



**2010
Health Benefits Program**

DPSRS Retirees

**Open Enrollment
October 1-November 15, 2009**

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

Rocky Mountain Health Plans

Group #00550000
1-888-281-0720
www.rmhp.org

Secure Horizons

Group—PERACare
1-800-610-2660 (pre-enrollment)
1-866-622-8055 (post-enrollment)
www.securehorizons.com

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

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

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

1-866-737-2261 (Special DPSRS Open Enrollment Assistance)
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 Open Enrollment Information

Welcome to PERACare and Open Enrollment for 2010

Transitioning from DPS Retiree Benefits to PERACare

This PERACare booklet includes information about PERACare's plans, enrollment process, and premiums. All DPSRS retirees have the opportunity to enroll in PERACare plans during this open enrollment period (October 1 – November 15, 2009). PERACare coverage will begin January 1, 2010.

What will be changing and what will stay the same?

Your DPS contribution (subsidy) will remain the same. DPS will advise PERA of the contribution/subsidy it is currently paying toward your health care premium. PERA will continue to pay the same subsidy.

Eligibility rules will be expanded under PERACare. All retirees, benefit recipients, and dependents will be eligible to be enrolled in health care, dental, and vision coverage during this open enrollment period, even if they have not had similar coverage with DPS. (This will be of special interest to DPS retirees who have not had access to dental coverage.)

Your coverage options are expanded under PERACare. You have more choices of carriers, and more choices of plans. PERACare and DPS share the same carriers: Kaiser Permanente, Secure Horizons, Delta Dental, and VSP. PERACare no longer offers PacifiCare plans, but instead has Anthem Blue Cross and Blue Shield. (Over 90 percent of PacifiCare doctors also are in Anthem's network.) PERACare also has two dental plan options with CIGNA.

More PERACare plans are available in more service areas (geographic locations) than were available through DPS benefits. For example, PERACare offers Kaiser Permanente plans (for both under and over age 65) in both Denver/Boulder and Southern Colorado (Colorado Springs and Pueblo). PERACare offers Secure Horizons HMO in the same expanded service area. PERACare offers Rocky Mountain Health Plans' Medicare HMO plan statewide in Colorado, except for Baca County. In addition, PERACare offers four pre-Medicare and three Medicare Supplement plans with Anthem Blue Cross and Blue Shield worldwide.

Retirees over age 65 will have up to six choices of health care plans. Under PERACare, retirees who do not have Medicare Part A will have all the same choices of plans as those who do have Part A. As under DPS, premiums for retirees with Medicare Part B-only are higher than those for retirees with Medicare A&B, and retirees will continue to receive a higher \$230 contribution/subsidy.

You will want to review the PERACare plan descriptions carefully, but note that PERACare's plans generally cover similar services and benefits as DPS's plans. In the HMO plans, some copays are higher with PERA, but in exchange, PERA's monthly premiums are lower. PERA's Anthem, Kaiser, and Secure Horizons plans all include the Silver Sneakers program at no additional charge. PERA's Anthem plans also include a customized fitness program, PERAFit, offered through National Jewish, at no additional charge.

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 health plan partners for Medicare coverage are Anthem Blue Cross and Blue Shield (Anthem), Kaiser Permanente, Rocky Mountain Health Plans, and Secure Horizons.

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

PERACare's vision plan partner is VSP.

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.

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.



HOW TO ENROLL

The *PERACare Enrollment Form for DPSRS Retirees* is a separate document accompanying this booklet. You may also download the *PERACare Enrollment Form for DPSRS Retirees* from the PERA Web site or call PERA's Customer Service Center to request one. You can submit your form in person, via U.S. mail, or by fax.

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.

Medicare Health Plans

PERACare offers Medicare health plans for retirees, benefit recipients, and their dependents who are age 65 and/or eligible for Medicare. Depending on where you live, you may have choices of one, two, or three HMO plans, as well as PERA's three Medicare Supplement plans administered by Anthem. Note that PERACare offers coverage options for you, even if you have never contributed to Medicare or Social Security.

All of the Medicare plans available through PERACare pay some or all of the Medicare deductibles, pay some or all of covered charges not paid by Medicare, include prescription drug coverage, and include some benefits in addition to what Medicare covers.

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 your copay or coinsurance to the provider at the time of the service, and the remaining charges are handled between the provider and the health plan. (Rocky Mountain Health Plans handles copays slightly differently in some areas.)

In PERACare, Kaiser Permanente, Rocky Mountain Health Plans, and Secure Horizons each offer a Medicare HMO plan.

Medicare Supplement Plans

In a Medicare Supplement plan, you have all of Original Medicare's benefits. Some plans, like PERA's, include additional benefits such as prescription drug and out-of-country benefits. Your providers submit their claims to Medicare, which is your "primary" payer. Your supplement plan pays next, and your providers will bill you for any remaining amounts that you must pay.

In PERACare, PERA's plans administered by Anthem are Medicare Supplement plans. In these plans, you may use any doctor you wish—you do not need to designate a primary care physician or go to any specific network of doctors. If you use providers who accept Medicare assignment, you will reduce costs to yourself and the plan. Providers file claims with Medicare, and claims processed by Medicare will electronically "cross over" to Anthem for processing of supplemental benefits. Note that if you do not have Medicare Part A, your hospital benefit is administered by Anthem rather than Medicare.



PRESCRIPTION BENEFITS

For questions about prescription benefits, you may call the following carriers directly:

- Caremark
(for those enrolled in PERA's Anthem plans only)
1-800-378-0755
- Kaiser Permanente Denver/Boulder:
303-338-4503
Southern Colorado:
1-888-681-7878
Ext. 4
- Rocky Mountain Health Plans
1-888-281-0720
- Secure Horizons
1-866-622-8055

PERA's Group Numbers with each of the carriers are on the inside front cover.

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 by most plans; 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 three-tier copay structures, with higher copays for brand-name drugs that are not on the plan's preferred drug list. Some plans have a fourth tier for high cost drugs. 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, Rocky Mountain Health Plans, or Secure Horizons, you have both retail and mail order options through those plans' prescription benefit managers.

Refer to 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.

Dental Plans

PERACare offers three dental plan options: CIGNA Dental HMO, CIGNA Dental PPO, and Delta Dental PPO. The dental HMO plan is similar to a health care HMO plan. You use dentists in the plan's network. You pay a specified copayment and/or coinsurance for each visit and the plan pays the rest. In the dental PPO plans, you have larger networks of participating dentists, and you have the ability to use non-network providers and receive some level of coverage. With Delta Dental's PPO plan, you can access two levels of network providers (PPO and Premier), as well as out-of-network providers. In a PPO plan, you are subject to deductibles and coinsurance and/or copays.

Vision Plans

PERACare offers three vision plan options with VSP (Vision Service Plan). The plans all offer access to the same nationwide provider network. Benefit levels and services covered differ between the plans. The least expensive plan covers an annual eye exam and offers discounts on materials. The other plans offer greater discounts and more comprehensive coverage for exams, glasses, and lenses.

Plan Descriptions

Colorado Health Plan Description Forms for Pre-Medicare Plans

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. Descriptions for Anthem’s Blue Cross and Blue Shield (Anthem) four pre-Medicare plans begin on page 6. Kaiser Permanente’s three pre-Medicare plan descriptions begin on page 16.

Medicare Supplement Plan Descriptions

The three Medicare Supplement plans, administered by Anthem Blue Cross and Blue Shield, are in a format that includes information on what Medicare pays, what PERA’s plan pays, and what you pay. The Medicare Supplement plan descriptions begin on page 22.

Medicare HMO Plan Descriptions

The three Medicare HMO plans (Kaiser Permanente, Rocky Mountain Health Plans, and Secure Horizons) are in a format that mirrors Colorado’s standardized “Health Plan Description” form. The plan descriptions begin on page 28. The plans are displayed side-by-side so that you can compare features among the three Medicare HMO plans available through PERACare. Note that Question #3 shows the areas of Colorado in which each plan is available.

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 pages 32 and 34, respectively.



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.

Anthem Pre-Medicare Plans

	HMO	PPO #1	
		In-Network	Out-of-Network
Part A: Type of Coverage			
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.

4. Annual Deductible²			
a. Individual	No deductible	\$1,500, excludes copays	\$3,000
b. Family	No deductible	\$3,000, excludes copays	\$6,000
5. Out-of-Pocket Maximum³	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 Maximum?	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

Anthem Pre-Medicare Plans

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	\$12,000	\$3,500	\$7,000
\$12,000	\$24,000	\$7,000	\$14,000
Excludes payments for prescription drugs	Excludes payments for prescription drugs		
\$16,000	\$32,000	\$5,950	\$11,900
\$32,000	\$64,000	\$11,900	\$23,800
Yes	Yes	Yes	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

Anthem Pre-Medicare Plans

	HMO		PPO #1	
			In-Network	Out-of-Network
Part B: Summary of Benefits (continued)				
8. Medical Office Visits⁴				
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				
a. Children's Services (Up to age 13)	Plan pays 100%		Preventive care services are not subject to deductible 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 physician. 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 care⁵	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	<i>Retail (30-day supply):</i> \$300 deductible (per person) then 50% covered; \$15 minimum, \$75 maximum <i>Mail order (90-day supply):</i> \$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		<i>Retail (30-day supply):</i> \$300 deductible (per person) then 50% covered; \$15 minimum, \$75 maximum <i>Mail order (90-day supply):</i> \$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

Anthem Pre-Medicare Plans

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
<i>Retail (30-day supply):</i> \$500 deductible (per person), then 50% covered; \$15 minimum; \$100 maximum after deductible <i>Mail order (90-day supply):</i> \$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 Pre-Medicare Plans

	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 Care⁸	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 any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other 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 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
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 any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other 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 60% 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 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
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	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
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

Anthem Pre-Medicare Plans

	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%	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)	<ul style="list-style-type: none"> • PERAFit • Silver Sneakers • 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 	<ul style="list-style-type: none"> • PERAFit • Silver Sneakers • 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 	<ul style="list-style-type: none"> • 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	Not covered	Plan pays 80% after deductible	Not covered
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		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	
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
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. 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
<ul style="list-style-type: none"> • PERAFit • Silver Sneakers • 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. 	<ul style="list-style-type: none"> • Members who desire another professional opinion may obtain a second surgical opinion 	<ul style="list-style-type: none"> • PERAFit • Silver Sneakers • 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. 	<ul style="list-style-type: none"> • Members who desire another professional opinion may obtain a second surgical opinion

Anthem Pre-Medicare Plans

	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	
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 Pre-Medicare Plans

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.

4. Annual Deductible²			
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 Maximum³			
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 Visits⁴			
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

Kaiser Permanente Pre-Medicare Plans

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. Maternity			
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 care⁵	\$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 Drugs⁶	Level of coverage and restrictions on prescriptions	Level of coverage and restrictions on prescriptions	Level of coverage and restrictions on prescriptions
	<i>Retail (30-day supply):</i> \$15 Generic \$40 Brand <i>Mail Order (90-day supply):</i> \$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	<i>Retail (30-day supply):</i> \$15 Generic \$40 Brand <i>Mail Order (90-day supply):</i> \$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: <i>Retail (30-day supply):</i> \$10 Generic \$25 Brand <i>Mail Order (90-day supply):</i> \$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

Kaiser Permanente Pre-Medicare Plans

	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 Care⁹	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

Kaiser Permanente Pre-Medicare Plans

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	Silver Sneakers 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	Silver Sneakers 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	Silver Sneakers 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 covered¹⁰	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 Pre-Medicare Plans

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.

Health Savings Account (HSA) Option

The Anthem and Kaiser Permanente High Deductible Health Plans (HDHP) qualify you to contribute to an HSA account. You may use an HSA with either Anthem or Kaiser’s HSA partner or any HSA plan of your choice. You also have the option of enrolling in either Anthem or Kaiser’s High Deductible Health Plan and not contributing to an HSA plan.

	Anthem HSA	Kaiser Permanente HSA
HSA Trustee	ARCUS Bank 1-877-373-9859 For enrollment forms, call Anthem at 1-877-PERABLU (1-877-737-2258)	Wells Fargo 1-866-890-8308 www.wfhs.com/kaiserpermanente
Administration/Maintenance Fee*	\$2.75 per month	\$3.25 per month, waived at \$2,500 balance
Set-Up Fee*	\$15.00 per account	None
Transaction Fee*	No charge for debit card transactions at merchant locations ATM withdrawals and inquiries \$1.00 per transaction	None
Checkbook order	\$9.95 per set of 12 checks	N/A
Minimum Balance	There is a minimum amount required to open the HSA Base account of \$15.00. Initial contribution is \$30.00, which includes the minimum balance amount and set-up fee	None
Investment Options	A variety of mutual funds in a range of asset classes. You must achieve a minimum HSA Base Account balance of \$2,000 prior to transferring funds into the Investment Account	Wells Fargo Funds: <ul style="list-style-type: none"> • Government Money Market Fund • Montgomery Total Return Bond Fund • Moderate Balanced Fund • Growth Balanced Fund • Index Allocation Fund • Diversified Equity Fund
Claim Process	Debit card transactions, ATM withdrawals, check writing, online bill pay	Debit card or mail

* Subject to change at any time by bank.

Medicare Supplement Plan #1—Administered by Anthem Blue Cross and Blue Shield

(Must be enrolled in Medicare Part B)

Effective for claims incurred beginning January 1, 2010, there will be a lifetime maximum benefit of \$1,000,000 per individual.

	Medicare Pays	Plan Pays	Participant Pays
Part A Services			
HOSPITAL STAYS			
<i>Covered costs include semiprivate room, meals, general nursing, other hospital services and supplies</i>			
Days 1-60 each benefit period	Costs above first \$1,068 (in 2009)	80% of Part A deductible	20% of Part A deductible
Days 61-90 each benefit period	Costs above \$267/day	\$267/day	\$0
Days 1-60 of "lifetime reserve days"	Costs above \$534/day	\$534/day	\$0
Any additional days	\$0	\$0	All charges
SKILLED NURSING FACILITY			
<i>Covered costs follow a 3-day hospital stay</i>			
Days 1-20 each benefit period	All covered costs	\$0	\$0
Days 21-100 each benefit period	Costs above \$133.50/day	50% of charges not covered by Medicare	50% of charges not covered by Medicare
Days over 100 in a benefit period	\$0	\$0	All charges
HOME HEALTH CARE			
<i>Covered costs include part-time skilled nursing care, therapy, and home health services</i>			
	All covered costs for home health services	\$0 for home health services	\$0 for home health services
HOSPICE CARE			
<i>Covered services include home care and inpatient</i>			
	All covered costs except some copayments	Copayments required by Medicare	\$0 for covered services
BLOOD			
	Covered costs after first 3 pints	Costs of first 3 pints	\$0

PERA's Replacement Part A Benefit

Benefits for Participants <i>without</i> Part A coverage			
PERA's Replacement Part A Benefit covers services that would be covered under Medicare Part A if the participant had Part A. PERA's Replacement Part A Benefit is structured similar to its pre-Medicare PPO (Preferred Provider Organization) benefit.	\$0	<p><i>In Network:</i> 70% of allowable charges after \$1,500 deductible, then 100% of allowable charges after \$4,500 maximum out-of-pocket is met each year</p> <p><i>Out-of-Network:</i> 50% of allowable charges after \$3,000 deductible, then 100% of allowable charges after \$9,000 maximum out-of-pocket is met each year</p>	<p><i>In Network:</i> \$1,500 deductible then 30% of allowable charges up to \$4,500 annual maximum out-of-pocket, then \$0 for additional charges</p> <p><i>Out-of-Network:</i> \$3,000 deductible, then 50% of allowable charges up to \$9,000 annual maximum out-of-pocket, then \$0 for additional charges</p>

Medicare Supplement Plan #1—Administered by Anthem Blue Cross and Blue Shield
(Must be enrolled in Medicare Part B)

	Medicare Pays	Plan Pays	Participant Pays
Part B Services			
DOCTORS' SERVICES <i>Includes doctors' visits, some preventive care, outpatient hospital, outpatient blood, some home health care, laboratory services, emergency care, mental health care</i>	Generally, 80% of Medicare-approved amount after deductible (\$135 in 2009), 60-80% of Medicare-approved amount for outpatient hospital services, and 50% of Medicare-approved amount for mental health care	80% of annual Part B deductible, then 20-40% of Medicare-approved amount (50% for mental health care), then 80% of Excess Charges, if any	20% of annual Part B deductible, then 20% of any Excess Charges up to \$2,000 Annual Out-of-Pocket Maximum
DURABLE MEDICAL EQUIPMENT (DME)	80% of Medicare-approved amount for DME	20% of Medicare-approved amount for DME and 80% of the amount above the Medicare-approved amount but not more than Anthem's Allowable Charge	20% of amount between Medicare-approved amount and Anthem's Allowable Charge and anything over Anthem's Allowable Charge

Additional Services

PRESCRIPTION DRUGS <i>(Administered by Caremark) Outpatient prescription drugs</i>	\$0	All charges above member deductible and copays	<i>Retail (30-day supply):</i> \$200 deductible, then 50% covered; \$7 minimum copay, \$75 maximum copay <i>Mail Order (90-day supply):</i> \$20 copay for Generic \$60 copay for Brand Prescription drug deductibles and copays do not apply toward the Out-of-Pocket Maximum
CARE OUTSIDE THE U.S. <i>Emergency</i>	\$0	80% of charges after \$250 copay per episode with a maximum payable of \$10,000 per year	\$250 copay per episode then 20% of charges up to \$10,000 annual benefit, then all additional charges
<i>Non-emergency</i>	\$0	50% of charges after \$1,500 annual deductible per year with a maximum payable of \$30,000 per year	\$4,500 annual deductible then 50% of charges up to \$50,000 annual benefit, then all additional charges
SMOKING CESSATION	\$0	Up to \$250 annual maximum and \$500 lifetime maximum for smoking cessation programs and drugs	

Annual Out-of-Pocket Maximum

<i>Applies to Replacement Part A Benefits, Part A Deductible, and Part B Services only. No out-of-pocket maximum for skilled nursing facility, outpatient prescription drugs, and services not covered by Medicare or PERA's plan.</i>	N/A	N/A	\$2,000 for participants with Medicare Parts A and B; \$4,500 for participants with Replacement Part A Benefits if only In-Network providers are used; \$9,000 for participants with Replacement Part A Benefits if both In- and Out-of-Network providers are used
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Medicare Supplement Plan #2—Administered by Anthem Blue Cross and Blue Shield

(Must be enrolled in Medicare Part B)

Effective for claims incurred beginning January 1, 2010, there will be a lifetime maximum benefit of \$1,000,000 per individual.

	Medicare Pays	Plan Pays	Participant Pays
Part A Services			
HOSPITAL STAYS			
<i>Covered costs include semiprivate room, meals, general nursing, other hospital services and supplies</i>			
Days 1-60 each benefit period	Costs above first \$1,068 (in 2009)	50% of Part A deductible	50% of Part A deductible
Days 61-90 each benefit period	Costs above \$267/day	\$267/day	\$0
Days 1-60 "lifetime reserve days"	Costs above \$534/day	\$534/day	\$0
Any additional days	\$0	\$0	All charges
SKILLED NURSING FACILITY			
<i>Covered costs follow a 3-day hospital stay</i>			
Days 1-20 each benefit period	All covered costs	\$0	\$0
Days 21-100 each benefit period	Costs above \$133.50/day	50% of charges not covered by Medicare	50% of charges not covered by Medicare
Days over 100 in a benefit period	\$0	\$0	All charges
HOME HEALTH CARE			
<i>Covered costs include part-time skilled nursing care, therapy, and home health services</i>			
	All covered costs for home health services	\$0 for home health services	\$0 for home health services
HOSPICE CARE			
<i>Covered services include home care and inpatient</i>			
	All covered costs except some copayments	Copayments required by Medicare	\$0 for covered services
BLOOD			
	Covered costs after first 3 pints	Costs of first 3 pints	\$0

PERA's Replacement Part A Benefit

Benefits for Participants <i>without</i> Part A coverage			
PERA's Replacement Part A Benefit covers services that would be covered under Medicare Part A if the participant had Part A. PERA's Replacement Part A Benefit is structured similar to its pre-Medicare PPO (Preferred Provider Organization) benefit.	\$0	<p><i>In Network:</i> 70% of allowable charges after \$3,000 deductible, then 100% of allowable charges after \$9,000 maximum out-of-pocket is met each year</p> <p><i>Out-of-Network:</i> 50% of allowable charges after \$6,000 deductible, then 100% of allowable charges after \$18,000 maximum out-of-pocket is met each year</p>	<p><i>In Network:</i> \$3,000 deductible then 30% of allowable charges up to \$9,000 annual maximum out-of-pocket, then \$0 for additional charges</p> <p><i>Out-of-Network:</i> \$6,000 deductible, then 50% of allowable charges up to \$18,000 annual maximum out-of-pocket, then \$0 for additional charges</p>

Medicare Supplement Plan #2—Administered by Anthem Blue Cross and Blue Shield
(Must be enrolled in Medicare Part B)

	Medicare Pays	Plan Pays	Participant Pays
Part B Services			
DOCTORS' SERVICES <i>Includes doctors' visits, some preventive care, outpatient hospital, outpatient blood, some home health care, laboratory services, emergency care, mental health care</i>	Generally, 80% of Medicare-approved amount after deductible (\$135 in 2009), 60-80% of Medicare-approved amount for outpatient hospital services, and 50% of Medicare-approved amount for mental health care	50% of annual Part B deductible, then 10-20% of Medicare-approved amount (40% for mental health care) When Medicare pays less than 80%, the remaining charges will be shared equally by the Plan and the Participant	50% of annual Part B deductible, 10-20% of Medicare-approved amount, and any Excess Charges up to \$4,000 Annual Out-of-Pocket Maximum When Medicare pays less than 80%, the remaining charges will be shared equally by the Plan and the Participant
DURABLE MEDICAL EQUIPMENT (DME)	80% of Medicare-approved amount for DME	20% of Medicare-approved amount for DME and 80% of the amount above the Medicare-approved amount but not more than Anthem's Allowable Charge	20% of amount between Medicare-approved amount and Anthem's Allowable Charge and anything over Anthem's Allowable Charge
Additional Services			
PRESCRIPTION DRUGS <i>(Administered by Caremark) Outpatient prescription drugs</i>	\$0	All charges above member deductible and copays	<i>Retail (30-day supply):</i> \$300 deductible, then 50% covered; \$10 minimum copay, \$80 maximum copay <i>Mail Order (90-day supply):</i> \$25 copay for Generic \$65 copay for Brand Prescription drug deductibles and copays do not apply toward the Out-of-Pocket Maximum
CARE OUTSIDE THE U.S. <i>Emergency</i>	\$0	80% of charges after \$500 copay per episode with a maximum payable of \$9,000 per year	\$500 copay per episode, then 20% of charges up to \$9,000 annual benefit, then all additional charges
<i>Non-emergency</i>	\$0	50% of charges after \$3,000 deductible per year with a maximum payable of \$40,000 per year	\$3,000 deductible, then 50% of charges up to \$40,000 annual benefit, then all additional charges
SMOKING CESSATION	\$0	Up to \$250 annual maximum and \$500 lifetime maximum for smoking cessation programs and drugs	
Annual Out-of-Pocket Maximum			
<i>Applies to Replacement Part A Benefits, Part A Deductible, and Part B Services only. No out-of-pocket maximum for skilled nursing facility, outpatient prescription drugs, and services not covered by Medicare or PERA's plan.</i>	N/A	N/A	\$4,000 for participants with Medicare Parts A and B; \$9,000 for participants with Replacement Part A Benefits if only In-Network providers are used; \$18,000 for participants with Replacement Part A Benefits if both In- and Out-of-Network providers are used

Medicare Supplement Plan #3—Administered by Anthem Blue Cross and Blue Shield

(Must be enrolled in Medicare Part B)

Effective for claims incurred beginning January 1, 2010, there will be a lifetime maximum benefit of \$1,000,000 per individual.

	Medicare Pays	Plan Pays	Participant Pays
Part A Services			
HOSPITAL STAYS			
<i>Covered costs include semiprivate room, meals, general nursing, other hospital services and supplies</i>			
Days 1-60 each benefit period	Costs above first \$1,068 (in 2009)	50% of Part A deductible	50% of Part A deductible
Days 61-90 each benefit period	Costs above \$267/day	\$267/day	\$0
Days 1-60 "lifetime reserve days"	Costs above \$534/day	\$534/day	\$0
Any additional days	\$0	\$0	All charges
SKILLED NURSING FACILITY			
<i>Covered costs follow a 3-day hospital stay</i>			
Days 1-20 each benefit period	All covered costs	\$0	\$0
Days 21-100 each benefit period	Costs above \$133.50/day	50% of charges not covered by Medicare	50% of charges not covered by Medicare
Days over 100 in a benefit period	\$0	\$0	All charges
HOME HEALTH CARE			
<i>Covered costs include part-time skilled nursing care, therapy, and home health services</i>			
	All covered costs for home health services	\$0 for home health services	\$0 for home health services
HOSPICE CARE			
<i>Covered services include home care and inpatient</i>			
	All covered costs except some copayments	Copayments required by Medicare	\$0 for covered services
BLOOD			
	Covered costs after first 3 pints	Costs of first 3 pints	\$0

PERA's Replacement Part A Benefit

Benefits for Participants <i>without</i> Part A coverage			
PERA's Replacement Part A Benefit covers services that would be covered under Medicare Part A if the participant had Part A. PERA's Replacement Part A Benefit is structured similar to its pre-Medicare PPO (Preferred Provider Organization) benefit.	\$0	<p><i>In Network:</i> 70% of allowable charges after \$4,500 deductible, then 100% of allowable charges after \$13,500 maximum out-of-pocket is met each year</p> <p><i>Out-of-Network:</i> 50% of allowable charges after \$9,000 deductible, then 100% of allowable charges after \$27,000 maximum out-of-pocket is met each year</p>	<p><i>In Network:</i> \$4,500 deductible then 30% of allowable charges up to \$13,500 annual maximum out-of-pocket, then \$0 for additional charges</p> <p><i>Out-of-Network:</i> \$9,000 deductible, then 50% of allowable charges up to \$27,000 annual maximum out-of-pocket, then \$0 for additional charges</p>

Medicare Supplement Plan #3—Administered by Anthem Blue Cross and Blue Shield

(Must be enrolled in Medicare Part B)

	Medicare Pays	Plan Pays	Participant Pays
Part B Services			
DOCTORS' SERVICES <i>Includes doctors' visits, some preventive care, outpatient hospital, outpatient blood, some home health care, laboratory services, emergency care, mental health care</i>	Generally, 80% of Medicare-approved amount after deductible (\$135 in 2009), 60-80% of Medicare-approved amount for outpatient hospital services, and 50% of Medicare-approved amount for mental health care	50% of annual Part B deductible	50% of annual Part B deductible, plus 20% of Medicare-approved amount, plus any excess charges up to \$6,000 Annual Out-of-Pocket Maximum
DURABLE MEDICAL EQUIPMENT (DME)	80% of Medicare-approved amount for DME	20% of Medicare-approved amount for DME and 50% of the amount above the Medicare-approved amount but not more than Anthem's Allowable Charge	50% of amount between Medicare-approved amount and Anthem's Allowable Charge and anything over Anthem's Allowable Charge
Additional Services			
PRESCRIPTION DRUGS <i>(Administered by Caremark) Outpatient prescription drugs</i>	\$0	All charges above member deductible and copays	<i>Retail (30-day supply):</i> \$350 deductible, then 50% covered; \$15 minimum copay, \$85 maximum copay <i>Mail Order (90-day supply):</i> \$30 copay for Generic \$70 copay for Brand Prescription drug deductibles and copays do not apply toward the Out-of-Pocket Maximum
CARE OUTSIDE THE U.S. <i>Emergency</i>	\$0	80% of charges after \$750 copay per episode with a maximum payable of \$8,000 per year	\$750 copay per episode then 20% of charges up to \$8,000 annual benefit, then all additional charges
<i>Non-emergency</i>	\$0	50% of charges after \$4,500 annual deductible per year with a maximum payable of \$30,000 per year	\$4,500 annual deductible then 50% of charges up to \$30,000 annual benefit, then all additional charges
SMOKING CESSATION	\$0	Up to \$250 annual maximum and \$500 lifetime maximum for smoking cessation programs and drugs	
Annual Out-of-Pocket Maximum			
<i>Applies to Replacement Part A Benefits, Part A Deductible, and Part B Services only. No out-of-pocket maximum for skilled nursing facility, outpatient prescription drugs, and services not covered by Medicare or PERA's plan.</i>	N/A	N/A	\$6,000 for participants with Medicare Parts A and B; \$13,500 for participants with Replacement Part A Benefits if only In-Network providers are used; \$27,000 for participants with Replacement Part A Benefits if both In- and Out-of-Network providers are used

Medicare HMO Plans

	Kaiser Permanente	Rocky Mountain Health Plans	Secure Horizons
Part A: Type of Coverage			
Medicare Coverage Required	Medicare Part B	Medicare Part B	Medicare Part B
1. Type of Plan	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
2. Out-of-Network Care Covered?	Only for Emergency Care	Yes	Only for Emergency Care
3. Areas of Colorado where Plan is Available	Plan is available as determined by ZIP code only in the following areas: Denver/Boulder and Southern Colorado (El Paso, Fremont, Pueblo, and Teller counties)	Plan is available throughout Colorado EXCEPT in Baca County	Plan is available only in the following areas: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Fremont, Jefferson, Larimer, Pueblo, and Teller counties

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.

4. Annual Deductible	No deductibles	No deductibles	No deductibles
5. Out-of-Pocket Maximum	\$2,500 per individual	No Out-of-Pocket annual maximum	No Out-of-Pocket annual maximum
6. Lifetime or Benefit Maximum Paid by the Plan for All Care	No lifetime maximum	No lifetime maximum	No lifetime maximum
7A. Covered Providers	Colorado Permanente Medical Group, P.C. and Kaiser Permanente affiliated network of primary care and specialty care physicians. See provider directory for complete list	Rocky Mountain Health Plans Medicare Network. See participating provider directory for a complete list of current providers	Secure Horizons network. See participating provider directory for a complete list of current providers
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes	Yes
8. Routine Medical Office Visits			
a. Primary Care Physician	\$20 copay per visit	\$20 copay per visit	\$20 copay per visit
b. Specialist	\$30 copay per visit	\$30 copay per visit	\$30 copay per visit
9. Preventive Care			
a. Annual physical	No copay (100% covered)	No copay (100% covered)	No copay (100% covered)
b. Most Medicare-covered preventive services	No copay (100% covered)	No copay (100% covered)	No copay (100% covered)
10. Maternity			
a. Prenatal care	No copay (100% covered)	\$20 copay for initial visit; no copay (100% covered) thereafter	\$20 copay per visit to PCP; \$30 copay per visit to specialist
b. Inpatient hospital	\$250 copay per day, maximum \$500 copay per admission	\$500 copay per admission, limited to 90 days covered per Medicare benefit period	\$500 copay per admission

Medicare HMO Plans

	Kaiser Permanente	Rocky Mountain Health Plans	Secure Horizons
Part B: Summary of Benefits (continued)			
11. Prescription Drugs Level of coverage and restrictions on prescriptions	<i>Retail (30-day supply):</i> \$15 Generic \$40 Brand <i>Mail Order (90-day supply):</i> \$30 Generic \$80 Brand For drugs on the approved list, call 303-338-4503 for a pharmacist	<i>Retail (31-day supply):</i> \$15 Generic \$45 Preferred Brand \$60 Non-preferred Brand \$75 Specialty <i>Mail Order (90-day supply):</i> \$30 Generic \$90 Preferred Brand \$120 Non-preferred Brand \$150 Specialty For drugs on the approved list, call 1-888-281-0720	<i>Retail (31-day supply):</i> \$15 Generic \$45 Preferred Brand \$60 Non-preferred Brand \$75 Preferred Specialty <i>Mail Order (90-day supply):</i> \$30 Generic \$90 Preferred Brand \$120 Non-preferred Brand \$150 Preferred Specialty For drugs on the approved list call 1-800-771-4347
12. Inpatient Hospital	\$250 copay per day; maximum \$500 copay per admission	\$500 copay per admission for up to 90 days per Medicare benefit period	\$500 copay per admission
13. Outpatient/Ambulatory Surgery	\$200 copay per visit	\$200 copay per visit	\$200 copay per visit
14. Diagnostics	Laboratory/X-ray: No copay (100% covered) MRI/CAT/PET: \$100 copay per procedure	Laboratory: No copay (100% covered) X-ray: \$20 copay MRI/CAT/PET: \$100 copay per visit	Laboratory: No copay (100% covered) X-ray: \$20 copay MRI/CAT/PET: \$100 copay per visit
15. Emergency Care	\$50 copay for hospital emergency room (waived if admitted)	\$50 copay for hospital emergency room (waived if admitted). Worldwide	\$50 copay for hospital emergency room (waived if admitted)
16. Ambulance	\$100 copay	\$100 copay	\$100 copay
17. Urgent, Non-Routine After Hours Care	\$30 copay per visit	\$30 copay per visit	\$30 copay per visit
18. Biologically-Based Mental Illness Care	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness
19. Other Mental Health Care	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness
20. Alcohol & Substance Abuse	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness	Coverage is no less extensive than the coverage provided for any other physical illness
21. Physical, Occupational & Speech Therapy			
a. Inpatient	\$250 copay per day; maximum \$500 copay per admission	\$500 copay per admission—limited to 90 days covered per Medicare benefit period	\$500 copay per admission
b. Outpatient	\$20 copay per visit	\$15 copay per visit	\$30 copay per visit
22. Durable Medical Equipment	20% copay (80% covered)	20% copay (80% covered)	20% copay (80% covered)
23. Oxygen	No copay (100% covered)	20% copay (80% covered)	20% copay (80% covered)
24. Organ Transplants	\$250 copay per day; maximum \$500 copay per admission	\$500 copay per admission	\$500 copay inpatient; \$200 copay outpatient

Medicare HMO Plans

	Kaiser Permanente	Rocky Mountain Health Plans	Secure Horizons
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Part B: Summary of Benefits (continued)

25. Home Health Care	No copay (100% covered)	No copay (100% covered)	No copay (100% covered)
26. Hospice Care	No copay (100% covered)	No copay (100% covered)	No copay (100% covered)
27. Skilled Nursing Facility Care	No copay (100% covered) up to 100 days per benefit period	No copay (100% covered) for days 1-20; \$75 copay per day for days 21-100, limited to 100 days per benefit period (following 3-day qualifying acute hospital stay)	No copay (100% covered) per day days 1-20; \$75 copay per day days 21-100, limited to 100 days per benefit period
28. Dental Care	Not covered	Routine: Not covered Non-Routine: \$30 copay per visit	Routine: Not covered Non-Routine: \$30 copay per visit
29. Vision Care	\$20 copay per visit for exam; \$100 credit for lenses, frames, cosmetic contact lenses; additional charge for contact lens fitting	\$30 copay for eye exam; \$80 frame or contact lens allowance every 24 months through VSP providers	\$30 copay for eye exam; \$70 frame allowance and \$105 contact lenses allowance every 24 months
Hearing Care	\$20 copay per visit for exam; \$500 benefit every three years per ear	\$20 copay for one exam per year; allowance of \$500 every three years for hearing aid through AHB providers	\$20 copay for one exam per year; allowance of \$500 every three years for hearing aid
30. Chiropractic Care	\$20 copay per visit—limited to 20 visits per year	\$20 copay per visit—limited to 12 visits per year at contracted providers. For additional Medicare-covered Chiropractic, 20% coinsurance via contracted providers	\$20 copay per visit—limited to 12 visits per year
31. Significant Additional Covered Services	<ul style="list-style-type: none"> • Silver Sneakers • Travel Clinic for Pre-Travel Health Risk assessments • Health Education Classes • Routine Foot Care: \$0 copay for 4 visits to contracted provider • \$0 copay for colonoscopy • \$0 copay for diabetic self-monitoring supplies 	<ul style="list-style-type: none"> • Silver & Fit Affinity Walking program • ChooseHealthy Complementary Care Discounted Services: Massage Therapy, Chiropractic, Acupuncture, Fitness Clubs, Dieticians, Vitamins and Minerals, ChooseHealthy.com wellness Web site • Nurseline 	<ul style="list-style-type: none"> • Silver Sneakers • Care Management • Renal dialysis 20% coinsurance • Nurseline • Caregiver

Part C: Limitations and Exclusions

32. Period during which Pre-Existing Conditions are not covered	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
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. List of exclusions is available upon request from your carrier. 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 upon request from your carrier. 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 upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy

Medicare HMO Plans

Kaiser Permanente

Rocky Mountain Health Plans

Secure Horizons

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
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 normally pays, does the enrollee have to pay the difference?	No	No	No
39. What is the main customer service number?	Denver: 303-338-3800 or 1-800-632-9700 Southern Colorado: 1-888-681-7878	1-888-281-0720	1-866-622-8055
40. Whom do I write/call if I have a complaint or want to file a grievance?	Customer Service Center 2500 S. Havana Street Aurora, CO 80014 303-338-3800	Rocky Mountain Health Plans Member Concerns Coordinator PO Box 10600 Grand Junction, CO 81502-5600 1-888-281-0720	Secure Horizons Customer Service PO Box 6770 Englewood, CO 80155 1-866-622-8055
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 group, or large group; and if it is a short-term policy.	Policy Form PERACare Medicare Senior Advantage Plan	Policy Form PERACare Medicare Plan Large Group Only	Policy Form PERACare Secure Horizons—Group 092170

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	Not covered	For the first 24 months of coverage, limitation applies
Orthodontics (Braces)	\$1,872 copay for children; \$2,184 copay for adults	50% covered after deductible up to \$1,500 lifetime maximum

Comparing the CIGNA Dental Plans

<p>Search for DHMO and DPPPO network providers at www.cigna.com or by calling 1-800-CIGNA24 (1-800-244-6224)</p>	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Visit any dentist you choose (general or specialist) Access to a large national DPPPO 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
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**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 up to \$25 Covered up to \$40 Covered up to \$55 Covered up to \$80	Covered once every 24 months	Covered up to \$35 Covered up to \$50 Covered up to \$65 Covered up to \$90		
Single Vision						
Lined Bifocal						
Lined Trifocal						
Lenticular						
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,
- Your employer/DPS subsidy (contribution), if any, and
- Your eligibility for Medicare Part A.

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)

Pre-Medicare Plan Premiums

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



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.

PLEASE NOTE

If you are a DPSRS retiree receiving a subsidy (district contribution) toward your health care premium, you would subtract the subsidy from the premium(s) shown here to determine your net premium. (For most retirees, the monthly DPSRS subsidy is \$115 or \$230.) PERA will be advised of your subsidy by DPSRS, and will deduct the net premium from your monthly benefit.

Medicare Plan Premiums

Anthem Monthly Premiums

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

Age 65+ with Medicare A&B Premiums

	Medicare Supplement #1	Medicare Supplement #2	Medicare Supplement #3
BR	\$304.00	\$181.00	\$143.00
BR+S	608.00	362.00	286.00
BR+C	608.00	362.00	286.00
BR+S+C	912.00	543.00	429.00

Age 65+ with Medicare B-only Premiums

	Medicare Supplement #1	Medicare Supplement #2	Medicare Supplement #3
BR	\$707.00	\$366.00	\$318.00
BR+S	1,414.00	732.00	636.00
BR+C	1,414.00	732.00	636.00
BR+S+C	2,121.00	1,098.00	954.00

Kaiser Permanente Monthly Premiums

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

With Medicare A&B

BR	\$163.00
BR+S	326.00
BR+C	326.00
BR+S+C	489.00

With Medicare B-only

BR	\$614.00
BR+S	1,228.00
BR+C	1,228.00
BR+S+C	1,842.00

Rocky Mountain Health Plans Monthly Premiums

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

With Medicare A&B

BR	\$225.00
BR+S	450.00
BR+C	450.00
BR+S+C	675.00

With Medicare B-only

BR	\$538.00
BR+S	1,076.00
BR+C	1,076.00
BR+S+C	1,614.00

Secure Horizons Monthly Premiums

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

With Medicare A&B

BR	\$163.00
BR+S	326.00
BR+C	326.00
BR+S+C	489.00

With Medicare B-only

BR	\$521.00
BR+S	1,042.00
BR+C	1,042.00
BR+S+C	1,563.00

PLEASE NOTE

If you are a DPSRS retiree receiving a subsidy (district contribution) toward your health care premium, you would subtract the subsidy from the premium(s) shown here to determine your net premium. (For most retirees, the monthly DPSRS subsidy is \$115 or \$230.) PERA will be advised of your subsidy by DPSRS, and will deduct the net premium from your monthly benefit.

BR+S, BR+C, and BR+S+C

The premiums for Medicare B-only assume all enrollees have only Medicare Part B coverage. If one or more enrollees has Medicare Part A, the premium will be lower.

Premiums are available by contacting PERA.

Combination Coverage Premiums

Anthem Monthly Premiums

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

	HMO/ Medicare Supplement #1	HMO/ Medicare Supplement #2	HMO/ Medicare Supplement #3
BR+S	\$1,079.00	\$956.00	\$918.00
BR+C	924.00	801.00	763.00
BR+S+C	1,699.00	1,576.00	1,538.00
	PPO #1/ Medicare Supplement #1	PPO #1/ Medicare Supplement #2	PPO #1/ Medicare Supplement #3
BR+S	\$957.00	\$834.00	\$796.00
BR+C	826.00	703.00	665.00
BR+S+C	1,479.00	1,356.00	1,318.00
	PPO #2/ Medicare Supplement #1	PPO #2/ Medicare Supplement #2	PPO #2/ Medicare Supplement #3
BR+S	\$609.00	\$486.00	\$448.00
BR+C	548.00	425.00	387.00
BR+S+C	853.00	730.00	692.00
	HDHP/ Medicare Supplement #1	HDHP/ Medicare Supplement #2	HDHP/ Medicare Supplement #3
BR+S	\$920.00	\$797.00	\$759.00
BR+C	797.00	674.00	636.00
BR+S+C	1,413.00	1,290.00	1,252.00

Kaiser Permanente Monthly Premiums

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

	HMO #1/ Medicare HMO	HMO #2/ Medicare HMO	HDHP/ Medicare HMO
BR+S	\$772.00	\$683.00	\$471.00
BR+C	650.00	579.00	409.00
BR+S+C	1,259.00	1,099.00	717.00

PLEASE NOTE

These combination coverage premiums are for one enrollee with Medicare Parts A and B and one or more pre-Medicare (under age 65) enrollees. If the Medicare enrollee does not have Medicare Part A, the combination coverage premium will be higher. Premiums are available by contacting PERA.

Dental Plan Premiums

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

Vision Plan Premiums

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

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.

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. For example, your payments for prescription drugs are typically not included in the calculation.

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
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