



PERACare Plans 2009

Colorado
Public
Employees'
Retirement
Association



PERACare Health Plan Descriptions For Active Members

Includes:
Anthem Blue Cross and Blue Shield
Kaiser Permanente
CIGNA Dental
VSP

PERACare Plan Contact Information/Resources

Anthem Blue Cross and Blue Shield

Group #195096
1-877-PERABLU (877-737-2258)
www.anthem.com

CIGNA Dental

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

Kaiser Permanente

Group #1804
Denver-Metro: 303-338-3800 or
1-800-632-9700
Colorado Springs: 1-888-681-7878
www.kaiserpermanente.org

VSP

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

PERA Contact Information

Colorado Public Employees' Retirement Association

Mailing Address

Colorado PERA
PO Box 5800
Denver, CO 80217-5800

Denver Main Office

1300 Logan 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

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

Web site/e-mail

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



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Colorado Health Plan Description Forms

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

Endnotes for the Health Plan Descriptions begin on page 18 (Anthem) and page 26 (Kaiser Permanente).

Dental and Vision Plan Descriptions

The dental and vision plan descriptions are in a format similar to the Health Plan Description Forms and begin on page 27.

	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 Deductible ²			
a. Individual	No deductible except for outpatient prescription drugs which have a separate \$250 deductible per person	\$1,500, excludes copays	\$3,000
b. Family	No deductible except for outpatient prescription drugs which have a separate \$250 deductible per person	\$3,000, excludes copays Cross accumulates between In-Network and Out-of-Network	\$6,000 Cross accumulates between In-Network and Out-of-Network
5. Out-of-Pocket Maximum ³			
a. Individual	\$10,000	\$10,000	\$20,000
b. Family	\$20,000 Excludes payments for prescription drugs	\$20,000 Excludes copays, excludes payments for prescription drugs. Cross accumulates between In-Network and Out-of-Network	\$40,000 Excludes payments for prescription drugs. Cross accumulates between In-Network and Out-of-Network
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. Infertility services have a lifetime maximum of \$2,000 per member. Bariatric surgery has a lifetime maximum payment of \$7,500 per member from a facility that has been designated as a Center of Excellence or \$1,500 from a facility that has not been designated as a Center of Excellence with a total lifetime maximum that shall not exceed \$7,500 per member. Major organ transplants have a lifetime maximum of \$1,000,000 per transplant per member.	\$2,500,000 per member In-Network and Out-of-Network combined for all covered services. Infertility services have a lifetime maximum of \$2,000 per member In- and Out-of-Network combined. Bariatric surgery has a lifetime maximum payment of \$7,500 per member from a facility that has been designated as a Center of Excellence or \$1,500 per member from a facility that has not been designated as a Center of Excellence with a total lifetime maximum that shall not exceed \$7,500 per member In- and Out-of-Network combined.	\$2,500,000 per member In-Network and Out-of-Network combined for all covered services. Infertility services have a lifetime maximum of \$2,000 per member In- and Out-of-Network combined. Bariatric surgery has a lifetime maximum payment of \$1,500 per member from a facility that has not been designated as a Center of Excellence with a total lifetime maximum that shall not exceed \$7,500 per member In- and Out-of-Network combined.



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	\$3,000	\$6,000
\$12,000	\$24,000	\$6,000	\$12,000
Cross accumulates between In-Network and Out-of-Network	Cross accumulates between In-Network and Out-of-Network	Cross accumulates between In-Network and Out-of-Network	Cross accumulates between In-Network and Out-of-Network
\$16,000	\$32,000	\$5,800	\$11,600
\$32,000 Excludes payments for prescription drugs. Cross accumulates between In-Network and Out-of-Network	\$64,000 Excludes payments for prescription drugs. Cross accumulates between In-Network and Out-of-Network	\$11,600 Cross accumulates between In-Network and Out-of-Network	\$23,200 Cross accumulates between In-Network and Out-of-Network
Yes	Yes	Yes	Yes
\$2,500,000 per member In-Network and Out-of-Network combined for all covered services. Infertility services have a lifetime maximum of \$2,000 per member In- and Out-of-Network combined. Bariatric surgery has a lifetime maximum payment of \$7,500 per member from a facility that has been designated as a Center of Excellence or \$1,500 per member from a facility that has not been designated as a Center of Excellence with a total lifetime maximum that shall not exceed \$7,500 per member In- and Out-of-Network combined.	\$2,500,000 per member In-Network and Out-of-Network combined for all covered services. Infertility services have a lifetime maximum of \$2,000 per member In- and Out-of-Network combined. Bariatric surgery has a lifetime maximum payment of \$1,500 per member from a facility that has not been designated as a Center of Excellence with a total lifetime maximum that shall not exceed \$7,500 per member In- and Out-of-Network combined.	\$2,500,000 per member In-Network and Out-of-Network combined for all covered services. Infertility services have a lifetime maximum of \$2,000 per member In- and Out-of-Network combined. Bariatric surgery has a lifetime maximum payment of \$7,500 per member from a facility that has been designated as a Center of Excellence or \$1,500 per member from a facility that has not been designated as a Center of Excellence with a total lifetime maximum that shall not exceed \$7,500 per member In- and Out-of-Network combined.	\$2,500,000 per individual In-Network and Out-of-Network combined for all services. Infertility services have a lifetime maximum of \$2,000 per member In- and Out-of-Network combined. Bariatric surgery has a lifetime maximum payment of \$1,500 per member from a facility that has not been designated as a Center of Excellence with a total lifetime maximum that shall not exceed \$7,500 per member In- and Out-of-Network combined.



	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
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
8. Routine Medical Office Visits⁴			
a. Primary Care Providers	\$25 copay per visit	\$25 copay per visit (not subject to deductible)	Plan pays 60% after deductible
b. Specialists	\$40 copay per visit	\$40 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) Exam	\$25 copay per visit for PCP \$40 copay per visit for specialist	\$25 copay per visit for PCP (not subject to deductible) \$40 copay per visit for specialist (not subject to deductible)	Plan pays 60% (not subject to deductible) for exam. Other services not covered
	Plan pays 100% up to \$250 per year for all services that are not billed as an office visit	Plan pays 80% (not subject to deductible) up to \$250 per year for all services that are not billed as an office visit	
Childhood Immunizations	Plan pays 100%	Plan pays 100% (not subject to deductible)	Plan pays 60% (not subject to deductible)
b. Adults' Services Exam	\$25 copay per visit for PCP \$40 copay per visit for specialist	\$25 copay per visit for PCP (not subject to deductible) \$40 copay per visit for specialist (not subject to deductible)	Not covered
	Plan pays 100% up to \$250 per year for all services that are not billed as an office visit	Plan pays 80% (not subject to deductible) up to \$250 per year for all services that are not billed as an office visit	



PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
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
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% (not subject to deductible)	Plan pays 60% (not subject to deductible) for exam. Other services not covered	Plan pays 80% (not subject to deductible)	Plan pays 60% (not subject to deductible) for exam. Other services not covered
Plan pays 80% (not subject to deductible) up to \$250 per year for all services that are not billed as an office visit		Plan pays 80% (not subject to deductible) up to \$250 per year for all services that are not billed as an office visit	
Plan pays 80% (not subject to deductible)	Plan pays 60% (not subject to deductible)	Plan pays 80% (not subject to deductible)	Plan pays 60% (not subject to deductible)
Plan pays 80% (not subject to deductible) per office visit	Not covered	Plan pays 80% (not subject to deductible) per office visit	Not covered
Plan pays 80% (not subject to deductible) up to \$250 per year for all services that are not billed as an office visit		Plan pays 80% (not subject to deductible) up to \$250 per year for all services that are not billed as an office visit	



	HMO		PPO #1	
			In-Network	Out-of-Network
Part B: Summary of Benefits (continued)				
9. Preventive Care (continued)				
b. Adults' Services				
• Mammogram Screening	Plan pays 100%		Plan pays 100% (not subject to deductible)	Plan pays 60% (not subject to deductible)
• Prostate Screening	Plan pays 100%		Plan pays 100% (not subject to deductible)	Plan pays 60% (not subject to deductible)
• Flu Shots	Plan pays 100%; office visit copay may apply		Plan pays 100% (not subject to deductible); office visit copay may apply	Plan pays 100% (not subject to deductible) up to an annual maximum reimbursement
• Colonoscopy	Plan pays 80%		Plan pays 80% (not subject to deductible)	Not covered
10. Maternity				
a. Prenatal care	\$200 copay per pregnancy. Plan pays 80% for all services that are not billed as an office visit		\$200 copay per pregnancy (not subject to deductible) Plan pays 80% after deductible for all services that are not billed as an office visit	Plan pays 60% after deductible
b. Delivery & Inpatient well baby care⁵	Plan pays 80% after \$1,000 copay per admission		Plan pays 80% after deductible	Plan pays 60% after deductible
11. Prescription Drugs				
Level of coverage and restrictions on prescriptions⁶	<p>Retail (34-day supply): \$250 deductible (per person) then 50% covered; \$15 minimum, \$50 maximum Mail order (90-day supply): \$30 for Generic, \$100 for Brand (not subject to deductible) Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem Blue Cross and Blue Shield, up to \$250 per member per calendar year, \$500 per lifetime.</p> <p>In addition to the cost sharing described above, if you purchase a brand name prescription drug when there is a FDA rated equivalent generic prescription drug available, you will pay the difference between the cost of the brand name prescription drug and the generic prescription drug.</p> <p>Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum</p>		<p>Retail (34-day supply): \$250 deductible (per person) then 50% covered; \$15 minimum, \$60 maximum Mail order (90-day supply): \$30 for Generic, \$120 for Brand (not subject to deductible) Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem Blue Cross and Blue Shield, up to \$250 per member per calendar year, \$500 per lifetime.</p> <p>In addition to the cost sharing described above, if you purchase a brand name prescription drug when there is a FDA rated equivalent generic prescription drug available, you will pay the difference between the cost of the brand name prescription drug and the generic prescription drug.</p> <p>Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum</p>	Not covered



PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Plan pays 100% (not subject to deductible)	Plan pays 60% (not subject to deductible)	Plan pays 100% (not subject to deductible)	Plan pays 60% (not subject to deductible)
Plan pays 100% (not subject to deductible)	Plan pays 60% (not subject to deductible)	Plan pays 100% (not subject to deductible)	Plan pays 60% (not subject to deductible)
Plan pays 80% (not subject to deductible)	Plan pays 100% (not subject to deductible) up to an annual maximum reimbursement	Plan pays 80% (not subject to deductible)	Plan pays 100% (not subject to deductible) up to an annual maximum reimbursement
Plan pays 80% (not subject to deductible)	Not covered	Plan pays 80% (not subject to deductible)	Not covered
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Retail (34-day supply): \$500 deductible (per person), then 50% covered; \$15 minimum; \$80 maximum Mail order (90-day supply): \$30 for Generic \$160 for Brand, (not subject to deductible) Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem Blue Cross and Blue Shield, up to \$250 per member per calendar year, \$500 per lifetime. In addition to the cost sharing described above, if you purchase a brand name prescription drug when there is a FDA rated equivalent generic prescription drug available, you will pay the difference between the cost of the brand name prescription drug and the generic prescription drug. Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum	Not covered	Plan pays 80% after deductible Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem Blue Cross and Blue Shield, up to \$250 per member per calendar year, \$500 per lifetime. In addition to the cost sharing described above, if you purchase a brand name prescription drug when there is a FDA rated equivalent generic prescription drug available, you will pay the difference between the cost of the brand name prescription drug and the generic prescription drug.	Not covered



	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
12. Inpatient Hospital	Plan pays 80% after \$1,000 copay per admission	Plan pays 80% after deductible	Plan pays 60% after deductible
13. Outpatient/Ambulatory Surgery	Plan pays 80% after \$500 copay per surgery	Plan pays 80% after deductible	Plan pays 60% after deductible
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 \$100 copay per procedure	Plan pays 80% after deductible	Plan pays 60% after deductible
15. Emergency Care^{7,8}	Plan pays 80% after \$150 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 \$50 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 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			
a. Inpatient Care	Plan pays 80% after \$1,000 copay per admission. Limited to 45 full or 90 partial days per year combined with Alcohol Abuse benefit	Plan pays 80% after deductible. Limited to 45 full or 90 partial days per year, combined with Alcohol Abuse benefit, combined for In-Network and Out-of-Network	Plan pays 60% after deductible. Limited to 45 full or 90 partial days per year, combined with Alcohol Abuse benefit, combined for In-Network and Out-of-Network
b. Outpatient Care	\$25 copay per visit for PCP, \$40 copay for specialist, or plan pays 80% for all other providers per visit. Limited to 25 visits per year	Plan pays 80% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network	Plan pays 60% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network



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 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
Plan pays 80% after deductible. Limited to 45 full or 90 partial days per year, combined with Alcohol Abuse benefit, combined for In-Network and Out-of-Network	Plan pays 60% after deductible. Limited to 45 full or 90 partial days per year, combined with Alcohol Abuse benefit, combined for In-Network and Out-of-Network	Plan pays 80% after deductible. Limited to 45 full or 90 partial days per year, combined with Alcohol Abuse benefit, combined for In-Network and Out-of-Network	Plan pays 60% after deductible. Limited to 45 full or 90 partial days per year, combined with Alcohol Abuse benefit, combined for In-Network and Out-of-Network
Plan pays 80% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network	Plan pays 60% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network	Plan pays 80% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network	Plan pays 60% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network



	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
20. Alcohol & Substance Abuse			
a. Inpatient Care	Alcohol Abuse: Plan pays 80% after \$1,000 copay per admission. Limited to 45 full or 90 partial days per year combined with Other Mental Health Benefits. Substance Abuse: Plan pays 80% after \$1,000 copay per admission. Limited to 20 days per lifetime.	Alcohol Abuse: Plan pays 50% after deductible. Limited to 45 full or 90 partial days per year combined with other mental health benefits, combined for In-Network and Out-of-Network. Substance Abuse: Plan pays 50% after deductible. Limited to 20 days per lifetime	Alcohol Abuse: Plan pays 50% after deductible. Limited to 45 full or 90 partial days per year combined with other mental health benefits, combined for In-Network and Out-of-Network. Substance Abuse: Not covered
b. Outpatient Care	Alcohol and Substance Abuse: \$25 copay per visit for PCP, \$40 copay per visit for specialist, or plan pays 80% for all other providers per visit. Limited to 25 individual or 50 group visits per year	Alcohol and Substance Abuse: Plan pays 80% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network	Alcohol and Substance Abuse: Plan pays 60% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network
c. Detox	Covered as a medical service	Covered as a medical service	Covered as a medical service
21. Physical, Occupational, and Speech Therapy			
a. Inpatient	Plan pays 80% after \$1,000 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	\$40 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



PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
<p>Alcohol Abuse: Plan pays 50% after deductible. Limited to 45 full or 90 partial days per year combined with other mental health benefits, combined for In-Network and Out-of-Network.</p> <p>Substance Abuse: Plan pays 50% after deductible. Limited to 20 days per lifetime</p>	<p>Alcohol Abuse: Plan pays 50% after deductible. Limited to 45 full or 90 partial days per year combined with other mental health benefits, combined for In-Network and Out-of-Network.</p> <p>Substance Abuse: Not covered</p>	<p>Alcohol Abuse: Plan pays 50% after deductible. Limited to 45 full or 90 partial days per year combined with other mental health benefits, combined for In-Network and Out-of-Network.</p> <p>Substance Abuse: Plan pays 50% after deductible. Limited to 20 days per lifetime</p>	<p>Alcohol Abuse: Plan pays 50% after deductible. Limited to 45 full or 90 partial days per year combined with other mental health benefits, combined for In-Network and Out-of-Network.</p> <p>Substance Abuse: Not covered</p>
<p>Alcohol and Substance Abuse: Plan pays 80% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network</p>	<p>Alcohol and Substance Abuse: Plan pays 60% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network</p>	<p>Alcohol and Substance Abuse: Plan pays 80% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network</p>	<p>Alcohol and Substance Abuse: Plan pays 60% after deductible. Limited to 25 individual or 50 group visits per year, combined for In-Network and Out-of-Network</p>
<p>Covered as a medical service</p>	<p>Covered as a medical service</p>	<p>Covered as a medical service</p>	<p>Covered as a medical service</p>
<p>Plan pays 80% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined</p>	<p>Plan pays 60% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined</p>	<p>Plan pays 80% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined</p>	<p>Plan pays 60% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined</p>
<p>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</p>	<p>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</p>	<p>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</p>	<p>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</p>

	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
22. Durable Medical Equipment	Plan pays 80%. Limited to a maximum payment of \$3,000 per year except for arm and leg prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of \$3,000. Disposable medical supplies are not subject to the \$3,000 maximum payment.	Plan pays 80% after deductible with benefits limited to a maximum payment of \$3,000 per calendar year. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum payment of \$3,000, but a claim for such a device will reduce the \$3,000 maximum payment for other Durable Medical Equipment. Disposable medical supplies are not subject to the \$3,000 maximum payment.	Not covered
23. Oxygen	Plan pays 80%	Plan pays 80% after deductible	Not covered
24. Organ Transplants			
a. Inpatient	Plan pays 80% after \$1,000 copay per admission	Plan pays 80% after deductible	Not covered
b. Outpatient	\$25 copay per visit for PCP \$40 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	\$25 copay per visit for PCP \$40 copay per visit for specialist Plan pays 80% after deductible for all services that are not billed as as office visit Benefits limited to \$1,000,000 payment 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 \$1,000 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



PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Plan pays 80% after deductible with benefits limited to a maximum payment of \$3,000 per calendar year. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum payment of \$3,000, but a claim for such a device will reduce the \$3,000 maximum payment for other Durable Medical Equipment. Disposable medical supplies are not subject to the \$3,000 maximum payment.	Not covered	Plan pays 80% after deductible with benefits limited to a maximum payment of \$3,000 per calendar year. For prosthetic devices (arms and legs) benefits are provided with the same deductible and coinsurance as provided by Medicare. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum payment of \$3,000, but a claim for such a device will reduce the \$3,000 maximum payment for other Durable Medical Equipment. Disposable medical supplies are not subject to the \$3,000 maximum payment.	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	Plan pays 80% after deductible	Not covered
Benefits limited to \$1,000,000 payment 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 payment 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



	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
28. Dental Care	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 80% for services received within 72 hours of the accident	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 80% after deductible	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 60% after deductible
29. Vision Care	Not covered	Not covered	Not covered
30. Chiropractic Care	\$25 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"> • For hemodialysis \$40 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 	Members who desire another professional opinion may obtain a second surgical opinion.	Members who desire another professional opinion may obtain a second surgical opinion

Part C: Limitations and Exclusions

32. Period during which Pre-Existing Conditions are not Covered.¹⁰	Not applicable; plan does not impose limitation periods for pre-existing conditions	Not applicable; plan does not impose limitation periods for pre-existing conditions
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



PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
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
Members who desire another professional opinion may obtain a second surgical opinion	Members who desire another professional opinion may obtain a second surgical opinion	Members who desire another professional opinion may obtain a second surgical opinion	Members who desire another professional opinion may obtain a second surgical opinion

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

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

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 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 copays, depending on the contract for that plan. The specific deductibles or copays 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.
 5. **“Well baby care”** includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copay applies to mother and well-baby together; there are not separate copays.
 6. **“Prescription drugs”** otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.
 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 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 copays 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.
-

Anthem Blue Cross and Blue Shield Health Savings Account (HSA) Option

Anthem's High Deductible Health Plan (HDHP) qualifies you to join an HSA plan. You may enroll in an HSA with Anthem's HSA partner or you may enroll in any HSA plan of your choice. You also have the option of enrolling in this High Deductible Health Plan and not enrolling in an HSA plan.

HSA Trustee	JPMorgan Chase Bank 1-888-854-0537 For enrollment forms, call Anthem at 1-877-PERABLU (1-877-737-2558)
Administration Fee*	\$3.00 per month
Set Up Fee*	\$20.00
Transaction Fee*	No charge for debit card transactions at merchant location ATM withdrawals \$1 per transaction Check writing \$0.25 per check
Minimum Balance	Initial contribution of \$50 is required and includes the \$20 set up fee; thereafter, the account will be closed if it falls to zero balance
Investment Options	A variety of mutual funds An investment account requires a \$2,000 minimum balance
Claim Process	Debit card, ATM withdrawals, check writing

*Subject to change at any time by bank.

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 and Boulder counties and portions of Adams, Arapahoe, Broomfield, Clear Creek, Douglas, Elbert, El Paso, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld counties 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 Deductible ² a. Individual b. Family	No deductibles No deductibles	\$1,000 per year \$3,000 per year	\$3,000 per year \$6,000 per year; family deductible must be met by one or more family members before coinsurance benefit applies
5. Out-of-Pocket Maximum ³ a. Individual b. Family c. Is deductible included in the Out-of-Pocket Maximum?	\$4,000 per year \$10,000 per year Not applicable	\$3,000 per year \$6,000 per year No, the Out-of-Pocket Maximum excludes deductible and copays	\$5,800 per year \$11,600 per year Yes; family Out-of-Pocket Maximum must be met by one or more family members if covered as a family unit
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. 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 ⁴ a. Primary Care Providers b. Specialists	\$25 copay per primary care office visit \$40 copay per specialist care office visit Line 13 may apply for procedures performed during an office visit	\$25 copay per primary care office visit, not subject to deductible \$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 primary care 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, after deductible is met



HMO #1	HMO #2	HDHP
In-Network Only (Out-of-Network care is not covered except as noted)		

Part B: Summary of Benefits (continued)

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
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	\$15 Generic/\$40 Brand per prescription up to a 60-day supply (Drugs may be ordered by mail) Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center	\$15 Generic/\$40 Brand per prescription up to a 60-day supply (Drugs may be ordered by mail) Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center	\$10 Generic/\$25 Brand per prescription up to a 60-day supply, after deductible is met. (Drugs may be ordered by mail) 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



HMO #1	HMO #2	HDHP
In-Network Only (Out-of-Network care is not covered except as noted)		

Part B: Summary of Benefits (continued)

<p>17. Urgent, Non-Routine After Hours Care</p>	<p>\$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</p>	<p>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</p>	<p>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</p>
<p>18. Biologically-Based Mental Illness and Mental Disorders Care⁹</p>	<p>Coverage is no less extensive than the coverage provided for a physical illness</p>	<p>Coverage is no less extensive than the coverage provided for a physical illness</p>	<p>Coverage is no less extensive than the coverage provided for a physical illness</p>
<p>19. Other Mental Health Care a. Inpatient Care b. Outpatient Care</p>	<p>Inpatient: \$1,000 copay per admission—up to 45 days each calendar year Outpatient: \$25 copay per visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit</p>	<p>Inpatient: 20% coinsurance—up to 45 days each calendar year, after deductible is met Outpatient: 50% coinsurance each visit up to 20 visits each calendar year, not subject to deductible, does not apply toward Out-of-Pocket Maximum</p>	<p>Inpatient: 20% coinsurance—up to 45 days each calendar year, after deductible is met Outpatient: 20% coinsurance each visit up to 20 visits each calendar year, after deductible is met</p>
<p>20. Alcohol & Substance Abuse a. Inpatient b. Outpatient</p>	<p>Inpatient Medical Detoxification: \$1,000 copay per admission Detoxification is limited to removing toxic substance from the body Inpatient Residential Rehabilitation: \$1,000 copay per admission Outpatient Chemical Dependency: \$25 copay per visit. Group visits an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit</p>	<p>Inpatient Medical Detoxification: 20% coinsurance after deductible is met. Detoxification is limited to removing toxic substance from the body Inpatient Residential Rehabilitation: 20% coinsurance after deductible is met Outpatient Chemical Dependency: 50% coinsurance each visit, not subject to deductible, does not apply toward Out-of-Pocket Maximum</p>	<p>Inpatient Medical Detoxification: 20% coinsurance after deductible is met. Detoxification is limited to removing toxic substance from the body Inpatient Residential Rehabilitation: 20% coinsurance per admission after deductible is met Outpatient Chemical Dependency: 20% coinsurance each visit after deductible is met</p>



HMO #1	HMO #2	HDHP
In-Network Only (Out-of-Network care is not covered except as noted)		

Part B: Summary of Benefits (continued)

<p>21. Physical, Occupational & Speech Therapy</p>	<p>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</p> <p>Therapy for congenital defects and birth abnormalities is covered for children up to age five for both acute and chronic conditions</p>	<p>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</p> <p>Therapy for congenital defects and birth abnormalities are covered for children up to age five for both acute and chronic conditions</p>	<p>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</p> <p>Therapy for congenital defects and birth abnormalities are covered for children up to age five for both acute and chronic conditions</p>
<p>22. Durable Medical Equipment</p>	<p>No charge (100% covered) up to \$2,000 annual maximum benefit per calendar year</p> <p>Prosthetic arms and legs covered at no charge (100% covered) with no annual maximum benefit See policy for types and circumstances of coverage.</p>	<p>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</p> <p>Prosthetic arms and legs covered at 20% coinsurance with no annual maximum See policy for types and circumstances of coverage.</p>	<p>20% coinsurance within the Service Area \$2,000 annual benefit maximum per calendar year, after deductible is met</p> <p>Prosthetic arms and legs covered at 20% coinsurance with no annual maximum, after deductible is met See policy for types and circumstances of coverage.</p>
<p>23. Oxygen</p>	<p>No charge (100% covered)</p>	<p>20% coinsurance, not subject to deductible, does not apply toward Out-of-Pocket Maximum</p>	<p>20% coinsurance, after deductible is met</p>
<p>24. Organ Transplants</p>	<p>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</p> <p>Transplant lifetime maximum \$1,000,000 per individual</p>	<p>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</p>	<p>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</p>
<p>25. Home Health Care</p>	<p>No charge (100% covered) for prescribed medically necessary part-time home health services. Not covered outside the Service Area</p>	<p>20% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area</p>	<p>20% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area</p>
<p>26. Hospice Care</p>	<p>No charge (100% covered) for home-based hospice care. Not covered outside the Service Area</p>	<p>20% coinsurance for home-based hospice care, after deductible is met. Not covered outside the Service Area</p>	<p>20% coinsurance for home-based hospice care, after deductible is met. Not covered outside the Service Area</p>
<p>27. Skilled Nursing Facility Care</p>	<p>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</p>	<p>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</p>	<p>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</p>



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	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	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	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 Service 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



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?"	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.
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.

Kaiser Permanente Health Savings Account (HSA) Option

Kaiser Permanente’s High Deductible Health Plan (HDHP) qualifies you to join an HSA plan. You may enroll in an HSA with Kaiser’s HSA partner or you may enroll in any HSA plan of your choice. You also have the option of enrolling in this High Deductible Health Plan and not enrolling in an HSA plan.

HSA Trustee	Wells Fargo 1-866-890-8308 www.wfhbs.com/kaiserpermanente
Administration Fee*	\$3.25 per month, waived at \$2,500 balance
Set Up Fee*	None
Transaction Fee*	None
Minimum Balance	None
Investment Options	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 or mail

*Subject to change at any time by bank.

	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	Nationwide
Annual Deductible a. Individual b. Family c. Accumulation Period	No deductible No deductible N/A	\$100 \$200 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 \$95 copay	80% covered after deductible
Endodontics (Root Canals)	\$10 to \$335 copay	80% covered after deductible
Periodontics (Gum Treatment)	\$30 to \$385 copay	80% covered after deductible
Oral Surgery (Extractions)	\$10 to \$95 copay	80% covered after deductible
Crowns and Bridges	\$40 to \$465 copay	50% covered after deductible
Prosthodontics (Dentures)	\$35 to \$615 copay	50% covered after deductible
Implants	Not covered	50% covered after deductible up to \$1,500 lifetime maximum
Missing Tooth Limitation	No limitation	For the first 24 months of coverage, limitation applies
Orthodontics (Braces)	\$1,700 copay for children; \$2,100 copay for adults	50% covered after deductible up to \$1,500 lifetime maximum

Comparing the Dental Plans

<p>Search for DHMO and DPPO 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 DPPO network • Savings when you visit a network provider (averaging 35% nationwide) • No referral necessary to see a specialist • Most network dentists file claim forms for members
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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	Covered up to \$25 Covered up to \$40 Covered up to \$55 Covered up to \$80	\$25 copay for lenses and frame	Covered once every 24 months Covered up to \$35 Covered up to \$50 Covered up to \$65 Covered up to \$90	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					
Single Vision Lined Bifocal Lined Trifocal Lenticular						
Frame	Covered up to \$120 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	\$120 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 30%	Not covered	Discounts average 30%	Not covered	Discounts average 20%	Not covered
Additional Glasses (Including sunglasses)	20% discount	Not covered	20% 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	



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

Colorado Public Employees' Retirement Association

Mailing Address: PO Box 5800, Denver, Colorado 80217-5800

Office Locations: 1300 Logan Street, Denver
1120 W. 122nd Avenue, Westminster
303-832-9550 • 1-800-759-PERA (7372)
www.copera.org