Boulder Valley School District-FAQ's

1. What is the Plan Year?
The Plan Year is July 1 - June 30. Deductibles and maximum accumulations are tracked on a Plan Year basis.

2. Who can I contact if I have questions?
Great-West Members Services is available to any questions you might have at **800-663-8081**. Information is also available at http://www.bvsd.org/C14/Benefits/default.aspx.

3. How many ID cards will I receive from Great-West?

4. Can I request additional ID cards?
Yes, you can request additional cards through the mygreatwest.com member website or by calling Member Services at 800-663-8081.

5. Who can be covered as a dependent?
Eligible dependents are your legal spouse, your domestic partner and your child as defined below.

A child must be unmarried, under the age 25 and depend on you for financial support. Child means your natural child, your stepchild, a natural child of your covered minor dependent, your adopted child, a foster child, a child of your covered domestic partner or a child who is recognized under a medical child support order as having a right to enrollment under the plan. The age limit of 25 does not apply to a child who becomes disabled, or became disabled, before reaching age 25 and who cannot hold a self-supporting job due to a permanent or physical handicap or mental retardation.

A domestic partner means the person, regardless of gender, named in the Affidavit of Domestic Partnership.

6. What are the main differences between HMO and PPO plans?
A primary care physician is not required (although we encourage you to develop a relationship with a primary care doctor).
No referral is required to see a specialist.
You have access to over 540,000 network providers' nation wide. If you use a network provider, your benefits will be paid at the highest level.
Benefits are available for non-network providers (with higher out-of-pocket costs)
Special arrangement with Boulder Community Hospital (BCH) and affiliated facilities – facility charges are payable at a higher coinsurance for BCH facilities.

7. Why should I use network providers?
Network providers have agreed to negotiated prices for their services, therefore the BVSD plans are designed with incentives for members to use network providers. Great-West enforces strong credentialing requirements only accepting quality providers into their network. As part of their contract with Great-West, network providers have agreed to file claims for you and handle any pre-certification requirements. If you use non-network physicians, you will be responsible for filing claims as well making sure the pre-certification process takes place.

8. How can I determine if my doctor is in the new network?
A complete list of network providers is available under Find a Provider at www.mygreatwest.com. Feel free to contact Member Services at 800-663-8081 for assist as well.

9. Can I refer my doctor if they do not participate in the Great-West network?
Yes, please call Great-West Member Services and request to refer your provider.

10. Can I elect one plan and have my dependents covered under another plan?
No, your entire family must be covered under the same plan.

11. What if I need to see a doctor while I am on vacation, or if I have a child going to college out of state?
Under a PPO plan, you have access to all 540,000 providers nationwide, regardless of why you are away from home. As long as you (or your child) use network providers, you will be entitled to the highest level of benefits. You can locate a network provider on line at mygreatwest.com or call Member Services. Benefits are also available for non-network providers (with higher out-of-pocket costs).

12. Do I have coverage if I am traveling out of the country?
You do have coverage while traveling outside of the U.S. Great-West does not contract with providers out of the country therefore you must use non-network providers. Benefits will be subject to the network deductibles and out-of-pocket levels and reimbursed at the PPO Out-of-Area Service coinsurance amount listed on your benefit summary. You may be required to pay for services up front and file a paper claim with Great-West for reimbursement. Claim forms are available at mygreatwest.com.

13. When is pre-certification required?
Pre-authorization is required on all inpatient admissions and outpatient surgery not performed in the doctors office. The following procedures require pre-certification: Outpatient Surgery, Home Health Care, Air Ambulance, High Cost Drug, Transplant Evaluations, Hospital Admissions, High Tech Radiology (examples include CAT scans, PET scans and MRI's), Skilled Nursing, Renal Disease, Durable Medical Equipment over $500, Genetic Testing.

As part of their contract with Great-West, network providers have agreed to handle any pre-certification requirements. If you use non-network physicians, you will be responsible for making sure the pre-certification process takes place.

14. For the Standard and Premium plans, the office visit co-pay for network services is $25 for physicians and $50 for specialists. What doctors fall under the $25 office visit co-pay?
General practitioners, family practice, internal medicine, pediatricians and OBGYNs are subject to the $25 co-pay. All other specialists, including chiropractors, will be subject to the $50 co-pay.

15. What is the special arrangement with Boulder Community Hospital (BCH)?
BCH is a contracted network provider with Great-West but is extending an additional discount to BVSD members who utilize their facilities. This additional discount is being given directly back to you as a member of the plan. If you use a BCH facility, you will find that services that are included in the facility bill (i.e. inpatient charges and outpatient surgery charges), will be reimbursed at a higher coinsurance level. A list of BCH facilities can be found at http://www.bvsd.org/C14/Benefits/default.aspx.

16. What types of services might be paid at the network level even though they are rendered by a non-GW provider?
If you are a patient in a network facility, you may not have control over the network status of an attending provider. Non-network services for the following will be paid at the network level in these circumstances: Inpatient Consultation (sub-specialties), Anesthesia, Assistant Surgery (when medically necessary), Hospitalists, Radiologists, Pathologists.

In addition, if you are admitted to a non-network hospital through the emergency room, benefits will be paid at the network level through stabilization. At that point, you will be transferred to a network facility.

17. **What do I do if I am taking a prescription found on the Specialty Pharmacy or Prior Authorization drug list?**
If you are prescribed an injectable drug (other than insulin) or other high priced medications listed on the Specialty Pharmacy or Prior Authorization lists, please contact Member Services at 800-663-8081.

18. What if the cost of my medication is less than the co-pay?
If what the pharmacy charges is less than your co-pay, you will just pay the cost of the drug.

19. What if I do not agree with the way my claim was paid?
If you have a question about how a specific claim was paid, please call Member Services at 800-663-8081. If a claim was denied, you can file an appeal by submitting a written request to the address on the claim denial notice or by calling Member Services. Detailed information regarding the appeal process is included in the Summary Plan Description.