of-Network care.

Providers

Network Providers

Providers who have entered into a network agreement with Great-West Healthcare are Network Providers. Services provided by a Network Provider are considered In-Network. When You visit a Network Provider, You have lower Out-of-Pocket Expenses. A Network Provider will bill Great-West Healthcare directly and accept Great-West Healthcare's Maximum Benefit Allowance as payment in full. The Maximum Benefit Allowance is the dollar amount approved by Great-West Healthcare for a specific covered service. The Network Provider will also coordinate Your care. Your In-Network cost-sharing responsibilities to Network Providers can be found on the *HEALTH PLAN DESCRIPTION FORMS* under the heading "In-Network." You are responsible for determining if Your Provider is a Network Provider. You may visit the Great-West website at <http://www.mygreatwest.com> or call the Great-West Customer Service Department at the phone number shown on Your medical identification card for provider information.

Great-West Healthcare makes no guarantee that a Network Provider will be available for all services and supplies covered under the Plan. For a limited number of services and supplies, Great-West Healthcare does not have arrangements with Network Providers. This information can be obtained by calling the Great-West Customer Service Department. Great-West Healthcare may require You to travel a reasonable distance for care within our Provider network to receive services from a Network Provider. Under these circumstances, if You knowingly choose to obtain the service from a Non-Network Provider rather than the Network Provider, You will be responsible for paying any charges from the Non-Network Provider that exceed the Maximum Benefit Allowance paid by Great-West Healthcare to the Provider.

Non-Network Providers

Non-Network Providers are those who have not entered into a network agreement with Great-West Healthcare. Services provided by a Non-Network Provider are considered Out-of-Network. If You visit a Non-Network Provider, You may have higher Out-of-Pocket Expenses. Your plan Out-of-Network Cost Sharing responsibilities to Non-Network Providers can be found on the *HEALTH PLAN DESCRIPTION FORMS* under the heading "Out-of-Network."

The Plan Will Pay a Non-Network Provider's reimbursement amounts directly to You. If Great-West Healthcare pays You directly, You will be responsible for paying the Non-Network Provider of services for all charges. These payments fulfill Our obligation to You for these services.

ABOUT YOUR MEDICAL COVERAGE - Continued

Cost Sharing Requirements

Cost Sharing refers to how the Plan and its Members share the cost of medical care services. It describes what the Plan is responsible for paying and what You are responsible for paying. You meet Your Cost Sharing requirements through the payment of Copayments, Deductibles and Coinsurance (as described below). Cost Sharing requirements depend upon the optional Plan design You select and the choices You make in accessing services. For example, if You choose to use a Network Provider or Network facility, Your Out-of-Pocket Expenses may be less than if You choose a Non-Network Provider or facility.

Great-West Healthcare has worked with Physicians, Hospitals, Pharmacies and other health care providers to control health care costs. As part of this effort, many providers agree to control costs by giving discounts to Great-West Healthcare.

In their contracts, Network Providers agree to accept Great-West Healthcare's maximum allowance as payment in full for covered services. Great-West Healthcare determines a Maximum Benefit Allowance for all procedures performed by Providers. For example, the Hospital may charge \$12,000 for a procedure (its' Billed Charge) and Great-West Healthcare's Maximum Benefit Allowance for that procedure is \$8,000. The Copayment, Deductible and Coinsurance are based on the Maximum Benefit Allowance of \$8,000, not the Hospital's billed charge of \$12,000. In this example, Your out-of-pocket costs would be lower if You use a Network Provider.

In addition to accepting Great-West Healthcare's Maximum Benefit Allowance, many Network Providers also give Great-West Healthcare additional discounts. These additional discounts help control health care costs and benefit Members. The discounts allow Your Employer to offer more extensive Benefit coverage with lower Copayments, Deductibles and Coinsurance amounts. These discounts are taken into account in a variety of ways in determining the amount Members pay for health care.

Using the example described above, if the Network Hospital charges \$12,000 for a procedure and the Maximum Benefit Allowance is \$8,000, any additional discounts are deducted, the Copayments, Deductibles and Coinsurance are then subtracted and the balance is paid by the Plan. **If You do not use a Network Provider, any amount over the Maximum Benefit Allowance is Your responsibility.**

Copayment

A "Copayment" is that portion of Covered Expenses a Member is required to pay out of their pocket before The Plan Will Pay Benefits for any remaining portion. Copayment amounts do not apply to Deductible and/or Coinsurance requirements. If the Doctor does not charge for the visit and only charges for the services rendered, the Copayment **will not** apply to such services.

Deductible

A "Deductible" is a specified amount of expense for covered services that You must pay within Your Plan Year before the Plan provides Benefits. The Deductible amount is listed on the *HEALTH PLAN DESCRIPTION FORM*.

There are two separate Deductibles: one for In-Network Providers and one for Out-of-Network Providers. Charges from a Non-Network Provider **cannot** be applied toward meeting the Network Deductible, and charges from a Network Provider cannot be applied toward meeting the Non-Network Deductible. A new Deductible is required for each Plan Year. The Non-Network Deductible applies if the Plan has a Network Provider to provide a covered service or supply and You receive the service or supply from a Non-Network Provider. Some services are not subject to the Deductible and are listed on the *HEALTH PLAN DESCRIPTION FORMS*.

ABOUT YOUR MEDICAL COVERAGE - Continued

Coinsurance

You must first meet Your required Deductible, if applicable. After the Deductible is met in Your Plan Year, the Plan pays a percentage of charges for covered services as listed on the *HEALTH PLAN DESCRIPTION FORM*. This percentage is called "Coinsurance."

You pay Coinsurance for covered services until the out-of-pocket Plan Year maximum is reached for Your Plan Year. Until the out-of-pocket maximum is reached, the Plan pays the remaining percentage. Once the out-of-pocket Plan Year maximum is reached, the Plan pays 100% of any remaining eligible charges for the remainder of Your Plan Year.

Maximum Benefit Allowance –The "Maximum Benefit Allowance" is the dollar amount determined and approved by Great-West Healthcare for covered services and procedures. Members' applicable Cost Sharing requirements are based on the Maximum Benefit Allowance, not on a provider's Billed Charges.

Maximum Lifetime Benefits

Under this Plan, the maximum lifetime payment is unlimited.

MANAGED CARE FEATURES

Managed Care is a system of health care delivery with the goal of giving You access to quality, cost-effective health care while optimizing utilization and cost of services, and measuring provider and coverage performance. Great-West's Medical Outreach Department uses a variety of administrative processes and tools, such as Pre-Treatment Authorization for certain health care services and/or supplies, case management, Concurrent Review, and Disease Management to help determine the most appropriate use of the health care services available to You. This section of the Booklet explains how these Managed Care features are used and guides You through the necessary steps to take to obtain care. Additional information on how You should proceed in case of an emergency can be found in the **YOUR BENEFITS** section.

This Booklet does not restrict or interfere with the right of anyone entitled to service and care in a Hospital to select a Hospital, or to choose an attending Physician. Great-West's Medical Outreach Department requires that Physicians hold a valid Physician's license, practice within the scope of that license and be a Member of, or acceptable to, the attending staff and board of directors of the Hospital in which the services are to be provided.

Benefits provided under this coverage do not regulate the amounts charged by Providers of medical care.

Process to Determine Whether Services Are Covered

To determine whether a health care service is a covered Benefit, Great-West Healthcare considers whether the service is Medically Necessary and whether the service is Experimental, Investigational or Unproven or cosmetic and is otherwise not excluded under this coverage. Great-West Healthcare uses numerous resources, including current peer-reviewed medical literature, Great-West Healthcare's adopted medical policies and practice guidelines, guidelines obtained from recognized national organizations and professional associations and Consultations with Physician specialists whether a particular service is covered. Great-West Healthcare will assist You by determining what services are covered under Your chosen coverage and what services are excluded from the health coverage.

Medically Necessary Health Care Services means health care services and supplies that a Physician, exercising prudent clinical judgment, provides to You for the purpose of preventing, evaluating, diagnosing or treating an Illness or Injury or its symptoms, and are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for Your Illness or Injury;
3. not deemed to be cosmetic or Experimental, Investigational or Unproven as defined herein;
4. specifically allowed by the licensing statutes that apply to the Physician who renders the service;
5. at least as medically effective as any standard care and treatment;
6. not primarily for the convenience, psychological support, education or vocational training of You, the Physician or other health care provider;
7. not more costly than an alternative service or sequence of services and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness or Injury.

Great-West's Medical Outreach Department may require satisfactory proof in writing that any type of treatment, service or supply received is Medically Necessary. Medical Necessity will be determined solely by Great-West's Medical Outreach Department, in accordance with the definition above.

Appropriate Place and Pre-Treatment Authorization

Health care services may be provided in an inpatient or outpatient setting, depending on the severity of the medical condition and the services necessary to manage the condition in a given circumstance. The Plan covers care received in both environments provided the care received is appropriate to the setting and is Medically Necessary. Inpatient settings include Hospitals. Outpatient settings include Physician's offices and ambulatory surgery centers.

MANAGED CARE FEATURES - Continued

Pre-Treatment Authorization is used to ensure Your care is provided in the most medically appropriate setting. The Pre-Treatment Authorization process may set limits on the care to be given. Certain health care services and supplies, including but not limited to the list shown below under the **Pre-Treatment Authorization** section, require Pre-Treatment Authorization by Great-West's Medical Outreach Department in order to determine the Medical Necessity of care.

1. Air Ambulance, when used for a non-Emergency Medical Condition;
2. Durable Medical Equipment charges over \$500;
3. Genetic testing;
4. Home Health Care (including IV therapy);
5. Hospital Confinements;
6. All treatment of Mental Health Conditions;
7. Outpatient high technology radiology (examples include: CT scans, PET scans and MRIs);
8. Outpatient surgery, except for surgery performed in a Physician's office;
9. Prescription drugs that need to be reviewed for Medical Necessity. This includes, but is not limited to:
 - a. certain drugs that are used for specialized medical treatment, to ensure that the drugs are used appropriately;
Examples of medical conditions that may require specialized drugs include: arthritis, growth deficiencies and immune disorders.
 - b. certain drugs that have multiple uses, to ensure that the drug is used according to acceptable medical practice and FDA guidelines;
10. Renal dialysis;
11. Skilled nursing facilities;
12. Transplant evaluations.

Great-West's Medical Outreach Department must be contacted as soon as one of these health care services or supplies is recommended. The telephone number for Great-West's Medical Outreach Department is shown on Your medical identification card.

If Great-West's Medical Outreach Department's procedures for requesting Pre-Treatment Authorization are not followed, You, Your Physician or Hospital will be notified of the proper procedures to follow for requesting Pre-Treatment Authorization within five days after the initial contact was made (within 24 hours if Urgent Care is involved).

If additional health care services and/or supplies are needed beyond those that were initially authorized by Great-West's Medical Outreach Department, Great-West's Medical Outreach Department must be contacted to obtain authorization for the additional health care services and/or supplies.

Emergency confinements must be reported to Great-West's Medical Outreach Department within 48 hours of an admission for an Emergency Medical Condition.

Great-West's Medical Outreach Department will obtain all information, including pertinent clinical information, necessary to make a decision regarding authorization. Requests for information will be limited to those necessary to make a determination. You will be notified of Great-West's Medical Outreach Department's decision no later than 15 days after the date Great-West's Medical Outreach Department is contacted for the authorization request. If a decision cannot be made due to matters beyond the control of Great-West's Medical Outreach Department, You will be notified, within the initial 15 day decision period, of the reason for the extension and the date by which a decision is anticipated. If additional information is needed, Your Physician or the Hospital will be notified within the initial 15 day decision period and will have at least 45 days from receipt of the notice to return the requested information.

MANAGED CARE FEATURES - Continued

If the information is received within the 45-day time frame, Great-West's Medical Outreach Department will render a decision no later than 15 days after the date the information is received. If Your Physician or Hospital fails to provide the necessary information, Great-West's Medical Outreach Department will not be able to authorize the services and/or supplies and the penalties shown herein may be applied to Your Benefits.

Great-West's Medical Outreach Department will make a determination on requests for Pre-Treatment Authorizations involving Urgent Care conditions no later than 72 hours after receipt of request. If additional information is needed in order to make a determination, Your Physician or Hospital will be notified within 24 hours of receipt of the request and will have at least 48 hours from receipt of the notice to provide the necessary information. Great-West's Medical Outreach Department will inform You and Your Physician or Hospital of the decision the earlier of 48 hours after receipt of the necessary information or 48 hours after the end of the time period for providing the necessary information.

"Urgent Care" means that the standard 15 day decision-making time period would place Your life or health in serious jeopardy, Your ability to regain maximum function would be jeopardized or, in the Physician's opinion would subject You to unmanageable pain. A Physician may determine whether Urgent Care is involved. If a Physician has not made that determination, the determination may be made by a representative of the Plan, applying the judgment of a prudent layperson possessing an average knowledge of health and medicine.

If You utilize a Network Provider, the Provider is responsible for contacting Great-West's Medical Outreach Department. If You **DO NOT** utilize a Network Provider, You are responsible for contacting Great-West's Medical Outreach Department.

If Great-West's Medical Outreach Department is not contacted, **the Plan will not pay Benefits** for any of these services and/or supplies.

Regardless of the network status of the provider, if You fail to comply with Great-West's Medical Outreach Department's determination, **the Plan will not pay Benefits** for any of these services and/or supplies.

For more information about services and supplies that require Pre-Treatment Authorization, contact Great-West's Medical Outreach Department at the telephone number shown on Your medical identification card.

Concurrent Review

In addition to having Hospital admissions authorized prior to admission, a Concurrent Review of treatment (again for Medical Necessity) will be conducted throughout the period of confinement. If additional days of confinement are requested beyond those initially authorized by Great-West's Medical Outreach Department, Great-West's Medical Outreach Department must be contacted to obtain authorization for the continued stay.

If the request involves Urgent Care and is made to Great-West's Medical Outreach Department at least 24 hours before the end of the initially authorized days, You will be notified within 24 hours as to whether the continued stay will be authorized. If the request is not made at least 24 hours before the end of the initially authorized days, the Urgent Care time periods described in the Pre-Treatment Authorization provision will apply. If Great-West's Medical Outreach Department's procedures for requesting Concurrent Review authorization are not followed, Your Physician or Hospital will be notified of the proper procedures to follow for requesting Concurrent Review authorization within five days after the initial contact was made (within 24 hours if Urgent Care is involved).

If the request does not involve Urgent Care, You will be notified of Great-West's Medical Outreach Department's decision no later than 15 days after the date Great-West's Medical Outreach Department is contacted for the authorization request. If a decision cannot be made due to matters beyond the control of Great-West's Medical Outreach Department, You will be notified, within the initial 15 day decision period, of the reason for the extension and the date by which a decision is anticipated. If additional information is needed Your Physician or the Hospital will be notified within the initial 15 day decision period and will have at least 45 days from receipt of the notice to return the requested information.

MANAGED CARE FEATURES - Continued

If You, Your Physician or Hospital fails to provide the necessary information, Great-West's Medical Outreach Department will not be able to authorize the services and the penalties shown herein may be applied to Your Benefits. If the information is received within the 45 days, Great-West's Medical Outreach Department will render a decision no later than 15 days after the date the information is received.

If, prior to the end of an authorized stay, Great-West's Medical Outreach Department finds the stay is no longer Medically Necessary, You will be notified in advance that the stay will not be covered by the Plan.

If You utilize a Network Provider, the Provider is responsible for contacting Great-West's Medical Outreach Department. If You **DO NOT** utilize a Network Provider, You are responsible for contacting Great-West's Medical Outreach Department.

If Great-West's Medical Outreach Department is not contacted, **the Plan will not pay Benefits** for each day of unapproved confinement.

Regardless of the network of the provider, if You fail to comply with Great-West's Medical Outreach Department's determination, **the Plan will not pay Benefits** for each day of unapproved confinement.

"Concurrent Review" means Great-West's Medical Outreach Department will evaluate the medical need for continued hospitalization. This will involve consultation with the Member's Physician and comparison of clinical information to professionally developed medical standards of care.

Retrospective Review

Great-West's Medical Outreach Department will evaluate the medical record of those Members who were not reviewed under Pre-Treatment Authorization or Concurrent Review. If Great-West's Medical Outreach Department is unable to authorize any portion of the stay or treatment, the Physician will be contacted to provide additional information. No Benefits will be paid for any days of the Hospital stay or treatment that would not have been authorized by Great-West's Medical Outreach Department. The decision concerning authorization will be made within 30 days after the claim that is the subject of the Retrospective Review is received. If additional information is needed, You or Your Physician or Hospital will be notified within 30 days of receipt of the claim and will have at least 45 days from receipt of the notice to provide the information. If the information is received within 45 days, a decision will be made within 15 days of the day Great-West's Medical Outreach Department receives the additional information.

If the additional information is not received within the 45 day period, You should consider the claim, or portion thereof that is under review, to be denied. The claim will be reconsidered if the information is subsequently received. Written notice of the decision will be sent to You.

"Retrospective Review" means Great-West's Medical Outreach Department will review the medical need for hospitalization or treatment after such hospitalization or treatment has taken place. This will involve consultation with Your Physician and comparison of clinical information to professionally developed medical standards of care.

Benefits for Services of a Network Provider

The Plan provides different levels of Benefits depending on whether or not You use the services of a Network Provider. Generally, Benefits will be payable at a higher level if services of a Network Provider are used; although there may be additional Plan requirements. Network Providers will submit claims on Your behalf and will contact Great-West's Medical Outreach Department to obtain necessary approvals. If You select a Network Provider, The Plan Will Pay Benefits, if any, directly to the provider of service.

MANAGED CARE FEATURES - Continued

However, if You receive Emergency Care and cannot reasonably reach a Network Provider, The Plan Will Pay Medical Care Benefits as if services were performed by a Network Provider. If You are admitted to a Non-Network Hospital following Emergency Care treatment, The Plan Will Pay Medical Benefits as if services were performed by a Network Hospital through the time You are stable and able to be moved to a Network facility.

If You choose not to use a Network Provider, You may be responsible for filing Your own claims and obtaining the proper approvals.

Transitional Care Upon Termination of a Physician and/or Hospital from the Network

If the Members' Physician and/or Hospital ceases to be a Network Provider for reasons other than quality-related reasons, fraud, or failure to adhere to Great-West Healthcare's policies and procedures, coverage may continue for a specified period of time for treatment in progress for a Member who is:

1. in her third trimester of pregnancy;
2. receiving care for end-stage renal disease and dialysis;
3. receiving outpatient treatment for a Mental Health Condition;
4. terminally ill, with anticipated life expectancy of six months or less;
5. undergoing an active course of treatment for which changing to a different Physician and/or Hospital would be likely to cause significant risk of harm to the Member's health;
6. undergoing Chemotherapy or radiation therapy for treatment of cancer;
7. a candidate for a solid organ or bone marrow transplant.

Contact the Great-West Customer Service Department through the website or telephone number shown on Your medical identification card to obtain a Transition of Care Request Form. The Transition of Care Request Form must be received by Great-West Healthcare within 60 days of the Physician's and/or Hospital's termination date. If Your or Your covered Dependent's request is approved, The Plan Will Pay Benefits for such care on the same basis as care provided by a Network Provider.

Out-of-Town Care

If You are out of town and need non-Emergency Care, You may be able to locate a Network Provider by calling the phone number or by accessing the internet web address indicated on Your medical identification card. Since the Plan's network is nationwide, You may be able to utilize a Network Provider. Generally, Benefits will be payable at a higher level if services of a Network Provider are used; although there may be additional Plan requirements.

Great-West's Medical Outreach Program

The Great-West Medical Outreach Program (the Program) includes various initiatives to assist Members to manage their health concerns and to stay healthy. The Program includes:

1. **Disease Management Program (DM Program)** – Under the DM Program, You have access to education and individualized care plans designed to help You manage a Chronic Medical Condition such as pain, asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and heart failure. The DM Program also provides services and support Members with conditions classified as Oncology, End Stage Renal Disease (ESRD) and Neonatology. Specially trained nurses who are available 24 hours a day, 7 days a week staff the DM Program. The Program takes a team approach that includes You, Your Physician and Your primary disease management nurse. The Program suggests changes to help You make healthy choices – today and in the future. The Program encourages You to become active in managing Your health, and we work directly with Your Physician to help You set and achieve health-improvement goals.

MANAGED CARE FEATURES - Continued

The Program is strictly confidential and available to You at no out-of-pocket cost. Members who may benefit from the DM Program are identified through a variety of means, such as medical and/or pharmacy claims, health risk assessments, Pre-Treatment Authorization, Physician referrals and self-referrals. Each enrolled Member will receive tailored educational material depending on the Member's condition. The care managers in the DM Program will assist in setting clinical goals and monitor adherence to goals. Based on the severity of the condition, the care managers will schedule ongoing telephonic contact or home care visits by trained professionals. The Member's Doctor will be able to access the information provided to Member s.

The Disease Management Program includes the following services:

- Direct access to a nurse 24 hours a day, 7 days a week via phone and e-mail;
- Nurses who specialize in chronic conditions and work in conjunction with Your Physician;
- Customized information to help You effectively manage Your condition;
- Personalized care plans with specific goals and health improvement action plans;
- Questions and guidelines to use when meeting with Your Physician.

You can learn more about the Disease Management programs by going to www.mygreatwest.com and clicking on the Disease Management Program link to access condition specific information and a health assessment.

There are no additional out-of-pocket expenses for services obtained through the DM Program.

2. **Care Management Program (CM Program)** – The CM Program manages the care of Members with serious illnesses. Under the CM Program, if You require inpatient care, such as surgery followed by long term medical care, a case manager who will work on Your behalf is assigned to You.

The case manager will help to coordinate and provide the most appropriate care in the most cost-effective manner. This includes handling the Pre-Treatment Authorization process, providing Concurrent Review for continued stay as an inpatient in a Hospital, Discharge Planning and post-discharge follow-up by the clinical staff to ensure that You are receiving proper care and support *outside* of a Hospital setting.

Members who may benefit from the CM Program are identified through a variety of means, such as the Pre-Treatment Authorization process and medical claims. Generally, You may choose to participate in the CM Program.

If You choose to participate in the CM program and if You and Your Physician decide that the recommended alternative treatment plan is right for You, it will be covered on the same basis as the care and treatment for which it is substituted, subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums.

3. **Condition Management:** Great-West Healthcare also offers two additional programs to help You manage at-risk pregnancies and cancer. An overview of these programs follow.

Oncology Management Program: This program offers You and Your family support after the initial diagnosis is made. Like our other Great-West Medical Outreach Programs, it is free of charge and completely confidential. While You're in treatment, the Oncology Management Program offers additional assistance and support to help You:

- Understand information about Your disease and treatments;
- Understand possible side-effects of Your treatment;

MANAGED CARE FEATURES - Continued

- Prepare for visits to the Physician and understand the information You receive from the Physician;
- Access the support services You may need;
- Understand and better use Your health care Benefits.

Care managers have an average of 10 years of experience and are available to help You 24 hours a day, 7 days a week. They understand the effects of cancer and the most current cancer treatments. They're familiar with Your Benefits and know where to call to help You get the services that You need.

Great-Beginnings – Maternity Support Program (GB Program) – The GB Program will assist You in identifying the care You need during Your pregnancy and avoid risks related to Your pregnancy. Members who may benefit from the GB Program are identified through a variety of means, such as review of medical claims, Pre-Treatment Authorization requests, Physician referrals and self-referrals. An enrolled Member will receive educational materials and a medical assessment. The care managers in the GB Program will work with You and Your attending Doctor and provide the care and education necessary during Your pregnancy. If it is determined that there are complications and that the pregnancy will qualify as high risk, then the progress of the Member's pregnancy will be followed more intensely and care will be coordinated with the attending obstetrician and perinatologist. All information is confidential and will only be shared with those directly involved in the Member's medical care.

There are no additional out-of-pocket expenses for these services obtained through the GB Program.

4. **Health Management Program (HM Program)** - The HM Program offers online health and wellness Services, programs and other resources that enable You to more easily and effectively obtain information about health-related topics. This includes the latest medical advances and a variety of information about eating healthy, diet and exercise support, and smoking cessation.

Contact the Great-West Customer Service Department through the website or telephone number shown on Your medical identification card for more information about these Programs.

See the **COMPLAINTS, CLAIM DECISIONS AND APPEALS** section for information on claim denials and appeals for Pre-Treatment Authorization, Concurrent Review and Retrospective Review.

YOUR COVERAGE IN THE PLAN

Eligible Employees

You are in an Eligible Class for coverage under the Plan if You are a person employed by the **STATE OF COLORADO**, who meets the definition of Employee as defined in Colorado Revised Statutes (CRS) 24-50-603(7) and You are employed on a Full-Time or Part-Time Basis, working Your normal hours as set by Your Employer (not temporary work) for Your Employer. Under C.R.S. 24-50-603(7), an "Employee" means any officer or Employee under the state personnel system of the **STATE OF COLORADO** whose salary is paid by state funds or any Employee of the Department of Education, the Colorado Commission on Higher Education, or the Colorado School for the Deaf and the Blind whose salary is paid by state funds. "Employee" includes any officer or Employee of the legislative or judicial branch, any elected or appointed state official or Employee who receives compensation other than expense reimbursement from state funds, any elected state official who does not receive compensation other than expense reimbursement from state funds, and includes any member of the Board of Assessment Appeals. "Employee" does not include persons employed on a temporary basis, leased employees or independent contractors.

Eligible Employees may apply for coverage for themselves and their eligible Dependents by completing appropriate state forms, which may be electronic. Such forms must be submitted (electronic submission may be required) within 31 days of date of hire, during the annual Open Enrollment period, or during certain Qualified Change in Status Events. The Effective Date will be (1) the next first of the month following the Employee's date of hire, or (2) if Enrolling during the annual Open Enrollment period, the next first of the Plan Year, or (3) if Enrolling within 31 days of a Qualified Change in Status Event, the next first of the month following submission of the appropriate state forms, which may be electronic, and documentation.

Employee Responsibilities

Initial enrollments, changes to enrollment and terminations of enrollment require that You complete, sign and date the appropriate state forms, which may be electronic, in accordance with criteria as defined in law and regulations, procedure and written directives. You also must provide supporting documentation, if requested. Your signature on the appropriate state form, which may be electronic, attests that the information provided is true and complete, authorizes the appropriate payroll deduction or authorizes the Employer to stop Your Contributions.

It is unlawful for You or Your Dependent to provide false, incomplete or misleading facts or information on any enrollment form, affidavit, claim or other document for the purpose of defrauding or attempting to defraud the **STATE OF COLORADO**. Such actions may result in coverage being terminated or denied. The State reserves the right to request documentation to establish the eligibility of an Employee or Dependent.

Once Enrolled in the Plan, You must verify the accuracy of Your enrollment elections and payroll deductions. Should You find an administrative error, You must notify Your department's HR or benefits administrator within 10 days of the first payroll deduction. Failure to notify Your department's HR or benefits administrator within the specified time period will result in having to maintain enrollment in the incorrect option until the next annual Open Enrollment period or Qualified Change in Status Event.

Any Qualified Change in Status Event that permits enrollment or modification of enrollment must be reported by completing the appropriate state forms, which may be electronic, and providing supporting documentation within 31 days of the Qualified Change in Status Event. If the appropriate state forms, which may be electronic, are not completed and filed with the Employer on or before the 31st day of the Qualified Change in Status Event, Your enrollment or modification will only be permitted during the next annual Open Enrollment period.

YOUR COVERAGE IN THE PLAN - Continued

To Enroll in the Plan, You must elect to have Contributions deducted on a pre-tax or after-tax basis, as defined by the **STATE OF COLORADO** Salary Reduction Plan, law and regulations, rules and written directives. Your Contribution is deducted from Your paycheck or, under certain circumstances, is made by personal payment for the selected Plan. The State Contribution is added to Your Contribution to complete the total Contribution for the selected Plan. If You are Enrolled and work or are on a paid leave, an approved Family Medical Leave or a disability leave one or more regularly scheduled workdays in a month, You are eligible for the full State benefit Contribution. When there is a difference in Your Contribution compared to the actual Contribution due, You must pay the difference. Members who do not receive compensation from the Employer due to leave of absence, termination of employment or any other reason are responsible for remitting payment of the Contribution. Contributions are due on the first calendar day of the month of coverage and are considered timely paid if received by Great-West Healthcare by the last calendar day of the month.

Leaves of Absence

While on an Approved Unpaid Leave of Absence, voluntary furlough, family/medical leave or short-term disability leave, You may continue coverage under the Plan for a period of up to six months. If You fail to pay Your Contribution by the due date while on unpaid leave, Your coverage in the Plan will be terminated. Re-enrollment is subject to conditions of the annual Open Enrollment and applicable law, procedure and written directives.

If You stop Active Work to take a qualified military leave of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA), You can elect to continue coverage for Yourself and Your Dependents for a period of 24 months. Continuation of coverage under COBRA and USERRA run concurrently.

Reinstatement

An Employee who re-enters an Eligible Class within 30 days after the date his or her coverage ends because he or she no longer performs Active Work on a Full-Time or Part-Time Basis in an eligible class shall be reinstated with no break in coverage.

Eligible Dependents

To be eligible for Dependent coverage under the Plan, Your Dependent(s) must be eligible as defined in Colorado Revised Statutes (CRS) under C.R.S. 24-50-603(5). If Your Dependents cease to meet the eligibility requirements, coverage may be continued as later described in the Federal Continuation Coverage (COBRA) section.

Dependent Definitions

Under C.R.S. 24-50-603(5), a "Dependent" means:

1. An Employee's Legal Spouse;
2. Each Unmarried Child, including Adopted Children, Stepchildren, and Foster Children, through the end of the month in which the child turns twenty-five (25) years of age and for whom the Employee is the major source of financial support or has the same legal residence, or for whom the Employee is directed by a court order to provide coverage; or
3. An Unmarried Child of any age who has either a physical or mental disability, as defined by Great-West Healthcare, not covered under other government programs, and for whom the Employee is the major source of financial support or for whom the Employee is directed by court order to provide coverage.

YOUR COVERAGE IN THE PLAN - Continued

Your eligible Dependents include:

1. Your Legal Spouse. If the Spouse is common-law, a signed common-law affidavit and supporting documentation is required as proof;
2. Your Dependent Child under 25 years of age. An Unmarried Child (including an Adopted Child, Stepchild or Foster Child) under 25 years of age can be covered under the terms of the Plan if: (1) the child is a Full-time Student enrolled in an educational or vocational institution, or (2) the child has the same legal residence as the parent, or (3) the child is financially dependent upon the parent. The child is removed from coverage as a Dependent at the end of the month in which they turn 25 unless they qualify as an over-age Disabled Dependent Child. You must submit change request on the appropriate state forms, which may be electronic, within 31 days of the Change in Status Event;
3. Your Adopted Child. Your Adopted Child is an eligible Dependent upon Placement For Adoption, the circumstances under which an Employee assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates when the legal obligation for support terminates;
4. An Unmarried Child who is required to be covered by You or Your Spouse pursuant to a Qualified Medical Child Support Order, whether or not the child lives with You or whether You are the child's major source of financial support;
5. Your Disabled Dependent Child. An Unmarried Child who is 25 years of age or older, medically certified as Disabled, and financially Dependent on the parent, can be covered under the terms of this Plan. A completed Mentally or Physically Disabled Dependent Form must be submitted for the Disabled Dependent to be eligible for or to continue coverage. First proof of incapacity must be given to the Plan (at Your expense) within 31 days of the child's 25th birthday or onset of Disability, if later. Completion of the Mentally or Physically Disabled Dependent Form does not guarantee continued coverage unless such request is approved by the Plan. The Employee and the Disabled Dependent's Physician must complete this form and submit it to Great-West Healthcare. You may obtain a Mentally or Physically Disabled Dependent Form from the benefit web site;
6. A Grandchild. A child born to Your covered minor Dependent Child (under age 19) may be covered as a Dependent under this Plan providing You submit the appropriate change form and documentation within 31 days of the grandchild's birth. The grandchild is covered only as long as the child/parent is a minor and covered under the Plan and the Employee must be the grandchild's major source of financial support. A grandchild of an Employee or an Employee's Spouse, other than a child born to a minor Dependent Child, is not eligible for coverage unless the Plan receives and approves proof of legal custody.

No person may be covered as a Dependent of more than one Employee. With respect to a husband and wife, who are Eligible Employees, no one may be covered as a Dependent and also as an Employee, and if both parents are covered as Employees, children may be covered as Dependents of one Employee only. Dependents in active military service are not covered under the Plan. A Member can only be covered under one health Plan option sponsored by the Employer. Dependents must be covered under the same health Plan option as the Employee.

NOTE: *If You elect Dependent coverage and wish to Enroll Your Dependent Child or children, You must provide the requested information (e.g., name, birth date, gender and Social Security Number). Dependents are not covered automatically by electing Dependent coverage.*

YOUR COVERAGE IN THE PLAN - Continued

Coverage for Newborns

A newborn child, born to You, Your Spouse or minor Dependent Child, is covered under Your coverage for the first 31 days after birth. If the addition of a newborn necessitates a change of Contribution tier, the change of Contribution is effective the first of the month following the birth. If You wish to continue coverage for Your newborn child beyond the first 31-day period, You must Enroll Your newborn child in the Plan by completing the appropriate state form, which may be electronic, within 31 days of the child's birth. (Notification of the birth of a newborn child is not required if there is no increase in premium for the additional dependent coverage.)

When charges for delivery are considered a Covered Expense for an expectant mother eligible for coverage under this Plan, any and all charges incurred by the newborn are to be considered as charges incurred by the mother until the mother is discharged.

During the **first** 31-day period after birth, coverage for a newborn child shall consist of Medically Necessary care for Injury and Illness, including care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities. However, services provided **after** the first 31 days of coverage are subject to the Cost Sharing requirements, limitations and exclusions that are applicable to other Illnesses, diseases and conditions otherwise covered.

NOTE: If You are Enrolled in the Open Access H Plan, please review page 44 regarding Deductible Requirements when adding a newborn child to Your single coverage Open Access H plan.

When Coverage Begins For Eligible Employees and Eligible Dependents

Coverage in the Plan is effective for You and Your eligible Dependents on the first day of the month following Your date of hire, provided the appropriate state forms, which may be electronic, are completed and submitted within 31 days of the date of hire. You and Your Dependents may also become eligible for coverage due to a Qualified Change in Status Event. The Effective Date of coverage for Qualified Change in Status Events is the first of the month following the date the appropriate state forms, which may be electronic, and provision of supporting documentation are completed and submitted, provided the enrollment is completed within 31 days of the Qualified Change in Status Event. If the appropriate state forms, which may be electronic, are not submitted on or before the 31st day, You and Your Dependents will be considered Late Enrollees and Your enrollment or modification will only be permitted during the next annual Open Enrollment period. Notification of the birth of a newborn child is not required if there is no increase in premium for the additional dependent coverage.

Late Enrollees

If You do not Enroll within 31 days after You are eligible for coverage, You will be a Late Enrollee. If You do not Enroll Your Dependents within 31 days after You are eligible for coverage or Your Dependents are not Enrolled within 31 days after they become eligible, or You wish to restore Dependent coverage, which ended because You did not make required Contributions, Your Dependents will be considered Late Enrollees.

A Late Enrollee may Enroll only during the next annual Open Enrollment period, as determined by the Plan. Until You are properly Enrolled in the Plan, You are not eligible for Benefits.

What Is Open Enrollment?

Open Enrollment is the period of time held each year when Eligible Employees can Enroll, modify or terminate enrollment in the Plan. You must make a positive election to Enroll in the Plan each Plan Year during the Open Enrollment period. You and Your eligible Dependents who are not Enrolled in the Plan may complete the appropriate state forms, which may be electronic, to Enroll during Open Enrollment. Your department's HR or benefits administrator will notify You of Open Enrollment. You may also contact Your department's HR or benefits administrator at any time for Open Enrollment information. Anyone who Enrolls during Open Enrollment and has the applicable payroll deduction will have an Effective Date of July 1.

YOUR COVERAGE IN THE PLAN - Continued

Eligible Events That May Allow Election Changes

All changes requested after Open Enrollment must be approved by Your department's HR or benefits administrator. Requested changes must be *on account of and corresponding with* a qualifying status change that affects eligibility for coverage under the Plan. Election changes must be requested on the appropriate state forms, which may be electronic, within 31 days of the Qualified Change in Status Event.

Qualified Change in Status Events

1. Change in Employee's Legal Marital Status that affects Eligibility:

- a. Gain Spouse (e.g., marriage):
 - i. Employee may Enroll or add newly-eligible Spouse and Dependent children;
 - ii. new and preexisting Dependents may also be Enrolled;
 - iii. Employee may revoke or decrease Employee's or Dependent's coverage only when such coverage becomes effective or is increased under the Spouse's employer's plan;
 - iv. must submit change request on the appropriate state forms, which may be electronic, within 31 days of a Qualified Change in Status Event;
 - v. new election is effective the first of the month following the marriage or the first of the month following submission of the appropriate state forms, which may be electronic, if later;
 - vi. also see *HIPAA Special Enrollment Rights* below.
- b. Lose Spouse (e.g., death, divorce, legal separation, or annulment):
 - i. Employee may revoke coverage for Spouse only;
 - ii. Employee may elect coverage for self or Dependents that lose eligibility under Spouse's plan as a result of the divorce, legal separation, annulment, or death;
 - iii. any Dependents may be Enrolled if at least one Dependent has lost coverage under Spouse's plan;
 - iv. must submit change request on the appropriate state forms, which may be electronic, within 31 days of Qualified Change in Status Event;
 - v. new election is effective the first of the month following the date of death, divorce or annulment or the first of the month following submission of the appropriate state forms, which may be electronic, if later.

2. Change in the Number of Employee's Tax Dependents Eligible for Coverage:

- a. Gain Dependent (e.g., birth, adoption, Placement for Adoption, marriage):
 - i. Employee may Enroll or increase coverage for newly-eligible Dependent and any other Dependents who were not previously covered;
 - ii. must submit change request on the appropriate state forms, which may be electronic, within 31 days of Qualified Change in Status Event;
 - iii. new election is effective the first of the month following date of birth, adoption, or Placement for Adoption, providing the change request is timely. **NOTE:** Coverage is effective on the date of birth, adoption, or Placement for Adoption even though Contribution is not payable until the next first of the month;
 - iv. also see *HIPAA Special Enrollment Rights* below.

YOUR COVERAGE IN THE PLAN - Continued

- b. Lose Dependent (e.g., death, attainment of limiting age, or loss of student status):
 - i. Employee may drop coverage only for the Dependent who loses eligibility;
 - ii. must submit change request on the appropriate state forms, which may be electronic, within 31 days of Qualified Change in Status Event, or loss of eligibility, if later;
 - iii. new election will be effective the first of the month following the status change event, or the first of the month following submission of the appropriate state forms, which may be electronic, if later.

3. Change in Employment Status of Employee, Spouse, or Dependent That Affects Eligibility:

- a. Commencement of employment by Spouse or Dependent or other employment event triggering eligibility under Spouse's or Dependent's plan:
 - i. Employee may revoke or decrease Employee's, Spouse's, or Dependent's coverage, but only if Employee, Spouse or Dependent is added to Spouse's or Dependent's employer's plan;
 - ii. must submit change request on the appropriate state forms, which may be electronic, within 31 days of Change in Status Event;
 - iii. new election will be effective the first of the month following the date of the status change event or the first of the month following submission of the appropriate state forms, which may be electronic, if later.
- b. Termination of employee's employment or other change in employment status resulting in a loss of coverage. Coverage ends the last day of the month of termination of employment or loss of eligibility.
- c. Coverage ends the last day of the month of termination of employment or loss of eligibility:
 - i. prior elections at termination are reinstated with no break in coverage unless another event has occurred that allows a change;
 - ii. missed Contributions must be made up.
- d. Termination of Spouse's or Dependent's employment (or other change in employment status resulting in a loss of coverage under their employer's plan):
 - i. Employee may Enroll or increase election for Employee, Spouse or Dependents who lose coverage under Spouse's or Dependent's employer's plan;
 - ii. other previously Eligible Dependents may also be Enrolled;
 - iii. must submit change request on the appropriate state forms, which may be electronic, within 31 days of Change in Status Event, or loss of eligibility, if later;
 - iv. new election will be effective the first of the month following the status change event, or the first of the month following submission of the change form, if later.

4. Dependent Satisfies or Ceases to Satisfy Eligibility Requirements

- a. Event by which Dependent satisfies eligibility requirements under employer's plan (e.g., attaining a specified age, becoming a student, becoming Disabled, etc.)
 - i. Employee may Enroll or increase election for newly-eligible Dependent;
 - ii. other previously-eligible Dependents may also be Enrolled;
 - iii. must submit change request on the appropriate state forms, which may be electronic, within 31 days of Change in Status Event;
 - iv. new election will be effective the first of the month following the status change event, or the first of the month following submission of the change form, if later.

YOUR COVERAGE IN THE PLAN - Continued

- b. Event by which covered Dependent ceases to satisfy eligibility requirements under employer's plan (e.g., attaining a limiting age, getting married, ceasing to be a student, etc.):
 - i. Employee may decrease or revoke election only for affected Dependent;
 - ii. must submit change request on the appropriate state forms, which may be electronic, within 31 days of Change in Status Event, or loss of eligibility, if later;
 - iii. new election will be effective the first of the month following the status change event, or the first of the month following submission of the change form if later.

5. **Dependent's Coverage under Children's Basic Health Plan is terminated:**

- a. Event by which Dependent satisfies eligibility requirements under employer's plan due to disenrollment under the state sponsored Children's Basic Health Plan:
 - i. Employee may Enroll or increase election for newly-eligible Dependent;
 - ii. must submit change request on the appropriate state forms, which may be electronic, within 90 days of Change in Status Event;
 - iii. new election will be effective the first of the month following the status change event, or the first of the month following submission of the change form, if later.

6. **Change in Place of Residence of Employee, Spouse, or Dependent that affects Eligibility:**

- a. Change in Place of Residence of Employee, Spouse, or Dependent that affects Eligibility:
 - i. Employee may elect coverage under another benefit package option providing similar coverage. If no option providing similar coverage is available, Employee may revoke election;
 - ii. must submit change request on the appropriate state forms, which may be electronic, within 31 days of Change in Status Event;
 - iii. new election will be effective the first of the month following the status change event, or the first of the month following submission of the change form, if later.

Significant Cost Changes

1. **Cost Decrease:**

- a. If the Employer determines that the decrease in cost is significant, Employee may Enroll (even if coverage was previously waived);
- b. Must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
- c. New election will be effective the first of the month following the specified event, or the first of the month following submission of the change form, if later;
- d. No change permitted for "insignificant" decrease in cost, as determined by the Employer.

2. **Cost Increase:**

- a. If the Employer determines that the cost increase is significant, Employee may elect coverage under another benefit package option providing similar coverage;
- b. If no option providing similar coverage is available, Employee may revoke election;
- c. Must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
- d. New election will be effective the first of the month following the specified event, or the first of the month following submission of the change form, if later;
- e. No change permitted for "insignificant" cost increase, as determined by the Employer.

YOUR COVERAGE IN THE PLAN - Continued

Significant Curtailment of Coverage (With or Without Loss of Coverage) (e.g., health care plan withdraws from the market or eliminates line of coverage)

1. If the Employer determines that the curtailment of coverage is significant, the Member may revoke election for curtailed coverage and make new prospective election for coverage or drop coverage if no similar benefit package option is available;
2. Must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
3. New election will be effective the first of the month following the specified event, or the first of the month following submission of the change form, if later;
4. No change permitted for "insignificant" curtailment of coverage as determined by the Employer.

Addition or Significant Improvement of Benefit Package Option (as determined by the Employer)

1. If the Employer determines that the addition or improvement is significant, Eligible Employees (whether currently participating or not) may revoke their existing election and elect the newly-added (or newly-improved) option;
2. Must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
3. New election will be effective the first of the month following the specified event, or the first of the month following submission of the change form, if later;
4. No change permitted for "insignificant" curtailment of coverage as determined by the Employer.

Change in Coverage Under Other Employer Cafeteria Plan or Qualified Benefits Plan (e.g., open enrollment under other employer plan)

1. Corresponding changes can be made under Your Employer's plan;
2. Employee may revoke or decrease Employee's, Spouse's, or Dependent's coverage, but only if the Employee, Spouse or Dependent is added to the Spouse's or Dependent's plan;
3. Must submit change request on the appropriate state forms, which may be electronic, within 31 days of specified event;
4. New election will be effective the first of the month following the date of the specified event or the first of the month following submission of the change form, if later.

HIPAA Special Enrollment Rights

1. **Special enrollment for loss of other health coverage:**
 - a. Employee may elect coverage for Employee, Spouse, or Dependent who has lost other coverage (e.g., COBRA coverage exhausted or terminated, no longer eligible for non-COBRA coverage, etc.);
 - b. must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
 - c. new election will be effective the first of the month following the specified event, or the first of the month following submission of the change form, if later.

YOUR COVERAGE IN THE PLAN - Continued

2. **Special enrollment for acquisition of new Dependent by birth, marriage, adoption or Placement For Adoption:**
 - a. Employee may elect coverage for Employee, Spouse, or Dependent;
 - b. election of coverage may also extend to previously eligible (but not yet Enrolled) Dependents;
 - c. must submit change request on the appropriate state forms, which may be electronic, within 31 days of HIPAA Special Enrollment Event;
 - d. if birth or adoption, coverage is effective on the date of birth, adoption or Placement for Adoption, providing the request is timely. However, Contributions are paid from the first of the month following the birth, adoption or Placement for Adoption;
 - e. if marriage, new election will be effective the first of the month following marriage, or the first of the month following submission of the change form, if later;
 - f. new and preexisting Dependents may also be Enrolled.

COBRA Qualifying Events

1. **Loss of eligibility under a Spouse's or Dependent's plan (e.g., loss of Dependent status or reduction in hours, etc.):**
 - a. Employee may Enroll or add Dependents who experience a COBRA qualifying event (loss of eligibility) if the individual still qualifies as a tax Dependent of Employee;
 - b. must submit change request on the appropriate state forms, which may be electronic, within 31 days of the COBRA qualifying event;
 - c. new election will be effective the first of the month following the specified event, or the first of the month following submission of the change form, if later.

Entry of a Qualified Medical Child Support Order (QMCSO)

1. **Order that requires coverage for the Child under Employee's Plan:**
 - a. Employee may change election to provide coverage for the Child, but only if the order is directed to the State;
 - b. retroactive changes not permitted;
 - c. change will be effective the first of the month following receipt of the order.
2. **Order that requires Spouse, or other individual to provide coverage for the Child:**
 - a. Employee may change election to cancel coverage for the child, providing other coverage is actually obtained;
 - b. change will be effective the first of the month following submission of the change form.

Gain or Loss of Medicare or Medicaid Entitlement

1. **Employee, Spouse or Dependent becomes entitled to Medicare or Medicaid:**
 - a. Employee may elect to cancel coverage for Employee, Spouse, or Dependent, as applicable;
 - b. must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
 - c. new election will be effective the first of the month following the specified event, or the first of the month following submission of the change form, if later.

YOUR COVERAGE IN THE PLAN - Continued

2. **Employee, Spouse or Dependent loses Medicare or Medicaid entitlement:**

- a. Employee may elect to commence or increase coverage for Employee, Spouse, or Dependent, as applicable;
- b. must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
- c. new election will be effective the first of the month following the specified event, or the first of the month following submission of the change form, if later.

Family Medical Leave of Absence (FMLA)

1. **Employee's commencement of unpaid FMLA leave:**

- a. Employee may revoke coverage or may continue coverage by making post-tax Contributions;
- b. must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
- c. new election will be effective the first of the month following commencement of unpaid FMLA leave or submission of the change form, if later;
- d. Benefits are not payable for Expenses Incurred in any month in which Contributions are not made.

2. **Employee's return from FMLA leave:**

- a. Employee may be reinstated to same level of coverage in effect prior to the leave, if coverage terminated while on FMLA leave;
- b. must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;

Military Leave under USERRA

1. **Employee's commencement of unpaid Military Leave:**

- a. Employee may revoke coverage or may continue coverage by making post-tax Contributions;
- b. must submit change request on the appropriate state forms, which may be electronic, within 31 days of the specified event;
- c. new election will be effective the first of the month following commencement of unpaid Military leave or submission of the change form, if later;
- d. Benefits are not payable for Expenses Incurred in any month in which Contributions are not made.

2. **Employee's return from Military Leave:**

- a. Employee may be reinstated to same level of coverage in effect prior to the leave, if coverage terminated while on Military leave;
- b. must submit change request on the appropriate state forms, which may be electronic, within 31 days of the date the employee is required to notify the Employer of an intent to return to work.

See the USERRA notice included in the Notice section at the back of this Summary for information on continuing coverage under USERRA.

NOTE: See Your department's HR or benefits administrator to request a change during the Plan Year. Your department's HR or benefits administrator will help You determine if an election change is allowed based on Your individual situation.

YOUR COVERAGE IN THE PLAN - Continued

When Coverage Ends

For Employees:

Your coverage will end on the date of the first of these events:

1. The last day of the month in which You terminate employment for any reason, including death and retirement, except that:
 - a. if You stop Active Work due to an Approved Unpaid Leave of Absence, Your coverage will continue as long as You make payment of the required Contributions. Your coverage will continue up to six months for an Approved Unpaid Leave of Absence;
 - b. if You stop Active Work to take a qualified military leave of absence pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), You may elect to continue coverage subject to payment of Contributions. See the section on continuation of coverage under USERRA later in this Section.
2. You stop paying required Contributions in a timely manner;
3. As to any one coverage or class, the date the Plan is amended or changed to exclude that coverage or class;
4. The date the Plan ends;
5. The date You or any of Your Dependents commit fraud against the State or the Plan or makes an intentional misrepresentation of material fact.

For Dependents:

A Dependent's coverage will end on the earlier of:

1. the date Your coverage ends;
2. the end of the month in which the Dependent ceases to be eligible as defined by the Plan, such as:
 - a. the end of the month in which a Dependent reaches age twenty-five (25) even if they remain a Full-Time Student;
 - b. the end of the month in which a Dependent no longer has the same legal residence as the covered parent; or
 - c. the end of the month in which a Dependent is no longer financially dependent upon the covered parent.
3. The end of the month in which the eligible Dependent child marries;
4. The date a Dependent enters the armed forces of any country on active full-time duty;
5. The end of the month in which a Dependent becomes an eligible Employee;
6. The end of the month of Your final divorce decree or legal separation from an eligible Employee.

Terminations of enrollment require that You complete, sign, date and submit the appropriate change forms, which may be electronic, in accordance with criteria as defined in law and regulations, procedure and written directives. You also must provide supporting documentation, if requested. The change form may be completed in advance of the date that Your Dependent loses eligibility (e.g., prior to a Dependent's birthday or impending marriage), but the change form must be completed no later than 31 days following the date that Your Dependent loses eligibility. Your signature on the change form, which may be electronic, attests that the information provided is true and complete and authorizes the Employer to stop Your Contributions, if applicable.

Certificate of Creditable Coverage

A Certificate of Creditable Coverage (CCC) will be sent when coverage for a Member ends. In addition, a CCC may be requested from Great-West Healthcare at any time while a Member is covered under the Plan and up to 24 months after coverage ends.

YOUR COVERAGE IN THE PLAN - Continued

Continuation of Coverage under COBRA and USERRA

If Your coverage under the Plan terminates because of certain qualifying events, You can continue Your coverage for a limited period of time under COBRA. If You stop Active Work due to temporary layoff, You are eligible to continuation of coverage under COBRA. If You return to active employment within 30 days, Your coverage will be reinstated with no break in coverage, subject to payment of Contributions. See the COBRA notice included in the Notice section at the back of this Summary for more information on continuing coverage under COBRA.

If You leave Your job to perform military service, You have the right to elect to continue Your coverage for You and Your dependents for up to 24 months while in the military. Even if You do not elect to continue coverage during Your military service, You have the right to reinstate Your coverage when You are re-employed, generally without any Waiting Periods or Exclusions except for service-connected Illnesses or Injuries. See the USERRA notice included in the Notice section at the back of this Summary for more information on continuing coverage under USERRA.

If coverage under USERRA is elected, You and Your Dependents will be required to pay up to 102% of the applicable group rate. However, if Your Uniformed Service leave of absence is less than 31 days, You are not required to pay more than the amount that You pay as an active Employee for that coverage. When You return to Active Work from a qualified military leave of absence, Your coverage will be reinstated as required by USERRA.

Extended Medical Care Benefits on Termination of Coverage

If You or Your Dependent is confined as a Hospital Inpatient when Medical Care Benefits end, Benefits will be payable for the Injury or Illness until the Member is discharged from the Hospital.

YOUR BENEFITS

This section describes covered services and supplies. Covered services and supplies are only Benefits if they are Medically Necessary or Preventive, not otherwise excluded under this document as determined by Great-West Healthcare and obtained in a manner required by this Booklet. All services must be standard medical practice where they are received for the Illness, Injury or condition being treated, and they must be legal in the United States. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does **not** make it Medically Necessary or a covered service, and does **not** guarantee payment. You must contact the Great-West's Medical Outreach Department for certain services to be sure that Pre-Treatment Authorization has been obtained by the ordering Provider.

Great-West's Medical Outreach Department bases its decisions about Pre-Treatment Authorizations, Medical Necessity, Experimental, Investigational or Unproven and new technology on medical policy developed by Great-West's Medical Outreach Department. Great-West's Medical Outreach Department will also consider published peer reviewed medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations, which review the medical effectiveness of health care services and technology.

All covered services are subject to the exclusions listed in this section in addition to those set forth elsewhere in this Booklet, including those in the **GENERAL EXCLUSIONS** section. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM* and the other conditions and limitations of this Booklet.

The following applies to Members who have elected the Open Access H (HSA-HDHP) Plan only:

NOTE: *The Open Access H (HSA-HDHP) Plan is a federally qualified High Deductible Health Plan (HDHP). This means that if You elect the Open Access H (HSA-HDHP) Plan, You may also elect to participate in and contribute to a Health Savings Account (HSA). HSA participation is **optional**. You may elect the HDHP with or without the HSA.*

Health Savings Account (HSA)-Qualified High Deductible Health Plan (HDHP) Option

Open Access H is a High Deductible Health Plan (HDHP) as defined by the HSA law (Tax Code Sec. 223). While You are Enrolled in Open Access H, You may be eligible to contribute to a Health Savings Account (HSA).

Please note that You are **not** eligible for an HSA if You are Enrolled under Medicare, can be claimed as a tax Dependent on another person's tax return or are covered by another health plan that is not a HDHP (including a traditional health care FSA).

A Health Savings Account is a tax-advantaged account for individuals covered under a HDHP. Funds in the account may be used to pay for qualified medical expenses. These are expenses for "medical care" as determined by the IRS that are paid by You, Your Spouse or Your tax Dependents, which aren't paid or payable by any health plan coverage. The expenses must be incurred after You have opened an HSA. For a detailed list of qualified health expenses and information on HSA's, please refer to the IRS Publications 502 and 969, available at the IRS website at www.treas.gov. Some examples include:

1. Copayments, Deductibles, Coinsurance and other out-of-pocket expenses for medical and dental care;
2. vision care expenses;
3. Prescription and some over-the-counter medications;
4. smoking cessation treatment and Prescriptions and some insurance premiums, such as long-term care, COBRA, and health care coverage premiums while You are receiving unemployment compensation.

YOUR BENEFITS - Continued

Contributions are made with after-tax dollars. You can deduct Your Contributions on Your personal Income Tax return. However, You will have to pay income tax and a 10% penalty tax if HSA money is used for expenses that are not considered medical care, such as air purifiers, cosmetic surgery and related expenses, illegal treatments, massages (for general well-being), vitamins and nutritional supplements, or other non-medical expenses.

A Health Savings Account is separate and apart from the Open Access H Plan. Even if Your Employer elects to contribute to Your HSA, the HSA is not an Employer-provided health or welfare benefit plan. An HSA, once opened, is Yours to keep. You can continue to contribute to and use Your HSA even after You move Your coverage from this plan to a different HDHP. However, if You are no longer Enrolled in a HDHP, You may continue to access Your money in the HSA but may no longer contribute additional money until such time that You are Enrolled in another HDHP.

You have an option of opening Your HSA with an HSA trustee or custodian of Your own choosing. You may also review material provided on the IRS web site at www.treas.gov.

Deductible Requirement

With respect to Employee Only coverage, Your Deductible Requirement will be met when Your Covered Medical Expenses Incurred while covered during each Plan Year equal the Employee Only Deductible Amount shown on the *HEALTH PLAN DESCRIPTION FORM*. You are required to pay this amount; the Plan will not reimburse You for this expense.

When adding newborn coverage to an Employee Only coverage plan, the newborn is considered part of the Plan as of the newborn's date of birth. The family will be responsible for the Family Deductible and Family Out-of-Pocket.

With respect to Family coverage, Your and Your Dependent's Family Deductible Amount will be met when the Covered Medical Expenses Incurred while covered during each Plan Year equal the Family Deductible Amount shown on the *HEALTH PLAN DESCRIPTION FORM*. The Plan will not pay any Benefits on Expenses Incurred by an individual until the Family Deductible has been met.

Out-of-Pocket Expense Maximum

With respect to Employee Only coverage, when You have paid the Employee Only Out-of-Pocket Maximum (as shown on the *HEALTH PLAN DESCRIPTION FORM*) during a Plan Year, the level of Benefit payments for services will automatically increase to 100% for any additional eligible Covered Expenses Incurred by You during the remainder of that Plan Year.

With respect to Family coverage, when the Family Out-of-Pocket Maximum (as shown on the *HEALTH PLAN DESCRIPTION FORM*) has been paid on behalf of all the covered Members of Your Family during a Plan Year, the level of Benefit payments for services will automatically increase to 100% for any additional eligible Covered Expenses Incurred by any covered family member during the remainder of that Plan Year. The Benefit payments for an individual will **not** increase to 100% until the Family Out-of-Pocket Maximum has been paid.

An "Out-of-Pocket Expense" is the share of any otherwise eligible allowable expense that You pay and any Medical Plan Year Deductible. Copayments, Pre-Treatment Authorization Penalties, Concurrent Review Penalties, and travel Expenses Incurred for Transplants, are not considered eligible Out-of-Pocket Expenses.

YOUR BENEFITS - Continued

The following applies to Members who have elected Any Other Plan:

Deductible Requirement

With respect to an Individual, Your Deductible Requirement will be met when Your Covered Medical Expenses Incurred while covered during each Plan Year equal the Individual Deductible Amount shown on the *HEALTH PLAN DESCRIPTION FORM*. You are required to pay this amount; the Plan will not reimburse You for this expense.

The Family Deductible Requirement will be met when all Covered Medical Expenses applied to individual Deductibles for covered Members of Your family, in a Plan Year, collectively equal the Family Deductible shown on the *HEALTH PLAN DESCRIPTION FORM*.

Out-of-Pocket Expense Maximum

When the Out-of-Pocket Maximum (as shown on the *HEALTH PLAN DESCRIPTION FORM*) has been paid by one Member during a Plan Year, the level of Benefit payments for services will automatically increase to 100% for any additional eligible Covered Expenses Incurred by that same person during the remainder of that Plan Year.

When the Out-of-Pocket Maximum (as shown on the *HEALTH PLAN DESCRIPTION FORM*) has been paid on behalf of all the covered Members of Your Family during a Plan Year, the level of Benefit payments for services will automatically increase to 100% for any additional eligible Covered Expenses Incurred by any covered family member during the remainder of that Plan Year.

An "Out-of-Pocket Expense" is the share of any otherwise eligible allowable expense that You pay and any Medical Plan Year Deductible. Copayments, Pre-Treatment Authorization Penalties, Concurrent Review Penalties, expenses incurred for Mental Health (does **not** include expenses incurred for Biologically based Mental Health or Mental Disorders) and travel Expenses Incurred for Transplants, are not considered eligible Out-of-Pocket Expenses.

YOUR BENEFITS - Continued

The Following Applies to All Plans

Important Notice

Your medical coverage includes one or more features to help control medical care costs. Some features will affect the amount of Benefits payable for Your medical care. **PLEASE REFER TO THE MANAGED CARE FEATURES SECTION FOR ALL SERVICES THAT REQUIRE PRE-TREATMENT AUTHORIZATION. PENALTIES MAY BE ASSESSED FOR FAILURE TO COMPLY WITH PRE-TREATMENT AUTHORIZATION REQUIREMENTS.**

Medical Care Benefits

When Injury or Illness causes You or Your Dependent, while covered under this Plan, to incur Covered Medical Care Expenses, the Plan will determine Benefits according to the *HEALTH PLAN DESCRIPTION FORM* and Schedule and the limitations and exclusions outlined in the Plan. Benefits for each Covered Expense will be calculated as follows:

1. the Maximum Benefit Allowance will be determined by Great-West Healthcare;
2. the appropriate Copayment will be paid by You and subtracted from the Maximum Benefit Allowance, resulting in the Benefit payable;
3. the Maximum Benefit Allowance will be reduced by any applicable Deductible, and the remaining amount will be multiplied by the appropriate Coinsurance Percentage and subtracted from the Maximum Benefit Allowance, resulting in the Benefit payable;
4. the Benefit payable will be subject to the Plan Year Maximums and Lifetime maximums shown on the *HEALTH PLAN DESCRIPTION FORM*. Charges in excess of these maximums will **not** be included as Covered Expenses under this Plan.

Preventive Care Services

Preventive medicine emphasizes treatment to avoid possible health problems as an alternative to postponing treatment until symptoms appear. The Plan includes Benefits to help You and Your covered Dependents avoid future health problems by providing Benefits for care that can prevent Illness or detect it in its early stages. This can often result in more cost-effective treatment and make recovery from Illness more likely.

Preventive exams and preventive services are covered according to the frequency determined by the provider. Check with Your provider for specific health guidelines based on Your age, sex and family history. For all plan designs, preventive Benefits are not subject to Plan Deductibles, but specific Plan Copayments and Coinsurance do apply as shown on the *HEALTH PLAN DESCRIPTION FORM*. Preventive Care Services means care that is rendered to prevent future health problems for a Member who does not exhibit any current symptoms. Preventive Care Services include:

Periodic Exams and Immunizations

1. periodic physical exams;
2. immunizations, including cervical cancer vaccines for all females for whom a vaccination is recommended by the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services;
3. routine hearing exams;
4. annual medical diabetes eye exams or in accordance with the frequency determined by Your Physician;
5. lipid profile (total blood cholesterol, HDL, LDL and triglycerides);
6. blood sugar;
7. blood count;
8. urinalysis.

YOUR BENEFITS - Continued

Routine Preventive Services

1. Mammograms are covered, up to one screening mammogram each Plan Year for women, or more frequently, based on a Physician's recommendation;
2. Routine cytologic screening (pap test);
3. Routine prostate-specific antigen (PSA) blood test and digital rectal examination for:
 - a. men over the age of 50;
 - b. men over the age of 40 who are in high-risk categories;
4. Routine colorectal cancer examination and related laboratory tests are covered regardless of age, or in accordance with the frequency determined by Your Physician, subject to outpatient facility Copayment;
5. Routine PKU tests for newborns;
6. Other routine services as determined appropriate for the Members' age and sex when performed on an asymptomatic patient.

Child Health Supervision Services

Covered Expenses Incurred for Child Health Supervision will be payable at the level shown on the *HEALTH PLAN DESCRIPTION FORM* without application of the Deductible, but subject to applicable Copayments or Coinsurance. Any Copayment or Coinsurance applicable to the Benefits received during the course of one visit will not exceed the Copayment or Coinsurance payment applicable to a Physician visit.

Coverage for Child-Health Supervision Services for Your Covered Dependent will be from birth to age thirteen and means those preventive services listed below and immunizations as recommended by the American Academy of Pediatrics. Such services will only be covered to the extent that they are provided during the course of one visit by or under the supervision of a single Physician, Physician's assistant or registered nurse.

Preventive Services

Ages 0 – 24 months.....	unlimited well child visits
Ages 13 - 35 months.....	3 well child visits
Ages 3 – 12.....	4 well child visits

"Well child visit" means a visit to a Physician that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, Injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

Preventive Care Exclusions – Certain Preventive Care services and supplies **are excluded** under the Plan, including, but not limited to, the following:

1. routine examinations and immunizations related to school, sports, insurance, condition of employment, for licensing, church, or camp and flight exams;
2. immunizations for travel;
3. routine care received in an Emergency Room.

YOUR BENEFITS - Continued

Family Planning

This section describes covered services and exclusions for birth control, surgical sterilization and infertility. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums, as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Birth Control

Benefits are provided for:

1. surgical sterilization (e.g., tubal ligation or vasectomy) and related services;
2. injections for birth control purposes;
3. fitting of diaphragm or cervical cap;
4. surgical implantation and removal of a contraceptive device;
5. insertion or removal of an IUD.

Birth Control Exclusions – Certain services for birth control **are excluded** under the Plan, including, but not limited to, the following:

1. reversals of sterilizations;
2. over the counter products for birth control (e.g., sponges, spermicides, or condoms).

Infertility

Benefits are provided to diagnose and treat the actual cause of infertility, up to a maximum Benefit payment of \$2,500 per Member per Plan Year. Covered services include:

1. surgical treatment for correction (e.g., opening an obstructed fallopian tube, epididymis, or vasdeferens);
2. artificial insemination in vivo with husbands' or donor sperm, as determined by generally accepted medical practice.

Infertility Exclusions – Certain services, supplies and care for infertility **are excluded** under the Plan, including, but not limited to, the following:

1. surgeries, treatments, or services when the obstruction is related to the reversal of a surgical sterilization;
2. in vitro (outside the body in an artificial environment) fertilization with husband's or other donor sperm and any related services;
3. cost of donor sperm or donor eggs;
4. diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy;
5. storage costs for sperm or frozen embryos.

Maternity and Newborn Care

This section describes covered services and exclusions for maternity and newborn care. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Benefits are provided for maternity and newborn child care, including diagnosis, care during pregnancy and for delivery services. Maternity Services include normal vaginal delivery, cesarean section, spontaneous termination of pregnancy prior to full term, therapeutic termination of pregnancy prior to viability, and Complications of Pregnancy.

YOUR BENEFITS - Continued

Benefits are provided for:

1. inpatient, outpatient and Physician office services (including pre-natal care) for vaginal delivery, cesarean section, and Complications of Pregnancy;
2. obstetrical services and medical expenses related to home delivery;
3. Anesthesia services;
4. routine nursery care for a covered newborn including Physician services;
5. for covered newborns, all Medically Necessary care and treatment of Injury and Illness, including medically diagnosed Congenital Defects and Birth Abnormalities;
6. circumcision of a covered newborn male;
7. laboratory services related to pre-natal care, post-natal care or termination of a pregnancy;
8. one routine ultrasound per pregnancy. Additional ultrasounds are based on Medical Necessity;
9. therapeutic termination of pregnancy is a Covered Expense only when the pregnant Member or unborn child is endangered. The procedure must be performed in a Hospital or other covered facility. There must be documentation of at least one of the following conditions:
 - a. the Member has a medical condition as determined by the Physician, which represents a serious threat to the life of the pregnant Member if the pregnancy is allowed to continue;
 - b. there is a medical condition in the unborn child, as confirmed by two Physicians, which would result in the death of the unborn child during the term of the pregnancy or at birth;
 - c. there is a psychiatric condition, which represents a serious and substantial threat to the life of the pregnant Member if the pregnancy continues. The Physician must obtain Consultation from a licensed Physician specializing in psychiatry confirming the presence of such a psychiatric condition unless the pregnant Member has been receiving prolonged psychiatric care.

Maternity Post-Delivery Coverage

The Plan Will Pay Benefits for post-delivery inpatient Hospital care for a Member and her newly born child, for any length of time not exceeding:

1. 48 hours following a vaginal delivery;
2. 96 hours following a cesarean section;

regardless of whether or not the birth occurred in a Hospital. The number of hours of Hospital length of stay provided above are not subject to the Concurrent Review or Pre-Treatment Authorization requirements of the **MANAGED CARE FEATURES** section. Hospital length of stays extending beyond the above number of hours are subject to the Concurrent Review requirements of the **MANAGED CARE FEATURES** section, except if the 48 or 96 hours end after 8 P.M., then coverage will continue until 8 A.M. the following morning.

A decision to shorten the above length of stay may be made by the attending Physician in Consultation with the Member.

The Plan Will Pay Benefits described in this provision on the same basis as any Illness, subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums.

When charges for delivery are considered a Covered Expense for an expectant mother eligible for coverage under this Plan, any and all charges incurred by the newborn are to be considered as charges incurred by the mother until the mother is discharged.

YOUR BENEFITS - Continued

During the first 31-day period after birth, coverage for a newborn child shall consist of Medically Necessary care for Injury and Sickness, including care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities. All services provided during the first 31 days of coverage are subject to the Cost Sharing requirements, limitations and exclusions that are applicable to other Illnesses and conditions otherwise covered. To learn how to Enroll the newborn child, see the **Qualified Change in Status Events** heading in the **YOUR COVERAGE IN THE PLAN** section for information.

Maternity and Newborn Care Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. services, including but not limited to, preconception counseling, or paternity testing;
2. storage costs for umbilical cord blood;

Diabetes Management

This section describes covered services and exclusions for diabetic management. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Benefits are provided to Members who have insulin Dependent diabetes, non-insulin Dependent diabetes and elevated blood glucose levels induced by pregnancy or other medical conditions, when Medically Necessary and when services and supplies are prescribed by a Physician or other appropriately licensed health care provider.

Covered services include diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams. Training and education are covered throughout the Member's disease course when provided by a certified, registered or licensed health care professional with expertise in diabetes. Insulin pumps and related supplies are covered subject to meeting Great-West's Medical Outreach Department's medical policy criteria. Diabetic supplies are only a Benefit when obtained from an In-Network provider.

Diabetes Management Exclusions – Certain services, supplies or care **are excluded** under the Plan.

Physician Office Services

This section describes covered services and exclusions for Physician office-based services. In order for You to receive these Benefits, the medical care and services must be received in a Physician's office by a Physician or other Professional Provider. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

For Preventive Care, refer to the heading **Preventive Care Services** in this section. For family planning services, refer to the heading **Family Planning** in this section and for Maternity Services, see **Maternity and Newborn Care**. For diabetes treatment, refer to the heading **Diabetes Management** in this section. To receive office services after hours, see the **Emergency Care and Urgent Care** section for information.

Benefits are provided for medical care, Consultations and second opinions to examine, diagnose, and treat an Illness or Injury when received in a Physician's or other Professional Provider's office. A Physician may also provide medication management for medical conditions or mental health disorders. Consultations and second opinions may be provided by another Physician at the request of You or the Physician. In certain cases, Great-West's Medical Outreach Department may request a second opinion.

YOUR BENEFITS - Continued

Benefits are provided for office-based surgery and surgical services, which include Anesthesia and supplies. Such surgical fees include local Anesthesia and normal post-operative care. Office-based surgical services are subject to Pre-Treatment Authorization guidelines. See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines.

Benefits are provided in a Physician's office for diagnostic services when required to diagnose or monitor a symptom, disease or condition including, but not limited to, the following:

1. x-ray and other radiology services;
2. Laboratory and Pathology Services;
3. ultrasound services for non-pregnancy related conditions. For pregnancy-related ultrasounds, see the **Maternity and Newborn Care** section for information;
4. allergy tests;
5. audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an Injury or an Illness;
6. routine hearing exam, hearing aids, including bone anchored hearing aids (BAHA) and their fitting up to a \$500 maximum payment every 3 years.

Physician Office Services Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. expenses for obtaining medical reports or transfer of files;
2. treatment for hair loss, even if caused by a medical condition, except for alopecia areata;
3. routine foot care, such as care for corns, toenails, and calluses (except for Members with diabetes);
4. telephone or Internet Consultations;
5. treatment for sexual dysfunction;
6. separate reimbursement for Anesthesia and post-operative care when services are provided by the same Physician in the Physician's office.

Inpatient Facility Services

This section describes covered services and exclusions for acute inpatient care, such as Hospital, ancillary and professional services. Acute inpatient services may be obtained from an Acute Care Hospital, Long-Term Acute Care Hospital, skilled nursing facility, rehabilitation Hospital, or other covered inpatient facility. **All inpatient services are subject to Pre-Treatment Authorization guidelines.** See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*

Refer to the section entitled **Biologically Based and Non-Biologically Based Mental Health Conditions and Mental Disorders** for those services covered by the Plan, including acute medical detoxification. For accident or Emergency Medical Care, refer to the **Emergency Care and Urgent Care** section. For Dental Services, refer to the heading **Dental Related Services** for those services covered by the Plan.

Facility Services

A broad spectrum of health care services are provided in the inpatient Hospital environment. The following are examples of such covered services:

1. charges for semi-private room (with two or more beds), board, and general nursing services. Benefits are provided for the treatment of medical conditions and rehabilitation care, which is part of an Acute Care Hospital stay;
2. use of operating room, recovery room, and related equipment;

YOUR BENEFITS - Continued

3. medical and surgical dressings, supplies, surgical trays, casts, and splints when supplied by the facility as part of an inpatient admission;
4. prescribed drugs and medicines administered as part of an inpatient admission;
5. a room in an approved special care unit. The unit must have facilities, equipment, and supportive services for Intensive Care of critically ill patients;
6. skilled nursing facility charges for **non-acute Hospital admissions** for Medically Necessary care to restore and/or improve lost functions following an Injury or Illness are limited to 30 days per Plan Year.

Ancillary Services

Numerous medical professionals and para-professionals work together in the inpatient Hospital environment to provide comprehensive care to patients. The following list includes, but is not limited to, the following examples of such covered Ancillary Services:

1. diagnostic services, such as laboratory and x-ray tests (e.g., CT scan, MRI);
2. Chemotherapy and radiation therapy;
3. dialysis treatment;
4. respiratory therapy;
5. charges for processing, transportation, handling and administration of blood. Blood and blood plasma is covered unless a refund or credit is made for those items.

Professional Services

Professional services are those services provided during the inpatient admission by a Physician for surgical and medical care. The following list includes, but is not limited to, examples of such covered professional services:

1. Physician services for the medical conditions while in the inpatient facility;
2. surgical services; the surgical fee includes normal post-operative care;
3. Anesthesia, Anesthesia supplies and services for a covered surgery;
4. intensive medical care for constant attendance and treatment when the Member's condition requires it;
5. professional service charges of an Assistant Surgeon, if Medically Necessary.

Professional Services Exclusions – Certain services, supplies, or care **are excluded** under the Plan, including, but not limited to, the following: charges made by a Physician for his/her time on "standby" status if he/she performs no actual service except for interventional cardiology procedures (such as angioplasty) and C-sections.

Long-Term Acute Care Facility

Long-Term Acute Care facilities are institutions that provide an array of long-term critical care services to Members with serious Illnesses or Injuries. Long-Term Acute Care is provided for Members with complex medical needs. These include high-risk pulmonary Members with ventilator or tracheotomy needs, medically unstable Members, extensive wound care or post-op surgery wound Members, and low-level closed-head Injury Members. Long-Term Acute Care facilities do not provide care for low intensity Member needs. Pre-Treatment Authorization for admission and for continued stay is required by Great-West's Medical Outreach Department. See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines.

YOUR BENEFITS - Continued

Inpatient Facility Services Exclusions – Certain services, supplies, or care **are excluded** under the Plan, including, but not limited to, the following:

1. room and board and related services in a nursing home;
2. blood, blood plasma, and blood derivatives when a refund or credit is made for those items;
3. if You leave a Hospital or other facility against the medical advice of the Physician, charges related to the non-compliance of care are not eligible for coverage;
4. charges from the facility for the discharge day;
5. procedures that are solely cosmetic in nature;
6. Custodial and/or maintenance Care;
7. any services or care for the treatment of sexual dysfunction;
8. sex change operations, preparation for a sex change operation, or complications arising from a sex change operation;
9. personal comfort and convenience items such as televisions, telephone, guest meals, articles for personal hygiene and other similar services and supplies;
10. surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct a visual refractive defect;
11. additional procedures that are routinely performed during the course of the main surgery.

Outpatient Facility Services

This section describes covered services and exclusions in outpatient facilities. Outpatient facility services may be obtained at facilities such as an acute Hospital outpatient department, ambulatory surgery center, radiology center, dialysis center, and outpatient Hospital clinics. Some outpatient facility services are subject to Pre-Treatment Authorization guidelines. See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Refer to the section entitled ***Biologically Based and Non-Biologically Based Mental Health Conditions and Mental Disorders*** for those services covered by the Plan. For emergency care, refer to the ***Emergency Care and Urgent Care*** heading in this section. For Dental Services, refer to the heading ***Dental Related Services*** for those services covered by the Plan.

Facility Services

A broad spectrum of health care services are provided in an outpatient facility setting. The following are examples of such covered services:

1. use of operating room, recovery room and related equipment;
2. medical and surgical dressings, supplies, surgical trays, casts and splints when supplied by the facility as part of an outpatient admission;
3. drugs and medicines when provided as part of an outpatient admission.

Ancillary Services

Numerous medical professionals and para-professionals work together to provide comprehensive care to patients in an outpatient facility. The following includes, but is not limited to, examples of such covered Ancillary Services:

1. diagnostic services such as laboratory and x-ray tests (e.g., CT scan, MRI);
2. medical and surgical dressings, supplies, surgical trays, or cast and splints when provided in the outpatient department facility;

YOUR BENEFITS - Continued

3. Chemotherapy and radiation therapy;
4. dialysis treatment;
5. respiratory therapy;
6. charges for processing, transportation, handling and administration of blood. Blood and blood plasma is covered unless a refund or credit is made for those items.

Professional Services

Professional services are those services provided during the outpatient admission by a Physician for surgical and medical care. The following list includes, but is not limited to, examples of such covered professional services:

1. Physician services for the medical conditions while in the outpatient facility;
2. surgical services; the surgical fee includes normal post-operative care;
3. Anesthesia, Anesthesia supplies and services for a covered surgery;
4. professional service charges of an Assistant Surgeon, if Medically Necessary;
5. Consultation by another Physician when requested by the Physician. Staff Consultation required by facility rules is excluded.

Outpatient Services Exclusions – Certain services, supplies, or care **are excluded** under the Plan, including, but not limited to, the following:

1. blood, blood plasma, and blood derivatives when a refund or credit is made for those items;
2. surgical Benefits will not be provided for subsequent procedures to correct further Injury or Illness resulting from Your non-compliance with prescribed medical treatment;
3. procedures that are solely cosmetic in nature;
4. any services or care for the treatment of sexual dysfunction;
5. sex change operations, preparation for a sex change operation, or complications arising from a sex change operation;
6. personal comfort and convenience items such as televisions, telephone, guest meals, articles for personal hygiene and other similar services and supplies;
7. surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct a visual refractive defect;
8. additional procedures that are routinely performed during the course of the main surgery.

Emergency Care and Urgent Care

This section describes covered services and exclusions for emergency and Urgent Care. “Emergency 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 Member’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. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

The Plan covers emergency services necessary to screen and stabilize a Member without Pre-Treatment Authorization if a prudent layperson 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. **Follow-up care received in an emergency department or Urgent Care center, including but not limited to, removal of stitches and dressing changes, are not considered Emergency Care.** By choosing an Urgent Care center when appropriate instead of an Emergency Room, You may reduce Out-of-Pocket Expenses.

YOUR BENEFITS - Continued

Emergency Room Care

If You or Your Dependent needs care for an Emergency Medical Condition, go to the nearest Hospital. Coverage for an Emergency Medical Condition is available 7 days a week, 24 hours a day. This includes care received outside of the United States to stabilize Your condition for return to the United States. Pre-Treatment Authorization is not required prior to receiving care in an emergency room.

Inpatient Hospital Care immediately following Emergency Room Care:

Inpatient care for an Emergency Medical Condition includes both Hospital and Physician's charges for initial medical screening examination as well as Medically Necessary treatment which is immediately required to stabilize Your condition. Great-West's Medical Outreach Department must be contacted within 48 hours of the admission after care is provided for an Emergency Medical Condition.

Care provided in a Non-Network Hospital, by a Non-Network Physician, for inpatient Hospital, inpatient Physician and other inpatient services and supplies through stabilization and upon approval by Great-West's Medical Outreach Department will be covered at the In-Network level of payment.

After Your condition is stabilized, You or Your Authorized Representative will be presented with the options described below. The inpatient Hospital and Physicians charges incurred after Your condition is stabilized, are determined based on the "Network status" of the Provider.

1. If You elect to be transferred to a Network Hospital after stabilization in a Non-Network Hospital, then the Benefits will continue to be paid at the In-Network Benefit level, as shown on the *HEALTH PLAN DESCRIPTION FORM*. Any transportation costs associated with this transfer will be paid at the In-Network Benefit level;
2. If You elect to continue to stay in a Non-Network Hospital and
 - a. receive treatment from a Non-Network Physician after stabilization of the Emergency Medical Condition, The Plan Will Pay Benefits at the Out-of-Network Benefit level for Hospital and Physician's charges as shown on the *HEALTH PLAN DESCRIPTION FORM*;
 - b. receive treatment from a Network Physician after stabilization of the Emergency Medical Condition, The Plan Will Pay Benefits at the Out-of-Network Benefit level for the Hospital charges and at the In-Network Benefit level for the Physician's charges as shown on the *HEALTH PLAN DESCRIPTION FORM*;
3. If You are admitted to a Network Hospital and are under the treatment of a Non-Network Physician, and if:
 - a. You elect to transfer the care to a Network Physician associated with the Network Hospital, then The Plan Will Pay Benefits at the In-Network Benefit level for Hospital and Physician's charges as shown on the *HEALTH PLAN DESCRIPTION FORM*;
 - b. You elect to continue to receive care from a Non-Network Physician associated with the Network Hospital, The Plan Will Pay Benefits at the Out-of-Network Benefit level for Physician's charges and at the In-Network Benefit level for the Hospital charges as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Urgent Care

Benefits are provided for accident or medical care received from an Urgent Care center or other facility such as a Physician's office. Urgent Care is not considered a life or limb-threatening emergency and does not require the use of an emergency room.

YOUR BENEFITS - Continued

Travel Outside the Country

In an emergency or Urgent Care situation, You should go to the nearest health care facility. You will need to pay the bill in full. Use of a credit card is encouraged because the credit card company will automatically transfer the foreign currency into American dollars. When You return home, You should fill out a claim form, which is available by contacting the Great-West Customer Service Department at the phone number shown on Your medical identification card. You must submit the claim form along with the receipts to Great-West Healthcare's address listed on the claim form. The amount submitted must be in American dollars. Great-West Healthcare may require medical records of the services received. You are responsible for providing such medical records. It may be necessary for You to provide an English translation of the medical records.

Emergency Care and Urgent Care Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following: Non-emergency continued care after Your condition has stabilized.

Ambulance and Transportation Services

(other than travel to a Great-West Healthcare Transplant facility for a covered transplant procedure)

This section describes covered services and exclusions for Ambulance services. All covered services are subject to applicable Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Benefits are provided for local transportation by a vehicle designed, equipped and used only to transport the sick and Injured. The vehicle must be operated by trained personnel and licensed as an Ambulance to take You:

1. from Your home, scene of an accident or medical emergency to the closest Hospital with appropriate emergency facilities;
2. between Hospitals for Medically Necessary transport by Ambulance for continuing inpatient or outpatient care.

Ground Ambulance is usually the approved method of transportation. Air Ambulance is only a Benefit when terrain, distance, or Your physical condition requires the services of an air Ambulance. Great-West Healthcare will determine whether transport by air Ambulance is a Benefit on a case-by-case basis. If Great-West Healthcare determines that ground Ambulance could have been used, Benefits will be limited to ground Ambulance Benefits. If You elect not to receive transport to an emergency facility after an Ambulance has been called, Your Deductible and Coinsurance will still apply.

For ground or air Ambulance, You pay the appropriate Deductibles and Coinsurance. These amounts are shown on the *HEALTH PLAN DESCRIPTION FORM*. For ground Ambulance, The Plan Will Pay a maximum of \$1,000 per occurrence. For air Ambulance, The Plan Will Pay a maximum of \$10,000 per occurrence. Amounts over the \$1,000 and \$10,000 maximums are Your responsibility.

Ambulance and Transportation Services Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. commercial transport (air or ground), private aviation, or air taxi services;
2. Ambulance transport if You could have been transported by automobile, commercial or public transportation without endangering Your health or safety;
3. transportation by private automobile, commercial or public transportation or wheelchair Ambulance (ambucab).

YOUR BENEFITS - Continued

Outpatient Therapies

This section describes covered services and exclusions for Physical Therapy, Speech Therapy, Occupational Therapy, pulmonary rehabilitation, and cardiac rehabilitation. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Physical Therapy may involve a wide variety of evaluation and treatment techniques. Examples include manual therapy, hydrotherapy, heat, or application of physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, prevent disability following Illness, Injury, loss of a body part, or Congenital Defect or Birth Abnormality. All care must be received from a licensed Physical Therapist.

Speech Therapy is for the correction of speech impairment resulting from Illness, Injury, or surgery. Speech Therapists are also involved in the medical management of swallowing disorders. All care must be received from a licensed Speech Therapist.

Occupational Therapy is the use of constructive activities designed to promote the restoration of Your ability to satisfactorily accomplish the ordinary tasks of daily living. All care must be received from a licensed Occupational Therapist.

Benefits are provided for 20 outpatient visits per Plan Year for each therapy, including Physical, Speech and Occupational Therapies.

From a Member's third birthday up to the Member's sixth birthday, Benefits include the care and treatment of Congenital Defects and Birth Abnormalities without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. Such care applies to the 20 outpatient visits per Plan Year for each therapy, including Physical, Speech and Occupational Therapies.

For a cleft palate or cleft lip condition, Speech Therapy Benefits are provided as indicated above for Speech Therapy and are subject to the limitations above unless additional visits are Medically Necessary with no age limits. Such Speech Therapy visits will reduce the number of Speech Therapy visits allowed but will not be subject to the maximum number of Speech Therapy visits allowed.

Other Outpatient Therapy Services

Cardiac rehabilitation is a program to restore an individual's functional status after a major cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of skilled program personnel in an intensive outpatient rehabilitation program.

Benefits are allowed for services administered by a chiropractor who acts within the scope of licensing for the chiropractic treatment of an Illness or Injury. Chiropractic services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*. Benefits are limited to a maximum Benefit amount of \$750 per Plan Year. Charges in excess of this maximum will not be included as Covered Expenses under the Plan.

Benefits are allowed for acupuncture services for the treatment of an Illness or Injury. Acupuncture services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*. Benefits are limited to a maximum Benefit amount of \$750 per Plan Year. Charges in excess of this maximum will not be included as Covered Expenses under the Plan.

YOUR BENEFITS - Continued

Outpatient Therapies Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following :

1. long term therapy (Speech Therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions) for Members over the age of 5 years;
2. home programs for on-going conditioning and maintenance;
3. therapies for learning disorders, behavioral or personality disorders, developmental delays, stuttering, voice or rhythm disorders;
4. Benefits are not covered for non-specific diagnoses relating to developmental delay and learning-related disorders;
5. therapeutic exercise equipment prescribed for home use such as treadmills and/or weights;
6. membership at health spas or fitness centers;
7. convenience items;
8. the purchase of pools, whirlpools, spas, and personal hydrotherapy devices;
9. services related to workers' compensation Injuries;
10. therapies and self-help programs not specifically identified above;
11. recreational, sex, primal scream, sleep, and Z therapies;
12. rebirthing therapy;
13. self-help, stress management and weight loss programs;
14. transactional analysis, encounter groups and transcendental meditation (TM);
15. sensitivity training, anger management or assertiveness training;
16. Rolfing, Pilate, Myotherapy or prolotherapy;
17. Holistic Medicine and other wellness programs;
18. educational programs such as behavior modification or arthritis classes, except as otherwise specifically provided herein;
19. services for sensory integration disorder;
20. Occupational Therapies for diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts).

Early Intervention Services

This section describes covered services and exclusions for Early Intervention Services.

If You are covered under the Open Access H Plan, Covered Expenses Incurred for Early Intervention Services are subject to the applicable Deductible and Coinsurance as shown on the *HEALTH PLAN DESCRIPTION FORM*.

If You are covered under any other Plan, Covered Expenses Incurred for Early Intervention Services will be payable without application of any Copayments or Deductibles, but subject to the applicable Coinsurance as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Benefits are provided for Early Intervention Services for eligible Dependent Children from birth to the child's third birthday, when services are provided by a qualified Early Intervention Service provider, and when the child has been identified as eligible for services under Part C of the Individuals with Disabilities Education Act (IDEA). The IDEA defines an infant or toddler with a disability to mean an individual under three years of age who needs Early Intervention Services because the child:

1. is experiencing developmental delays as measured by appropriate diagnostic instruments and procedures in one or more of the areas of cognitive development, physical development, communication development, social or emotional development and adaptive development; or
2. has a diagnosed physical or mental condition which has a high probability of resulting in developmental delay.

YOUR BENEFITS - Continued

“Early Intervention Services” means services as defined by the Colorado Department of Human Services in accordance with Part C of the IDEA, that are authorized through an eligible child's Individualized Family Service Plan (IFSP).

The Plan Will Pay a maximum of \$5,725 per child per Plan Year. This annual limitation will be adjusted annually by the Department of Human Services. Coverage for early intervention services will not be applied to any other Plan maximums, including Your Lifetime Maximum benefit. The annual maximum does not apply to:

1. rehabilitation or therapeutic services that are necessary as the result of an acute medical condition; or
2. services provided to a child who is not participating in Part C of the IDEA and to services that are not provided as part of an IFSP.

Early Intervention Services Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. non-emergency medical transportation;
2. respite care;
3. service coordination as defined in 34 CFR 303.12(d)(11); and
4. assistive technology.

Home Health Care/Home IV Therapy

This section describes covered services and exclusions for home health and home infusion therapy (IV) care. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Benefits are provided for services performed by a home health agency engaged in arranging and providing nursing services, home health aide services and other therapeutic related services. Home health services are covered only when such services are necessary as alternatives to hospitalization. Prior hospitalization is not required. Home health services must be rendered pursuant to a Physician's written order, under a plan of care established by the Physician in collaboration with a home health agency. Subject to any applicable Maximum Benefits and to the Plan's retrospective review of the treatment plan, Home Health Care coverage will continue as long as Your Physician continues to certify the need for such care.

Covered services include the following for up to 100 visits in a Plan Year:

1. professional nursing services performed by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) (visits are limited to one a day and may not exceed four hours per day);
2. certified nurse aide services under the supervision of an R.N. or an L.P.N. or a qualified therapist with professional nursing services (visits are limited to one a day and may not exceed four hours per day);
3. Physical Therapy provided by a Professional Provider;
4. Occupational Therapy provided by a Professional Provider;
5. Respiratory and inhalation therapy;
6. Speech and hearing therapy and audiology services;
7. medical social services;
8. Medical Supplies (including respiratory supplies), Durable Medical Equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances;
9. nutritional counseling by a nutritionist or dietitian;
10. intravenous medications and other Prescription drugs ordinarily not available through a retail pharmacy.

YOUR BENEFITS - Continued

Home Health Care Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. services for personal comfort or convenience, including homemaker services;
2. food services, meals, formulas and supplements, other than those provided for dietary counseling, subject to Medical Necessity;
3. religious or spiritual counseling.

Home Infusion/Injection Therapy

Benefits for home infusion therapy (IV therapy) include a combination of nursing, Durable Medical Equipment and pharmaceutical services in the home. Home IV therapy includes, but is not limited to, antibiotic therapy, hydration therapy and Chemotherapy. Intra-muscular, intravenous and continuous intravenous injections are also covered services.

Hospice Care

This section describes covered services and exclusions for Hospice care. Hospice includes medical, physical, social and psychological and spiritual services stressing palliative care for patients. See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Covered Hospice care can be provided in two environments: (1) the home of the Member; or (2) in an inpatient facility.

To be eligible for Hospice care Benefits or inpatient Hospice care Benefits, the patient must have a life expectancy of six months, or less, as certified by the attending Physician.

Hospice care services are covered when such services are provided under active management through a Hospice which is responsible for coordinating all Hospice care services, regardless of the location or facility in which such services are furnished. Any services provided in connection with an unrelated illness or medical condition will be subject to this Booklet's provisions that apply to other illness or injuries.

The Plan Will Pay Benefits incurred as part of a Hospice care plan for up to six months from the date it was established, not to exceed:

1. 30 days of inpatient care in a Hospice facility;
2. 91 days per Plan Year for outpatient Hospice Care.

Covered services are allowed up to \$100 per day for routine home Hospice care, including any of the following services:

1. intermittent and 24-hour on-call professional services provided by or under the supervision of an R.N.;
2. intermittent and 24-hour on-call social/counseling services;
3. certified nurse aide services or nursing services delegated to other persons pursuant to applicable state law;
4. Benefits are allowed for the following services and are **not** subject to the dollar limitation specified above:
 - a. inpatient Hospice care;
 - b. inpatient Hospice respite care. Inpatient Hospice respite care may be provided only on an intermittent, non-routine, short-term basis. It is limited to periods of ten days or less, up to two admissions per lifetime;

YOUR BENEFITS - Continued

- c. intravenous medications and other Prescription drugs ordinarily not available through a retail pharmacy;
- d. short-term inpatient (acute) Hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management. Benefits are limited to a separate 30-day period;
- e. diagnostic testing;
- f. transportation;
- g. Medical Supplies (including respiratory supplies), Durable Medical Equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances;
- h. bereavement support services for covered family members during the twelve-month period following the death of the Member, limited to a maximum total payment of \$1,150;
- i. Physician services;
- j. Physical, occupational, speech and respiratory therapies;
- k. nutritional counseling by a nutritionist or dietitian.

Hospice Care Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

- 1. services for personal comfort or convenience, including homemaker services;
- 2. food services, meals, formulas and supplements, other than those provided for dietary counseling, subject to Medical Necessity;
- 3. pastoral and spiritual counseling;
- 4. services not directly related to the medical care of the Member, including but not limited to, estate planning, drafting of wills, funeral counseling or arrangement, or other legal services.

Clinical Trials

Services and supplies (such as medications) provided as part of clinical trials are generally not covered under the Plan, because they are Experimental, Investigational or Unproven.

However, the Plan covers clinical services, as defined in this provision, when a Member participates in a phase III or IV clinical trial that has been preauthorized by Great-West's Medical Outreach Department for treatment of cancer or other life-threatening illness, if all of the following criteria are met:

- 1. the Member has a current diagnosis that will likely be terminal in less than 2 years under generally accepted treatment options in the absence of the clinical trial; and
- 2. standard therapies have not been effective in significantly improving the condition or standard therapies are not medically appropriate; and
- 3. the Member must be enrolled in the clinical trial and not be treated off protocol; and
- 4. treatment is provided in a clinical trial that meets certain criteria established by Great-West Healthcare. For more information, contact the Great-West Customer Service Department at the phone number or website address shown on the Member's ID card.

All Plan provisions, including but not limited to Pre-Treatment Authorization and review by Great-West's Medical Outreach Department, apply to a Member's participation in a clinical trial.

For the purposes of this provision, "clinical services" means services, supplies or medication that are:

- 1. necessary to administer the service or supply that is the focus of the clinical trial.
- 2. necessary for management of the patient's health within the clinical trial.

YOUR BENEFITS - Continued

3. required for the clinically appropriate monitoring of the effects of the focus of the clinical trial (example: blood tests to measure tumor markers).
4. required for the prevention, diagnosis or treatment of complications that result from the clinical trial treatment.

Clinical Services do **not** include:

1. services and supplies that:
 - a. are excluded from coverage under the Plan in absence of an approved clinical trial.
 - b. are customarily provided by the trial sponsor at no cost to the patient.
 - c. are provided solely to determine trial eligibility.
 - d. are provided solely to satisfy the trial's data collection needs (examples: monthly CT scans for a condition that usually requires a single scan, protocol-induced costs).
2. costs that are funded by other agencies or research sponsors.
3. services such as travel, housing, companion expenses that may result from a Member's participation in a clinical trial.
4. administrative services (example: statistical analysis).
5. charges related to covered services, supplies or medication that have not or cannot be separated from costs related to non-covered services, supplies or medication.

Transplant Services

A Member who is a transplant patient will be Enrolled in the Plan's Care Management Program (the Program). For information about the Program, contact the Great-West Customer Service Department at the phone number or website address shown on the Your medical identification card. Transplant Benefits will be subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums, as shown on the *HEALTH PLAN DESCRIPTION FORM*, unless otherwise specified.

Transplants must be preauthorized by Great-West's Medical Outreach Department to be covered under this Plan. The transplant must be performed in a Transplant Network facility authorized by Great-West's Medical Outreach Department to be covered at the Plan's In-Network level of Benefits.

The Plan's Transplant Network facilities have been selected as designated transplant facilities on the basis of improved patient outcomes for particular transplants. Great-West's Medical Outreach Department can direct the patient to the appropriate facility for the patient's specific type of transplant.

Transplants performed at facilities that are not Great-West Healthcare Transplant facilities will not be covered.

The Plan covers the following transplants: heart, kidney, liver, lung, heart-lung, kidney-pancreas, pancreas, small bowel and bone marrow (allogenic-related and unrelated, autologous, peripheral stem cell and umbilical cord blood). Coverage includes preauthorized donor search, procurement, and other transplant services and supplies subject to the following:

1. **Travel Expenses** – This travel Benefit is available only if You utilize a Plan Transplant Network Facility for transplant services. This includes transportation costs and miscellaneous expenses such as lodging, meals and parking incurred for travel to and from a Plan Transplant facility, if the site is outside a 50-mile radius from Your home. Travel expenses must be preauthorized by Great-West's Medical Outreach Department in order to be covered.

YOUR BENEFITS - Continued

Travel expense coverage will be for You (the transplant recipient) and one other individual, or two other individuals if the transplant recipient is a minor, accompanying You. While there is no maximum limit to the number of days per trip, miscellaneous expenses such as lodging, meals and parking are limited to **\$100** per person, per day. Transportation expenses do not have a daily limit. Travel coverage, including transportation and miscellaneous expenses, is limited to a lifetime maximum of **\$10,000** per transplant.

You are responsible for monitoring the accumulation of expenses and for submitting supporting documentation of travel expenses. No Benefits will be paid until after the transplant services are received.

Travel expenses do not apply to any Plan Deductible or any Plan Out-of-Pocket Expense amount.

2. **Living Donor Travel** – This travel Benefit is available only if You utilize a Plan Transplant Network Facility for transplant services. If a living Donor is used, reimbursement for the Donor's travel expenses is limited to one trip and \$100 per day for travel and lodging. All living Donor travel and lodging charges are applied to Your transplant expense maximum.

As used in this Transplant provision, the term "Donor" means a person who furnishes an organ or tissue for transplantation. If a human organ or tissue transplant is provided from a Donor to a transplant recipient, the following will apply:

- a. when the transplant recipient and Donor are both Enrolled for coverage under the Plan, Benefits for Covered Expenses will be provided for both patients under the recipient's coverage;
- b. when only the transplant recipient is Enrolled for coverage under the Plan, Benefits for Covered Expenses will be provided for the recipient. Benefits may also be provided for the Donor for Covered Expenses under the recipient's coverage, but only if those services are not eligible under any other coverage available to the Donor;
- c. when the Donor is Enrolled for coverage under the Plan but the transplant recipient is not, Benefits for Covered Expenses rendered to the Donor will not be provided. Benefits will not be provided for services rendered to the transplant recipient.

Covered services related to the donor and/or donated organ or tissue, such as Hospital, surgical, medical, storage and transportation costs are subject to a maximum of \$25,000 per transplant.

Transplant Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. Benefits for services performed at any Hospital that is not designated or approved to provide human organ and tissue transplant services for the organ or tissue being transplanted;
2. Benefits for services if You are not a suitable candidate as determined by the Hospital designated and approved to provide such services;
3. any Experimental, Investigational or Unproven transplant, treatment, procedure, facility, equipment, drug, device, service, or supply. Any service or supply associated with or provided in follow-up to any of the above;
4. any transplant, treatment, procedure, facility, equipment, drug, device, service, or supply that requires Federal or other governmental agency approval and such approval is not granted at the time services are provided. Any service or supply associated with or provided in follow-up to any of the above;
5. Transplants of non-human organs;
6. services and supplies related to artificial and/or mechanical hearts or ventricular and/or arterial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/ arterial assist devices or the failure of those devices as long as any of the above devices remain in place, subject to Medical Necessity. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant;

YOUR BENEFITS - Continued

7. no Benefits will be provided for procurement of a donor organ or organ tissue which is not used in a covered transplant procedure, unless the transplant is cancelled due to Your medical condition or death and the organ cannot be transplanted to another person. No Benefits will be provided for procurement of a donor organ or organ tissue that has been sold rather than donated;
8. only those organ and tissue transplants and directly related procedures specified in the Transplant section of Medical Care Benefit Provisions are covered services under this Plan. Benefits will only be provided for covered services and supplies furnished to the transplant recipient during the period beginning five days before the covered transplant procedure and ends 365 days after the covered transplant procedure is performed.

Medical Supplies

This section describes covered services and exclusions for Medical Supplies and oxygen, and equipment for its administration. Information on diabetic management supplies that are covered by the Plan can be found under the heading ***Diabetes Management***. Supplies are subject to Pre-Treatment Authorization guidelines. See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the **HEALTH PLAN DESCRIPTION FORM**.

Medical Supplies

Disposable items (except Prescription drugs) that are required for the treatment of an Illness or Injury on an inpatient or outpatient basis are covered under this Plan. Benefits are provided for syringes, needles, surgical dressings, splints and other similar items that treat a medical condition. For supplies received from a Pharmacy, refer to the **PRESCRIPTION DRUG BENEFITS** section.

Oxygen and Equipment

Benefits are provided for oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per Member).

Durable Medical Equipment

Durable Medical Equipment including such things as crutches, wheelchairs, breathing equipment and Hospital beds, are covered if Medically Necessary and prescribed by a Physician up to a maximum payment allowance of \$5,000 per Plan Year. Durable Medical Equipment generally can withstand repeated use and must serve a medical purpose. Rental costs must not be more than the purchase price and will be applied to the purchase price. Other situations will be reviewed on a case-by-case basis. Durable Medical Equipment used as part of an inpatient admission is covered as part of the inpatient Hospital admission. See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the **HEALTH PLAN DESCRIPTION FORM**.

Orthopedic Appliances

An orthopedic appliance is a rigid or semi-rigid supportive device that helps to increase the use of a malfunctioning body part or extremity, which limits or stops motion of a weak or poorly functioning body part. An example of an orthopedic appliance is a knee brace. Benefits are provided for the purchase, fitting, needed adjustments and repairs of orthopedic appliances. Covered Benefits are limited to the most appropriate model that adequately meets Your medical needs.

YOUR BENEFITS - Continued

Prosthetic Devices

A prosthetic device replaces all or part of a missing body part or extremity (leg or arm) to increase Your ability to function. Benefits are provided for purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices. **Prosthetic devices are not subject to the Maximum Benefit Allowed for Durable Medical Equipment**, nor do they reduce the Maximum Benefit Allowance of \$5,000 per Plan Year.

Other Appliances

Benefits for other appliances include:

1. either one set of standard Prescription eyeglasses or one set of contact lenses (whichever is appropriate for the medical condition) when necessary to replace human lenses absent at birth or lost through intraocular surgery, ocular Injury or for the treatment of keratoconus or aphakia. Replacements are only covered if a Physician recommends a change in Prescription;
2. prosthetic bra, and pads, following a mastectomy, limited to 2 per Plan Year;
3. routine hearing exam, hearing aids, including bone anchored hearing aids (BAHA) and their fitting up to a \$500 maximum payment every 3 years;
4. the first wig (if hair loss is due to Chemotherapy, radiation therapy, or similar medical treatment);
5. diabetic insulin pumps; and
6. a maximum of two pairs of special shoes per Member per Plan Year needed because of foot disfigurement provided the shoes are prescribed by a Physician. Foot disfigurement includes, but is not limited to, disfigurement from:
 - a. cerebral palsy;
 - b. arthritis;
 - c. polio;
 - d. spina bifida;
 - e. diabetes;
 - f. an accident; or
 - g. developmental disability.

Benefits will also be provided for adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in Your condition (excluding dental appliances).

Specifically excluded from coverage are items such as support hosiery; bandages; diapers; formula; toilets; shower or bath equipment; air conditioners or air filters; exercise equipment; whirlpools; hot tubs; and splinting of teeth.

Covered Expenses for the rental of Durable Medical Equipment will not exceed the purchase price for such equipment.

Medical Supplies and Durable Medical Equipment Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g., wheelchair sidecars, fashion eyeglass frames, or Cryocuff unit). Equipment or appliances that You request that includes more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters);
2. any items available without a Prescription such as over the counter items and items usually stocked in the home for general use, including, but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly;

YOUR BENEFITS - Continued

3. air conditioners, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports and corsets or other articles of clothing, whirlpools, hot tubs, and saunas;
4. self-help devices that are not medical in nature, regardless of the relief or safety they may provide for a medical condition. These include, but are not limited to, bath accessories, home modifications to accommodate wheelchairs, wheelchair convenience items, wheelchair lifts, or vehicle modifications;
5. dental prosthesis, hair/cranial prosthesis, penile prosthesis or other prosthesis for cosmetic purposes;
6. orthotics, except for previously stated, whether functional or otherwise, regardless of the relief they provide;
7. home exercise and therapy equipment;
8. consumer beds or waterbeds;
9. repair or replacement needed due to misuse or abuse of any covered Medical Supply or equipment;
10. modifications to home, vehicle or workplace, regardless of medical condition or disability.

Reconstructive Services and Surgery

This section describes covered services and exclusions for reconstructive services and surgery. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

The Plan covers reconstructive services and surgery, including but not limited to treatment of covered newborn children's congenital defects and birth abnormalities, when the reconstruction meets **one** of the following primary purposes:

1. When the primary purpose is to restore large skin defects due to a port wine stain.
2. When the primary purpose is to relieve physical pain caused by an abnormal body structure.
3. When the primary purpose is reconstruction following a mastectomy. See "Post-Mastectomy Coverage."
4. When the primary purpose is to:
 - a. treat a functional impairment caused by an abnormal body structure; or
 - b. restore the Covered Person's normal appearance, regardless of whether a functional impairment exists.

when the abnormality results from a documented Illness or Injury that occurred within the preceding 12 months.

Subsequent procedures integral or linked to the covered reconstruction that cannot be performed within the 12-month period due to medical considerations, may be covered after the 12-month period if documented planning for these procedures takes place within 12 months of the Illness or Injury.

"Functional impairment" means an impairment that interferes with normal bodily function. For the purpose of this provision, interference with psychological function or well-being is not considered to be a functional impairment.

Reconstructive Services and Surgery Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following: cosmetic procedures, services, equipment or supplies for psychiatric or psychological reasons, to change family characteristics, to improve appearance or to improve conditions caused by aging. Services required as a result of a complication or adverse outcome of a non-covered Cosmetic Service are also not covered by this Plan. Examples of cosmetic procedures include, but are not limited to: face lifts; botox injections; breast augmentation; rhinoplasty; and scar revisions.

YOUR BENEFITS - Continued

Enteral Nutrition Benefits

This section describes covered services and exclusions for enteral nutrition. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Enteral nutrition means medical foods that are specially formulated for enteral feedings or oral consumption. Coverage includes medically approved formulas prescribed by a Physician for the treatment of phenylketonuria (PKU).

The Plan covers enteral nutrition and supplies required for enteral feedings when **all** of the following conditions are met:

1. it is necessary to sustain life or health;
2. it is used in the treatment of, or in association with, a demonstrable disease, condition or disorder;
3. it requires ongoing evaluation and management by a Physician; and
4. it is the sole source of nutrition or a significant percentage of the daily caloric intake.

Enteral Nutrition Benefits Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. regular grocery products that meet the nutritional needs of the patient (e.g., over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
2. medical food products:
 - a. prescribed without a diagnosis requiring such foods;
 - b. used for convenience purposes;
 - c. that have no proven therapeutic benefit without an underlying disease, condition or disorder;
 - d. used as a substitute for acceptable standard dietary intervention; or
 - e. used exclusively for nutritional supplementation.

Dental Related Services

This section describes covered services and exclusions for accident-related Dental Services, Anesthesia for children, inpatient services for dental related services, and cleft palate and cleft lip conditions. Dental Services are **not** covered under this Booklet, except under the specific circumstances described below. **This Booklet provides coverage for medical conditions and should not be considered as the Member's dental coverage.** All Dental Services and supplies are subject to Pre-Treatment Authorization guidelines. See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

Accident-Related Dental Services

Benefits are provided for accident-related dental expenses when the Member meets all of the following criteria:

1. Dental Services, supplies and appliances are needed because of an accident in which You sustained other significant bodily Injuries outside the mouth or oral cavity;
2. the Injury occurred on or after Your Effective Date in the Plan;
3. treatment must be for Injuries to sound natural teeth;

YOUR BENEFITS - Continued

4. treatment must be necessary to restore Your teeth to the condition they were in immediately before the accident;
5. the first Dental Services must be performed within 90 days after the accident;
6. related services must be performed within one year after the accident. Services after one year are not covered, even if coverage in the Plan is still in effect.

Benefits for restorations are limited to those services, supplies, and appliances Great-West Healthcare determines to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately prior to the accident.

Dental Anesthesia

Benefits are provided for general Anesthesia, when provided in a Hospital, outpatient surgical facility or other facility, and for associated Hospital or facility charges for dental care provided to a Dependent Child who:

1. has a physical, mental or medically compromising condition;
2. had dental needs for which local Anesthesia is not effective because of acute infection, anatomic variation or allergy;
3. is extremely uncooperative, unmanageable, uncommunicative or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred;
4. has sustained extensive orofacial and dental trauma.

Inpatient Admission for Dental Care

Benefits are provided for inpatient facility services including room and board, but not including charges for the Dental Services, **only** if You have a non-dental related physical condition, such as a bleeding disorder or heart condition that makes the hospitalization Medically Necessary.

Cleft Palate and Cleft Lip Conditions

Benefits are allowed for inpatient care and medical services, including orofacial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons, orthodontics, prosthetic treatment such as obturators, speech appliances, prosthodontic and surgical reconstruction for the treatment of cleft palate and/or cleft lip. If You have a dental plan, the dental plan must fully cover orthodontics and dental care subject to the same Copayment provisions for the coverage of cleft palate and/or cleft lip as apply to other conditions or procedures covered by the Plan.

Dental Surgery

Benefits are provided for inpatient hospitalization, Physician, Dentist or oral surgeon services, (not including charges for Dental Services) if You are in a Hospital for one of the following reasons:

1. excision of exostosis of the jaw (removal of bony growth);
2. surgical correction of Injuries to the jaws, cheek, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis);
3. treatment of fractures of the facial bones;
4. incision and drainage of cellulitis (infection of the soft tissue);
5. incision of accessory sinuses, salivary glands, or ducts.

Benefit allowances for surgery include payment for visits to the Physician or Dentist prior to the surgery, administration of local Anesthesia for surgery, and follow-up medical care.

YOUR BENEFITS - Continued

Dental Services Exclusions – Certain services, supplies or care **are excluded** under the Plan, including, but not limited to, the following:

1. restoring the mouth, teeth, or jaws because of Injuries resulting from biting, chewing, or an accident or Injury principally damaging the teeth;
2. restorations, supplies, or appliances. Examples of such non-covered items include, but are not limited to:
 - a. cosmetic restorations;
 - b. cosmetic replacement of serviceable restorations;
 - c. materials (such as precious metal) that are not Medically Necessary to stabilize damaged teeth.
3. inpatient or outpatient services required due to Your age, medical condition and/or nature of the Dental Services, except as described elsewhere;
4. upper or lower jaw augmentation or reductions (orthognathic surgery), even if the condition is due to a genetic, congenital or acquired characteristic;
5. artificially implanted devices and bone grafts for denture wear;
6. medical or surgical services related to temporomandibular joint therapy or surgery is not covered, unless a known, documented, disease of the joint;
7. administration of Anesthesia for Dental Services, operating and recovery room charges, and surgeon services unless shown elsewhere.

Biologically Based and Non-Biologically Based Mental Health Conditions and Mental Disorders

This section covers services and exclusions for Biologically Based and Non-Biologically Based Mental Health Conditions and Mental Disorders.

Biologically Based Mental Health and Mental Disorders

Biologically Based Mental Health conditions and Mental Disorders are covered under the Member's Medical Benefits and are not subject to the limitations of the Mental Health Benefit. The Plan Will Pay Benefits for the treatment of Biologically Based Mental Health and Mental Disorders, as defined below, on the **same basis as any Illness**. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

"Biologically Based Mental Health" means:

1. schizophrenia;
2. schizo-affective disorder;
3. bipolar affective disorder;
4. major depressive disorder;
5. specific obsessive-compulsive disorder;
6. panic disorder.

"Mental Disorders" means:

1. post-traumatic stress disorder;
2. drug and alcohol disorders;
3. dysthymia;
4. cyclothymia;
5. social phobia;

YOUR BENEFITS - Continued

6. agoraphobia with panic disorder;
7. general anxiety disorder; and
8. 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).

If Benefits are paid under this provision for any Covered Expense, payment for that same expense will not be duplicated under any other Plan provision.

Mental Health Conditions (excluding Biologically Based Mental Health Conditions and Mental Disorders)

Mental Health Conditions described in this section are conditions that are not considered Biologically Based Mental Health Conditions or Mental Disorders. Mental Health Conditions are those that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition. Inpatient services must be provided by a licensed Hospital, psychiatric Hospital, or an In-Network residential treatment center. Services for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) are covered as Mental Health Conditions if provided by a licensed Mental Health Provider. Benefits are then paid under the Mental Health Benefit. **Drug and Alcohol Disorders are not considered a Mental Health Condition for the purpose of this Benefit.** Services for Drug and Alcohol Disorders are described in the provision entitled ***Biologically Based Mental Health and Mental Disorders***.

Treatment of Mental Health Conditions as described in the above paragraph is subject to Pre-Treatment Authorization guidelines. See the **MANAGED CARE FEATURES** section for information on Pre-Treatment Authorization guidelines. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORMS*.

Mental Health Conditions Covered Services

Benefits are also provided for Medically Necessary inpatient care, outpatient care, and Provider office services for the diagnosis, crisis intervention and treatment of Mental Health Conditions. Inpatient services must be provided by a licensed Hospital, psychiatric Hospital or residential treatment center. Outpatient facility and Provider office services must be performed by a Physician, licensed clinical psychologist or other Professional Provider who is properly licensed or certified to practice psychotherapy.

Benefits are provided for medication management for Mental Health Conditions by the Member's medical Provider, psychiatrist, or prescriptive nurse. If the medication management is provided by the Member's medical Provider or if the condition is a Biologically Based Mental Health condition or Mental Disorder, Benefits are covered under the Medical Benefit. If medication management is provided by a psychiatrist or a prescriptive nurse, Benefits are paid under the Mental Health Benefit.

Inpatient treatment of Mental Health Conditions, including if the Member is admitted for an unscheduled emergency admission, is subject to Pre-Treatment Authorization guidelines. See the **MANAGED CARE FEATURES** section for additional information. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORMS*.

"Residential Treatment " means a 24-hour a day program under the clinical supervision of a mental health professional, in a community residential setting other than an Acute Care Hospital, for the active treatment of mentally ill persons, including a residential treatment center (RTC).

YOUR BENEFITS - Continued

Mental Health Conditions – Inpatient Services

Inpatient Services for the treatment of Mental Health Conditions are subject to medical policy and Medical Necessity. Treatment for inpatient Mental Health Conditions is limited to a total of 45 full or 90 partial days per Plan Year as listed on the *HEALTH PLAN DESCRIPTION FORMS*. Provider visits received during a covered admission are also covered and limited to a total of 45 full or 90 partial days per Plan Year.

Covered services include, but are not limited to:

1. inpatient semi-private room and Ancillary Services including laboratory and X-ray services;
2. individual psychotherapy;
3. group psychotherapy;
4. psychological testing;
5. family counseling with family members to assist in the Members' diagnosis and treatment;
6. medication management;
7. visits during a covered admission that are rendered by a:
 - a. Physician;
 - b. licensed psychologist;
 - c. registered professional nurse;
 - d. a licensed clinical social worker;
 - e. licensed professional counselor.

Partial Hospitalization Services

Partial hospitalization services are covered for Mental Health Conditions. The same services covered for Inpatient Services are also covered for Partial Hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as less than or equal to 3 hours, but no more than 12 hours of therapy per day. Partial day treatment is covered only when the Member receives care through a day treatment program. Every two partial day treatments count as one full inpatient day and will be applied against the Member's maximum inpatient Benefit.

"Partial Hospitalization" means continuous treatment for at least three hours, but not more than 12 hours, in any 24 hour period, in a licensed facility by a licensed health care professional acting within the scope of his/her license for the treatment of Mental Health Conditions. This may be referred to as a Partial Hospitalization Program (PHP) or Day program.

Mental Health Conditions – Outpatient Services

The same services covered as inpatient services are also covered for outpatient and intensive outpatient program services (except room, board, general nursing and Ancillary Services) if such services are for less than 3 hours per day for Mental Health Conditions. Benefits are limited to a total of 30 visits per Plan Year, as described on the *HEALTH PLAN DESCRIPTION FORMS*.

Benefits for outpatient laboratory and radiology services for the diagnosis and treatment of Mental Health Conditions are provided at the same Coinsurance level as other Mental Health Conditions.

YOUR BENEFITS - Continued

Mental Health Conditions Exclusions – Certain services, supplies and care for Mental Health Conditions **are excluded** under the Plan. These include, but not limited to, the following:

1. services or care provided or billed by a school, halfway house, Custodial Care facility for the developmentally Disabled, or outward bound programs, even if psychotherapy is included;
2. private room expenses;
3. hypnotherapy;
4. religious, marital and social counseling;
5. the cost of any damages to a treatment facility caused by the Member;
6. recreational, sex, primal scream, sleep, and Z therapies;
7. self-help, stress management, and weight-loss programs (except as provided in Disease Management);
8. transactional analysis, encounter groups, and transcendental meditation;
9. sensitivity training and assertiveness training;
10. behavior modification programs;
11. marriage and family counseling (**except** to assist in the Members' diagnosis and treatment);
12. rebirthing therapy.

PRESCRIPTION DRUG BENEFITS

This section describes covered services and exclusions for outpatient Pharmacy Prescription Drugs and medications. The Plan provides inpatient Pharmacy Benefits for Prescription Drugs when billed by a Hospital or other facility for a covered inpatient stay. These drugs would then be covered as an inpatient Hospital expense. Refer to the ***Inpatient Facility Services*** heading in the **YOUR BENEFITS** section for information on inpatient care. Home intravenous (IV) therapy is also a Benefit, as stated under the heading ***Home Health Care/Home IV Therapy***.

The outpatient Prescription Drug Benefits available under this Plan are managed by Express Scripts®. Express Scripts® offers a nationwide network of retail pharmacies, a mail order service pharmacy and clinical services that provide formulary management. All covered services are subject to applicable Copayments, Deductibles, Coinsurance and Plan Maximums as shown on the *HEALTH PLAN DESCRIPTION FORM*.

NOTE: *Two different Outpatient Prescription Drug Benefit Plans are provided—one in conjunction with the Open Access H Plan and the second Plan of Benefits is associated with the remaining Open Access Plans. An overview of specific Benefits can be found in the HEALTH PLAN DESCRIPTION FORM section. The following section provides details for both sets of Benefits.*

How to Obtain Outpatient Prescription Drug Benefits

How You obtain Benefits depends on whether You use a Retail Pharmacy or Mail Order Service and whether You use In-Network (Participating) or Out-of-Network (Non-Participating) Pharmacies.

If You have elected the **Open Access H Plan**, the Outpatient Prescription Drug Benefits Plan includes both In-Network and Out-of-Network Benefits. If You have elected **any other Plan**, the Outpatient Prescription Drug Benefits Plan includes In-Network Benefits **only**.

In-Network Retail Pharmacy

If You are Enrolled in the **Open Access H Plan**, You should present the written Prescription order from the Physician and Your medical identification card to the Pharmacist at a Retail Pharmacy. The Pharmacy will file the claim for You, and You will be charged at the point of purchase for applicable Deductible and Coinsurance amounts. The Plan Will Pay Benefits for those Covered Expenses that exceed the Deductible, as shown on the *HEALTH PLAN DESCRIPTION FORM*. Once the Plan Year Medical Plan Deductible has been met (Employee Only Deductible Amount for Employee Only coverage and Family Deductible Amount for Family coverage), the Plan Will Pay Benefits at 85% for In-Network Participating Pharmacies, for Preferred, Non-Preferred or Generic prescription drugs.

If You are Enrolled in **any other Plan**, You should present the written Prescription order from the Physician and Your medical identification card to the Pharmacist at a Retail Pharmacy. The Pharmacy will file the claim for You. You will be charged at the point of purchase for the applicable Prescription Drug Deductible of \$150* per Member per Plan Year and Copayment amounts. Your Copayment amount depends on whether a Preferred, Non-Preferred or Generic drug is obtained and is shown on the *HEALTH PLAN DESCRIPTION FORM*.

***NOTE:** The Prescription Drug Deductible applies to Preferred and Non-Preferred drugs only. It is **waived** for all Generic drugs.

If You do not present Your medical identification card at an In-Network Pharmacy, You will have to pay the full cost of the Prescription. If You do pay the full charge, You should ask the Pharmacist for an itemized receipt and submit it to Express Scripts® with a written request for reimbursement. You will be reimbursed based on the charge for the covered drug, less the network pharmacy discount payable after review and approval of the claim, less the applicable Copayment or Coinsurance. Prescription drugs dispensed in excess of a 34-day supply or medication are not reimbursable.

PRESCRIPTION DRUG BENEFITS - Continued

Out-of-Network Retail Pharmacy

If You are Enrolled in the **Open Access H Plan** and You go to an Out-of-Network Pharmacy, You will have to pay the full cost of the Prescription. If You pay the full charge, You should ask the Pharmacist for an itemized receipt and submit it to Express Scripts® with a written request for reimbursement. You will be reimbursed based on the charge for the covered drug, less the network pharmacy discount payable after review and approval of the claim, less Your 35% Coinsurance. Your Coinsurance amount is shown on the *HEALTH PLAN DESCRIPTION FORM*.

If You are Enrolled in **any other Plan** and You go to an Out-of-Network Pharmacy, You will have to pay the full cost of the Prescription and will not be reimbursed.

Mail Service

Your Prescription Drug Benefit includes a Mail Service Benefit. As a result, You can order long-term medications from the Express Scripts® Mail Service Pharmacy.

When You use the Express Scripts® Mail Service Pharmacy, You can receive a multiple-month supply of most drugs, and You may save money on Your applicable Deductible, Copayment and/or Coinsurance costs. Your Copayment and/or Coinsurance amount depends on whether a Preferred, Non-Preferred or Generic drug is obtained and is shown on the *HEALTH PLAN DESCRIPTION FORM*. Your Prescription is filled promptly and standard shipping is **free**.

You can order refills quickly and easily on the Internet or by phone, and You can check Your order's status 24-hours a day.

Express Scripts® Mail Service Pharmacy fills Prescriptions for long-term conditions such as asthma, diabetes, high cholesterol, hypertension, and arthritis. Controlled substances and medications requiring special packaging or refrigeration can also be ordered.

Express Scripts® uses skill and care to fill Your Prescriptions and ensure Your safety. Two registered Pharmacists check every new Prescription. Information concerning drug interactions, side effects and other safety issues is included with Your medication, just as with a local Retail Pharmacy. Your medication is delivered in a plain, weather-resistant package, ensuring its safety, security and privacy.

Our Pharmacists are available 24-hours a day, and they are eager to answer any questions You may have. To contact a Pharmacist, call the toll-free number printed in Your Mail Service materials or on Your Express Scripts® Prescription bottle.

Specialty Pharmacy Program

The Specialty Pharmacy Program covers certain drugs commonly referred to as high-cost specialty drugs. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through **CuraScript** Pharmacies. These Pharmacies comprise the Specialty Pharmacy Network (SPN). The SPN specializes in dispensing and delivering drugs that require special handling. Specialty Pharmacies provide additional helpful services, including free delivery of medication to Your home or an alternate address of Your choice, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the specialty drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis.

With a new Specialty Pharmacy Prescription, You may contact the Great-West Customer Service Department or access the internet website address shown on Your medical identification card to identify the drugs contained on the Specialty Pharmacy list. You may also contact the Great-West Customer Service Department or access the internet website for assistance in locating the Specialty Pharmacy that can be used to obtain medication.

PRESCRIPTION DRUG BENEFITS - Continued

If You are Enrolled in the **Open Access H Plan**, The Plan Will Pay for certain high-cost specialty drugs subject to the Employee Only or Family Deductible and at the same Coinsurance levels as for all other prescription drugs. The Plan Will Pay 70% for the Administration of Injectable drugs, subject to the applicable Medical Plan Deductible, for drugs administered in a Physician's office or an outpatient facility.

If You are Enrolled in **any other Plan**, Your Copayment for certain high-cost specialty drugs will depend upon the type of drug that is prescribed (Self-Administered Injectables or other), whether the drug is a Preferred, Non-Preferred or Generic drug and whether it is filled by a Participating Retail Pharmacy or a Participating Mail Order Pharmacy. The way the prescription is written by the Physician (e.g., 30-day supply or 90-day supply) and the type of name-brand drug, will dictate the Copayment Amount. A 30-day supply will require a Participating Retail Pharmacy Copayment Amount.

The Plan Will Pay 70% after the applicable Prescription Drug Deductible for all Self-Administered Injectables dispensed through a Participating Retail Pharmacy or a Participating Mail Order Pharmacy. Your 30% Coinsurance amount for Self-Administered Injectables dispensed through a Participating Retail or Mail Order Pharmacy will not exceed \$300 per 34-day supply or \$750 per 90-day supply.

The Plan will pay 70% after the applicable Plan Year deductible for all injectables dispensed through a Physician's office or an outpatient facility.

Ninety-day Retail Participating Provider Pharmacy Program

For convenience, You may elect to have a three-month supply of a Maintenance Prescription Drug filled at certain designated retail In-Network Pharmacies. This option is available **only after You have filled a 30-day Prescription for the same Maintenance Prescription Drug**, and is subject to the Prescription Drug Deductible and Copayment (or Deductible and Coinsurance for Open Access H Plan) for three 30-day supplies. To locate a retail In-Network Pharmacy that is equipped to fill a 90-day supply of Maintenance Prescription Drugs, You may contact the Great-West Customer Service Department or access the website shown on Your medical identification card.

Prescription Drug Generic Option

If a Generic Drug is available for the prescribed drug and You receive the Generic Drug, You pay only the Generic Copayment; if a Generic Drug is not available, You pay only the Prescription Drug Deductible and applicable Preferred Copayment (or applicable Deductible and Coinsurance for Open Access H Plan).

However, 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 Prescription Drug Deductible and applicable Preferred Copayment (or applicable Deductible and Coinsurance for Open Access H Plan) PLUS the difference in cost between the Generic and Preferred Drug. Once You have met Your Out-of-Pocket, if a Preferred Drug is dispensed, You will still be liable for the difference in cost between the Generic and Preferred Drug.

Mandatory Generic Drug Replacement

If Your Physician prescribes a Preferred drug that has a generic equivalent, the Pharmacy will dispense the Generic Drug. If You request to have the Preferred drug instead of the generic equivalent, You will pay the Prescription Drug Deductible and Preferred Copayment (or applicable Deductible and Coinsurance for Open Access H Plan) PLUS the difference in cost between the Generic Drug and the Preferred drug.

PRESCRIPTION DRUG BENEFITS - Continued

Preferred Drug Option

If Your Physician prescribes a drug that has been selected as a Preferred Drug, You pay the Prescription Drug Deductible and Preferred Drug Copayment (or applicable Deductible and Coinsurance for Open Access H). You may check whether a Preferred drug is on the list or if new Preferred drugs have been added by referring to the current listing available on the internet through a link to Express Scripts® on the internet website indicated on Your medical identification card. This list is reviewed periodically and can change.

If Your Prescription is not for a drug on this list and is not a Generic Drug, You will pay the Prescription Drug Deductible and appropriate Non-Preferred Copayment (or applicable Deductible and Coinsurance for Open Access H).

The Prior Authorization Program

The Great-West Healthcare Prior Authorization Program requires that certain high cost medications be approved for Medical Necessity before being covered. The Prior Authorization Program was developed to offer broad Prescription Drug coverage while promoting safe, clinically appropriate drug use. In addition, the Prior Authorization Program is able to help control costs incurred by the Member by requiring that certain medications be reviewed for Medical Necessity.

A copy of the Prior Authorization List and the Managed Drug List is available on the internet through a link to Express Scripts® on the internet website indicated on Your medical identification card. A Prescription Drug that is covered by the Plan and is on the Prior Authorization List must be reviewed and authorized by the Prescription Drug Management Unit for Medical Necessity prior to the Prescription being filled through a Participating Provider Pharmacy.

The Managed Drug Limit Program

The Managed Drug Limit (MDL) Program helps promote safe, clinically appropriate Prescription Drug use. Unit dose limits for Prescription Drugs are developed based upon recommendations by the federal Food and Drug Administration (FDA) and the manufacturer of the Prescription Drug. A Prescription for a drug that is on the MDL list and that exceeds the recommended unit dose limit (herein "Excess Amount") must be reviewed and authorized by the Prescription Drug Management Unit for Medical Necessity. When You take such a Prescription to a Participating Provider Pharmacy, You will be able to obtain the recommended amount and will be notified that authorization will be required in order to obtain the Excess Amount.

The Prior Authorization and Managed Drug Limit Lists

Your Employer will initially supply You with a printed copy of the Prior Authorization List and the Managed Drug Limit List. However, the printed lists may not always include all the Prescription Drugs subject to the program at the time You present Your Prescription at the Pharmacy. Because the program must be able to respond to drug misuses as they are identified, the lists are subject to ongoing review and are changed periodically. To avoid a delay when filling Prescriptions, You should always check whether a drug is still on the lists or if new Prescription Drugs have been added to the lists by referring to the most current lists which are always available on the internet website indicated on Your medical identification card.

NOTE: You will receive instructions for moving through the website to the most current Prior Authorization List and MDL List.

Refer to the **MANAGED CARE FEATURES** section for information about claim denials and appeals.

PRESCRIPTION DRUG BENEFITS - Continued

Unit Dose Limits

Participating Retail Pharmacy:	30-day supply
Participating Mail Order Pharmacy:	90-day supply
Participating Specialty Pharmacy:	30-day supply or 90-day supply depending upon what is prescribed
Self-Administered Injectables dispensed through the Specialty Pharmacy:	34-day supply or 90-day supply depending upon what is prescribed

These Prescription Drugs and medicines must be prescribed by a Physician and obtained from a licensed Pharmacist or Physician operating within the scope of his/her license. Certain high-cost specialty drugs must be obtained through the Specialty Pharmacy Program. If drugs or medicines are dispensed by a nonparticipating Pharmacy, charges in excess of the Reasonable and Customary charge are not covered. You or Your Dependent incurs an expense on the date the drug or medicine is furnished.

Prescription Drug Definitions

1. **"Generic Drug"** means a Prescription Drug known by its chemical name rather than by Brand Name.
2. **"Mail Order Service"** means the Maintenance Prescription Drugs are delivered directly to You or Your Dependent by mail.
3. **"Mail Order Service Pharmacy"** means a U.S. Pharmacy that has a written contract with the Plan or the Plan's authorized representative for Mail Order Delivery of Maintenance Prescription Drugs.
4. **"Maintenance Prescription Drug"** means a Prescription Drug that You or Your Dependent will take or use for more than 30 days.
5. **"Non-Preferred Drug"** means a Prescription Drug that is not included on the list of Preferred Drugs and is not a Generic Drug.
6. **"Pharmacy"** means a licensed establishment where a Pharmacist licensed in that state dispenses drugs. "Pharmacy" also includes a Hospital Pharmacy. "Participating Provider Pharmacy" means a U.S. Pharmacy that has a written contract with the Plan or the Plan's authorized representative.
7. **"Preferred Drug"** means Brand Name Prescription Drugs selected by the Plan's authorized representative for their high degree of overall clinical and cost effectiveness prescribed for use in treating common health conditions.
8. **"Prescription"** means the request for a drug by a Physician licensed to prescribe drugs and each authorized refill.
9. **"Prescription Drug"** means a Prescription legend drug that is:
 - a. medicine required by federal law to bear the legend, "Caution: Federal law prohibits dispensing without a Prescription";
 - b. any other drug, which, under the applicable state law, may only be dispensed upon the Prescription order of a Physician.

The Plan will also consider the following to be Prescription Drugs:

- a. Adderall®, Dexedrine®, and Desoxyn®, for persons through the age of 25 years;
 - b. birth control pills, regardless of the purpose for which prescribed, and birth control devices;
 - c. diabetic supplies such as glucose strips, alcohol swabs, and lancets;
 - d. injectable insulin and syringes used for administration of insulin;
 - e. needles and syringes;
 - f. prescription vitamins;
 - g. self-administered injectable drugs;
 - h. tretinoin, all dosage forms (e.g. Retin-A® or Avita®), for persons through the age of 25 years.
10. **"Reasonable and Customary"** means the charge for the same drug or supply at an In-Network Pharmacy.

PREScription DRUG BENEFITS - Continued

Prescription Drug Exclusions

Your Outpatient Prescription Drug Benefits Plan provides many Benefits. There are some things, however, that **are excluded** under the Plan as Prescription Drug Benefits. These include, but are not limited to:

1. Drugs or medicines prescribed for Injury or Illness arising out of employment, whether or not You or Your dependent is covered by Workers' Compensation or similar laws.
2. Drugs or medicines which can be legally obtained without a Prescription, except those items included in the definition of "Prescription Drug."
3. Drugs or medicines provided without charge.
4. The administration of drugs or insulin.
5. Drugs or medicine marked "Caution: Limited by federal law to investigational use."
6. Experimental, Investigational or Unproven drugs or medicines.
7. Drugs or injectable insulin in a quantity greater than that prescribed by a Doctor.
8. Drugs or injectable insulin purchased more than one year after the date of the Prescription.
9. Drugs or insulin while confined in a Hospital, skilled nursing facility or a similar facility.
10. Healing devices; immunization agents; organic serum; blood or blood plasma; drugs given as shots other than insulin; vitamins; diet aids; health or beauty aids; and delivery charges.
11. That part of one purchase of a drug or medicine that exceeds the Unit Dose Limits specified above.
12. The following items (whether Generic or Preferred) will not be covered regardless of the reason prescribed:
 - a. Adderall®, Dexedrine®, and Desoxyn®, for individuals 26 years of age or older;
 - b. anorexigenic (any drug or medicine used for the purpose of weight loss);
 - c. diet supplements;
 - d. medications used to treat infertility;
 - e. minoxidil (Rogaine) for the treatment of alopecia;
 - f. Nicorette (or any other drug containing nicotine or other smoking deterrent medications);
 - g. Prescription Drugs intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction, such as Viagra®);
 - h. tretinoin, all dosage forms (e.g. Retin-A® or Avita®), for individuals 26 years of age or older.

Prescription Drug Claims

A Prescription presented to a Pharmacist is not a claim for Benefits under the Plan. You may submit a claim for Prescription Drug Benefits:

1. If You or Your Dependent pays for all or a portion of a Prescription Drug or medicine at the time such drug or medicine is dispensed and wishes to seek reimbursement for the amount paid;
2. If You or Your Dependent was charged a Deductible or Copayment Amount (or Deductible or Coinsurance Amount for Open Access H Plan) that You feel is incorrect;

In either case, contact Your Employer for a Prescription Drug claim form. Follow the instructions on the form to submit Your claim.

GENERAL EXCLUSIONS

These general exclusions apply to all Benefits described in this Booklet. This coverage provides Benefits for specific services described in this Booklet and not listed as an exclusion. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. In addition to these general exclusions, specific limitations, conditions and exclusions apply to specific covered services, which can be found in the **YOUR BENEFITS** section and elsewhere in this Booklet.

If a service is not covered, then all services performed in conjunction with that service are not covered. Great-West Healthcare is the final authority for determining if services and supplies are Medically Necessary for the purposes of payment.

The Plan provides many Benefits. There are some services, supplies, situations, or related expenses, however, that will not be covered. These include, but are not limited to:

1. **Abortions.** This Plan does not cover elective abortions except as provided under **Maternity and Newborn Care** found in the **YOUR BENEFITS** section.
2. **Alternative or complementary medicines.** This Plan does not cover alternative or complementary medicine. Services in this category include, but are not limited to, Holistic Medicine; homeopathy; hypnosis; aromatherapy; massage therapy; Reiki therapy; herbal medicine; vitamin or dietary products or therapies; naturopathy; thermography; orthomolecular therapy; contact reflex analysis; bioenergetic synchronization technique (BEST); clonics; or iridology.
3. **Artificial conception.** All services related to artificial conception are not covered, except as provided under the heading **Family Planning** found in the **YOUR BENEFITS** section.
4. **Before Effective Date.** This Plan does not cover any service received before Your Effective Date of coverage.
5. **Blood, plasma or derivatives.** This Plan does not cover blood, blood plasma, and blood derivatives when a refund or credit is made for those items.
6. **Birth control.** This Plan does not cover the following services, supplies or care:
 - a. over the counter products for birth control (e.g., sponges, spermicides, or condoms);
 - b. reversals of sterilization.
7. **Care and supplies** for which:
 - a. no charge is made;
 - b. You or Your Dependent would not have to pay if You did not have this coverage.
8. **Chelating agents.** This Plan does not cover any service, supply, or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.
9. **Clinical research.** This Plan does not cover any services or supplies provided as part of clinic research unless allowed by the Plan. A signed consent form for human research subjects will be considered proof that a Member is involved in a clinical research program.
10. **Clinical trials.** This Plan does not cover any services or supplies provided as part of clinic trials except as provided under the heading **Clinical Trials** found in the **YOUR BENEFITS** section.
11. **Complications of non-covered services.** This Plan does not cover Complications of non-covered services and supplies, including, but not limited to:
 - a. cosmetic surgery;
 - b. sex-change operations;
 - c. procedures that are determined to be Experimental, Investigational or Unproven.
12. **Convalescent care.** Except as otherwise specifically provided, this Plan does not cover convalescent care from a period of Illness, Injury, or surgery, unless normally received for a specific condition, as determined by the Plan. Convalescent care includes the Physician's or facility's services.

GENERAL EXCLUSIONS - Continued

13. **Convenience/luxury/deluxe-services/or equipment.** This Plan does not cover services and supplies used primarily for Your personal comfort or convenience. Such services and supplies include but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs. Supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or Cryocuff unit) are not covered. Equipment or appliances You request that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters) are not covered.
14. **Cosmetic Services.** This Plan does not cover cosmetic procedures, services, equipment or supplies (except as provided in the **YOUR BENEFITS** section under **Reconstructive Services and Surgery**) for psychiatric or psychological reasons, to change family characteristics, to improve appearance or to improve conditions caused by aging. Services required as a result of a complication or adverse outcome of a non-covered Cosmetic Service are also not covered by this Plan. Examples of cosmetic procedures include, but are not limited to:
 - a. face lifts;
 - b. botox injections;
 - c. breast augmentation;
 - d. rhinoplasty;
 - e. scar revisions.
15. **Court ordered services.** This Plan does not cover services that are required under court order, parole or probation unless those services would otherwise be covered under this Plan.
16. **Custodial Care.** This coverage does not cover care primarily for the purpose of assisting You in the activities of daily living or in meeting personal rather than medical needs, and which is not a specific treatment for an Illness or Injury. Custodial Care cannot be expected to substantially improve a medical condition, and has minimal therapeutic value. Care can be custodial even if it is recommended or performed by a professional and whether or not it is performed in a facility (e.g., Hospital or skilled nursing facility) or at home. Such care includes, but is not limited to:
 - a. Assistance with walking, bathing, or dressing;
 - b. Transfer or positioning in bed;
 - c. Administration of medication that is usually self-injected;
 - d. Meal preparation;
 - e. Assistance with feeding;
 - f. Oral hygiene;
 - g. Routine skin and nail care;
 - h. Suctioning;
 - i. Toileting;
 - j. Supervision of medical equipment or its use.
17. **Dental Services.** Dental Services are not covered except as provided in the **YOUR BENEFITS** section under **Dental Related Services**.
18. **Discharge.** The Plan does not cover inpatient services received after the date Great-West Healthcare's medical policy determines discharge is appropriate (using managed care guidelines).
19. **Discharge against medical advice.** This Plan does not cover Hospital services if You leave a Hospital or other facility against the medical advice of the Physician.
20. **Discharge day expense.** This Plan does not cover services related to a discharge day, except as provided in the **YOUR BENEFITS** section.

GENERAL EXCLUSIONS - Continued

21. **Domiciliary care.** This Plan does not cover care provided in a residential, non-treatment institution, halfway house or school.
22. **Duplicate (double) coverage.** This Plan does not cover services and supplies already covered by other valid coverage, except as described in the Coordination of Benefits section.
23. **Enteral feedings and supplies.** This Plan does not cover enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except as provided in the **YOUR BENEFITS** section under **Enteral Nutrition Benefits**.
24. **Experimental, Investigational or Unproven Procedures.** This Plan does not cover any treatment, procedure, drug or device that has not been found to meet the eligible-for-coverage medical criteria established by Great-West Healthcare. Also not covered by the Plan are (a) health services and supplies that are Experimental, Investigational or Unproven. This includes pharmacological regimens; and (b) health services and supplies that are provided concomitantly to Experimental, Investigational or Unproven services and supplies.
25. **Genetic testing/counseling.** This Plan does not cover services including, but not limited to: preconception testing/counseling; paternity testing; court-ordered genetic counseling and testing; testing for inherited disorders; discussion of family history or testing to determine the sex or physical characteristics of an unborn child. Genetic tests to evaluate risks of disorders for certain conditions may be covered based on Great-West Healthcare's medical policy, review and criteria and only after appropriate Pre-Treatment Authorization.
26. **Government operated facility.** This Plan does not cover services and supplies for all military service connected disabilities furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, including a veterans administration facility, unless payment is authorized in writing before the services are performed.
27. **Hair loss.** This Plan does not cover treatment for hair loss, drugs, wigs (except the first wig after cancer treatment), hair pieces, artificial hairpieces, hair or cranial prosthesis, hair transplants or implants even if there is a Physician Prescription, and a medical reason for the hair loss.
28. **Illness or Injury from illegal conduct.** The Plan does not cover services resulting from taking part in the commission of a crime or being engaged in an illegal occupation, except as required by State law.
29. **Learning deficiency and/or behavioral problem therapies.** This Plan does not cover services or supplies related to therapies for learning deficiencies and/or behavioral problems, except as provided in the **YOUR BENEFITS** section.
30. **Maintenance therapy.** This Plan does not cover any treatment that does not significantly enhance or increase Your function or productivity, or care provided after You have reached Your Maximum Medical Improvement, except as provided in the **YOUR BENEFITS** section.
31. **Medical Necessity.** This Plan does not cover expenses for services and supplies that are not Medically Necessary. Services may be denied before or after payment unless Pre-Treatment Authorization has been received by the Plan's Claim Administrator. A decision as to whether a service or supply is Medically Necessary is based on the Plan's Claim Administrator's medical policy, and peer reviewed medical literature as to what is "approved and generally accepted medical or surgical practice." **The fact that a provider may prescribe, order, recommend, or approve a service does not, of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.**
32. **Missed appointments.** This Plan does not cover charges for Your failure to keep scheduled appointments. You are solely responsible for such charges.

GENERAL EXCLUSIONS - Continued

33. **Non-covered providers of service.** This Plan does not cover services and supplies prescribed or administered by a provider or other person, supplies, or facility not specifically listed as covered in this Booklet. These non-covered providers or facilities include, but are not limited to:
- a. Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider);
 - b. School infirmary;
 - c. halfway house;
 - d. Massage therapist;
 - e. Nursing home;
 - f. Residential institution or halfway house (facility where the primary services are room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require Acute Care hospitalization);
 - g. Dental Services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group (unless shown elsewhere);
 - h. Services provided by You upon Yourself, by a family member, or by a person who ordinarily resides in Your household.
34. **Non-medical expenses.** This Plan does not cover non-medical expenses, including but not limited to:
- a. Adoption expenses;
 - b. Educational classes and supplies not provided by Your provider unless specifically allowed as a Benefit under this Plan;
 - c. Vocational training services and supplies;
 - d. Mailing and/or shipping and handling expenses;
 - e. Interest expenses and delinquent payment fees;
 - f. Modifications to home, vehicle, or workplace regardless of medical condition or disability;
 - g. Membership fees for spas, health clubs, personal trainers, or other such facilities even if medically recommended, regardless of any therapeutic value;
 - h. Personal convenience items such as air conditioners, humidifiers, or exercise equipment;
 - i. Personal services such as haircuts, shampoos, guest meals, and radio or televisions;
 - j. Voice synthesizers or other communication devices, except as specifically allowed by this Plan.
35. **Orthognathic surgery.** This Plan does not cover upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic, congenital or acquired characteristic.
36. **Over the counter products.** This Plan does not cover any items available without a Prescription such as over the counter items and items usually stocked in the home for general use, including, but not limited to, bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This Plan also does not cover laboratory test kits for home use. These include, but are not limited to, home pregnancy tests and home HIV tests.
37. **Post termination Benefits.** Benefits are not provided for care received after coverage is terminated, except as provided in the **YOUR COVERAGE IN THE PLAN** section.
38. **Plan Maximums.** The Plan does not cover charges in excess of any Plan Maximums.
39. **Private Duty Nursing.** The Plan does not cover any services related to private duty nursing, except as provided in the **Home Health Care** or **Hospice Care** sections of **YOUR BENEFITS**.
40. **Private room expenses.** This Plan does not cover services related to a private room, except as provided in the **YOUR BENEFITS** section.
41. **Professional courtesy.** This Plan does not cover charges for services and supplies when You have received a professional or courtesy discount from a Provider. This coverage does not cover any services where Your portion of the payment is waived due to professional courtesy or discount.

GENERAL EXCLUSIONS - Continued

42. **Radiology services.** This Plan does not cover Ultrafast CT scan and peripheral bone density testing, whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy.
43. **Report preparations.** This Plan does not cover charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the Provider when requested by You.
44. **Sex-change operations.** This Plan does not cover services or supplies related to sex-change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation.
45. **Sexual dysfunction.** This Plan does not cover services, supplies, or Prescription drugs for the treatment of sexual dysfunction or impotence.
46. **Taxes.** This Plan does not cover charges for sales, service, or other taxes imposed by law that apply to Benefits covered under this Plan.
47. **Temporomandibular joint surgery or therapy.** This Plan does not cover surgical or non-surgical services, supplies or appliances related to temporomandibular joint therapy or surgery or orthognathic surgery, including invasive (internal) and non-invasive (external) procedures and tests, unless a known, documented, disease of the joint.
48. **Transplants,** except as provided in the Transplants benefit provision. Non-human organs and Experimental, Investigational or Unproven transplant services and supplies, and any transplant expenses which are eligible to be paid under any private or public research fund, government program or other funding program, are not covered.
49. **Travel expenses.** This Plan does not cover travel (other than travel to a Great-West Healthcare Transplant facility for a covered transplant procedure), or lodging expenses for You, Your family or the Physician, except as provided under the **Transplant Services** heading of the **YOUR BENEFITS** section.
50. **Vision.** The Plan does not cover:
- routine eye examinations or routine refractive examinations (except one exam every 12 months if You are covered under the Open Access H (HSA-HDHP) Plan only. Vision Benefits for Members covered by all other Medical Plans are described in the Vision Care Benefits section.);
 - any eyeglasses;
 - Prescriptions for such services and supplies;
 - any surgical, medical, or Hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism;
 - vision therapy, including but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.
51. **War-related conditions.** This Plan does not cover services or supplies necessary to treat Illness or Injury resulting from war, civil war, insurrection, rebellion, or revolution.
52. **Weight-Loss Programs.** The Plan does not cover services related to weight loss, except following Pre-Treatment Authorization, surgical services for Medically Necessary treatment of morbid obesity, up to a lifetime maximum of \$7,500, including charges for complications related to such surgery, as provided in the **YOUR BENEFITS** section.
53. **Workers' compensation.** This Plan does not cover services and supplies for a work-related accident or Illness. See the **ADMINISTRATIVE INFORMATION** section for information.

Medical Assistance

Benefits cannot be denied or reduced solely because You or Your Eligible Dependent are eligible for medical assistance for such expenses under the provisions of the Colorado Medical Assistance Act or the Alternatives to Long Term Nursing Home Care Act (Article 4 or 4.5 of title 26, C.R.S.).

ADMINISTRATIVE INFORMATION

Notice and Proof of Claim

You must give the Plan a written notice of claim within 12 months after a Covered Expense is incurred. If You do not file a proper claim with Great-West Healthcare within 12 months after the date an expense is incurred, the Plan will not pay any Benefits that would otherwise be a Covered Expense.

Within 15 days after the Plan receives the notice of claim, the Plan will send claim forms to You for giving proof of claim. If You do not receive these forms, You will satisfy the proof of claim requirement by giving the Plan a written statement of the nature and extent of the loss within the time limit provided below.

You must give positive proof of claim to the Plan or the Plan's authorized claim office for a medical or health claim within 12 months after a Covered Expense is Incurred.

You must give the Plan proper written notice and proof of loss before the Plan will be liable for any loss. If You send the Plan proof as soon as reasonably possible, the Plan will not reduce or deny claims merely because You cannot reasonably give notice and proof in writing within the time required.

The Plan may, as required by law, accept claims submitted by a third-party custodial parent or a provider (with the custodial parent's approval) for Covered Expenses Incurred by a covered Dependent Child who is also eligible for a state medical assistance program (i.e., Medicaid).

Claims must be submitted to the address shown on Your identification card. The time periods shown under the ***Claim Decisions*** heading of the **COMPLAINTS, CLAIM DECISIONS AND APPEALS** section will begin to apply when the claim is received by the Plan or the Plan's authorized claim office after being filed according to these Notice and Proof of Claim procedures.

Payment of Claims

1. All Benefits due and not validly assigned will be paid to You as soon as the Plan receives due proof.
2. If You die before the Plan Pays all of the Benefits to You, the Plan may pay any remaining Benefits in this order:
 - a. to Your spouse, if living;
 - b. to Your surviving children, in equal shares;
 - c. to Your parents, in equal shares, or to the survivor;
 - d. to Your estate.
3. In any case where the person to whom the Plan would pay Benefits cannot give a valid release, The Plan Will Pay any remaining Benefits in this order:
 - a. to Your spouse, if living;
 - b. to Your surviving children, in equal shares;
 - c. to Your parents, in equal shares, or to the survivor;
 - d. to Your estate.If no person listed above survives You, the Plan may pay Benefits to the person or institution it determines gave You care.
4. The Plan may, to the extent required by law, pay Benefits for claims incurred by a covered Dependent Child directly to a custodial parent, a state agency or a provider.
5. In the case of a minor child who is covered under the Plan, if the child has a representative who is not covered under the Plan, then The Plan Will Pay Benefits on behalf of such child to the representative. The person must submit proof that he or she is the child's representative and that he or she qualifies to be paid the Benefits.

ADMINISTRATIVE INFORMATION - Continued

6. If You use a Network Provider, The Plan Will Pay Benefits, if any, to the provider of service.
7. The Plan may pay Benefits to the person or institution that gave You care.
8. Any payments the Plan makes under the above, will discharge the Plan's liability to the extent of the Plan's payment. The Plan is not responsible for how the Benefits the Plan pays are used.

Legal Actions

You may not sue the Plan for Benefits under the Plan:

1. before 60 days following the date You send the Plan proof of claim;
2. after 3 years following the end of the period required for giving proof of claim.

Assignment of Benefits

You may assign Medical or Health Care Benefits directly to the Physician, Hospital or an appropriate state agency. You can either sign the necessary forms given to You by the provider of services or sign the designated assignment on Your claim form. Otherwise, Benefits will be paid according to the Payment of Claims provision. If You use a Network Provider, The Plan Will Pay Benefits, if any, to the provider of service. The Plan will not be responsible for the validity of any assignment. Nor will the Plan be liable for any action, payment or other settlement made before the Plan receives such assignment.

To the extent permitted by law, neither the Benefits nor payments under the Plan will be subject to the claim of creditors or to any legal process.

Physical Examinations

The Plan may have a Physician of the Plan's choice examine You, at the Plan's expense, as often as is reasonably necessary while Your claim is pending. The Plan may also have an autopsy performed, at the Plan's expense, except if prohibited by law.

Incontestability and Misstatement

The Plan cannot contest Your or Your Dependent's coverage after it has been in effect for two years during Your lifetime unless required Contributions are not paid. However, no provision of this Plan shall make the coverage of an ineligible person valid.

Any statement about Your age made in writing and signed by You may be used to contest Your coverage.

If You misstate Your age, the Plan Will only Pay Benefits based on Your correct age. The Plan will a) adjust required Contributions, b) validate, or c) void coverage as necessary.

Refund to the Plan for Overpayment of Benefits

If You or Your Dependent recovers money for medical, Hospital, dental, Prescription drug or vision Expenses Incurred due to an Illness or Injury for which a Benefit has been paid under the Plan, the Plan will have the right to a refund from You or Your Dependent. The amount refunded to the Plan will be the lesser of:

1. the amount You or Your Dependent recovers;
2. the amount of Benefits the Plan has paid.

ADMINISTRATIVE INFORMATION - Continued

You or Your Dependent (or a parent or legal guardian, if required) will help the Plan do whatever else may be reasonably needed to obtain this refund.

Right of Subrogation

If You or Your covered Dependent has a claim for damages or a right to recover damages from another party or parties for any Illness or Injury for which Benefits are payable under this Plan, the Plan is subrogated to such a claim or right of recovery. The Plan's right of subrogation will be to the extent of any Benefits paid or payable under this Plan, and shall include any compromise settlements. The Plan may assert this right independently of You. Acceptance of Benefits is constructive notice of this provision in its entirety.

If You, or legal representative, Your estate or heir, recovers damages, by settlement, verdict or otherwise, for an Illness or Injury for which a Benefit has been paid under this Plan, You, or legal representatives, Your estate or heirs, agree to promptly reimburse the Plan for Benefits paid. The Plan's right to receive reimbursement applies to Your recovery from any source, including but not limited to, any party's liability and medical pay insurance, uninsured and underinsured motorist coverage, no-fault automobile coverage and Workers' Compensation coverage.

The Plan will have a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that You receive or is entitled to receive from any source, regardless of whether You receive a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of medical expenses paid under this Plan. The Plan's first priority rights will not be reduced due to Your own negligence.

The Plan is entitled to reimbursement even if You are not made whole or fully compensated by the recovery. Any share of attorney fees or costs or Common Fund fees shall not reduce the Plan's recovery unless agreed to by the Plan in writing.

If the Injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of whether the minor's representative has access to or control of any recovery funds.

The Member (or parent or legal guardian) will cooperate with the Plan and the Plan's agents and help the Plan do what may be reasonably needed to protect the Plan's subrogation rights and obtain the refund. This includes furnishing all relevant information, making assignments in the Plan's favor and signing and delivering any documents needed to protect the Plan's rights. The Member shall not take any action that prejudices the Plan's rights.

No Member shall make any settlement which specifically reduces or excludes, or attempts to exclude, the Benefits provided by the Plan.

If the Member makes a recovery from any source and fails to reimburse the Plan the lesser of:

1. the amount recovered, (including amounts to be recovered through future installment payments);
2. the amount of Benefits paid related to this Illness or Injury,

the Member will be personally liable to the Plan for this amount. The Plan may also offset future Benefits up to the amount due to the Plan.

The terms of this subrogation and right of reimbursement provision shall apply regardless of state laws to the contrary.

COORDINATION OF BENEFITS

Warning: If You are insured under a separate group medical policy or plan, You may be subject to Coordination of Benefits, as explained in this Booklet.

If this is not Your only Health coverage, the Benefits payable under this Plan, and any other group plan for the Allowable Expenses Incurred during any Benefit Determination Period will be coordinated so that the combined Benefits paid or provided by all plans will not exceed 100% of such Allowable Expenses.

You must inform the Plan if You have other coverage (for example, through Your spouse's employer), and give Your consent to the release of information so that the Plan may use this provision. You should first file Your claim with the primary plan (as determined below). When the claim is paid, send a copy of the charges and a copy of the Explanation of Benefits Statement from the first plan to the secondary plan (as determined below). This will accelerate the processing of Your claim.

One of Your Plans will be determined to be primary (using the rules below). The primary plan pays its full benefits first. The plan paying second takes the benefits of the primary plan into account when it determines its benefits.

A plan is primary when:

1. the plan does not have a COB provision;
2. the plan designates itself as an "excess" or "always secondary" plan;
3. if both plans have a COB provision, under the rules it is determined to be primary.

When both plans have a COB provision, the order in which the plans provide benefits is determined using the first of the following rules which applies:

1. **Employee/Dependent.** The plan that covers the person as an active Employee is primary. If You or Your Dependent is also covered by Medicare, the plan covering the person as an active Employee is primary, the plan covering the person as a Dependent of an active Employee is secondary, and then Medicare.
2. **Dependent children.**
 - a. If the parents are not separated or divorced, the plan that covers the parent whose birthday (month and day) falls earlier in the calendar year is primary. If both parents have the same birthday (month and day), the plan that covered the parent longer is primary. If the other plan does not have the "Birthday Rule", the rule in the other plan will determine the primary plan.
 - b. If the parents are separated or divorced, the plan that covers the natural parent with custody is primary; followed by the plan which covers the step-parent who has married the natural parent with custody; and finally, the plan which covers the natural parent without custody.

However, if the court decrees one of the parents responsible for health care expenses, the plan that covers that parent is primary.

If the decree names the parent other than the natural parent with custody, the Plan must be notified and have actual knowledge of those terms. Any Benefits paid prior to actual knowledge will not be affected. The plan of the other parent and the plan of the spouse of the parent with custody will be secondary and third, respectively.

If joint custody is granted by the court, the rules pertaining to parents who are not separated or divorced apply.

3. **Active/inactive Employee.** The plan covering the Employee who is neither laid off nor retired is primary. If the other plan does not have this rule, this rule is ignored.

COORDINATION OF BENEFITS - Continued

4. **Continuation coverage.** Continuation coverage provided under either federal or state law is secondary. If the other plan does not have this rule, this rule is ignored.
5. **Length of coverage.** If the primary plan cannot be determined using any of the rules above, the plan which has covered the person for the longest period of time will be considered primary.

If this Plan is determined to be secondary, the Plan will reduce Benefits payable so that the total benefits provided by all plans during a claim determination period are not more than the total Allowable Expenses for the Member.

The actual benefit amounts available are determined by each plan's benefit provisions. Benefits payable under this Plan will never exceed the amount that would have been paid if there were no other plans involved. If Benefit payments under this Plan are reduced by COB, only the reduced amounts will be charged against Your Plan maximums.

If during Coordination of Benefits, payments are made in error, the plans will have the right to adjust payments among themselves. Such payments satisfy the Plan's liability. If the Plan overpays a claim, the Plan will have the right to recover such overpayments from any person for, to whom, or with respect to whom such payments were made, any other insurance company, or any other organization.

Definitions

An "Allowable Expense" is the Reasonable and Customary amount for any necessary medical, dental, vision, or health care service that is covered (at least in part) by one of the plans. It does not include Prescription Drugs covered under Your Prescription Drug Benefits. If a health plan provides services (rather than cash payments) a dollar value will be assigned in order to use this provision.

When the primary plan penalizes You for not complying with plan provisions, such as failing to pre-certify, the amount of the reduction is not considered an Allowable Expense.

A "Benefit Determination Period" means a Plan Year, as determined by Your Employer.

A "plan" as used in this provision, is any of the following that provides health benefits or services:

1. a group or group blanket plan on an insured basis;
2. other plans which cover people as a group;
3. a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. a pre-payment plan which provides medical, vision, dental or health service;
5. government plans, except Medicaid;
6. group auto insurance, but only to the extent medical benefits are payable under group auto insurance;
7. no-fault auto insurance on an individual basis, except where not allowed by the state in which this Plan is issued;
8. single or family subscribed plans issued under a group or blanket type plan;

but, the definition of plan shall not include:

1. Hospital indemnity type plans;
2. school accident-type coverage.

COORDINATION OF BENEFITS - Continued

Medicare

This section applies to a Member who is eligible for Medicare coverage. It provides rules for determining the order of benefit payments between coverage under this Plan and those of Medicare. The intent of this section is to conform the Plan to the requirements of the federal Medicare Secondary Payer law. Accordingly, the section and its stated rules will be adjusted, if the Plan deems necessary, so that the Plan's liability for Benefit payment is neither greater nor less than those required under the law.

1. If, pursuant to the rules:
 - a. this Plan is determined to be secondary to Medicare, it will pay secondary to and coordinate its Benefits with Medicare;
 - b. this Plan is determined to be primary to Medicare, it will pay Benefits without regard to Medicare benefits.
2. The order of benefit payments rules is outlined below.

a. Rules applicable to a person covered under the Plan by virtue of that person's "Current Employment Status" with an Employer or as a Dependent of such person:

Basis of Medicare Eligibility:

This Plan Will:

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> - Attaining age 65* (or age as determined by the Federal Government) - Disability (other than ESRD) - End Stage Renal Disease (ESRD) - Attaining age 65 (or age as determined by the Federal Government) or Disability, preceding or beginning concurrently with ESRD | <ul style="list-style-type: none"> Be primary. Be primary. Be primary for the first 30 months of ESRD Medicare coverage, be secondary thereafter. Continue to be primary until the end of the first 30 months of ESRD Medicare coverage; be secondary thereafter. |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*If a Member elects to have Medicare as primary coverage, such person's Health Care coverage (including any Prescription Drug coverage), under this Plan will terminate. If the Employee's Health Care coverage terminates in accordance with this provision, coverage on the Employee's covered Dependents will cease on the same date.

b. Rules applicable to a person covered under the Plan on any basis other than those stated in 2.a. above (including but not limited to COBRA participants):

Basis of Medicare Eligibility:

This Plan Will:

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> - Attaining age 65* (or age as determined by the Federal Government) - Disability (other than ESRD) - End Stage Renal Disease (ESRD) - Attaining age 65 (or age as determined by the Federal Government) or Disability, preceding ESRD | <ul style="list-style-type: none"> Be secondary. Be secondary. Be primary for the first 30 months of ESRD Medicare coverage, be secondary thereafter. Continue to be secondary. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

For purposes of this section, "Current Employment Status": a person is considered to have Current Employment Status with an Employer if the person is an Employee, is the Employer (including self-employed person), or is associated with the Employer in a business relationship.

REMEMBER: The Medicare section outlined above applies from the date a Member is first eligible for Medicare (either Part A or Part B), whether or not the Member is Enrolled and is receiving Medicare benefits.

COMPLAINTS, CLAIM DECISIONS AND APPEALS

This section explains what to do if You disagree with Great-West Healthcare's denial, in whole or in part, of a claim, requested service or supply and includes instructions on initiating a complaint, claim decisions and filing an appeal with Great-West Healthcare.

Complaints

If You have a complaint about any aspect of Great-West Healthcare's service or claims processing, You should contact the Great-West Customer Service Department at **1-888-ST8-OFCO** or **1-888-788-6326**. A representative will work to clear up any confusion and resolve Your concerns. You may submit a written complaint to the address listed below. If You are not satisfied with the resolution of Your concerns by the Great-West Customer Service associate, You may file an appeal, as explained under the heading **Appeals Process**, in this section.

Great-West Life & Annuity Insurance Company
Kennett Mail Center
1000 Great-West Drive
Kennett, Missouri 63857

Claim Decisions

Decisions on medical claims will be made within 30 days of the date the Plan receives the claim. If a decision cannot be made for reasons beyond control of the Plan, the Plan will notify You of:

1. the reason for the delay;
2. any information needed to perfect the claim;
3. the date by which the Plan expects to make a decision.

You will have 45 days from the date You receive the notice to provide the requested information. If the Plan receives the necessary information within the 45-day time frame, a decision will be made within 15 days of the Plan's receipt of the information, unless You agree to a longer period of time. If You do not provide the requested information within this time period, You should consider the claim to be denied. This denial will be reconsidered if the information is subsequently received.

Decisions on claims involving Pre-Treatment Authorization, Concurrent Review or Retrospective Review will be made in accordance with the procedures shown under the **MANAGED CARE FEATURES** section.

Appeals Procedure for Pre-Treatment Authorization, Concurrent Review or Retrospective Review

In the event that a request for Pre-Treatment Authorization or Concurrent Review or Retrospective Review is denied in whole or in part, You will be notified in writing of the following:

1. the reason for denial;
2. specific reference to the Plan provisions on which the denial was based;
3. any additional material or information needed for further review of the claim;
4. an explanation of the Plan's review procedure and time limits;
5. with respect to medical claims the specific rule, guideline, protocol or similar criterion, or other relevant information if any, that was relied upon in deciding the claim, or a statement that such was relied upon and is available upon request;
6. with respect to medical claims, an explanation of the scientific or clinical judgment for determining a denial based on a medical judgment, Medical Necessity, or treatment that is Experimental, Investigational or Unproven, or a statement that such explanation is available free of charge upon request.

COMPLAINTS, CLAIM DECISIONS AND APPEALS - Continued

This denial is called an Adverse Determination. "Adverse Determination" means that Your Hospital admission, continued Hospital stay or other health care service has been reviewed and, based upon the information provided, does not meet Great-West's Medical Outreach Department's requirements for being Medically Necessary, Appropriate, effective or in the proper setting and may result in a denial of coverage for the health care service.

First Level Appeal

If You or Your Physician acting on Your behalf, or other Authorized Representative do not agree with an Adverse Determination, You or Your Physician acting on Your behalf or other Authorized Representative may initiate an appeal by telephoning, faxing or submitting a written request to Great-West's Medical Outreach Department. Additional evidence may be presented for consideration on appeal. Initial appeal requests must be received within 180 calendar days of the initial Adverse Determination. The address to which to send an appeal and any other contact information will be included with the notice of Adverse Determination.

"Authorized Representative" means the Member's Spouse, parent (if the Member is a minor), legal counsel, or any person who submits proof that he or she has been designated by the Member or a court of law to act on such person's behalf. It will also include Your Physician or Hospital for the purposes of requesting Pre-Treatment and Concurrent Review Authorizations, and submitting claims and appeals on Your behalf.

In connection with the Plan's review of the appeal, You have the right to 1) see the Plan and other relevant papers affecting the claim, 2) argue against the Adverse Determination, 3) have a representative act on Your behalf in the appeal. All comments, documents, records and other information submitted in connection with the claim being reviewed will be considered.

There are two types of First Level Appeals, a Standard First Level Appeal and an Expedited First Level Appeal.

Standard First Level Appeal

Within 15 days of receiving the appeal request, Great-West's Medical Outreach Department will notify the person who submitted the appeal of its decision in writing. The appeal will be reviewed by a Physician who:

1. has appropriate training and experience in the field of medicine involved in the medical judgment;
2. was not previously involved with the Adverse Determination;
3. is not the subordinate of the person previously involved with the Adverse Determination.

Expedited First Level Appeal

If the Standard Appeal process would place Your life or health in serious jeopardy or Your ability to regain maximum function would be jeopardized, a request for an Expedited First Level Appeal may be phoned in by You, a Physician with knowledge of Your medical condition or other Authorized Representative (if any). Great-West's Medical Outreach Department will conduct the review by telephone or through the exchange of written information. You, Your Authorized Representative (if any), and Your Physician will be informed of the decision by telephone or fax within 72 hours of Great-West's Medical Outreach Department's receipt of the appeal request.

The appeal will be reviewed by a Physician who:

1. has appropriate training and experience in the field of medicine involved in the medical judgment;
2. was not previously involved with the Adverse Determination;
3. is not the subordinate of the person previously involved with the Adverse Determination.

COMPLAINTS, CLAIM DECISIONS AND APPEALS - Continued

Voluntary Second Level Appeal

If you disagree with the First Level Appeal Decision, you have two choices. You may appeal a First Level Appeal Decision that was a result of the Standard or Expedited Appeal either by requesting an External Review or by making a written request to appear in person utilizing the Voluntary Second Level Appeal process. This voluntary appeal is available if You desire to have the opportunity to explain your grievance and to provide additional relevant evidence in support of your claim for benefits in person or by telephone conference call. You must notify Great-West's Medical Outreach Department of Your desire to pursue a Voluntary Second Level Appeal within 30 calendar days from Your receipt of the First Level Appeal Decision. The Voluntary Second Level Appeal will be handled by a physician, with appropriate expertise, who was not previously involved in the appeal and who does not have a direct financial interest in the appeal or the outcome of the appeal.

Great-West's Medical Outreach Department will schedule, hold and complete the Voluntary Second Level Appeal on a mutually agreeable date within 30 calendar days of receipt of Your request for a Voluntary Second Level Appeal, providing You with at least 10 calendar days advance notice of the review date. You may request a one-time, additional 30 calendar days to schedule the review if needed. Upon receipt of your request to schedule a Voluntary Second Level Appeal, Great-West will assign a member liaison who will assist you with the logistics of scheduling the appeal and walk you through the process.

You may be present, either in person or by telephone conference, and may bring legal counsel, advocates and/or health care professionals to the Voluntary Second Level Appeal to assist you in presenting Your appeal. Great-West's Medical Outreach Department and You must provide a copy of the materials to be presented at the appeal to the other party, upon request, at least three calendar days prior to the appeal, or as soon as is practicable for materials developed after the three day deadline. Great-West's Medical Outreach Department will make an audio and a video recording of the review, unless both You and Great-West's Medical Outreach Department agree to forego the video recording. The Voluntary Second Level Appeal determination will be rendered in writing within seven (7) calendar days of the review date.

Any Adverse Voluntary Second Level Appeal Determination may then be sent to the External Appeal step as described below. You or Your Authorized Representative must file this appeal within 60 calendar days after the denial from the Voluntary Second Level Appeal.

External Appeal

You or Your Physician or other Authorized Representative may initiate an External Appeal of an Adverse Determination by submitting a written request to Great-West's Medical Outreach Department within 60 calendar days of the date you received either the Adverse First Level Appeal Decision, or the Voluntary Second Level Appeal Decision if You exercised this optional appeal. An independent external reviewer will evaluate all relevant information and render a decision whether the particular item or service is Medically Necessary, Experimental, Investigational or Unproven. Great-West is required to provide the independent external reviewer all information used in its determination, including all information and supporting documents submitted by You, Your Physician, or other Authorized Representative, and copies of all denial notices. Upon Your request, Great-West shall provide a copy of all information supplied to the independent external reviewer. The written decision will be rendered within 15 calendar days of the date Great-West's Medical Outreach Department receives the appeal request. Decisions regarding a First Level Expedited Appeal Decision will be rendered within a time frame appropriate to the medical condition of the patient. The decision will be in writing and contain the content noted above for the six items in the Adverse Determination. The determination will also include the title and the credentials of the person(s) conducting the review.

The External Appeal is the final appeal under the Plan and there are no other appeal rights available with respect to the Pre-Treatment Authorization, Concurrent Review or Retrospective Review for Medical Necessity. Great-West Healthcare follows the determination of the external reviewer.

COMPLAINTS, CLAIM DECISIONS AND APPEALS - Continued

Appeals Procedure for Claim Denials

In the event a claim (other than a request for Pre-Treatment Authorization or Concurrent Review) is denied in whole or in part, You will be notified in writing of the following:

1. the reason for denial;
2. specific reference to the Plan provisions on which the denial was based;
3. any additional material or information needed for further review of the claim;
4. an explanation of the Plan's review procedure and time limits;
5. with respect to medical claims the specific rule, guideline, protocol or similar criterion, if any, that was relied upon in deciding the claim, or a statement that such was relied upon and is available upon request;
6. with respect to medical claims, an explanation of the scientific or clinical judgment for determining a denial based on a medical judgment, Medical Necessity, or treatment that is Experimental, Investigational or Unproven, or a statement that such explanation is available free of charge upon request.

If a claim is denied in whole or in part, You, Your Physician or other Authorized Representative may appeal the denial by making a written request for review to the Plan within:

1. 180 days of the time You receive the notice of denial of the initial claim, or within 60 days of the time You receive the notice of denial of a first appeal with respect to medical claims;
2. 60 days of the time You receive the denial notice of a second appeal for the purpose of submitting a voluntary appeal.

In connection with the Plan's review of the appeal, You have the right to 1) see the Plan and other relevant papers affecting the claim, 2) argue against the denial in writing, 3) have a representative act on Your behalf in the appeal. All comments, documents, records and other information submitted in connection with the claim being reviewed will be considered.

The decision on the appeal shall be in writing, and shall be made within 30 days of the date the Plan receives the request for review with respect to medical claims.

The decision shall include specific reasons for the denial, written in a manner understandable to You and contain specific reference to the pertinent Plan provisions on which the decision was based.

With respect to medical claim reviews, the review will be conducted by someone other than the person who made the initial determination. If the initial denial was based on a medical judgment, Medical Necessity or treatment that is Experimental, Investigational or Unproven, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted. If the claim is still denied in whole or in part, You will again be advised of items 1 through 6 above of the Claim Denials procedure along with Your right to request information regarding any voluntary appeals provided under Your Plan once the required appeals have been exhausted.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is presented. Voluntary appeals are not applicable to decisions involving medical judgment, Medical Necessity or treatment considered to be Experimental, Investigational or Unproven. You may request information regarding voluntary appeals procedures.

GENERAL DEFINITIONS

This section defines words and terms used throughout the Booklet to help You understand the content. You should refer to this section to find out exactly how, for the purposes of this Booklet, a word or term is used.

1. **Active Work:** means You work for Your Employer at his/her place of business (or such other places as required by Your Employer) in accordance with his/her established employment practices.
2. **Acupuncture:** means the treatment of a disease or condition by inserting special needles along specific nerve pathways for therapeutic purposes. The placement of the needles varies with the disease or condition being treated.
3. **Acute Care:** means care that is provided in an office, Urgent Care setting, Emergency Room or Hospital for a medical illness, accident or injury. Acute Care may be emergency, urgent or non-urgent, but is not primarily preventive in nature.
4. **Ambulance:** means a specifically designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an Ambulance.
5. **Ancillary Services:** means services and supplies (in addition to room services) that Hospitals and other facilities bill for and regularly make available for the treatment of Your condition. Such services include, but are not limited to:
 - a. Use of operating room, recovery room, emergency room, treatment rooms and related equipment;
 - b. Drugs and medicines, biologics (medicines made from living organisms and their products), and pharmaceuticals;
 - c. Dressings and supplies, sterile trays, casts, and splints;
 - d. Diagnostic and therapeutic services;
 - e. Blood processing and transportation and blood handling costs and administration.
6. **Anesthesia:** means the loss of normal sensation or feeling. There are two different types of Anesthesia:
 - a. General Anesthesia, also known as total body Anesthesia, causes the patient to become unconscious or "put to sleep" for a period of time;
 - b. Local Anesthesia causes loss of feeling or numbness in a specific area usually injected with a local anesthetic drug such as Lidocaine.
7. **Approved Unpaid Leave of Absence:** means a leave of absence period approved by the Employer pursuant to the Family and Medical Leave Act of 1993, or other applicable leave rules that apply to the Employer.
8. **Associated Company:** means those under common control through stock ownership, contract or otherwise with Your Employer as named in the Plan.
9. **Average Semiprivate Room Charge:** means a) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one level of such charges, or b) 80% of the Hospital's lowest charge for single bed room and board accommodations when the Hospital does not provide any semiprivate accommodations.
10. **Benefit(s):** means the amount The Plan Will Pay for Covered Expenses after You or Your covered dependents have met the Deductible and/or Copayment, if any.

GENERAL DEFINITIONS - Continued

11. **Benefit Period:** means the number of days or units of service, such as two office visits per Plan Year, for which the Plan will provide Benefits during a specified length of time.
12. **Billed Charges:** means a provider's regular charges for services and supplies, as offered to the public generally and without any adjustment for any applicable Network, Network Provider or other discounts.
13. **Birth Abnormality:** means a condition that is recognizable at birth, such as a fractured arm.
14. **Birthdate Rule** — the guideline that determines which of two parents' health coverage is primary for the coverage of Dependent Child(ren). Generally, under the Birthdate Rule, the parent whose birthday comes first during the year is considered to have the primary coverage for the child(ren). Any balance may be submitted to the other parent's insurance carrier for additional consideration.
15. **Booklet:** means this document, which explains the Benefits, limitations, exclusions, terms and conditions of the health coverage.
16. **Chemotherapy:** means drug therapy administered as treatment for malignant conditions and diseases of certain body systems.
17. **Chronic Medical Condition:** means an illness for which there is no cure; however, medical treatment is available. It is a long-term illness that does not ordinarily pose an immediate threat to one's life. Chronic Medical Conditions covered under the Member Disease Management program may include, but are not limited to, diabetes, asthma or cardiac conditions.
18. **COBRA:** means an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law allows individuals, in certain cases, to continue their group health coverage for a specified period after termination of their employment for other qualifying events.
19. **Coinsurance:** means a provision under which You and Great-West Healthcare share costs incurred after the Deductible is met, according to a specific formula. The amount of Coinsurance You pay to a provider is calculated as a percentage of the Maximum Benefit Allowance. Coinsurance payments apply toward any Out-of-Pocket Maximum Amounts.
20. **Complications of Pregnancy:** means a disease, disorder or condition which is diagnosed as distinct from normal pregnancy but adversely affected by or caused by pregnancy. This includes:
 - a. inter-abdominal surgery, including cesarean section;
 - b. pernicious vomiting (hyperemesis gravidarum);
 - c. toxemia with convulsions (eclampsia);
 - d. extra-uterine pregnancy (ectopic);
 - e. postpartum hemorrhage;
 - f. rupture or prolapse of the uterus;
 - g. spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible;
 - h. similar medical and surgical conditions of comparable severity.Complications of Pregnancy will not include:
 - a. elective abortion;
 - b. false labor;
 - c. occasional spotting;
 - d. Physician prescribed rest;
 - e. morning sickness;
 - f. similar conditions associated with the management of a difficult pregnancy.

GENERAL DEFINITIONS - Continued

Services and supplies rendered at the termination of pregnancy will not be considered treatment of Complications of Pregnancy.

21. **Congenital Defect:** means a defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.
22. **Contributions:** mean the amount You are required to pay for the coverage provided under the Plan.
23. **Copayment:** means that portion of covered services, usually a flat dollar amount, that You are required to pay out of Your pocket before The Plan Will Pay Benefits for any remaining portion up to the Maximum Benefit Allowance. Copayments do not apply toward any Out-of-Pocket Maximum Amounts.
24. **Cosmetic Services:** means beautification procedures, services or surgery of a physical characteristic to improve an individual's appearance.
25. **Cost Sharing:** means the general term for out-of-pocket expenses, e.g., Copayments, Deductibles and Coinsurance paid by You.
26. **Covered Expense:** means a listed Covered Expense under a Benefit description that will be paid under the Plan if it is:
 - a. prescribed by a Physician for the therapeutic treatment of Injury, Illness, or pregnancy;
 - b. Medically Necessary except for services and/or supplies provided under the Member Care Management Program;
 - c. not more than what the Plan determines as Reasonable and Customary;
 - d. not excluded under any exclusions of the Plan.

If You use a Network Provider, Covered Expense means the agreed upon rate set between the Plan and such provider for services which meet all of the above standards.

27. **Creditable Coverage:** means any of the following coverages a Covered Person had prior to enrollment under the Plan:
 - a. a group health plan;
 - b. health insurance coverage, individual and group, including coverage through a Health Maintenance Organization (HMO);
 - c. Medicare;
 - d. Medicaid;
 - e. TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families;
 - f. a medical care program of the Indian Health Service or of a tribal organization;
 - g. a state health risk pool;
 - h. a health plan offered under the Federal Employee Health Benefits Program;
 - i. a public health plan established or maintained by a political subdivision of a state to provide insurance coverage;
 - j. a State Children's Health Insurance Program (S-CHIP).
28. **Cryocuff:** means water-circulating pad with pump. A machine that circulates fluid through a specially designed pad to provide continuous cold or heat therapy to a specific area.

GENERAL DEFINITIONS - Continued

29. **Custodial Care:** means services, provided by a licensed, skilled nurse or a non-skilled person, for:
- a. a person with a Chronic Medical Condition;
 - b. a convalescent person.

This care basically provides assistance to a person in daily living; it does **not** require technical skills or qualifications. This care is not reasonably expected to improve the underlying medical condition of a person even though it may relieve symptoms or pain.

Custodial Care includes, but is not limited to:

- a. help in grooming, bathing, dressing, walking;
- b. help in getting in and out of bed;
- c. help in housekeeping, preparing meals, and eating;
- d. giving or helping to use or apply medications, creams and ointments;
- e. administering medical gasses after a therapy program has been set up;
- f. changing dressings, diapers and protective sheets;
- g. periodic turning and positioning in bed;
- h. routine care of casts, braces and other like devices;
- i. routine care of colostomy and ileostomy bags;
- j. routine tracheostomy care;
- k. routine care of catheters and other like equipment;
- l. supervising exercise programs that do not need the skills of a therapist.

Care that does require the technical skills of a licensed medical professional, who is acting within the scope of his/her license, is not considered to be Custodial Care.

30. **Deductible:** means that portion of Covered Expenses You are required to pay out of Your pocket each Plan Year before The Plan Will Pay Benefits for any remaining portion up to the Maximum Benefit Allowance. The Deductible applies toward any out-of-pocket maximum amounts.
31. **Dental Services:** means services performed for treatment of conditions related to the teeth or structures supporting the teeth.
32. **Disabled:** means that due to Illness or Injury You cannot perform the material and substantial duties of Your regular occupation or Your covered Dependent cannot perform normal activities, except as provided elsewhere in the Plan.
33. **Discharge Planning:** means the evaluation of Your medical needs and arrangement of appropriate care after discharge from a facility.
34. **Durable Medical Equipment:** means any equipment that can withstand repeated use, is made to serve a medical condition, is useless to a person who is not ill or Injured, and is appropriate for use in the home.
35. **Effective Date:** means the date coverage under this Booklet begins.
36. **Emergency Medical Condition:** means the sudden onset of a health condition that manifests itself by symptoms of sufficient severity, including severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required and that lack of such care could reasonably be expected to result in:
- a. placing the patient's health in serious jeopardy;
 - b. serious impairment of bodily functions;
 - c. serious dysfunction of any bodily organ or part;
 - d. with respect to a pregnant woman, placing the woman's health, or that of her unborn child, in serious jeopardy.

GENERAL DEFINITIONS - Continued

37. **Employer:** means the entity to which the Plan is issued and includes any affiliated entities or subsidiaries or Associated Companies shown in the Eligible Class or Classes section of the Group Plan.
38. **Enroll:** means completion of all forms required for coverage under the Plan and agreement to make any required Contribution.
39. **Expense Incurred:** means the date the care, service or supply is provided and received.
40. **Experimental, Investigational or Unproven:** means a service or supply (such as medication) that meets any of the following criteria:
- a. for a service or supply that is subject to Federal Drug Administration (FDA) approval:
 - i. it does not have FDA approval; or
 - ii. it has FDA approval, but it is being used for an indication or at a dosage that is not an Accepted Off-Label Use.

An "Accepted Off-Label Use" is a use that is:

 - a) established based on reliable evidence as defined in this provision; or
 - b) is included and favorably recognized for treatment of the indication in at least one of the following publications: DrugDex, Drug Facts and Comparisons, Clinical Pharmacology or other established reference compendia as designated by Great-West's Medical Outreach Department, and the data are sufficiently conclusive as to efficacy to allow recognition of the off-label use; or
 - b. is being provided pursuant to Phase I, II, III or IV clinical trials, unless in the case of Phase III or Phase IV clinical trials is provided in accordance with the clinical trials coverage described in the Plan; or
 - c. is being provided pursuant to a written protocol that describes among its primary objectives determination of maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
 - d. is being provided pursuant to a written informed consent used by the treating provider that refers to the service or supply as Experimental, Investigational or Unproven or for research; or
 - e. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the Department of Health & Human Services (HHS) and the FDA; or
 - f. based upon review and analysis of the published peer-reviewed medical literature, the weight of the evidence demonstrates that it is the predominant opinion of independent experts that the service or supply:
 - i. is substantially confined to use in research settings; or
 - ii. is subject to further research studies, or clinical trials, in order to determine maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
 - iii. is Experimental, Investigational or Unproven; or
 - g. is not a covered service or supply as defined under Medicare because it is considered investigational or experimental as determined by HHS/Centers for Medicare & Medicaid Services (CMS); or
 - h. is not currently the subject of active investigation because prior investigations and/or studies have failed to establish proven efficacy and/or safety.

GENERAL DEFINITIONS - Continued

In making the determination whether a service or supply is Experimental, Investigational or Unproven, Great-West's Medical Outreach Department reserves the right to certify coverage of a service or supply, notwithstanding that the service or supply meets one of the above criteria, if there is reliable evidence as defined in this provision, that would support use of the service or supply as efficacious in the unique circumstances present in a particular case.

For these purposes, "reliable evidence" means evidence of all of the following:

- a. there are at least two articles in peer-reviewed U.S. scientific medical or pharmaceutical publications supporting the use of the service or supply outside the investigational setting; and
 - b. the published articles evidence a well-designed investigation that has been reproduced by non-affiliated authoritative sources with measurable, clinically meaningful results; and
 - c. the investigation evidences that the probable benefits of using the service or supply in the unique circumstances in the particular case in question outweigh the risks associated with such use in situations where conventional alternatives have not or would not be efficacious.
41. **Explanation of Benefits:** means a printed form (also known as an "EOB") sent by Great-West Healthcare to a Member after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of provider, amount covered and patient balance. An explanation of Medicare Benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.
42. **Family Membership:** means a membership that covers two or more persons (You and one or more Dependents).
43. **Foster Child:** means a child who is placed with You in Your home by a social service agency that retains control of the child.
44. **Full-Time or Part-Time Basis:** means You work Your full number of hours for Your full rate of pay as required by Your Employer.
45. **Health Plan Description Form:** means the forms found in the front of the Booklet, which identify the type of coverage, Copayment, Deductible and Coinsurance information.
46. **Holistic Medicine:** means various preventive and healing techniques, that are theoretically based on the influence of the external environment and the various ways different body tissues affect each other along with the body's natural healing powers.
47. **Home Health Care Agency:** means a home health service or agency operating under a valid certificate of approval issued under the statutes of the state where services are provided.
48. **Hospice:** means an agency that provides counseling and incidental medical services and may provide room and board to a terminally ill person and meets all of the following tests:
- a. it has obtained any required governmental Certificate of Need approval;
 - b. it provides service for a period of 24 hours per day on every day of the week;
 - c. it is operated under the direct supervision of a duly qualified Physician;
 - d. it has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience, at least two of which involved caring for terminally ill patients;
 - e. it has a social service coordinator who is licensed in the jurisdiction in which it is located;
 - f. it is an agency that has as its primary purpose the provision of Hospice services;

GENERAL DEFINITIONS - Continued

- g. it has a full-time administrator;
- h. it maintains written records of services provided;
- i. its Employees are bonded, and it provides malpractice and malplacement insurance;
- j. it is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law.

49. **Hospital:** means a place that meets all of the standards below:

- a. has permanent and full-time care for bed patients;
- b. is under the supervision of a Physician;
- c. has an R.N. on duty or call 24 hours a day;
- d. is mainly engaged in giving medical care and services for Injuries or Illness but not including:
 - i. rest homes;
 - ii. nursing homes;
 - iii. convalescent homes;
 - iv. homes for the aged;
- e. has surgical facilities except that this standard does not apply to such place operated mainly for treatment of the chronically ill;
- f. is operated lawfully in its area.

"Hospital" also means a place that is mainly engaged in treating Drug and Alcohol Disorders, if it meets the standards below:

- a. has permanent and full-time care for at least 15 bed patients;
- b. has a Physician in regular attendance;
- c. provides 24 hour per day care by R.N.s;
- d. has a full-time psychiatrist or psychologist on the staff.

Hospital also means and will include an "Ambulatory Surgical Center" which meets all of the standards below:

- a. is a licensed public or private place;
- b. has an organized medical staff of Physicians;
- c. has permanent facilities that are equipped and operated mainly for doing surgery and giving skilled nursing care;
- d. has R.N. services when a patient is in the facility;
- e. does not provide services or beds for patients to stay overnight.

50. **Illness:** means an Injury, a sickness, a disease, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

51. **In-Network:** means a term for providers or facilities that enter into a network agreement with Great-West Healthcare.

52. **Injury:** means a sudden and unforeseen event from an external agent or trauma, resulting in Injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

GENERAL DEFINITIONS - Continued

53. **Intensive Care:** means care to critically ill patients, with special supplies and equipment available for immediate use, providing room and board and bedcare under the constant watch of a highly trained Hospital staff. Normal post-operative or recovery room care is not Intensive Care no matter where located.
54. **Late Enrollee:** means an Eligible Employee or Dependent who requests Enrollment in the Employer's health Benefit plan other than during the initial enrollment period, during an Open Enrollment period or during the Qualified Change in Status Periods provided under the terms of the Plan.
55. **L.P.N.:** means a licensed practical nurse acting in the scope of his/her license.
56. **L.V.N.:** means a licensed vocational nurse acting in the scope of his/her license.
57. **Laboratory and Pathology Services:** means testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material that has been removed from the body.
58. **Long-Term Acute Care:** means an institution that provides an array of long term critical care services to Members with serious Illnesses or Injuries. Long-Term Acute Care (LTAC) is provided for patients with complex medical needs. These include high-risk pulmonary patients with ventilator or tracheotomy needs, medically unstable Members, extensive wound care or post operative surgery wound Members, and low level closed head Injury Members. LTAC facilities do not provide care for low intensity patient needs.
59. **Maternity Services:** means services required by a Member for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:
- a. normal vaginal delivery;
 - b. cesarean section delivery;
 - c. spontaneous termination of pregnancy prior to full term;
 - d. therapeutic or elective termination of pregnancy prior to viability;
 - e. Complications of Pregnancy.
60. **Maximum Benefit Allowance:** means the maximum dollar amount determined and approved by Great-West Healthcare which Great-West Healthcare allows for covered services and procedures. Great-West Healthcare's determination of a Maximum Benefit Allowance is the maximum amount Great-West Healthcare approves for any particular service. Cost Sharing amounts are based on this allowance and are the amounts the Member pays to a Provider.
61. **Maximum Medical Improvement:** means a determination at Great-West Healthcare's sole discretion that no further medical care can reasonably be expected to measurably improve Your condition. Maximum Medical Improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life sustaining.
62. **Medical Necessity/Medically Necessary:** means health care services and supplies such as medication, that a Physician, exercising prudent clinical judgment, provides to a Member for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease, or its symptoms, and are:
- a. In accordance with generally accepted standards of medical practice; and
 - b. Clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Member's Illness, Injury or disease; and

GENERAL DEFINITIONS - Continued

- c. Not deemed to be cosmetic or Experimental, Investigational or Unproven as defined in the Plan; and
- d. Specifically allowed by the licensing statutes which apply to the Physician who provides the service or supply; and
- e. At least as medically effective as any standard care and treatment; and
- f. Not primarily for the convenience, psychological support, education or vocational training of the Member, Physician or other health care provider; and
- g. Not more costly than an alternative service, supply or sequence of services and supplies and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means the:

- a. Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- b. Recommendations of an American Medical Association-recognized Physician specialty society;
- c. Prevalent practices of Physicians in the relevant clinical area; or
- d. Any other relevant factors.

Great-West's Medical Outreach Department may require satisfactory proof in writing that any type of treatment, service or supply received is Medically Necessary. Medical Necessity will be determined solely by Great-West's Medical Outreach Department, in accordance with the definition above.

- 63. **Medical Supplies:** means items (except Prescription drugs) required for the treatment of an Illness or Injury.
- 64. **Medicare:** means the plan of Benefits provided by Title XVIII of the U.S. Social Security Act of 1965 as amended from time to time.
- 65. **Member:** means an Enrolled person meeting the eligibility requirements of the Plan.
- 66. **Myotherapy:** means the physical diagnosis, treatment and pain management of conditions which cause pain in muscles and bones.
- 67. **Non-Network Provider:** means a provider defined as one of the following:
 - a. a facility provider, such as a Hospital, that has not entered into an agreement with Great-West Healthcare;
 - b. a Professional Provider, such as a Physician, who has not entered in to an agreement with Great-West Healthcare;
 - c. Providers who have not contracted or affiliated with Great-West Healthcare's designated subcontractor(s) for the services they perform under this Booklet.
- 68. **Occupational Therapy:** means the use of educational and rehabilitative techniques to improve Your functional ability to live independently. Occupational Therapy requires that a properly accredited Occupational Therapist (OT) or certified Occupational Therapy assistant (COTA) perform such therapy.
- 69. **Out-of-Network:** means providers or facilities that do not enter into a network agreement with Great-West Healthcare, usually at a higher out-of-pocket expense to You than services rendered by an In-Network provider.

GENERAL DEFINITIONS - Continued

70. **Network Provider:** means a facility provider (such as a Hospital) or a Professional Provider (such as a Physician) that has entered into an agreement with Great-West Healthcare to bill the Plan directly for covered services, and to accept Great-West Healthcare's Maximum Benefit Allowance as the maximum amount of payment for covered services.
71. **Network Provider Organization:** means a managed care arrangement consisting of a network of Network Providers that are available to provide medical services to You.
72. **Physical Therapy:** means the use of physical agents to treat Disability resulting from disease or Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage and therapeutic exercise. Physical Therapy must be performed by a Physician or registered Physical Therapist.
73. **Physician:** means a medical practitioner licensed to perform surgery and administer drugs acting in the scope of that license. It will also include any other licensed practitioner of the healing arts required to be recognized by law, when that person is acting within the scope of his/her license and is performing a service for which Benefits are provided under the Plan.
74. **Placed For Adoption:** means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child's placement with You is considered terminated upon the termination of such legal obligation.
75. **Plan:** means the Benefits described in this Booklet as established by the Plan Sponsor for the purpose of providing health care coverage to its Employees and Eligible Dependents of such Employees.
76. **Plan Administrator:** means Great-West Life & Annuity Insurance Company, the entity designated by the Plan Sponsor to pay claims for Benefits under this Plan.
77. **Plan Year:** means from July 1 of one year through June 30 of the next year.
78. **Plan Sponsor:** means the **STATE OF COLORADO**, which has established this Employee welfare benefits Plan for the purpose of providing health care coverage to its Employees and Dependents of such Employees.
79. **Preventive Care:** means comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education.
80. **Primary Care Physician:** means a Doctor that is a family Physician, a general practitioner, an internist or a pediatrician. It also includes an OB/GYN who has agreed to serve as a Primary Care Physician. A provider's classification may be determined by contacting the Great-West Customer Service Department at the phone number shown on Your medical identification card.
81. **Professional Provider:** means a medical practitioner licensed to perform surgery and administer drugs acting in the scope of that license. It will also include any other licensed practitioner of the healing arts required to be recognized by law, when that person is acting within the scope of his/her license and is performing a service for which Benefits are provided under the Plan.
82. **Qualified Change in Status:** means an event such as birth, adoption, marriage, loss of other coverage, etc., that allows an Employee to Enroll, modify or terminate coverage.

GENERAL DEFINITIONS - Continued

83. **Reasonable and Customary:** means, with regard to charges for medical services or supplies, the lowest of:
- the usual charge by the provider for the same or similar medical services or supplies;
 - the usual charge of most providers of similar training and experience in the same or similar geographic area for the same or similar medical service or supplies;
 - the actual charge for the medical services or supplies;
 - the negotiated rate a provider has agreed to accept.
- "Area" means a region the Plan determines to be large enough to obtain a representative sample of providers of medical care or supplies.
84. **R.N.:** means a licensed registered nurse acting in the scope of his/her license.
85. **Specialist:** means a Doctor who is **not** a family Physician, a general practitioner, an internist or a pediatrician. It also does not include an OB/GYN who has agreed to act as a Primary Care Physician.
86. **Speech Therapy (also called Speech Pathology):** means services used for diagnosis and treatment of speech and language disorders. A licensed and accredited speech/language pathologist must perform Speech Therapy.
87. **The Plan Will Pay:** means that when You send the Plan proof of claim, Great-West Healthcare will determine the Benefits payable and make payment, if any, according to the Payment of Claims provisions, as detailed in this Booklet.
88. **Urgent Care Facility:** means a freestanding facility which is engaged primarily in providing minor emergency and episodic medical care and which has:
- a board-certified Physician, a registered nurse (R.N.) and a registered x-ray technician in attendance at all times;
 - has x-ray and laboratory equipment and a life support system.
89. **You and Your:** means an Employee covered under the Plan.

LEGAL COMPLIANCE AND IMPORTANT NOTICES

This section contains important notices that are required to be given to Members covered under the Plan.

Authority of the Plan Administrator

The Plan Administrator is:

Great-West Life & Annuity Insurance Company
Quality Management, F1-22
13045 Tesson Ferry Road
St. Louis, MO 63128

If You have any questions about Your Plan, You should contact the Great-West Customer Service Department at **1-888-ST8-OFCC** or **(1-888-788-6326)**. The Plan Administrator is the entity designated for service of legal process for issues related to claims, benefit payments, benefit denials and claim appeals process under the Plan. The State Attorney General office is the entity designated for service of legal process for issues related to all other Plan's matters.

The Plan Administrator is also the Plan fiduciary. The Plan Administrator has the sole and absolute discretion to interpret the terms of the Plan and determine the right of a Member to receive Benefits under the Plan. The Plan Administrator's decision shall be final, conclusive and binding upon all Plan Participants.

The State's Right

The State reserves the right to add, modify or discontinue the State Benefit Plans as deemed necessary.

Funding and Compliance with Applicable Law

The **STATE OF COLORADO** sponsors the Employee Group Health Plan for Eligible Employees and their Dependents. The Medical, Prescription Drug and Vision Coverage provided under the Plan as described in this Summary are funded and provided by the **STATE OF COLORADO**. Effective July 1, 2005, the Plan is self-funded by the State; the State also obtains an insurance protection against Plan's excess claim liability under an Excess Loss Policy issued by Great-West Life & Annuity Insurance Company.

The Plan is not subject to regulation by the Colorado Division of Insurance since the Plan is self-funded. The Employee Benefits Act, C.R.S. 24-50-605(f) requires that any Benefit plan comply with the mandated coverage required by C.R.S. 10-16-104. The Plan is a governmental plan and exempt from complying with the requirements of the Employee Retirement Income Security Act (ERISA) and COBRA, however, the Plan is subject to the continuation of coverage rules under the Public Health Services Act (PHSA). References in this Summary to COBRA shall mean and include continuation of coverage under the PHSA.

HIPAA Portability Rules

The Plan is required to comply with the portability and special enrollment rules of the Health Insurance Portability and Accountability Act (HIPAA). Refer to the Special Enrollment provisions in the Eligibility section of this Summary. When You or a covered Dependent terminates coverage under the Plan, the Plan will send You a certificate of coverage that identifies the length of coverage under the Plan. The HIPAA Certificate of Coverage may be needed if You Enroll in another health plan that imposes a pre-existing condition waiting period. If You are eligible for Medicare and did not Enroll in the Medicare drug card program, Medicare Part D, during the initial Open Enrollment in November, 2005, You are also entitled to a notice of creditable Prescription drug coverage. You will need this notice to later Enroll in Medicare Part D without penalty.

LEGAL COMPLIANCE AND IMPORTANT NOTICES - Continued

HIPAA Privacy & Security

The Plan is subject to federal privacy rules and restrictions under the Health Insurance Portability and Accountability Act (HIPAA) regarding use and disclosure of protected health information. Generally, these rules and restrictions provide Plan Participants with certain protections and rights against improper use and disclosure of protected health information. In order to provide You with information regarding Your privacy rights with respect to protected health information, the Plan is required to provide You with a notice describing the Plan's privacy practices and other required information. This notice is provided to all new Plan Participants at time of enrollment and to all Plan Participants within 60 days of any material revision of the notice. The HIPAA Notice of Privacy Practices is included at the back of this Summary Plan Description. Copies of the notice will also be available at all times at the State Employee Benefits Unit.

The Plan is subject to HIPAA rules and restrictions regarding the security of electronic protected health information. These security provisions require the Plan to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic protected health information.

Women's Health and Cancer Rights Act

The **STATE OF COLORADO** Employee Health Plan provides coverage for certain reconstructive services under the Women's Health and Cancer Rights Act. These services include:

- Reconstruction of the breast upon which a mastectomy has been performed;
- Surgery /reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses;
- Treatment related to physical complications during all stage of mastectomy, including lymphedemas.

Newborns' and Mothers' Health Protection Act

The Plan may not under this federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of these periods.

LEGAL COMPLIANCE AND IMPORTANT NOTICES - Continued

COBRA CONTINUATION COVERAGE

Consolidated Omnibus Budget Reconciliation Act

In compliance with a federal law commonly called COBRA, this Plan offers its employees and their covered Dependents (Qualified Beneficiaries) the opportunity to elect a temporary continuation coverage (COBRA) of the group medical, dental and FSA plans sponsored by the State of Colorado, when the coverage would otherwise end due to certain events (Qualifying Event). The participant must be covered by one or all of the group health plans sponsored by the State of Colorado the day before the Qualifying Event in order to be eligible for COBRA. Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This is only a summary of the rights and obligations under the COBRA Federal Regulations. Since this is only a summary, actual rights will be provided according to the Department of Labor COBRA Regulations. It is important that You and Your spouse take the time to read this information thoroughly.

Eligibility for COBRA coverage

Active employees and their covered dependents (Qualified Beneficiaries) who have coverage in place the day before a Qualifying Event occurs.

Availability of COBRA coverage:

The COBRA eligibility period begins the first of the month after a Qualified Beneficiary experiences a Qualifying Event which results in loss of coverage.

Maximum Period of COBRA Continuation Coverage:

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the time the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months if the Social Security Administration has made a disability determination to any Qualified Beneficiary. Examples of Qualified Beneficiaries, Qualifying Events and maximum COBRA continuation periods are shown in the chart below.

Qualifying Event Causing Loss of Coverage	Qualified Beneficiaries	Maximum COBRA Continuation Coverage Period
Employee termination	Employee, Spouse, Dependent child(ren)	18
Death of employee	Spouse, Dependent child(ren)	36
Employee's divorce/legal separation	Spouse, Dependent child(ren)	36
Employee's Entitlement to Medicare	Spouse; Dependent child(ren)	36
Dependent Child loses eligibility	Dependent child	36
Military Leave	Employee, Spouse; Dependent; Child(ren)	24

LEGAL COMPLIANCE AND IMPORTANT NOTICES - Continued

Notice to the Plan of a Qualifying Event by the Qualified Beneficiary:

Spouses or covered dependents who wish to elect COBRA Continuation Coverage after a divorce or a child losing eligibility under the Plan, must notify The State of Colorado in writing within 60 days after the Qualifying Event occurs. If the Qualified Beneficiary fails to notify the State of Colorado within the 60-day period, the Qualified Beneficiary forfeits his/her rights to COBRA Continuation Coverage.

Notice to the Qualified Beneficiary by the Plan:

If You are an Employee, You will become a Qualified Beneficiary if You lose Your coverage under the Plan because either one of the following Qualifying Events happens:

- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an Employee, You will become a Qualified Beneficiary if You lose Your coverage under the Plan because any of the following Qualifying Events happens:

- Your spouse dies;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare Benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your spouse.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

- The parent-Employee dies;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare Benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent Child."

The State of Colorado will provide You and/or Your covered Dependents with an Election Notice which will include information and documents to allow You to elect COBRA Continuation Coverage. COBRA Regulations state that You and/or Your covered Dependents will have only 60 days from the later of: the date of notice or the date coverage ends to inform the State of Colorado of your intent to enroll in COBRA Continuation Coverage.

If the Qualified Beneficiary fails to provide the State of Colorado with the COBRA enrollment form within the 60-day period, the Qualified Beneficiary forfeits his/her rights to COBRA Continuation Coverage.

Coverage Plans under COBRA Continuation Coverage:

As a COBRA Qualified Beneficiary You are entitled to the same health coverage that You had when the Qualifying Event occurred which caused You to lose coverage under the Plan. As a COBRA participant You are responsible for the entire premium (once a Qualifying Event occurs the State contribution is no longer applied) plus a 2% administrative fee.

LEGAL COMPLIANCE AND IMPORTANT NOTICES - Continued

Extensions of COBRA Continuation Coverage:

Second Qualifying Events

If Your family experiences a second Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan.

This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare Benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred. Notice of the second Qualifying Event must be provided in writing to the State of Colorado within 60-days after the occurrence of the Second Qualifying Event.

Disability Extension of 18-Month Period of Continuation Coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be Disabled and You notify the Plan Administrator within 60-day of the determination, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage.

Employee's Medicare Entitlement Prior to COBRA Qualifying Event

If You become entitled to Medicare within 18 months prior to Your employment termination, Your spouse and Dependents who are entitled to COBRA continuation coverage will become eligible for a continuation period of not shorter than 36 months from the date You become entitled to Medicare. This continuation period is measured from the time You are entitled to Medicare. The maximum continuation period for Your spouse or Dependents will not exceed 36 months.

Addition of Newly Acquired Dependents:

A COBRA participant who marries or has a newborn child (adopt or placed adoption) may enroll that spouse or child for COBRA Continuation Coverage only for the remainder of the employee's COBRA Continuation Coverage. The Plan must be notified within 31 days of a marriage, birth or adoption. In the case of a birth of a newborn, notification is required only if there is an increase in premium for the additional dependent coverage.

Loss of Other Group Health Plan Coverage:

If Your spouse or Dependent loses coverage under another group health plan while You are enrolled in COBRA, they may enroll for the remainder of Your COBRA Continuation Coverage period, as long as they were previously eligible to enroll and declined.

The Cost of COBRA

The State, as an employer, contributes to a portion of the health and dental insurance premiums for active employees and their Dependents. Once an employee, or a Dependent of an employee, experiences a COBRA Qualifying event, they are no longer eligible for the State's contribution towards premiums. If they elect COBRA Continuation coverage, their cost is the *FULL* premium, including that portion previously paid by the State, plus a 2% administrative fee. When a Disability extension occurs, due to a determination by the Social Security Administration, the Plan may add an additional 50% during the 11-month additional COBRA period.

LEGAL COMPLIANCE AND IMPORTANT NOTICES - Continued

Grace Periods

The initial payment for COBRA Continuation Coverage is due 45 days from the date the enrollment form is mailed to the State. This is determined by the postmark on the envelope. The 45-day period **IS NOT** calculated using the signature date on the enrollment form. For example, if the COBRA election form has a postmark of July 1st, then the payment is due to the Plan's COBRA Premium Collection company August 14th.

Except for the first COBRA premium payment, all other COBRA premium payments are due the first of every month, **whether or not** a statement is received. Payments must be postmarked by the U.S. Postal Service on or before the first of the month to be considered timely. *If payment is not received, coverage is suspended.* Coverage can be retroactively reinstated if payment is then received within the 30-day grace period.

This grace period expires on the 30th of the month for which the premium is due. Payments must be postmarked by the U.S. Postal Service on or before the 30th of the month to be considered within the grace period. *If payment is not postmarked by this date, coverage will be canceled with no avenue for reinstatement.*

To avoid the loss of any of Your COBRA rights You must notify the State of Colorado:

- 1) within 31 days if You have changed marital status; or have a new dependent child
- 2) within 60 days of the date You or a family member has been determined to be totally disabled
- 3) within 60 days if a covered child loses dependant status

Plan Contact Information

Colorado Department of Personnel & Administration
Employee Benefits Unit – COBRA Coordinator
Division of Human Resources
1313 Sherman Street, First Floor
Denver, CO 80203

Great-West Healthcare COBRA Contact Information

If You have any questions about this notice or Your rights to COBRA continuation coverage, You may contact:

Great-West Healthcare
IBT Department, Mail Code: C2-32
P O Box 66803
St. Louis, MO 63166-6803
Telephone: 1-800-392-5368

If You Have Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contacts identified in this notice.

The **State of Colorado** reserves the right to add, modify or discontinue the State group Benefits plans as deemed necessary. The **State of Colorado** Employee health plan is controlled by contracts, rules and statutes. In the event of a conflict between this Summary and the governing laws or regulations, the governing laws or regulations will prevail.

LEGAL COMPLIANCE AND IMPORTANT NOTICES - Continued

It is unlawful for any Employee or Dependent to provide false, incomplete or misleading facts or information on any state group Benefit enrollment form, affidavit, claim or other document for the purpose of defrauding or attempting to defraud the **State of Colorado** or the Plan. Any Employee or Dependent who provides false, incomplete or misleading facts or information on any document shall be reviewed by the Director. If the Director has reasonable suspicion to believe that an Employee or Dependent has defrauded or attempted to defraud any state group Benefit plan, coverage shall be terminated, and the Employee or Dependent may be denied future enrollment and may be subject to other action.

LEGAL COMPLIANCE AND IMPORTANT NOTICES - Continued

USERRA RIGHTS AND RESPONSIBILITIES

Uniformed Services Employment and Reemployment Rights Act

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service. This includes the right to continue the medical and prescription drug coverage that You (the Employee) had in effect for Yourself and Your Dependents.

“Uniformed Service” means the performance of active duty in the Uniformed Services under competent authority which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

You must notify Your Employer verbally or in writing of Your intent to leave employment and terminate Your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of Your leave, unless it is unreasonable or impossible for You to provide advance notice due to reasons such as military necessity.

Continued Medical and Prescription Drug Coverage

Under USERRA, You are eligible to elect continued medical and prescription drug coverage for Yourself and Your Dependents when You stop Active Work with the Employer for the purpose of Uniformed Service.

The Employer should establish reasonable procedures for electing continued medical and prescription drug coverage and for payment of Contributions. See the Plan Administrator for details.

If You do not provide advance notice of Your leave and You do not elect continued coverage prior to Your leave

Coverage for You and Your Dependents will terminate on the date that coverage would otherwise terminate because You stop Active Work.

However, if You are excused from giving advance notice because it was unreasonable or impossible for You to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if You elect coverage for Yourself and Your Dependents and pay all unpaid Contributions within the period specified in the Employer’s reasonable procedures.

If You provide advance notice of Your leave but You do not elect continued coverage prior to Your leave

Coverage for You and Your Dependents will terminate on the date that coverage would otherwise terminate because You stop Active Work, when the duration of Uniformed Service is at least 30 days.

However, coverage will be retroactively reinstated if the Employer has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and You elect coverage for Yourself and Your Dependents and pay all unpaid Contributions within the time period specified in the procedures.

If the Employer has not established reasonable procedures, then the Employer must permit You to elect continued coverage for Yourself and Your Dependents and pay all required Contributions at any time during the period of continued coverage, and the Employer must retroactively reinstate coverage.

LEGAL COMPLIANCE AND IMPORTANT NOTICES - Continued

If You elect continued coverage but do not make timely payments for the cost of coverage

If the Employer has established reasonable payment procedures and You do not make payments according to the procedures, then coverage for You and Your covered Dependents will terminate as described in the procedures.

Period of Continued Coverage

During a leave for Uniformed Service, the period of continued coverage begins immediately following the date You and Your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

Cost of Continued Coverage

If the period of Uniformed Service is less than 31 days, You are not required to pay more than the amount that You paid as an active Employee for that coverage for continued coverage.

If the period of Uniformed Service is 31 days or longer, then You will be required to pay up to 102% of the applicable group rate for continued coverage.

COBRA Coverage

If You are entitled to COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

Reinstatement of Coverage

Coverage for an Employee who returns to Active Work with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

For medical coverage, a Pre-Existing Condition Limitation may be imposed on an Illness that is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, Uniformed Service. See the Plan Administrator for details.

STATE OF COLORADO



HIPAA NOTICE OF PRIVACY PRACTICES

DPA

Effective: July 1, 2008

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Colorado Department of Personnel and Administration (DPA), on behalf of the State of Colorado (State), is committed to protecting the privacy of health information maintained by the self-funded group health plans sponsored by the State. In this notice, the terms Your "medical information" or Your "health information" mean personal information that identifies You and that relates to Your past, present, or future physical or mental health; the provisions of health care services to You; or the payment of health care services provided to You. The terms "we," "us," and "our" in this notice refer to the following **STATE OF COLORADO** Group Health Plans:

- Great-West Healthcare Open Access 750, Open Access 1500, Open Access 3000, and Open Access H;
- Delta Dental Basic, Basic Plus, and Direct Reimbursement;
- Healthcare flexible spending account.

The group health Plans do not have Employees. They are administered by select State Employees and third party administrators. For a more detailed explanation of the limited ways that State employees provide plan administration functions, please see the section below on Plan Sponsor.

This notice explains how we use Your health information and when we can share that information with others. It also informs You of Your rights with respect to Your health information and how You can exercise those rights. We are required to follow the terms of this notice until the notice is replaced. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide You with a copy of the new notice.

How We May Use Or Disclose Your Health Information

Federal law allows us to use or disclose protected health information without Your authorization for the purposes of treatment, payment, and health care operations.

Treatment. We may use and disclose information when communicating with Your Physicians to help them provide medical care to You. For example, we might suggest to Your Physician a disease management or wellness program that could improve Your health.

Payment. We may use and disclose information about You so that the medical services You receive can be properly billed and paid. For example, we may need to give Your insurance information to health care providers so they can bill us for treating You.

Operations. We may use and disclose information about You for our business operations. For example, we may disclose information about You to consultants who provide legal, actuarial, or auditing services. We will not disclose Your health information to outside groups unless they agree in writing to keep it protected.

We may also use or disclose Your health information for other health-related Benefits and services. For example, we may send You appointment reminders or information about programs that may be of interest to You, such as smoking cessation or weight loss.

HIPAA NOTICE - Continued

There are also state and federal laws that may require or allow DPA to use or disclose Your health information without Your authorization. The examples below are provided to describe generally the ways in which we may use or disclose Your information.

- To state and federal regulatory agencies;
- For public health activities;
- To public health agencies if we believe there is a serious health or safety threat;
- With a health oversight agency for certain activities such as audits and examinations;
- To a court or administrative agency pursuant to a court order or search warrant;
- For law enforcement purposes;
- To a government authority regarding child abuse, neglect, or domestic violence;
- With a coroner or medical examiner, or with a funeral director;
- For procurement, banking or transplantation of organs, eyes, or tissue;
- For specialized government functions, such as military activities and national security;
- Due to the requirements of state worker compensation laws.

Plan Sponsor

Health information may be disclosed to or used by the State, as plan sponsor. For example, We may disclose to the State, information on whether You are participating in, enrolled in, or dis-enrolled from a group health plan. We may also disclose to the State, as plan sponsor, health information necessary to administer the group health plans. For example, the State may need Your health information to review denied claims, to audit or monitor the business operations of the group health Plans, or to ensure that the group health Plans are operating effectively and efficiently. We will not use or disclose Your health information to the State for any employment-related functions. State employees who perform services to administer the group health plans are primarily, but not exclusively, in DPA's Division of Human Resources, Employee Benefits Unit. When State employees are conducting plan administration functions, they are acting as an administrator of the group health plans. Group health plan administrators will keep Your health information separate from employment information and will not share it with anyone not involved in plan administration.

For us to use or disclose Your health information for any reason other than those identified in this section ("How We May Use or Disclose Your Health Information"), we must get written authorization from You. You may revoke the authorization at any time, but Your revocation must also be in writing. The revocation will not affect any uses or disclosures consistent with the authorization made prior to receipt of the revocation by DPA's HIPAA Compliance Officer.

Your Rights

The following are Your rights with respect to Your health information.

You have the right to ask us to restrict how we use or disclose Your information for treatment, payment, or health care operations. All requests must be made in writing and state the specific restriction requested. We will try to honor Your request, but we are not required to agree to a restriction.

You have the right to ask to receive confidential communications of information. For example, if You believe You would be harmed if we send information to Your current mailing address (for example, in situations involving domestic disputes or violence), You can ask us to send the information by alternative means (for example, by telephone) or to an alternative address. We will accommodate a reasonable request if the normal method or disclosure could endanger You and You state that in Your request. Any such request must be made in writing.

HIPAA NOTICE - Continued

You have the right to inspect and obtain a copy of information that we maintain about You in Your designated record set. A “designated record set” is a group of records that may include enrollment, payment, claims adjudication, and case or medical management records. *However, You do not have the right to access certain types of information* such as psychotherapy notes and information compiled for legal proceedings. If we deny Your request, we will notify You in writing and may provide You with a right to have the denial reviewed.

You have the right to ask us to amend the information we maintain about You in Your designated record set (as defined above). Your request must be made in writing and You must provide a reason for the request. If we agree to Your request, we will amend our records accordingly. We will also provide the amendment to any person that we know has received Your health information from us, and to other persons identified by You. If we deny Your request, we will notify You in writing of the reason for the denial. Reasons may include that the information was not created by us, is not part of the designated record set, is not information that is available for inspection, or that the information is accurate and complete.

You have the right to receive an accounting of certain disclosures of Your information made by us during the six years prior to Your request, but no earlier than July 1, 2005. We are not required to account for certain disclosures, such as disclosures made for purposes of treatment, payment, or health care operations, and disclosures made to You or authorized by You. Your request must be made in writing. Your first accounting in a 12-month period will be free. We may charge You a fee for additional accountings made within 12 months of the free accounting. We will inform You in advance of the fee and provide You with an opportunity to withdraw or modify Your request.

You have a right to receive a copy of this notice upon request at any time.

Contacts

To exercise Your rights, please contact Our Plan Administrator, Great-West Healthcare by calling their privacy line at (303) 737-3824. Great-West Healthcare will send You the appropriate form to exercise Your rights and respond to Your request.

For further information, to receive a copy of this notice, or if You believe Your privacy rights may have been violated and You want to file a complaint, please contact DPA’s HIPAA Compliance Officer by U.S. mail or by e-mail, as follows:

U.S. Mail: HIPAA Compliance Officer
Colorado Department of Personnel and Administration
Division of Human Resources
1313 Sherman Street
Denver, CO 80203

E-mail: dpahipaacompliance@state.co.us

You may also notify the Secretary of the U.S. Department of Health and Human Services of Your complaint.

No action will be taken against You for exercising Your rights or for filing a complaint.

VISION CARE BENEFITS

The following Vision Care Benefits are applicable to all plans **except** the Open Access H (HSA-HDHP) Plan. Great-West Healthcare is partnering with Avesis® Vision Plan to provide Benefits for annual eye examinations and for discounted hardware for Members and their families who are Enrolled in **any Plan except** the Open Access H (HSA-HDHP) Plan. (The Open Access H vision exam benefit is outlined in the *HEALTH PLAN DESCRIPTION FORM* section.)

To find an Avesis® Participating Provider or to get information on Your vision benefits, Members may call Great-West Healthcare/Avesis® toll free at **1-800-672-7375**. You may also access information regarding Vision Care Benefits and Network Providers by going to the Avesis® website www.avesis.com and clicking on “Member.” *When scheduling an appointment with an Avesis® Network Provider of Your choice; identify Yourself as a **STATE OF COLORADO** Employee.*

Vision coverage includes one exam every 12 months and for in-network providers, You may access the Avesis® discounts or “Preferred Pricing”. Network Providers offer discounted pricing with substantial savings on frames, lenses, contact lenses, lens treatment and specialized lenses.

Following is an overview of the Benefits payable under the Vision Care Plan associated with each of the **STATE OF COLORADO** plan design offerings. **NOTE:** *There are both In-Network and Out-of-Network Benefits.*

Vision Care Benefits

Benefit	Great-West Healthcare Medical Plan Option	Vision Benefit from Avesis® Network Provider	Non-Network reimbursement
Vision Examination: Each eligible Member is entitled to a comprehensive vision examination. One exam is covered every 12 months. ¹ This examination does not include the separate contact lens professional fitting fee.	Open Access 750	\$50 copay	Up to \$35 reimbursement
	Open Access 1500	\$50 copay	Up to \$35 reimbursement
	Open Access 3000	\$50 copay	Up to \$35 reimbursement
	Open Access H	Not covered	Not covered
Materials: Prescription lenses and frames		Available at Avesis® Preferred Pricing	Not Covered
Contact Lenses:		Available at Avesis® Preferred Pricing	Not Covered

VISION CARE BENEFITS - Continued

A vision examination includes a determination as to the need for correction of visual acuity and prescribing lenses, if needed, that is performed by a licensed Physician who is operating within the scope of his or her license. A vision examination includes, but is not limited to, the following procedures:

- Case history including chief complaint and/or reason for visit;
- Patient medical/eye health history and record of current medications;
- Record of visual acuities with and without present correction, if applicable;
- Pupil responses;
- Internal and external exam findings;
- Screening of visual fields perception;
- Present Prescription;
- Retinoscopy (when applicable);
- Subjective refraction at far and near point;
- Binocular and ocular mobility testing;
- Test of accommodation and/or near point refraction;
- Tonometry, to include pressures, time of day, and type of instrument used (a reasonable attempt at tonometry or equivalent testing will be made unless, in the Physician's professional opinion, tonometry is contra-indicated);
- Diagnosis/prognosis;
- Specific recommendations.

Limitations and Exclusions

This is a primary vision care Benefit and is intended to cover only eye examinations. Materials and other services not covered are offered by Avesis® Network Providers at Avesis® Preferred Pricing discounts. Certain services, supplies or care **are excluded** under the Vision Care Benefits including, but not limited to, the following:

1. orthoptics or vision training and any supplemental testing;
2. Medical or surgical treatment of the eyes;
3. any eye exam or corrective eyewear required by Employer as condition of employment;
4. any Injury or Illness covered under Worker's Compensation or similar law or which is work related;
5. sub-normal vision aids;
6. Experimental, Investigational or Unproven or non-conventional treatments or devices;
7. safety Eyewear.

Submitting a Claim

If the exam is rendered by an Avesis® Network Provider, the claim will be filed for You and You only need to pay the appropriate Copayment amount at the time You receive services. Members may also seek care from a Non-Network Provider and pay the Provider directly for the examination. To receive reimbursement for these claims according to the above referenced schedule of benefits, You may either submit an Avesis® Vision Benefits Claim Form as described below, or mail the following information to Avesis®: Your Name, Address, Phone Number, Social Security Number, Date of Service, Provider's Name, and an Itemized Receipt.

¹ Covered Members are eligible for one vision exam in each successive Benefit Period.

VISION CARE BENEFITS - Continued

The Avesis® Vision Benefits Claim Form (in PDF format) can be found by accessing the Avesis® website at www.avesis.com and clicking “print a claim form.”

Please mail the completed form (or above referenced information) and with a copy of Your itemized receipt to:

**Avesis® Incorporated
Vision Claims Department
P.O. Box 7777
Phoenix, AZ 85011-7777**

