



MEDICAL BENEFIT SUMMARY*

Effective July 1, 2009



GENERAL SERVICES	KAISER HMO – Plan 220	GREAT WEST BASIC PLAN OPEN ACCESS NETWORK	GREAT WEST STANDARD PLAN OPEN ACCESS NETWORK	NON-NETWORK FOR GREAT WEST BASIC AND STANDARD PLANS
Plan Year Deductible (excludes copays)	No Deductible	\$1,500 Individual \$3,000 Family	\$500 Individual \$1,000 Family	\$6,000 Individual \$12,000 Family
Coinsurance	N/A	20%	20%	50%
Out of Pocket Maximum (includes deductible)	\$2,000 Individual \$4,500 Family	\$4,500 Individual \$9,000 Family	\$2,750 Individual \$5,500 Family	\$13,500 Individual \$27,000 Family
Lifetime Maximum	No Lifetime Maximum	\$5,000,000 per member	\$5,000,000 per member	\$5,000,000 per member
Physician Visit	\$20 Copay	\$25 Copay	\$25 Copay	50% after deductible – up to Out of Pocket Maximum
Specialist Visit	\$40 Copay	20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay	50% after deductible – up to Out of Pocket Maximum
Preventive Care • Immunizations • Routine physicals • X-Ray & Lab (excluding High Tech Radiology) • Basic Gynecological care • Routine Mammogram	\$20 Copay	\$25 Copay Physician	\$25 Copay Physician \$50 Copay Specialist	50% after deductible - up to Out of Pocket Maximum
Colonoscopy	\$70 Copay	\$70 Copay	\$70 Copay	50% after deductible – up to Out of Pocket Maximum
Performance Pharmacy Plan (includes contraceptives) Tier 1 = Generic Tier 2 = Preferred Tier 3 = Non-preferred	\$15 Generic Copay \$30 Brand Copay Per prescription up to a 60-day supply (certain drugs limited to a 30-day supply) Drugs may be ordered by mail	Retail Pharmacy ~ 30 day supply \$5 Generic Copay \$25 Tier 2 brand \$50 Tier 3 brand Retail Pharmacy ~ 90 day supply \$15 Generic Copay \$75 Tier 2 brand \$150 Tier 3 brand Mail Order ~ 90 day supply \$12.50 Generic Copay \$62.50 Tier 2 brand \$125 Tier 3 brand	Retail Pharmacy ~ 30 day supply \$5 Generic Copay \$25 Tier 2 brand \$50 Tier 3 brand Retail Pharmacy ~ 90 day supply \$15 Generic Copay \$75 Tier 2 brand \$150 Tier 3 brand Mail Order ~ 90 day supply \$12.50 Generic Copay \$62.50 Tier 2 brand \$125 Tier 3 brand	Appropriate copay level +50% of the full cost of the prescription



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Durable Medical Equipment	20% Coinsurance / up to \$2,000 benefit paid by Health Plan per plan year	20% after network deductible Maximum of \$3,500 per plan year	100% covered - no deductible Maximum of \$3,500 per plan year	20% after network deductible Maximum of \$3,500 per plan year	
Oxygen	20% Coinsurance	20% after deductible Up to Out-of-Pocket Maximum	100% covered - no deductible	50% after deductible Up to Out of Pocket Maximum	
Lab & X-ray Services – outpatient, independent lab or related to an office visit	<u>Diagnostic Lab and X-ray</u> 100% Therapeutic X-ray \$40 copay each visit	20% after deductible Up to Out-of-Pocket Maximum (except for preventive care – covered at 100%)	20% after deductible – Up to Out-of-Pocket Maximum (except for preventive care – covered at 100%)	50% after deductible Up to Out of Pocket Maximum	
High Tech Radiology (MRI, Pet, CAT scans)	\$150 Copay Per procedure	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible – Up to Out-of-Pocket Maximum	50% after deductible Up to Out of Pocket Maximum	
Spinal Adjustment Treatment	\$20 Copay 20 visits limit Per plan year	20% after deductible 60 visit maximum Per plan year	\$50 Copay 60 visit maximum Per plan year	50% after deductible 60 visit maximum Per plan year	
Emergency Room Care	\$150 Copay ¹	20% after network deductible Up to Out-of-Pocket Maximum	\$200 Copay (Lab & X-Ray Services subject to 20% coinsurance after deductible)	Basic Plan: Same as in-network	Standard Plan: Same as in-network
Urgent Care	After-hours care - \$75 Copay ¹	20% after deductible Up to Out-of-Pocket Maximum	\$100 Copay (Lab & X-Ray Services subject to 20% coinsurance after deductible)	50% after deductible Up to Out of Pocket Maximum	
Ambulance	20% Coinsurance up to a maximum of \$500 per trip	20% after network deductible Up to Out-of-Pocket Maximum	20% after network deductible Up to Out-of-Pocket Maximum	Same as in network	
Eye Exam	<u>1 every 12 months</u> – \$20 Copay	Not Covered	Not Covered	Not Covered	

¹ Kaiser - Special procedures (MRI/CT/PET) performed while receiving Emergency or Urgent Care Services will generate a separate copayment per procedure in addition to the emergency/urgent care copay.



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HOSPITAL SERVICES	KAISER HMO – Plan 220	GREAT WEST BASIC PLAN OPEN ACCESS NETWORK	GREAT WEST STANDARD PLAN OPEN ACCESS NETWORK	NON-NETWORK FOR GREAT WEST BASIC AND STANDARD PLANS
Inpatient Hospital Services • Including anesthesia • Requires pre-certification • Lab & X-Ray based on Facility Network Status	\$500 Copay per admission	20% after deductible Facility Charges only for services rendered at Boulder Community Hospital – 10% after the deductible	20% after deductible Facility Charges only for services rendered at Boulder Community Hospital – 10% after the deductible	50% after deductible Up to Out-of-Pocket Maximum
Outpatient Hospital Services • Outpatient Surgery • Including anesthesia • Requires pre-certification • Ambulatory Surgery • Lab & X-Ray paid based on Facility Network Status	\$200 Copay for each procedure in any setting other than inpatient	Up to Out-of-Pocket Maximum	Up to Out-of-Pocket Maximum	
Outpatient Surgery	\$200 Copay	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible Up to Out-of-Pocket Maximum	50% after deductible Up to Out-of-Pocket Maximum
Hospice Care • Inpatient • Outpatient	100% Covered (not covered outside the service area)	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible - Up to Out-of-Pocket Maximum 100% covered - no deductible	50% after deductible Up to Out-of-Pocket Maximum
Skilled Nursing Facility Care	100% Covered 100 days per Plan Year at approved facilities. (not covered outside the service area)	20% after deductible 60 days per Plan Year Maximum Requires pre-certification	20% after deductible 60 days per Plan Year Maximum Requires pre-certification	50% after deductible 60 days per Plan Year Maximum Requires pre-certification
Home Health Care	100% Covered For medically necessary part-time home health care	20% after deductible Up to 1 visit per day/100 visits per Plan Year Maximum	100% covered - no deductible Up to 1 visit per day/100 visits per Plan Year Maximum	50% after deductible Up to 1 visit per day/100 visits per Plan Year Maximum
Transplants	See Inpatient and Outpatient Hospital Services	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible Up to Out-of-Pocket Maximum	Not Covered



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MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES	KAISER HMO – Plan 220	GREAT WEST BASIC PLAN OPEN ACCESS NETWORK	GREAT WEST STANDARD PLAN OPEN ACCESS NETWORK	NON-NETWORK FOR GREAT WEST BASIC AND STANDARD PLANS
Mental Health Inpatient: Requires pre-certification	\$500 Copay per admission*	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible Up to Out-of-Pocket Maximum	50% after deductible Up to Out-of-Pocket Maximum
Mental Health Outpatient:	\$20 Copay each visit*	20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay per visit	50% after deductible Up to Out-of-Pocket Maximum
Chemical Dependency Inpatient: Requires pre-certification	\$500 Copay per admission	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible Up to Out-of-Pocket Maximum	50% after deductible Up to Out-of-Pocket Maximum
Chemical Dependency Outpatient:	\$20 Copay each visit	20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay per visit	50% after deductible Up to Out-of-Pocket Maximum
Outpatient Physical Therapy • 60 visit Maximum per Plan Year	\$20 Copay each visit (20 visits per year for each type of therapy i.e. physical, occupational, and speech therapy)	20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay	50% after deductible Up to Out-of-Pocket Maximum
Outpatient Speech, Hearing and Occupational Therapy • 60 visit Maximum per Plan Year		20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay	50% after deductible Up to Out-of-Pocket Maximum
	*Biologically based mental illness care – coverage is no less extensive than the coverage provided for any other physical illness.			

* This is a comparison tool for Great-West and Kaiser. For more specific, detailed information, see each individual Plan Benefit Summary.