PERA Care

2010 Health Benefits Program

Pre-Medicare Coverage

COLORADO PERA®

PERACare Plan Contact Information/Resources

Anthem Blue Cross and Blue Shield
Group #195096
1-877-PERABLU (877-737-2258)
www.anthem.com

Caremark
Group #PERA
1-800-378-0755
www.caremark.com

CIGNA Dental
Dental HMO
Group #10080104
Dental PPO
Group #3171792
1-877-635-PERA (7372)
www.cigna.com

Delta Dental
Group #9426
1-800-610-0201
www.deltadentalco.com

Kaiser Permanente
Group #1804
Denver/Boulder: 303-338-3800 or
1-800-632-9700
Southern Colorado: 1-888-681-7878
www.kaiserpermanente.org

VSP
Group #12144626
1-800-877-7195
www.vsp.com

Centers for Medicare and Medicaid Services (CMS)
1-800-MEDICARE (633-4227)
www.medicare.gov

Social Security Administration
1-800-772-1213
www.socialsecurity.gov

SilverSneakers
1-888-423-4632
www.silversneakers.com

PERAFit
1-877-550-PERA (7372)
www.perafit.org

PERA Contact Information

Colorado Public Employees' Retirement Association
Mailing Address
Colorado PERA
PO Box 5800
Denver, CO 80217-5800

Denver Main Office
1301 Pennsylvania Street
Denver, CO 80203-5011

Denver Main Office Hours (Mountain time)
7:30 a.m.–4:30 p.m. Monday–Friday

Westminster Office
1120 W. 122nd Avenue
Westminster, CO 80234

Westminster Office Hours (Mountain time)
7:30 a.m.–4:30 p.m. Monday, Tuesday, Thursday, and Friday
1:00 p.m.–4:30 p.m. Wednesday

Customer Service Center Phone Hours (Mountain time)
7:00 a.m.–5:30 p.m. Monday–Thursday
7:00 a.m.–4:30 p.m. Friday

Phone
303-832-9550 or
1-800-759-7372 (PERA)
303-863-3727 (Fax)

Web site/e-mail
www.copera.org (e-mail via "Contact Us" link on the PERA home page)

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PERACare Program Enrollment Guidelines

Who is Eligible to Enroll in PERACare?

PERA benefit recipients and their eligible dependents may enroll in PERACare.

"Benefit recipient" means a retiree, spouse, cobeneficiary, qualified child, or dependent parent receiving monthly service retirement, disability retirement, or survivor benefits.

The individual receiving the PERA benefit (the benefit recipient) must be enrolled in order for any dependents to be enrolled. If the benefit recipient is enrolled, he/she may enroll the following dependents:

- Spouses;
- Domestic partners; and
- Unmarried, dependent children under age 25, certain mentally or physically incapacitated adult children, and dependent parents. (Any child claimed as a dependent for income tax purposes who lives with the benefit recipient and meets these guidelines also is eligible.)

In addition, the following individuals have eligibility to be enrolled in PERACare:

- Guardians of children receiving PERA survivor benefits, as long as the children also are enrolled.
- Surviving spouses of deceased retirees who chose single-life annuity options, if the surviving spouse was enrolled in the PERACare program when the retiree's death occurred.*
- Divorced spouses of retirees who are not receiving PERA benefits but were enrolled in the PERACare program when the divorce from the PERA retiree occurred.*

* *If a surviving spouse or divorced spouse discontinues coverage, re-enrollment is not allowed.*

When Can I Enroll, Change Plans, or Add Dependents?

If you are enrolling in PERACare when you retire, you have 30 days from your first benefit payment date to submit your enrollment form. If you do not enroll when you retire, you are eligible to enroll, change plans, or add dependents based on certain "life events" and annually during the open enrollment period. See the PERACare Enrollment Eligibility chart on page 3.

Note that if you are adding PERACare coverage anytime other than when you are first eligible or during the annual open enrollment period, the effective date of your PERACare coverage must coincide with the end of your other coverage.

PERACare coverage is effective on the first day of the month. Any additions or changes can be effective on the first day of the month of eligibility.

If you are enrolling at retirement, you may choose an effective date up to six months in the future, as long as you remain covered by your employer's plan in the interim.

ENROLLING IN PERACARE

You must complete a *PERACare Enrollment/Change Form* in order to enroll in PERACare. Enrollment in PERACare is not automatic, even if you are choosing PERACare coverage under the same health plan you had with a prior employer or group.

If I'm Enrolled in a Pre-Medicare Plan, What Happens When I Turn Age 65?

When you turn age 65, you are no longer eligible to be enrolled in a PERACare pre-Medicare health plan. Instead, you become eligible to enroll in a PERACare Medicare health plan. Three months before your 65th birthday, you should contact Social Security and enroll in Medicare Part B. (You are eligible for Medicare Part B even if you never worked under Social Security or contributed to Medicare.) With your Medicare Part B in place, you can enroll in any of the PERACare Medicare plans for which you are eligible (see the PERACare Enrollment Eligibility Chart on page 3). Note that you are not required to have, or to purchase, Medicare Part A.

If you become eligible for Medicare before age 65 because of a medical condition or disability, you should request Medicare plan information from PERA.

BEFORE YOUR 65TH BIRTHDAY

Three months before your 65th birthday, PERA will send you a booklet containing information about your PERACare Medicare plan options. Plan information is also available on PERA's Web site at www.copera.org.

Options for Combination Coverage

If you or your spouse is over 65 and has Medicare, but one of you is pre-Medicare, you have several options for combination coverage. PERA's self-insured plans administered by Anthem Blue Cross and Blue Shield offer both pre-Medicare and Medicare coverage worldwide. Kaiser Permanente also offers combination coverage in its Denver/Boulder and Southern Colorado service areas. If you are interested in combination coverage, contact PERA and request the *PERACare Combination Coverage Premium Information/Enrollment Form.*

Traveling

If you are traveling and have a medical emergency, you have in-network coverage for emergency and urgent care services. You may also receive non-emergency care (routine care) while traveling if you are enrolled in one of PERA's Anthem PPO plans. If you use a provider that contracts with Anthem, you can receive in-network benefits. If you use a provider that does not contract with Anthem, you will generally have higher costs because the claims will be paid as out-of-network claims. If you are enrolled in a Kaiser Permanente plan, you can receive non-emergency care while traveling only if you obtain that care at another Kaiser facility.

Moving

If you move, notify PERA promptly of your new address and PERA will advise your health care, dental, or vision carrier.

If you are enrolled in a Kaiser Permanente plan and move outside of Kaiser's Colorado service area, your Kaiser coverage must be canceled. You will have 30 days from the date you move to enroll in one of PERA's Anthem plans by completing a *PERACare Enrollment/Change Form.*

If you are enrolled in Anthem's HMO plan and move outside of Colorado, you will have 30 days from the date you move to enroll in one of Anthem's other plans.

Note that you do not have to change plans during the open enrollment period in anticipation of a move during the following year. You can make the change at the time of your move, as long as you are no longer eligible to be enrolled in your HMO because of your new address.

Cancellation of Coverage

You may cancel coverage for yourself and/or any dependent with 30–days advance written notice to PERA. Be sure to sign and date your cancellation request. PERA may cancel coverage if you and/or any dependents are no longer eligible to participate in PERACare or if your premium payments are not current.

PERACare Enrollment Eligibility

The chart below summarizes the different times that a benefit recipient is eligible to enroll in PERACare, or add or change coverage. You may enroll or make changes within 30 days of the Enrollment Eligibility Events listed below.

ENROLLMENT ELIGIBILITY EVENTS	PROOF REQUIRED	WHO CAN BE ENROLLED OR ADDED	CHANGE(S) YOU CAN MAKE
When you are first eligible to enroll			
• Within 30 days of the date of your first PERA benefit payment (as a retiree, cobeneficiary, or survivor benefit recipient)	None for the benefit recipient*	Yourself, your spouse, and children*; your guardian (if benefit recipient is a child)	Enroll
Life events when you can enroll or change			
• Marriage	Copy of marriage certificate	Your new spouse	Add coverage for spouse
• Birth or adoption of child(ren)	Copy of birth certificate or adoption papers*	Your new child(ren)*	Add coverage for children
• During PERA's annual open enrollment period (October 1–November 15 each year)	None for the benefit recipient*	Yourself, your spouse, and children*	Enroll, add coverage for spouse or children, change plans
• Moving out of your HMO's service area	Address change notice to PERA	Yourself, your spouse, and children* (if they were covered under PERA's plan prior to move)	Change from HMO to another plan
• Turning age 65 (you or your spouse)	CPHC** and a copy of Medicare card(s)	Yourself, your spouse, and children*	Enroll, add coverage for spouse or children, change plans
• Loss of other employer/group coverage, either your own or your spouse's	CPHC** and a copy of HIPAA certificate or employer letter***	Yourself, your spouse, and children* (if they were covered in the employer's plan)	Enroll yourself and your spouse and children (if they were covered in in the employer's plan)
• Loss of individual coverage	CPHC** and a copy of insurer's cancellation or market exit letter***	Yourself, your spouse, and children* (if they were covered in the plan)	Enroll yourself and your spouse and children (if they were covered in the plan)
• Completion of COBRA coverage period (18, 29, or 36 months)	CPHC** and a copy of HIPAA certificate or COBRA letter***	Yourself, your spouse, and children* (if they were covered in the employer's plan)	Enroll yourself and your spouse and children (if they were covered in the employer's plan)
• Divorce	CPHC**	Yourself (if you were covered by your former spouse's plan)	Enroll

* If children are being enrolled, proof of dependent status may be required.

** CPHC—PERA's *Certification of Previous Health Care Coverage* form.

*** Loss of coverage must be a non-voluntary event. If you remain eligible for coverage but choose not to pay premiums or select a new plan, you are not eligible to enroll in PERACare.

Plan Benefit Choices

What Plans Does PERACare Offer?

PERACare includes health care, dental, and vision plans. You may enroll in any or all of these types of coverage. You may also enroll any eligible dependents in any of the plans in which you are enrolled.

PERACare's health plan partners for pre-Medicare coverage are Anthem Blue Cross and Blue Shield (Anthem) and Kaiser Permanente.

PERACare's dental plan partners are CIGNA Dental and Delta Dental.

PERACare's vision plan partner is VSP.

ONLINE PROVIDER DIRECTORIES

Provider directories for all of the health, dental, and vision plans in PERACare are available online through PERA's Web site. Log on to www.copera.org and click on Retirees/Benefit Recipients, then PERACare from the left-hand bar. From this page you can choose "Provider Directories." If you do not have Internet access, call the plan directly for assistance or to request a printed directory. Phone numbers and plan group numbers for each of the plans are listed on the inside front cover of this booklet.

How Should I Choose a Health Plan?

This may not be an easy decision, especially because you have a number of good plans from which to choose. Here are some of the factors that you should use in your decision:

Your location

Depending on where you live, some or all of the plans will be available to you. Your choices could be as few as three (if you live outside of Colorado where only PERA's PPO plans administered by Anthem are available), or as many as seven (if you live in the Denver/Boulder area or Southern Colorado).

Your current coverage

Think about whether you like the kind of plan you have now or whether you want to make a change. PERACare offers three kinds of plans: HMO, PPO, and HDHP/HSA. See the descriptions on page 5 for more information about each type of plan. If you like the plan you have now, and a similar plan is available through PERACare, you might want to enroll in that plan.

Your doctor(s)

If you have a doctor whom you would like to continue to use when you enroll in a PERACare plan, you will want to choose a plan that either contracts with that doctor or has an out-of-network benefit that allows you to see that doctor. Anthem has a large network of contracted providers, so it is likely that your doctor will be in Anthem's network. If not, you might choose one of the Anthem PPO plans that provide for out-of-network coverage. If you are in a Kaiser Permanente plan now, you will probably want to enroll in one of PERA's Kaiser plans so that you can continue to see your Kaiser doctors.

Your usage of health services

If you're healthy, have minimal prescription expenses, and rarely see a doctor, you might choose a plan like PPO #2 or HMO #2. These plans have lower premiums, but higher out-of-pocket costs when you use the plan. If you have the need for frequent and/or expensive health care services, you might be better served in a plan with higher premiums and more generous benefits like PPO #1 or HMO #1.

Your prescription drug needs

If you take any prescription drugs, you may want to compare the coverage and costs in different plans. Each plan has a formulary or preferred drug list, and may or may not cover drugs not on their formulary. You may want to review the formularies on the plan Web sites or you may call the plans (see page 6).

Premiums

Consider all of your potential health care costs—not just your premium—when you evaluate costs. Look at deductibles, copays, and out-of-pocket maximums when estimating your total health care costs. Plans with higher premiums are more likely to have lower copays; plans with lower premiums have more cost-sharing when you use services. Premium information starts on page 27.

Pre-Medicare Health Plans

PERACare offers a variety of pre-Medicare (under age 65) health plan options. The following types of plans are available through PERACare. (See pages 8-23 for more specific plan information.)

HMO Plans

In an HMO plan, you have a comprehensive set of benefits, including preventive care benefits. You use doctors and hospitals in the plan's network, and generally have no coverage if you see a non-network provider. You pay a specified copayment and/or coinsurance for each office visit and the plan pays the rest. You generally don't have to worry about filing claims or dealing with bills from providers.

PPO Plans

In a PPO plan, you have more flexibility for accessing benefits than in an HMO plan. The network of preferred/participating providers is usually larger, and often covers a broader geographic area. You have the ability to use non-network providers in a PPO plan and receive some level of coverage. You are subject to deductibles and coinsurance and/or copays.

HDHP and HSA Plans

A High Deductible Health Plan (HDHP) is usually a variation of a PPO plan, and it must meet specific requirements set forth in federal law. You can enroll in an HDHP alone, or you can enroll in an HDHP and then set up a Health Savings Account (HSA) to set aside funds to cover your deductible and out-of-pocket costs on a tax-deductible basis. In an HDHP, you have the same type of benefits as in other plans, but you must meet the plan's high deductible before the plan starts to pay for those benefits. An HDHP can offer first-dollar coverage for some preventive services, but for most health care needs, including prescription drugs, you pay 100 percent of costs until you have met the plan's deductible. After you meet the plan's deductible, you share in costs through coinsurance and/or copays.

If you are participating in an HDHP, you are eligible to contribute to an HSA. For 2010, you can contribute $3,050 (plus $1,000 "catch up" if you are age 55 or older) no matter what your HDHP plan's deductible is, and your contributions can be tax-deductible. Funds in your HSA are invested and earnings accumulate tax-free. If you withdraw HSA funds for qualified health care expenses, they can remain tax-free upon distribution. You may establish an HSA with your bank, credit union, or any financial institution of your choice, including the bank that has an arrangement with your carrier's HDHP. You are not required to contribute to an HSA if you enroll in an HDHP, but many individuals choose an HDHP so they can contribute to an HSA.

QUESTIONS ABOUT PRESCRIPTION BENEFITS?

- If you are enrolled in PERA's Anthem Blue Cross and Blue Shield plans, call Caremark at 1-800-378-0755.
- If you are enrolled in Kaiser Permanente plans, call Kaiser Permanente at one of the following phone numbers:
  Denver/Boulder
  303-338-4503
  Southern Colorado
  1-888-681-7878
  Ext. 4.

Prescription Drug Coverage

All of the health plans offered through PERACare include prescription drug coverage. Benefits, copayments, deductibles, and coverage levels vary between plans. Formularies (lists of preferred drugs) are used; there may be limited or no coverage for drugs that are not included on the formulary.

In efforts to control costs and premiums, plans use a number of cost-containment designs. Most plans require that generic drugs be dispensed whenever possible. Some plans have closed formularies and will cover only those drugs that are on their formulary. Some plans use a preferred drug list, but also cover drugs that are not on the preferred drug list. Most plans use a prior authorization process for some types of medications.

Most plans have special procedures and cost-sharing for specialty pharmacy. Specialty pharmacy includes high cost pharmaceutical products that are generally biotech in nature. Most require injection or other unique methods of administration and refrigeration or special handling.

If you are enrolled in one of PERA's self-insured plans administered by Anthem, you have a comprehensive prescription drug benefit through Caremark, a national pharmacy benefit manager. You may get your prescriptions filled at local retail pharmacies and through Caremark's mail order pharmacies. If you are enrolled in Kaiser Permanente Denver/Boulder, your prescription drug benefit is an integral part of your Kaiser plan, and you get your prescriptions filled when you visit your Kaiser facility. Kaiser also offers a home delivery option which is similar to mail order. If you are enrolled in Kaiser Permanente Southern Colorado, you may get your prescriptions filled at local retail pharmacies and through Kaiser's mail pharmacy service.

Refer to Question #11 in the Health Plan Descriptions for information about each plan's prescription drug benefits. If you use high cost prescriptions and/or a number of different drugs, you will want to compare the different plans' coverage and costs carefully.

Fitness and Wellness Programs

Fitness and wellness benefits have been proven to improve health and reduce health care costs. If you enroll in an Anthem or Kaiser Permanente health plan, you will receive information about the following value-added benefits once your coverage becomes effective.

SilverSneakers

All of PERA's plans with Anthem and Kaiser include membership in The SilverSneakers® Fitness Program. With SilverSneakers, you receive a free basic fitness center membership to over 9,000 participating locations nationwide including Curves® locations. You can use any of the fitness center's amenities that come with a basic membership. You also have access to SilverSneakers classes, Senior Advisors℠, health education, and social activities.

PERAFit

Enrollees in PERA's Anthem plans also have access to PERAFit, a fitness and wellness program developed by National Jewish Health in Denver. It is a medically sound program that focuses on healthy behaviors, exercise, and long-term weight management. It was designed for enrollees to exercise on their own, but now it can be combined with SilverSneakers for the added benefit of exercise and classes in a fitness center.

Plan Descriptions

Colorado Health Plan Description Forms

This section of the booklet features summaries of the pre-Medicare plans offered by PERACare. These summaries are called "Colorado Health Plan Description Forms" and are in a standardized format set forth in State law.

Dental and Vision Plan Descriptions

The dental and vision plan descriptions are in a format similar to the Health Plan Description Forms and begin on page 24.

ENDNOTES
Endnotes for the Health Plan Descriptions are found on page 23. Premium information begins on page 28.

Anthem

	HMO	PPO #1	
		In-Network	Out-of-Network

Part A: Type of Coverage

	HMO	PPO #1
1. Type of Plan	Health Maintenance Organization (HMO)	Preferred provider plan
2. Out-of-Network Care Covered?[1]	Only for emergency and urgent care	Yes, but the patient pays more for Out-of-Network
3. Areas of Colorado where Plan is Available	Plan is available throughout Colorado	Plan is available worldwide

Part B: Summary of Benefits

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 policy, 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 prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copay options reflect the amount the plan will pay.

	HMO	PPO #1 In-Network	PPO #1 Out-of-Network
4. Annual Deductible[2]			
a. Individual	No deductible	$1,500, excludes copays	$3,000
b. Family	No deductible	$3,000, excludes copays	$6,000
5. Out-of-Pocket Maximum[3]	Excludes payments for prescription drugs	Excludes copays and payments for prescription drugs	Excludes payments for prescription drugs
a. Individual	$10,000	$10,000	$20,000
b. Family	$20,000	$20,000	$40,000
c. Is Deductible Included in the Out-of-Pocket	Not applicable	Yes	Yes
6. Lifetime or Benefit Maximum Paid by the Plan for All Care	$2,500,000 per individual	$2,500,000 per individual In-Network and Out-of-Network combined for all covered services	$2,500,000 per individual In-Network and Out-of-Network combined for all covered services
7A. Covered Providers	HMO Colorado managed care network. See provider directory for complete list of current providers	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers	All providers licensed or certified to provide covered benefits
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes	Yes

PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Preferred provider plan		Preferred provider plan	
Yes, but the patient pays more for Out-of-Network		Yes, but the patient pays more for Out-of-Network	
Plan is available worldwide		Plan is available worldwide	

$6,000, excludes copays $12,000	$12,000 $24,000	$3,500 $7,000	$7,000 $14,000
Excludes copays and payments for prescription drugs $16,000 $32,000 Yes	Excludes payments for prescription drugs $32,000 $64,000 Yes	$5,950 $11,900 Yes	$11,900 $23,800 Yes
$2,500,000 per individual In-Network and Out-of-Network combined for all covered services	$2,500,000 per individual In-Network and Out-of-Network combined for all covered services	$2,500,000 per individual In-Network and Out-of-Network combined for all covered services	$2,500,000 per individual In-Network and Out-of-Network combined for all services
Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers	All providers licensed or certified to provide covered benefits	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers	All providers licensed or certified to provide covered benefits
Yes	Yes	Yes	Yes

Part B: Summary of Benefits (continued)

	HMO	PPO #1 In-Network	PPO #1 Out-of-Network
8. Medical Office Visits[4]			
a. Primary Care Providers	$30 copay per visit	$30 copay per visit (not subject to deductible)	Plan pays 60% after deductible
b. Specialists	$45 copay per visit	$45 copay per visit (not subject to deductible)	Plan pays 60% after deductible
	Plan pays 80% for all other services that are not billed as an office visit	Plan pays 80% after deductible for all other services that are not billed as an office visit	
9. Preventive Care		Preventive care services are not subject to deductible	
a. Children's Services (Up to age 13)	Plan pays 100%	Plan pays 100%	Not covered
Childhood Immunizations	Plan pays 100%	Plan pays 100%	Not covered
b. Adults' Services	Plan pays 100%	Plan pays 100%	Not covered
Mammogram Screening	Plan pays 100%	Plan pays 100%	Not covered
Prostate Screening	Plan pays 100%	Plan pays 100%	Not covered
Flu Shots	Plan pays 100%	Plan pays 100%	Plan pays 100% up to an annual maximum reimbursement
Colonoscopy	$300 copay	$300 copay	Not covered
10. Maternity			
a. Prenatal care	$200 copay per pregnancy for office visits and delivery services from the physican. Plan pays 80% for all services that are not billed as an office visit	$200 copay per pregnancy (not subject to deductible) for office visits and delivery services from the physician. Plan pays 80% after deductible for all services that are not billed as an office visit	Plan pays 60% after deductible for office visits and delivery services from the physician
b. Delivery & Inpatient well baby care[5]	Plan pays 80% after $1,200 copay per admission for facility services	Plan pays 80% after deductible for facility services	Plan pays 60% after deductible for facility services
11. Prescription Drugs Level of coverage and restrictions on prescriptions	*Retail (30-day supply):* $300 deductible (per person) then 50% covered; $15 minimum, $75 maximum *Mail order (90-day supply):* $35 for Generic, $125 for Brand (not subject to deductible) Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum	*Retail (30-day supply):* $300 deductible (per person) then 50% covered;$15 minimum, $75 maximum *Mail order (90-day supply):* $35 for Generic, $150 for Brand (not subject to deductible) Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum	
12. Inpatient Hospital	Plan pays 80% after $1,200 copay per admission	Plan pays 80% after deductible	Plan pays 60% after deductible
13. Outpatient/Ambulatory Surgery	Plan pays 80% after $600 copay per surgery	Plan pays 80% after deductible	Plan pays 60% after deductible

PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive care services are not subject to deductible Plan pays 100%	Not covered	Preventive care services are not subject to deductible Plan pays 100%	Not covered
Plan pays 100%	Not covered	Plan pays 100%	Not covered
Plan pays 100%	Not covered	Plan pays 100%	Not covered
Plan pays 100%	Not covered	Plan pays 100%	Not covered
Plan pays 100%	Not covered	Plan pays 100%	Not covered
Plan pays 100%	Plan pays 100% up to an annual maximum reimbursement	Plan pays 100%	Plan pays 100% up to an annual maximum reimbursement
$300 copay	Not covered	$300 copay	Not covered
Plan pays 80% after deductible for office visits and delivery services from the physician	Plan pays 60% after deductible for office visits and delivery services from the physician	Plan pays 80% after deductible for office visits and delivery services from the physician	Plan pays 60% after deductible for office visits and delivery services from the physician
Plan pays 80% after deductible for facility services	Plan pays 60% after deductible for facility services	Plan pays 80% after deductible for facility services	Plan pays 60% after deductible for facility services
Retail (30-day supply): $500 deductible (per person), then 50% covered; $15 minimum; $100 maximum after deductible *Mail order (90-day supply):* $35 for Generic, $175 for Brand (not subject to deductible) Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum		Plan pays 80% after deductible	Plan pays 80% after deductible
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible

Anthem

	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
14. Diagnostics			
a. Laboratory & X-ray	Plan pays 80%	Plan pays 80% after deductible	Plan pays 60% after deductible
b. MRI, nuclear medicine, and other high-tech services	Plan pays 80% after $200 copay per procedure	Plan pays 80% after deductible	Plan pays 60% after deductible
15. Emergency Care[6,7]	Plan pays 80% after $250 copay per emergency room visit. Care is covered In-Network or Out-of-Network	Plan pays 80% after deductible	Plan pays 80% after deductible
16. Ambulance	Plan pays 80% per trip for ground or air ambulance	Plan pays 80% after deductible for ground or air ambulance	Plan pays 80% after deductible for ground or air ambulance
17. Urgent, Non-Routine After-Hours Care	Plan pays 80% after $60 copay per urgent care visit. Urgent care may be received from your PCP or from an urgent care center. Care is covered In-Network or Out-of-Network	Plan pays 80% after deductible	Plan pays 80% after deductible
18. Biologically Based Mental Illness and Mental Disorders Care[8]	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
19. Other Mental Health Care	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
20. Alcohol & Substance Abuse	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
21. Physical, Occupational, and Speech Therapy			
a. Inpatient	Plan pays 80% after $1,200 copay per admission. Limited to 30 non-acute inpatient days per year	Plan pays 80% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined
b. Outpatient	$45 copay per visit Plan pays 80% for all services that are not billed as a therapy visit. Limited to 20 visits per year each for physical, occupational and speech therapy	Plan pays 80% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined
22. Durable Medical Equipment	Plan pays 80%. Limited to a maximum payment of $4,000 per year. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum payment of $4,000 but a claim, for such a device will reduce the $4,000 maximum payment for other Durable Medical Equipment. Disposable medical supplies are not subject to the $4,000 maximum payment	Plan pays 80% after deductible with benefits limited to a maximum payment of $4,000 per year. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum payment of $4,000, but a claim for such a device will reduce the $4,000 maximum payment for other Durable Medical Equipment. Disposable medical supplies are not subject to the $4,000 maximum payment	Not covered

PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible	Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible
Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Plan pays 80% after deductible for ground or air ambulance	Plan pays 80% after deductible for ground or air ambulance	Plan pays 80% after deductible for ground or air ambulance	Plan pays 80% after deductible for ground or air ambulance
Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
Plan pays 80% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined Plan pays 80% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined Plan pays 60% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined	Plan pays 80% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined Plan pays 80% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined Plan pays 60% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined
Plan pays 80% after deductible with benefits limited to a maximum payment of $4,000 per year. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum payment of $4,000 but a claim for such a device will reduce the $4,000 maximum payment for other Durable Medical Equipment. Disposable medical supplies are not subject to the $4,000 maximum payment	Not covered	Plan pays 80% after deductible with benefits limited to a maximum payment of $4,000 per year. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum payment of $4,000, but a claim for such a device will reduce the $4,000 maximum payment for other Durable Medical Equipment. Disposable medical supplies are not subject to the $4,000 maximum payment	Not covered

	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
23. Oxygen	Plan pays 80%	Plan pays 80% after deductible	Not covered
24. Organ Transplants **a. Inpatient**	Plan pays 80% after $1,200 copay per admission	Plan pays 80% after deductible	Not covered
b. Outpatient	$30 copay per visit for PCP $45 copay per visit for specialist Plan pays 80% for all services that are not billed as an office visit Benefits limited to $1,000,000 per transplant with a maximum payment of $10,000 for transportation and lodging and maximum payment of $25,000 for donor services	$30 copay per visit for PCP $45 copay per visit for specialist Plan pays 80% after deductible for all services that are not billed as an office visit Benefits limited to $1,000,000 per transplant with a maximum payment of $10,000 for transportation and lodging and maximum payment of $25,000 for donor services	Not covered
25. Home Health Care	Plan pays 80%	Plan pays 80% after deductible	Plan pays 60% after deductible
26. Hospice Care **a. Inpatient**	Plan pays 80% after $1,200 copay per admission	Plan pays 80% after deductible	Plan pays 60% after deductible
b. Outpatient	Plan pays 80%	Plan pays 80% after deductible	Plan pays 60% after deductible
27. Skilled Nursing Facility Care	Plan pays 80% Limited to 100 days per year	Plan pays 80% after deductible. Limited to 100 days per year In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 100 days per year In-Network and Out-of-Network combined
28. Dental Care	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 80% for services received within 72 hours of the accident	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 80% after deductible	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 60% after deductible
29. Vision Care	Not covered	Not covered	Not covered
30. Chiropractic Care	$30 copay per visit. Plan pays 80% for all services that are not billed as an office visit. Limited to 20 visits per year	Plan pays 80% after deductible to a maximum of $1,000 per year In-Network and Out-of-Network combined	Plan pays 60% after deductible to a maximum of $1,000 per year In-Network and Out-of-Network combined
31. Significant Additional Covered Services (list up to 5)	• PERAFit • SilverSneakers • Smoking cessation programs and prescriptions up to annual maximum of $250 and lifetime maximum of $500 • For hemodialysis $45 copay per visit • Members who desire another professional opinion may obtain a second opinion • Osteopathic manipulative therapy (OMT) is limited to a maximum of 6 outpatient visits per year	• PERAFit • SilverSneakers • Smoking cessation programs and prescriptions up to annual maximum of $250 and lifetime maximum of $500 • Members who desire another professional opinion may obtain a second surgical opinion	• Members who desire another professional opinion may obtain a second surgical opinion

PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Plan pays 80% after deductible	Not covered	Plan pays 80% after deductible	Not covered
Plan pays 80% after deductible	Not covered	Plan pays 80% after deductible	Not covered
Plan pays 80% after deductible Benefits limited to $1,000,000 per transplant with a maximum payment of $10,000 for transportation and lodging and maximum payment of $25,000 for donor services	Not covered	Plan pays 80% after deductible Benefits limited to $1,000,000 per transplant with a maximum payment of $10,000 for transportation and lodging and maximum payment of $25,000 for donor services	Not covered
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible	Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible
Plan pays 80% after deductible. Limited to 100 days per year In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 100 days per year In-Network and Out-of-Network combined	Plan pays 80% after deductible. Limited to 100 days per year In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 100 days per year In-Network and Out-of-Network combined
Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 80% after deductible	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 60% after deductible	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 80% after deductible	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 60% after deductible
Not covered	Not covered	Not covered	Not covered
Plan pays 80% after deductible up to $1,000 per year In-Network and Out-of-Network combined	Plan pays 60% after deductible up to $1,000 per year In-Network and Out-of-Network combined	Plan pays 80% after deductible up to $1,000 per year In-Network and Out-of-Network combined	Plan pays 60% after deductible up to $1,000 per year In-Network and Out-of-Network combined
• PERAFit • SilverSneakers • Smoking cessation programs and prescriptions up to annual maximum of $250 and lifetime maximum of $500 • Members who desire another professional opinion may obtain a second surgical opinion	• Members who desire another professional opinion may obtain a second surgical opinion	• PERAFit • SilverSneakers • Smoking cessation programs and prescriptions up to annual maximum of $250 and lifetime maximum of $500 • Members who desire another professional opinion may obtain a second surgical opinion	• Members who desire another professional opinion may obtain a second surgical opinion

Anthem

	HMO	PPO #1	
		In-Network	Out-of-Network
Part C: Limitations and Exclusions			
32. Period during which Pre-Existing Conditions are not Covered.[9]	Not applicable; plan does not impose limitation periods for pre-existing conditions	Not applicable; plan does not impose limitation periods for pre-existing conditions	
33. Exclusionary Riders Can an individual's specific pre-existing condition be entirely excluded from the policy?	No	No	
34. How does the Policy define a "Pre-Existing Condition?"	Not applicable; plan does not exclude coverage for pre-existing conditions	Not applicable; plan does not exclude coverage for pre-existing conditions	
35. What treatments and conditions are excluded under this policy?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier or plan sponsor. Review them to see if a service or treatment you may need is excluded from the policy	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier or plan sponsor. Review them to see if a service or treatment you may need is excluded from the policy	
Part D: Using the Plan			
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining the preauthorization	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
39. What is the main customer service number?	1-877-PERABLU (877-737-2258)	1-877-PERABLU (877-737-2258)	
40. Whom do I write/call if I have a complaint or want to file a grievance?[10]	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 1-877-PERABLU (877-737-2258)	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 1-877-PERABLU (877-737-2258)	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800	
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 form #'s 98770_HMO Group—all sizes	Policy form #'s _PPO1 Group—all sizes	
43. Does the plan have a binding arbitration clause?	Yes	Yes	

PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Not applicable; plan does not impose limitation periods for pre-existing conditions		Not applicable; plan does not impose limitation periods for pre-existing conditions	
No		No	
Not applicable; plan does not exclude coverage for pre-existing conditions		Not applicable; plan does not exclude coverage for pre-existing conditions	
Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier or plan sponsor. Review them to see if a service or treatment you may need is excluded from the policy		Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier or plan sponsor. Review them to see if a service or treatment you may need is excluded from the policy	

PPO #2 In-Network	PPO #2 Out-of-Network	HDHP In-Network	HDHP Out-of-Network
No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield	No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield
Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield
No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
1-877-PERABLU (877-737-2258)		1-877-PERABLU (877-737-2258)	
Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 1-877-PERABLU (877-737-2258)		Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 1-877-PERABLU (877-737-2258)	
Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800		Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800	
Policy form #'s _PPO2 Group—all sizes		Policy form#'s _HSA Compatible Group—all sizes	
Yes		Yes	

Kaiser Permanente

	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
Part A: Type of Coverage			
1. Type of Plan	Health Maintenance Organization (HMO)		
2. Out-of-Network Care Covered?[1]	Only for Emergency Care		
3. Areas of Colorado where Plan is Available	Plan is available only in the following areas: Denver/Boulder and Southern Colorado as determined by ZIP code		

Part B: Summary of Benefits

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 policy, 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 prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	HMO #1	HMO #2	HDHP
4. Annual Deductible[2]			
a. Individual	No deductibles	$1,000 per year	$3,500 per year
b. Family	No deductibles	$3,000 per year	$7,000 per year; for family memberships, the individual deductible does not apply; family deductible must be met by one or more family members before coinsurance benefit applies
5. Out-of-Pocket Maximum[3]			
a. Individual	$4,000 per year	$3,000 per year	$5,950 per year
b. Family	$10,000 per year	$6,000 per year	$11,900 per year; for family memberships, the individual Out-of-Pocket Maximum does not apply; family Out-of-Pocket Maximum must be met by one or more family members if covered as a family unit
c. Is deductible included in the Out-of-Pocket Maximum?	Not applicable	No, the Out-of-Pocket Maximum excludes deductible and copays	Yes
6. Lifetime or Benefit Maximum Paid by the Plan for All Care	Transplant lifetime maximum $1,000,000 per individual No other lifetime maximum	Transplant lifetime maximum $1,000,000 per individual No other lifetime maximum	Transplant lifetime maximum $1,000,000 per individual No other lifetime maximum
7A. Covered Providers	Colorado Permanente Medical Group, P.C. and Kaiser Permanente affiliated network of primary care and specialty physicians. See provider directory for complete list.	Colorado Permanente Medical Group, P.C. and Kaiser Permanente affiliated network of primary care and specialty physicians. See provider directory for complete list.	Colorado Permanente Medical Group, P.C. and Kaiser Permanente affiliated network of primary care and specialty physicians. See provider directory for complete list.
7B. Are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes	Yes
8. Routine Medical Office Visits[4]			
a. Primary Care Providers	$25 copay per primary care office visit	$25 copay per primary care office visit, not subject to deductible	20% coinsurance per primary care office visit, after deductible is met
b. Specialists	$40 copay per specialist care office visit Line 13 may apply for procedures performed during an office visit	$45 copay per specialist care office visit, not subject to deductible 20% coinsurance for procedures received during an office visit, after deductible is met	20% coinsurance per specialist care office visit, after deductible is met 20% coinsurance for procedures received during an office visit including office-administered drugs, after deductible is met
9. Preventive Care			
a. Children's services	$25 copay per visit	No charge (100% covered), not subject to deductible	No charge (100% covered), not subject to deductible
b. Adults' services	$25 copay per visit	No charge (100% covered), not subject to deductible	No charge (100% covered), not subject to deductible

	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
Part B: Summary of Benefits (continued)			
10. Maturity			
a. Prenatal care	$25 copay per visit	No charge (100% covered), not subject to deductible	20% coinsurance, after deductible is met
b. Delivery & inpatient well baby care[5]	$1,000 copay per admission	20% coinsurance after deductible is met	20% coinsurance per admit, after deductible is met 20% coinsurance for procedures received during an office visit, after deductible is met
11. Prescription Drugs[6] **Level of coverage and restrictions on prescriptions**	*Retail (30-day supply):* $15 Generic $40 Brand *Mail Order (90-day supply):* $30 Generic $80 Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center	*Retail (30-day supply):* $15 Generic $40 Brand *Mail Order (90-day supply):* $30 Generic $80 Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center	After deductible is met: *Retail (30-day supply):* $10 Generic $25 Brand *Mail Order (90-day supply):* $20 Generic $50 Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center
12. Inpatient Hospital	$1,000 copay per admission	20% coinsurance after deductible is met 20% coinsurance for inpatient professional visits, after deductible is met	20% coinsurance after deductible is met 20% coinsurance for inpatient professional visits, after deductible is met
13. Outpatient/Ambulatory Surgery	$300 copay per visit for outpatient surgery performed in any setting other than inpatient	20% coinsurance after deductible is met for outpatient surgery performed in any setting other than inpatient	20% coinsurance after deductible is met for outpatient surgery performed in any setting other than inpatient
14. Diagnostics			
a. Laboratory & X-ray	Diagnostic lab and X-ray: No charge (100% covered) Therapeutic X-ray: $40 copay per visit	Diagnostic lab: No charge (100% covered), not subject to deductible Diagnostic X-ray, including therapeutic: 20% coinsurance after deductible is met	Diagnostic lab: 20% coinsurance after deductible is met Diagnostic X-ray, including therapeutic: 20% coinsurance after deductible is met
b. MRI, nuclear medicine, and other high-tech services	MRI/CAT/PET: $100 copay per procedure	MRI/CAT/PET: 20% coinsurance after deductible is met	MRI/CAT/PET: 20% coinsurance after deductible is met
15. Emergency Care[7,8]	$150 copay per visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient. Line 14b procedures will generate a separate copay per procedure	20% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met	20% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met
16. Ambulance	20% coinsurance up to a maximum of $500 per trip	20% coinsurance up to $500 per trip, not subject to deductible, does not apply toward Out-of-Pocket Maximum	20% coinsurance, after deductible is met
17. Urgent, Non-Routine After Hours Care	$150 copay per visit at a designated Kaiser Permanente emergency room $25 copay per visit at a Kaiser Permanente medical office during office hours $50 copay per after hours visit at designated Kaiser Permanente medical offices	20% coinsurance at a designated Kaiser Permanente emergency room, after deductible is met $25 copay per visit at a Kaiser Permanente medical office during office hours, not subject to deductible; 20% coinsurance for procedures received during the visit, after deductible is met $45 copay per after hours visit at designated Kaiser Permanente medical offices, not subject to deductible; 20% coinsurance for procedures received during the visit, after deductible is met	20% coinsurance at a designated Kaiser Permanente emergency room, after deductible is met 20% coinsurance at a Kaiser Permanente medical office during office hours, after deductible is met; 20% coinsurance for procedures received during the visit, after deductible is met 20% coinsurance per after hours visit at designated Kaiser Permanente medical offices, after deductible is met; 20% coinsurance for procedures received during an office visit, after deductible is met

	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
Part B: Summary of Benefits (continued)			
18. Biologically-Based Mental Illness and Mental Disorders Care[9]	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
19. Other Mental Health Care	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
20. Alcohol & Substance Abuse	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
21. Physical, Occupational & Speech Therapy	For conditions subject to significant improvement within two months Inpatient: $1,000 copay per admission Outpatient: $25 copay per visit for up to 20 visits per year for each type of therapy	For conditions subject to significant improvement within two months Inpatient: 20% coinsurance after deductible is met Outpatient: $25 copay per visit for up to 20 visits per year for each type of therapy, not subject to deductible	For conditions subject to significant improvement within two months Inpatient: 20% coinsurance after deductible is met Outpatient: 20% coinsurance for up to 20 visits per year for each type of therapy, after deductible is met
22. Durable Medical Equipment	No charge (100% covered) up to $2,000 annual maximum benefit per calendar year Prosthetic arms and legs covered at no charge (100% covered) with no annual maximum benefit See policy for types and circumstances of coverage	20% coinsurance within the Service Area, not subject to deductible, does not apply toward Out-of-Pocket Maximum $2,000 annual benefit maximum per calendar year Prosthetic arms and legs covered at 20% coinsurance with no annual maximum See policy for types and circumstances of coverage	20% coinsurance within the Service Area $2,000 annual benefit maximum per calendar year, after deductible is met Prosthetic arms and legs covered at 20% coinsurance with no annual maximum, after deductible is met See policy for types and circumstances of coverage
23. Oxygen	No charge (100% covered)	20% coinsurance, not subject to deductible, does not apply toward Out-of-Pocket Maximum	20% coinsurance, after deductible is met
24. Organ Transplants	Applicable inpatient and outpatient copays apply—no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver Transplant lifetime maximum $1,000,000 per individual	20% coinsurance after deductible is met—no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. 20% coinsurance for inpatient professional visits after deductible is met Transplant lifetime maximum $1,000,000 per individual	20% coinsurance after deductible is met—no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. 20% coinsurance for inpatient professional visits, after deductible is met Transplant lifetime maximum $1,000,000 per individual
25. Home Health Care	No charge (100% covered) for prescribed medically necessary part-time home health services. Not covered outside the Service Area	20% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area	20% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area
26. Hospice Care	No charge (100% covered) for hospice care. Not covered outside the Service Area	20% coinsurance for hospice care, after deductible is met. Not covered outside the Service Area	20% coinsurance for hospice care, after deductible is met. Not covered outside the Service Area
27. Skilled Nursing Facility Care	No charge (100% covered) for up to 100 days each calendar year for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area	20% coinsurance for up to 100 days each calendar year for prescribed skilled nursing facility services at approved skilled nursing facilities, after deductible is met. Not covered outside the Service Area	20% coinsurance for up to 100 days each calendar year for prescribed skilled nursing facility services at approved skilled nursing facilities, after deductible is met. Not covered outside the Service Area

	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
Part B: Summary of Benefits (continued)			
28. Dental Care	Not covered	Not covered	Not covered
29. Vision Care	$25 copay per vision exam (refraction) performed by an optometrist Hardware not covered	$25 copay per vision exam (refraction) performed by an optometrist, not subject to deductible Hardware not covered	20% coinsurance per vision exam (refraction) performed by an optometrist, after deductible is met Hardware not covered
30. Chiropractic Care	$25 copay per visit up to 20 visits each calendar year	Not covered	Not covered
31. Significant Additional Covered Services	SilverSneakers Travel Clinic for pre-travel health risk assessments, immunizations (except those used exclusively for travel) and prescriptions; Mail-order pharmacy; health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care; limited coverage for dependent students attending an accredited college or vocational school outside any Kaiser Permanente Service Area	SilverSneakers Travel Clinic for pre-travel health risk assessments, immunizations (except those used exclusively for travel) and prescriptions; Mail-order pharmacy; health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care; limited coverage for dependent students attending an accredited college or vocational school outside any Kaiser Permanente Service Area	SilverSneakers Travel Clinic for pre-travel health risk assessments, immunizations (except those used exclusively for travel) and prescriptions; Mail-order pharmacy; health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care; limited coverage for dependent students attending an accredited college or vocational school outside any Kaiser Permanente Service Area
Part C: Limitations and Exclusions			
32. Period during which Pre-Existing Conditions are not covered[10]	Not applicable; plan does not impose limitation periods for pre-existing conditions	Not applicable; plan does not impose limitation periods for pre-existing conditions	Not applicable; plan does not impose limitation periods for pre-existing conditions
33. Exclusionary Riders: Can an individual's pre-existing condition be entirely excluded from the policy?	No	No	No
34. How does the policy define a "Pre-Existing Condition?"	Not applicable; plan does not exclude coverage for pre-existing conditions	Not applicable; plan does not exclude coverage for pre-existing conditions	Not applicable; plan does not exclude coverage for pre-existing conditions
35. What treatments and conditions are excluded under this policy?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy

Kaiser Permanente

	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
Part D: Using the Plan			
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes	Yes
38. If the provider charges more for a covered service than the plan pays, does the enrollee have to pay the difference?	No	No	No
39. What is the main customer service phone number?	Denver: 303-338-3800 or 1-800-632-9700 Colorado Springs: 1-888-681-7878	Denver: 303-338-3800 or 1-800-632-9700 Colorado Springs: 1-888-681-7878	Denver: 303-338-3800 or 1-800-632-9700 Colorado Springs: 1-888-681-7878
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Member Services 2500 S. Havana Street Aurora, CO 80014 303-338-3800	Member Services 2500 S. Havana Street Aurora, CO 80014 303-338-3800	Member Services 2500 S. Havana Street Aurora, CO 80014 303-338-3800
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small, or large group; and if it is a short-term policy.	Policy forms LGEOC-DENCOS (01-09) and GA-Large-DENCOS (01-09) Large Group	Policy forms DEDEOC-DENCOS (01-09) and GA-Large-DENCOS (01-09) Large Group	Policy forms LGHDEOC-DENCOS (01-09) Large Group
43. Does the plan have a binding arbitration clause?	Yes	Yes	Yes

Endnotes

1. **"Network"** refers to a specified group of physicians, hospital, medical clinics and other health care providers that your plan may require you to use in order 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).
2. **"Deductible"** means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible may be noted in boxes 8 through 31.
3. **"Out-of-Pocket Maximum"** means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.
4. **"Routine medical office visits"** include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness and mental disorders.
5. **"Well baby care"** includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
6. **"Prescription Drugs"** include expendable medical supplies for the treatment of diabetes. Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or nonpreferred.
7. **"Emergency care"** means services delivered by an emergency care facility, which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person 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.
8. **"Non-emergency"** care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.
9. **"Biologically based mental illnesses"** means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. "Mental disorders" means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. The term includes 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.
10. **"Waiver of pre-existing condition exclusions."** State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask carrier or plan sponsor for details.
11. **"Grievances."** Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

CIGNA Dental

	Dental HMO	Dental PPO In- and Out-of-Network
Type of Plan	Dental HMO Plan	Preferred Provider Organization (PPO) Plan
Out-of-Network Care Covered?	Plan covers out-of-network emergencies only up to $50; participant pays any other charges	Yes, the dental plan pays the same benefit level whether you use a participating PPO provider or a non-network provider. However, when you use a non-participating provider, you pay any charges above the PPO contracted fee schedule for covered services (the amount participating providers agree to accept as payment in full)
Areas where Plan is available	Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo, and Weld counties, and major metropolitan areas in many other states	Nationwide
Annual Deductible		
a. Individual	No deductible	$100
b. Family	No deductible	$200
c. Accumulation Period	N/A	Calendar Year
Annual Maximum Benefit	None	$1,500
Covered Providers	CIGNA Dental Care HMO Providers	CIGNA Dental PPO Network
Office Visits	$5 copay (in addition to any other copay)	Included in benefit for procedure
Diagnostic and Preventive	$0 to $155 copay	100% covered (not subject to deductible)
Restorative (Fillings)	$0 to $100 copay	80% covered after deductible
Endodontics (Root Canals)	$11 to $375 copay	80% covered after deductible
Periodontics (Gum Treatment)	$30 to $430 copay	80% covered after deductible
Oral Surgery (Extractions)	$11 to $105 copay	80% covered after deductible
Crowns and Bridges	$41 to $480 copay	50% covered after deductible
Prosthodontics (Dentures)	$39 to $675 copay	50% covered after deductible
Implants	Not covered	50% covered after deductible up to $1,500 lifetime maximum
Missing Tooth Limitation	No limitation	For the first 24 months of coverage, limitation applies
Orthodontics (Braces)	$61–$1,872 copay for children; $61–$2,184 copay for adults	50% covered after deductible up to $1,500 lifetime maximum

Comparing the CIGNA Dental Plans

Search for DHMO and DPPO network providers at www.cigna.com or by calling 1-800-CIGNA24 (1-800-244-6224)	• **Fixed copayments for covered services** • **No claim forms to file** • **No deductibles to meet, so your coverage starts right away** • **No annual dollar maximums** • **Access to a large credentialed national dental provider network** • **Specialty care available with a referral**	• **Visit any dentist you choose (general or specialist)** • **Access to a large national DPPO network** • **Savings when you visit a network provider (averaging 35% nationwide)** • **No referral necessary to see a specialist** • **Most network dentists file claim forms for members**

	Delta Dental PPO In- and Out-of-Network
Type of Plan	Preferred Provider Organization (PPO) Plan
Out-of-Network Care Covered?	Yes, the dental plan pays the same benefit level whether you use a participating PPO provider, a participating Premier provider or a non-network provider. However, when you use a Premier dentist or a non-participating provider, you pay any charges above the PPO contracted fee schedule for covered services (the amount participating providers agree to accept as payment in full).
Areas where Plan is available	Nationwide
Annual Deductible	
a. Individual	$100
b. Family	$200
c. Accumulation Period	Calendar Year
Annual Maximum Benefit	$1,500
Covered Providers	Delta Dental PPO Network and Delta Dental Premier Network
Office Visits	Included in benefit for procedure
Diagnostic and Preventive	100% covered (not subject to deductible)
Restorative (Fillings)	80% covered after deductible
Endodontics (Root Canals)	80% covered after deductible
Periodontics (Gum Treatment)	80% covered after deductible
Oral Surgery (Extractions)	80% covered after deductible
Crowns and Bridges	50% covered after deductible
Prosthodontics (Dentures)	50% covered after deductible
Implants	50% covered after deductible up to $1,500 lifetime maximum
Missing Tooth Limitation	No limitation applies
Orthodontics (Braces)	50% covered (not subject to deductible) up to $1,500 lifetime maximum

Considering the Delta Dental PPO Plan

Search for participating dentists at www.deltadentalco.com or by calling Delta Dental at 303-741-9305 or toll-free 1-800-610-0201

- **Visit any dentist you choose (general or specialist)**
- **Access to the largest dental network in the country**
- **Two distinct provider networks in Colorado: PPO and Premier**
- **Greatest savings when you visit a PPO network dentist**
- **PPO dentists accept Delta's contracted PPO fee schedule. Premier dentists may charge you the difference between the PPO fee schedule and the Premier fee schedule**
- **Both PPO and Premier dentists file claims for members**

VSP

	Vision PPO #1		Vision PPO #2		Vision PPO #3	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Out-of-Network Coverage	For some services, but patient pays more for Out-of-Network care		For some services, but patient pays more for Out-of-Network care		For some services, but patient pays more for Out-of-Network care	
Plan Availability	Nationwide		Nationwide		Nationwide	
Eye Exam (Every 12 months)	$10 copay	Covered up to $35	$25 copay	Covered up to $45	$10 copay	Covered up to $35
Prescription Glasses*	$25 copay for lenses and frame		$25 copay for lenses and frame		20% discount off complete pair of glasses only; no discount for lenses only, frame only or replacement parts or repairs	Not covered
Lenses	Covered once every 12 months		Covered once every 24 months			
Single Vision		Covered up to $25		Covered up to $35		
Lined Bifocal		Covered up to $40		Covered up to $50		
Lined Trifocal		Covered up to $55		Covered up to $65		
Lenticular		Covered up to $80		Covered up to $90		
Frame	Covered up to $130 retail allowance once every 24 months	Covered up to $40	Covered up to $105 retail allowance once every 24 months	Covered up to $50		
Contacts*	$130 allowance for evaluation, fitting and lenses; allowance does not apply to the contact lens exam Covered once every 12 months	$105 allowance for evaluation, fitting and lenses	$105 allowance for evaluation, fitting and lenses; allowance does not apply to the contact lens exam Covered once every 24 months	$105 allowance for evaluation, fitting and lenses	15% discount off evaluation and fitting; no discount for lenses	Not covered
Lens Options	Discounts average 35-40%	Not covered	Discounts average 35-40%	Not covered	Discounts average 20%	Not covered
Additional Glasses (Including sunglasses)	20-30% discount	Not covered	20-30% discount	Not covered	20% discount	Not covered
Laser Vision Correction	15% discount	Not covered	15% discount	Not covered	15% discount	Not covered
VSP Network Doctors	VSP PPO providers See VSP directory for a complete list of current doctors	Non-VSP providers licensed or certified to provide covered benefits	VSP PPO providers See VSP directory for a complete list of current doctors	Non-VSP providers licensed or certified to provide covered benefits	VSP PPO providers See VSP directory for a complete list of current doctors	Non-VSP providers licensed or certified to provide covered benefits
VSP Member Services	1-800-877-7195 or www.vsp.com		1-800-877-7195 or www.vsp.com		1-800-877-7195 or www.vsp.com	

* You may choose prescription glasses or contacts, but not both, once every 12 or 24 months as noted above.

Premiums

Premium Information

Your health care premium is determined by:

- The plan(s) you select,
- The number of people you enroll, and
- Your PERA subsidy.

PERACare uses four "tiers" of coverage.

- Retiree/benefit recipient only (BR)
- Retiree/benefit recipient plus spouse (BR+S)
- Retiree/benefit recipient plus child(ren) (BR+C)
- Retiree/benefit recipient plus spouse plus child(ren) (BR+S+C)

How does the PERA health care subsidy work?

PERA provides a health care subsidy to help offset your health care premium. The subsidy amount is set in State law, and is applied toward your health care premium (but by law cannot be applied to dental or vision premiums).

The subsidy is based upon your years of earned and projected (for disability retirements) service credit, and for all except DPS Division retirees, purchased and reinstated service credit is also considered. The maximum subsidy is paid for retirees with 20 or more years of service credit. If you have less than 20 years of service credit, the subsidy is reduced by 5 percent per year less than 20.

The maximum subsidy is $230 for pre-Medicare (under age 65) retirees.

PREMIUM PAYMENT

Premiums for health, dental, and vision are deducted from your monthly benefit. If your monthly benefit is not large enough to accommodate this, PERA will contact you to arrange direct payment.

HOW TO ENROLL
The *PERACare Enrollment/Change Form* is a separate document accompanying this booklet. You may also download the *PERACare Enrollment/Change Form* from the PERA Web site (*Forms and Publications* section) or call PERA's Customer Service Center to request one. You can submit your form in person, via U.S. mail, by fax, or electronically using your PIN on the PERA Web site.

Calculating Your Health Care Premium

After you have selected a health plan and chosen a level of coverage, you are ready to calculate your premium for that plan.

A. Enter the total premium amount.. A. $ ______
(from the premium chart on page 29)

B. Enter your Pre-Medicare Benefit Recipient Subsidy......................... B. $ ______
(from the subsidy chart below)

C. Subtract line B from line A (A – B) .... C. $ ______

This is your monthly health care premium.

Pre-Medicare Benefit Recipient (BR) Subsidy Chart

YEARS OF SERVICE	PRE-MEDICARE BR SUBSIDY
20+	$230.00
19	218.50
18	207.00
17	195.50
16	184.00
15	172.50
14	161.00
13	149.50
12	138.00
11	126.50
10	115.00
9	103.50
8	92.00
7	80.50
6	69.00
5	57.50
4	46.00
3	34.50
2	23.00
1	11.50

Anthem Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	HMO	PPO #1	PPO #2	HDHP
BR	$775.00	$653.00	$305.00	$616.00
BR+S	1,550.00	1,306.00	610.00	1,232.00
BR+C	1,395.00	1,175.00	549.00	1,109.00
BR+S+C	2,170.00	1,828.00	854.00	1,725.00

Kaiser Permanente Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	HMO #1	HMO #2	HDHP
BR	$609.00	$520.00	$308.00
BR+S	1,217.00	1,039.00	615.00
BR+C	1,096.00	936.00	554.00
BR+S+C	1,705.00	1,456.00	862.00

CIGNA Dental Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	HMO	PPO
BR	$16.38	$34.57
BR+S	32.75	69.14
BR+C	37.66	79.52
BR+S+C	52.40	110.63

Delta Dental Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	PPO
BR	$34.73
BR+S	69.46
BR+C	79.88
BR+S+C	111.14

VSP Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	PPO #1	PPO #2	PPO #3
BR	$7.47	$4.94	$0.78
BR+S	11.94	7.94	1.27
BR+C	12.20	8.11	1.30
BR+S+C	19.67	13.08	2.08

To calculate your net health care premium, subtract your PERA subsidy from the above health care premium. You may use the formula on page 28 or the PERACare calculator on the PERA Web site at www.copera.org.

PLANS AND PREMIUMS

Plans and premiums on this page are for pre-Medicare coverage only. If you are enrolling dependents who are age 65 or over or have Medicare, contact PERA to request the *PERACare Combination Coverage Premium Information/ Enrollment Form.*

Glossary of Key Terms

The health care terms listed below are used in this booklet, and are defined here in the context of their usage by PERA. The definitions are not meant to be comprehensive, but rather to be helpful to your understanding of PERA's program and plans.

Carrier
Insurance company or administrator offering coverage.

Coinsurance
The percentage of covered medical expenses that you pay. For example, if your coinsurance for a hospital stay is 20%, you would pay 20% of the charges and the plan would pay the other 80%.

Copay or Copayment
The dollar amount that you pay to a provider for a covered service. For example, if your copay for a hospital stay is $1,000, you would pay $1,000 and the plan would pay all or a percentage of remaining charges.

Deductible
Individual Deductible
What you must pay for covered expenses each year before the plan starts to pay. In some plans, you must pay the deductible before the plan pays for any covered services. In other plans, some routine and preventive services (those referenced as "not subject to the deductible") are covered before you have met the deductible.

Family Deductible
Limits a family's potential costs by not requiring all family members to satisfy their individual deductibles.

Formulary
A list of covered drugs. Also called preferred drug list. Includes drugs that you can receive through the plan, and includes both generic and brand-name drugs.

HDHP or High Deductible Health Plan
HSA or Health Savings Account
An HDHP meets the definitions of federal law and can be used alone or in conjunction with an HSA. (See page 5.)

HMO or Health Maintenance Organization
Members receive care from the HMO's provider network, but do not have access to providers who are outside of the plan's network. HMOs typically use the "gatekeeper" approach, where a patient's care is managed by his/her PCP.

Out-of-Network Provider
A doctor, hospital, or other provider who does not contract with your health plan. In PPO plans, you can see an out-of-network provider and receive some plan benefits. In HMO plans, you generally cannot receive any plan benefits if you see an out-of-network provider.

Out-of-Pocket Costs
The actual costs you pay when you receive health care services.

Out-of-Pocket Maximum
The most you may have to pay in a plan year for covered services. Generally includes your deductible, copays, and coinsurance. Once you have reached your out-of-pocket maximum, the plan pays 100% for all of your covered services for the rest of the calendar year. Note that most plans specify that some types of services are not included in the out-of-pocket maximum.

PBM or Pharmacy Benefit Manager
Also called prescription benefit manager. Company that administers a plan's prescription drug benefit.

PCP or Primary Care Provider
The doctor who works with you and other doctors to provide, prescribe, approve, and coordinate your medical care and treatment. An HMO plan may require you to see your PCP before you can see a specialist.

PPO or Preferred Provider Organization
A network of providers (physicians, hospitals, specialty providers, ancillary services) that offers discounted charges, in exchange for a benefit structure that channels patients to network providers. PPO plans do not require you to see providers in their network, but they generally cover less of your costs if you see a provider outside the network.

Premium
The amount you are charged each month for your coverage.

Specialist
A doctor who has special training in a specific kind of medical care, like a cardiologist or neurologist.

This booklet provides information about PERA's health benefits program. Your rights, benefits, and obligations as a PERA member are governed by Title 24, Article 51 of the Colorado Revised Statutes, and the Rules of the Colorado Public Employees' Retirement Association, which take precedence over any interpretations in this booklet.

Colorado Public Employees' Retirement Association
1301 Pennsylvania Street
Denver, Colorado 80203-5011
www.copera.org

2/106 (REV 1-10) 10M