

HEALTH PLAN DESCRIPTION FORM – Open Access

Open Access – 30		
	In-Network Only	Out-of-Network Only
<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	No, except for emergency.	
3. Areas of Colorado where Plan is Available	Plan is available nationally.	
Part B: Summary of Benefits		
4. Plan Year Deductible a) Individual b) Family	Not Applicable	Not Applicable
5. Plan Year Out-of-Pocket maximum ² a) Individual b) Family	\$1,000 plus copays \$3,000 plus copays	Not Applicable Not Applicable
6. Lifetime Maximum	No lifetime maximum with 2 exceptions: a) surgical treatment of morbid obesity, if Medically Necessary, is covered up to a lifetime maximum of \$7,500 including complications; b) Substance Abuse 60-day inpatient and 60 visit outpatient lifetime maximum.	
7. Covered Providers	Great-West Healthcare Open Access Provider Network. Pharmacy Services provided by Express Scripts® and Vision Services provided by Avesis®. Both are by arrangement with Great-West Healthcare.	
8. Medical Professional Services	Plan pays 100%	Not Applicable
9. Office Visits	After \$30 copay for PCP and/or after \$50 copay for Specialist, Plan pays 100%	Not Applicable
10. Scheduled Preventive Care: a) Children b) Adults	After \$30 copay, plan pays 100% After \$30 copay, plan pays 100%	Not Applicable Not Applicable
11. Maternity a) Prenatal care b) Delivery & Inpatient well baby care c) Delivery Professional services	After \$30 copay per visit, plan pays 100% After \$250 copay per day, up to 3 days per admission, plan pays 100% Plan pays 100%	Not Applicable Not Applicable Not Applicable
12. Prescription Drugs Level of coverage and restrictions on prescriptions a) Retail Copay - Generic - Preferred - Non-Preferred b) Mail Order Copay - Generic - Preferred - Non-Preferred c) Self-admin. Injectables disp. thru Pharmacy d) Injectables admin. in office or OP facility	a), b) and c) subject to \$100 per member RX deductible before copay applies \$10 \$25 \$50 (30 day supply) \$20 \$50 \$100 (90 day supply) Plan pays 70%. Member share not to exceed \$250 per 34-day supply or \$500 per 90-day supply Plan pays 70%	Not Applicable Not Applicable Not Applicable Not Applicable
<p>The Prescription Drug Program has been designed to encourage the use of generic medications. If a generic drug is available, but the preferred drug is dispensed (whether by your request or upon a physician specifying "Dispense As Written,") you are required to pay the applicable preferred copayment PLUS the difference in cost between the generic and preferred drug. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as preferred drugs.</p>		
13. Inpatient Hospital	After \$250 copay per day, up to 3 days per admission, Plan pays 100%	Not Applicable

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14. Outpatient / Ambulatory Surgery	After \$150 copay per surgery or invasive diagnostic tests, Plan pays 100%	Not Applicable
15. Other services		
a) Laboratory	If not part of an office visit or inpatient, Plan pays 80%	Not Applicable
b) X-ray	If not part of an office visit or inpatient, Plan pays 80%	Not Applicable
c) MRI / PET / CAT scans	After a \$75 copay, Plan pays 80% per visit	Not Applicable
<i>b) & c) subject to Pre-Treatment Authorization</i>		
16. Emergency Care	After \$100 copay (waived if admitted), Plan pays 100%	
"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	Member pays 20%, maximum benefit \$1,000	
b) Air	Member pays 20%, maximum benefit \$10,000	
18. Urgent Care	\$50 copay, plan pays 100%	Not Applicable
"Urgent Care" means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a member's health.		
19. Biologically Based Mental Health³ Care	Covered same as any other illness	Not Applicable
20. Other Mental Health Care	Maximum 45 full/90 partial days inpatient services and 30 visits for outpatient services per Plan Year. Maximum number of days and visits combined with Substance Abuse.	
a) Inpatient care	Plan pays 50%	Not Applicable
b) Outpatient care	Plan pays 50%	Not Applicable
21. Substance Abuse	Maximum 45 full/90 partial days inpatient services and 30 visits for outpatient services per Plan Year. Number of days and visits are combined with Other Mental Health care. Lifetime maximum 60 full days for inpatient and 60 visits for outpatient. Other Mental Health Care is not subject to the 60-day or 60-visit lifetime limit, but inpatient days and outpatient visits for such services do apply to and reduce the 60-day or 60-visit lifetime limit for Substance Abuse.	
a) Inpatient Rehab	Plan pays 50%	Not Applicable
b) Outpatient	Plan pays 50%	Not Applicable
22. Physical, Occupational & Speech Therapy		
a) Inpatient	Included in Hospital	
b) Outpatient	After \$30 copay, Plan pays 100%. Maximum 20 visits per Plan Year for each therapy.	
23. Durable Medical Equipment		
a) Inpatient	Included in Hospital	
b) Outpatient including supp.	Plan pays 80%, up to \$5,000 per Plan Year. (Prosthetic devices are not subject to \$5,000 max., but expenses for such devices are applied to and reduce the \$5,000 max.)	
24. Medical Supplies	Plan pays 80%	Not Applicable
25. Oxygen		
a) Inpatient	Included in Hospital	
b) Outpatient	Member pays 20%	
26. Transplants	After \$250 copay per day, up to 3 days per admission, Plan pays 100%	Not Applicable
27. Home Health Care <i>(Subject to Pre-Treatment Authorization)</i>	After \$30 copay for 60 visits per Plan Year, Plan pays 100%	Not Applicable
28. Hospice		
a) Inpatient	Member pays 20% for 30 days per Plan Year	
b) Outpatient	Member pays 20% for 91 days per Plan Year	
29. Skilled Nursing Facility Care	Member pays 20% for 30 days per Plan Year	Not Applicable

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30. Dental Care	Not Covered	Not Covered
31. Vision Care	After \$30 copay, Plan pays 100%. One eye exam every Plan Year. No benefit for hardware, but a discount is available through Avesis® network.	Not Applicable
32. Chiropractic Care and Acupuncture	After \$30 copay, Plan pays 100%. Maximum benefit of \$750 per Plan Year per benefit.	Not Applicable
33. Significant Additional Covered Services a) Hearing Aids b) Infertility	Plan pays 100%, up to \$500, every 3 years Plan pays 80%, up to \$2,500, per Plan Year	Not Applicable Not Applicable
Part C: Limitations and Exclusions		
34. Period during which Pre-Existing Conditions are not Covered.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.	
35. What Treatments & Conditions are excluded Under this Policy?	See Summary Plan Description for list of exclusions.	
Part D: Using the Plan		
36. Does the enrollee have to obtain a referral for specialty care in most or all cases?	No	
37. Is Pre-Treatment Authorization required for surgical procedures and hospital care (except in an emergency)?	Yes. See Summary Plan Description for list of procedures.	
38. If the provider charges more for a covered service than the Plan normally pays, does the enrollee have to pay the difference?	Not if the provider participates with Great-West Healthcare.	
39. What is the main customer service number?	1-888-ST8-OFCO (1-888-788-6326)	
40. 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)	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Submit Appeals form to: Great-West Healthcare Attention: Appeals/Grievances 8525 E. Orchard Road, 4T3 Greenwood Village, Colorado 80111	
42. 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	
43. Does the Plan have a binding arbitration clause?	No	

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Part E: Costs

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

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

¹Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your Plan may require you to use in order for you to get any coverage at all under the Plan, or that the Plan may encourage you to use because it pays more of your bill if you use their network providers (i.e. go in-network) than if you don't (i.e. go out-of-network).

²Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health Plan, which may or may not include the deductible or copay, depending on the contract for that Plan.

³Biologically based Mental Health means schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.