



MEDICAL BENEFIT SUMMARY
Effective July 1, 2008

GENERAL SERVICES	STANDARD PLAN		PREMIUM PLAN		BASIC PLAN	
	NETWORK SERVICES	NON-NETWORK SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES
Plan Year Deductible (excludes copays)	\$500 Individual \$1,000 Family	\$6,000 Individual \$12,000 Family	\$300 Individual \$600 Family	\$1,000 Individual \$2,000 Family	\$1,500 Individual \$3,000 Family	\$6,000 Individual \$12,000 Family
Coinsurance	80%	50%	90%	70%	80%	50%
Out of Pocket Maximum (excludes deductible)	\$2,250 Individual \$4,500 Family	\$7,500 Individual \$15,000 Family	\$1,500 Individual \$3,000 Family	\$4,500 Individual \$9,000 Family	\$3,000 Individual \$6,000 Family	\$7,500 Individual \$15,000 Family
Lifetime Maximum	\$5,000,000 per member		\$5,000,000 per member		\$5,000,000 per member	
Physician Visit	\$25 Copay	50% after deductible	\$25 Copay	70% after deductible	\$25 Copay	50% after deductible
Specialist Visit	\$50 Copay	50% after deductible	\$50 Copay	70% after deductible	80% after deductible	50% after deductible
Preventive Care • Immunizations • Routine physicals • Basic Gynecological care • Routine Mammogram	\$25 Copay Physician \$50 Copay Specialist	50% after deductible	\$25 Copay Physician \$50 Copay Specialist	70% after deductible	First \$500 in expenses - 100%, no deductible Additional expenses - 80% after deductible	50% after deductible
Colonoscopy	\$250 Copay	50% after deductible	\$250 Copay	70% after deductible	80% after deductible	50% after deductible
Performance Pharmacy Plan (includes contraceptives) • Tier 1 = Generic • Tier 2 = Preferred • Tier 3 = Non-preferred	Retail Pharmacy ~ 30 day supply \$10: Generic Copay \$30: Tier 2 brand \$50: Tier 3 brand Retail Pharmacy ~ 90 day supply \$30: Generic Copay \$90: Tier 2 brand \$150: Tier 3 brand Mail Order ~ 90 day supply \$25: Generic Copay \$75: Tier 2 brand \$125: Tier 3 brand	Appropriate copay level +50% of the full cost of the prescription	Retail Pharmacy ~ 30 day supply \$10: Generic Copay \$30: Tier 2 brand \$50: Tier 3 brand Retail Pharmacy ~ 90 day supply \$30: Generic Copay \$90: Tier 2 brand \$150: Tier 3 brand Mail Order ~ 90 day supply \$25: Generic Copay \$75: Tier 2 brand \$125: Tier 3 brand	Appropriate copay level +50% of the full cost of the prescription	Retail Pharmacy ~ 30 day supply \$10: Generic Copay \$30: Tier 2 brand \$50: Tier 3 brand Retail Pharmacy ~ 90 day supply \$30: Generic Copay \$90: Tier 2 brand \$150: Tier 3 brand Mail Order ~ 90 day supply \$25: Generic Copay \$75: Tier 2 brand \$125: Tier 3 brand	Appropriate copay level +50% of the full cost of the prescription



MEDICAL BENEFIT SUMMARY
Effective July 1, 2008

GENERAL SERVICES	STANDARD PLAN		PREMIUM PLAN		BASIC PLAN	
	NETWORK SERVICES	NON-NETWORK SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES
Durable Medical Equipment • Maximum of \$3,500 per Plan Year	100% no deductible		90% after network deductible		80% after network deductible	
Oxygen	100% no deductible		100% no deductible		80% after deductible	50% after deductible
Lab & X-ray Services – outpatient, independent lab or related to an office visit	100% no deductible	50% after deductible	100% no deductible	70% after deductible	80% no deductible	50% after deductible
High Tech Radiology (MRI, Pet, CAT scans)	\$250 Copay	50% after deductible	\$250 Copay	70% after deductible	80% after deductible	50% after deductible
Spinal Adjustment Treatment • 60 visit Maximum per Plan Year	\$50 Copay	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
Emergency Room Care	\$200 Copay		\$200 Copay		80% after network deductible	
Urgent Care	\$100 Copay	50% after deductible	\$100 Copay	70% after deductible	80% after deductible	50% after deductible
Ambulance	80% after network deductible		90% after network deductible		80% after network deductible	
Eye Exam • 1 every 24 months.	\$10 Copay You pay provider at time of service and will be reimbursed 100% of UCR less your copay.		\$10 Copay You pay provider at time of service and will be reimbursed 100% of UCR less your copay.		Not Covered	
PPO Out-of Area Services	Services rendered outside of any PPO geographical area are paid at 70% of UCR, subject to out of pocket maximums and plan year deductibles.		Services rendered outside of any PPO geographical area are paid at 80% of UCR, subject to out of pocket maximums and plan year deductibles.		Services rendered outside of any PPO geographical area are paid at 70% of UCR, subject to out of pocket maximums and plan year deductibles.	



MEDICAL BENEFIT SUMMARY
Effective July 1, 2008

HOSPITAL SERVICES	STANDARD PLAN		PREMIUM PLAN		BASIC PLAN	
	NETWORK SERVICES	NON-NETWORK SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES
Inpatient Hospital Services <ul style="list-style-type: none"> Including anesthesia Requires pre-certification Lab & X-Ray based on Facility Network Status 	80% after deductible		90% after deductible		80% after deductible	
Outpatient Hospital Services <ul style="list-style-type: none"> Outpatient Surgery Including anesthesia Requires pre-certification Ambulatory Surgery Lab & X-Ray paid based on Facility Network Status 	Facility Charges only for services rendered at Boulder Community Hospital will be payable at 90% after the deductible	50% after deductible	Facility Charges only for services rendered at Boulder Community Hospital will be payable at 95% after the deductible	70% after deductible	Facility Charges only for services rendered at Boulder Community Hospital will be payable at 90% after the deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
Hospice Care <ul style="list-style-type: none"> Inpatient Outpatient 	80% after deductible 100% no deductible	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
Skilled Nursing Facility Care <ul style="list-style-type: none"> 60 days per Plan Year Maximum Requires pre-certification 	80% after deductible	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
Home Health Care <ul style="list-style-type: none"> Up to 1 visit per day/100 visits per Plan Year Maximum 	100% no deductible	50% after deductible	100% no deductible	70% after deductible	80% after deductible	50% after deductible
Transplants	80% after deductible	Not Covered	90% after deductible	Not Covered	80% after deductible	Not Covered



MEDICAL BENEFIT SUMMARY
Effective July 1, 2008

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICE	STANDARD PLAN		PREMIUM PLAN		BASIC PLAN	
	NETWORK SERVICES	NON-NETWORK SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES
Mental Health Inpatient: • 45 days Maximum per Plan Year Requires pre- certification	\$75 Copay per day	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
Mental Health Outpatient: • 20 visit Maximum per Plan Year	\$35 Copay per day	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
Chemical Dependency Inpatient: • 20 days Maximum per Plan Year Requires pre- certification	\$75 Copay per day	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
Chemical Dependency Outpatient: • 20 visit Maximum per Plan Year	1 st two visits - \$15 Copay Remaining visits – \$35 Copay	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
THERAPY SERVICES						
Outpatient Physical Therapy • 60 visit Maximum per Plan Year	\$50 Copay	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible
Outpatient Speech, Hearing and Occupational Therapy • 60 visit Maximum per Plan Year	\$50 Copay	50% after deductible	90% after deductible	70% after deductible	80% after deductible	50% after deductible



MEDICAL BENEFIT SUMMARY

Effective July 1, 2008

More highlights of your Great-West Healthcare Health Plan are listed below. This list is not all inclusive; the Summary Plan Description will give detailed information about your plan, exclusions, and coverage limitations.

COMPLEMENTARY ALTERNATIVE MEDICINE DISCOUNT PROGRAM

- Receive 20% savings for services received from an ACN Group Inc., network acupuncturist, massage therapist, dietitian, nutritionist, or naturopathic doctor.
- Access www.mygreatwest.com for an overview of the program, examples of services provided by Alternative Care practitioners and information on how to look up a provider.
- ACN Group Inc., and its alternative care providers are solely responsible for the services and products they provide.

ONLINE HEALTH AND WELLNESS TOOLS

- All enrolled members have access to a personalized wellness focused website with information regarding nutrition, lifestyle and fitness.
- Health articles are available and updated daily for many different conditions.
- Pharmaceutical information, including drug interactions and supplement information is available online.
- Through the CareCompare tool, you can compare facilities based on many different criteria including cost, number of treatments provided by category, average length of stay and others.
- Through the secure website, you can also check the status of your claims, find in-network providers, view your benefit specifics and find claim forms.

AWARD WINNING DISEASE MANAGEMENT PROGRAM

- Great-West Healthcare nurses work directly with enrolled members to help manage chronic conditions such as Asthma, Diabetes, Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Pain Management, End Stage Renal Disease and Maternity Management.
- You may take online assessments to receive information about chronic diseases and send specific questions to a nurse through the Web site.

PRESCRIPTION DRUG COVERAGE

- The mail order program provides a 90 day supply vs. a retail supply of 30 days for a reduced cost.

GENERAL NOTICE OF PREEXISTING CONDITION EXCLUSION

- This Plan may impose a Preexisting Condition Exclusion (PCE). This means that if you have a medical condition before coming to our Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a three-month period. Generally, this three-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the three-month period ends on the day before the waiting period begins. The PCE does not apply to pregnancy or to a child who is enrolled in the Plan within 31 days after birth, adoption or placement for adoption.
- This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the PCE if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior Plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.
- All questions about the PCE and creditable coverage should be directed to your HR/Benefits Director.



MEDICAL BENEFIT SUMMARY

Effective July 1, 2008

PRE-CERTIFICATION PENALTY

Pre-authorization is required on all inpatient admissions and outpatient surgery not performed in the doctors office. See the below list for services requiring pre-authorization. Network providers are contractually obligated to perform pre-authorization on behalf of their clients; the member must verify that a non-network provider performs the pre-authorization procedures. If a non-network provider does not obtain pre-treatment authorization or if a Member does not follow the recommended care plan, a \$250 penalty will be applied.

- * Outpatient Surgery
- * Home Health Care
- * Air Ambulance
- * High Cost Drug
- * Transplant Evaluations
- * Hospital Admissions (including partial hospitalization programs for mental nervous)
- * High Tech Radiology (examples include CAT scans, PET scans and MRI's)
- * Skilled Nursing
- * Renal Dialysis
- * Durable Medical Equipment over \$500
- * Genetic Testing

SPECIAL ENROLLMENT RIGHTS NOTICE

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health Plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for the other coverage or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after your or your dependents' other coverage ends or after the employer stops contributing toward the other coverage.
- In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days of the marriage, birth, adoption or placement for adoption.
- To request special enrollment or obtain more information, contact your HR/Benefits Director.

WHAT'S NOT COVERED (THIS IS NOT ALL INCLUSIVE)

- * services that aren't medically necessary
- * experimental or investigational treatments
- * infertility treatment
- * accidental injury or sickness for which benefits are paid or payable under any Worker's Compensation or similar law
- * services provided by government health plans
- * cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption.
- * weight loss treatment, including but not limited to Bariatric surgery, Gastroplasty or any residual treatment from gastro surgery.
- * Massage, except when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.
- * custodial care
- * sex transformation
- * surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses.
- * vision therapy or orthoptic treatment
- * reversal of sterilization procedures
- * nonprescription drugs or anti-obesity drugs
- * gene manipulation therapy
- * smoking cessation programs
- * treatment of temporomandibular disorders and craniofacial muscle disorders (TMJ).
- * Hearing aids or the fitting of hearing aids.

Great-West Healthcare refers to products and services provided by Great-West Life & Annuity Insurance Company and its subsidiaries (Alta Health & Life Insurance Company and Great-West Healthcare HMO/HCSC companies). It also refers to the group business that is underwritten by New England Life Insurance Company and Metropolitan Life Insurance Company which is currently administered by Great-West Life & Annuity Insurance Company. Great-West Life & Annuity Insurance Company is not licensed to do business in New York. Products are sold in New York by its subsidiary First Great-West Life & Annuity Insurance Company, White Plains, N.Y.