PERACare Plans 2010

PERACare Health Plan Descriptions

For Active Members

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

Colorado
Public
Employees'
Retirement
Association

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

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

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

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

PERA Contact Information

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

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

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

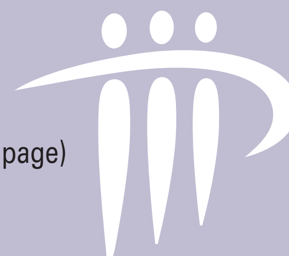
Westminster Office
1120 W. 122nd Avenue
Westminster, CO 80234

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

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

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

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



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VSP Vision Plans 27

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 are on page 16 (Anthem) and page 24 (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 25.

	HMO
Part A: Type of Coverage	
1. Type of Plan	Health Maintenance Organization (HMO)
2. Out-of-Network Care Covered?[1]	Only for emergency and urgent care
3. Areas of Colorado where Plan is Available	Plan is available throughout Colorado

Part B: Summary of Benefits

Important Note: This form is not a contract; it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copay options reflect the amount the plan will pay.

	HMO
4. Annual Deductible[2]	
a. Individual	None
b. Family	None
5. Out-of-Pocket Maximum[3]	Excludes payments for prescription drugs
a. Individual	$10,000
b. Family	$20,000
c. Is Deductible Included in the Out-of-Pocket Maximum?	Not applicable
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.

PPO #1		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	
$1,500, excludes copays $3,000, excludes copays	$3,000 $6,000	$3,500 $7,000	$7,000 $14,000
Excludes copays and payments for prescription drugs. $10,000 $20,000 Yes Yes	Excludes payments for prescription drugs. $20,000 $40,000	$5,950 $11,900 Yes	$11,900 $23,800 Yes
$2,500,000 per individual In-Network and Out-of-Network combined for all covered services. 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 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 individual 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 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.

	HMO
Part B: Summary of Benefits (continued)	
7A. Covered Providers	HMO Colorado managed care network. See provider directory for 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
8. Routine Medical Office Visits[4]	
a. Primary Care Providers	$30 copay per visit
b. Specialists	$45 copay per visit Plan pays 80% 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%
Childhood Immunizations	Plan pays 100%
b. Adults' Services	Plan pays 100%
Mammogram Screening	Plan pays 100%
Prostate Screening	Plan pays 100%
Flu Shots	Plan pays 100%
Colonoscopy	$300 copay
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
b. Delivery & Inpatient well baby care[5]	Plan pays 80% after $1,200 copay per admission

PPO #1		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
$30 copay per visit (not subject to deductible)	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
$45 copay per visit (not subject to deductible)	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Plan pays 80% after deductible for all other services that are not billed as an office visit			
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	$600 copay	$300 copay	$600 copay
$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	Plan pays 80% after deductible for office visits and delivery services from the physician	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

	HMO
Part B: Summary of Benefits (continued)	
11. Prescription Drugs Level of coverage and restrictions on prescriptions[6]	*Retail (34-day supply)* Tier 1 $15 copay Tier 2 $40 copay Tier 3 $70 copay *Mail Order (90-day supply)* Tier 1 $15 copay Tier 2 $80 copay Tier 3 $140 copay Injectibles 30% coinsurance with a maximum payment of $250 per prescription through specialty pharmacy 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 and coinsurance do not apply toward the Out-of-Pocket Maximum
12. Inpatient Hospital	Plan pays 80% after $1,200 copay per admission
13. Outpatient/Ambulatory Surgery	Plan pays 80% after $600 copay per surgery
14. Diagnostics	
a. Laboratory & X-ray	Plan pays 80%
b. MRI, nuclear medicine, and other high-tech services	Plan pays 80% after $200 copay per procedure
15. Emergency Care[7,8]	Plan pays 80% after $250 copay per emergency room visit. Care is covered In-Network or Out-of-Network

PPO #1		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Retail (34-day supply) Tier 1 $15 copay Tier 2 $40 copay Tier 3 $70 copay *Mail Order (90-day supply)* Tier 1 $15 copay Tier 2 $80 copay Tier 3 $140 copay Injectibles 30% coinsurance with a maximum payment of $250 per prescription through specialty pharmacy 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 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
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 60% after deductible Plan pays 60% after deductible	Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible
Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible

Part B: Summary of Benefits (continued)

	HMO
16. Ambulance	Plan pays 80% per trip 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
18. Biologically Based Mental Illness and Mental Disorders Care[9]	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
20. Alcohol & Substance Abuse	Coverage is no less extensive than the coverage provided for a physical illness
21. Physical, Occupational, and Speech Therapy	
a. Inpatient	Plan pays 80% after $1,200 copay per admission. Limited to 30 non-acute inpatient days per year
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
22. Durable Medical Equipment	Plan pays 80%. Limited to a maximum payment of $4,000 per year except for arm and leg prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of $4,000. Disposable medical supplies are not subject to the $4,000 maximum payment.
23. Oxygen	Plan pays 80%

PPO #1		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Plan pays 80% after deductible for ground or air ambulance	Plan pays 80% after deductible for ground or air ambulance	Plan pays 80% after deductible for ground or air ambulance	Plan pays 80% after deductible for ground or air ambulance
Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
Plan pays 80% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined Plan pays 80% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined Plan pays 60% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined	Plan pays 80% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined Plan pays 80% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined	Plan pays 60% after deductible. Limited to 30 non-acute inpatient days per year In-Network and Out-of-Network combined Plan pays 60% after deductible. Limited to 20 visits per year each for physical, occupational and speech therapy In-Network and Out-of-Network combined
Plan pays 80% after deductible with benefits limited to a maximum payment of $4,000 per 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 $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 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 $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	Not covered	Plan pays 80% after deductible	Not covered

	HMO
Part B: Summary of Benefits (continued)	
24. Organ Transplants	
a. Inpatient	Plan pays 80% after $1,200 copay per admission
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
25. Home Health Care	Plan pays 80%
26. Hospice Care	
a. Inpatient	Plan pays 80% after $1,200 copay per admission
b. Outpatient	Plan pays 80%
27. Skilled Nursing Facility Care	Plan pays 80% Limited to 100 days per year
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
29. Vision Care	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.
31. Significant Additional Covered Services (list up to 5)	• 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

PPO #1		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
$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 as office visit	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
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

	HMO
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
33. Exclusionary Riders Can an individual's specific pre-existing condition be entirely excluded from the policy?	No
34. How does the Policy define a "Pre-Existing Condition?"	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
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
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
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No

PPO #1		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

	HMO
Part D: Using the Plan (continued)	
39. What is the main customer service number?	1-877-PERABLU (877-737-2258)
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	HMO Colorado, 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
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
43. Does the plan have a binding arbitration clause?	Yes

PPO #1		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
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 _PPO1 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 and mental disorders.

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 contribute to an HSA plan. You may use an HSA with Anthem's HSA partner or an HSA plan of your choice. You also have the option of enrolling in this High Deductible Health Plan and not contributing to an HSA plan.

HSA Trustee	ARCUS Bank 1-877-373-9859 For enrollment forms, call Anthem at 1-877-PERABLU (1-877-737-2258)
Administration Fee*	$2.75 per month
Set Up Fee*	$15.00 per account
Transaction Fee*	No charge for debit card transactions at merchant location ATM withdrawals and inquiries $1 per transaction
Checkbook Order	$9.95 per set of 12 checks
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
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
Claim Process	Debit card, ATM withdrawals, check writing, online bill pay

*Subject to change at any time by bank.

Kaiser Permanente

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

Part B: Summary of Benefits

Important Note: This form is not a contract; it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	HMO #1	HMO #2	HDHP
4. Annual Deductible[2] **a. Individual** **b. Family**	 No deductibles No deductibles	 $1,000 per year $3,000 per year	 $3,500 per year $7,000 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	 $5,950 per year $11,900 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 care[5]	$1,000 copay per admission	20% coinsurance after deductible is met	20% coinsurance per admit, after deductible is met 20% coinsurance for procedures received during an office visit, after deductible is met
11. Prescription Drugs[6] **Level of coverage and restrictions on prescriptions**	*Retail (30-day supply):* $15 Generic $40 Brand *Mail Order (90-day supply):* $30 Generic $80 Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center	*Retail (30-day supply):* $15 Generic $40 Brand *Mail Order (90-day supply):* $30 Generic $80 Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center	After deductible is met: *Retail (30-day supply):* $10 Generic $25 Brand *Mail Order (90-day supply):* $20 Generic $50 Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center
12. Inpatient Hospital	$1,000 copay per admission	20% coinsurance after deductible is met 20% coinsurance for inpatient professional visits, after deductible is met	20% coinsurance after deductible is met 20% coinsurance for inpatient professional visits, after deductible is met
13. Outpatient/Ambulatory Surgery	$300 copay per visit for outpatient surgery performed in any setting other than inpatient	20% coinsurance after deductible is met for outpatient surgery performed in any setting other than inpatient	20% coinsurance after deductible is met for outpatient surgery performed in any setting other than inpatient
14. Diagnostics **a. Laboratory & X-ray**	Diagnostic lab and X-ray: No charge (100% covered). Therapeutic X-ray: $40 copay per visit	Diagnostic lab: No charge (100% covered), not subject to deductible Diagnostic X-ray, including therapeutic: 20% coinsurance after deductible is met	Diagnostic lab: 20% coinsurance after deductible is met Diagnostic X-ray, including therapeutic: 20% coinsurance after deductible is met
b. MRI, nuclear medicine, and other high-tech services	MRI/CAT/PET: $100 copay per procedure	MRI/CAT/PET: 20% coinsurance after deductible is met	MRI/CAT/PET: 20% coinsurance after deductible is met
15. Emergency Care[7,8]	$150 copay per visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient Line 14b procedures will generate a separate copay per procedure	20% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met	20% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met
16. Ambulance	20% coinsurance up to a maximum of $500 per trip	20% coinsurance up to $500 per trip, not subject to deductible, does not apply toward Out-of-Pocket Maximum	20% coinsurance, after deductible is met

Kaiser Permanente

	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
Part B: Summary of Benefits (continued)			
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
18. Biologically-Based Mental Illness and Mental Disorders Care[9]	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
19. Other Mental Health Care	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
20. Alcohol & Substance Abuse	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
21. Physical, Occupational & Speech Therapy	For conditions subject to significant improvement within two months Inpatient: $1,000 copay per admission Outpatient: $25 copay per visit for up to 20 visits per year for each type of therapy Therapy for congenital defects and birth abnormalities is covered for children up to age five for both acute and chronic conditions	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 Therapy for congenital defects and birth abnormalities are covered for children up to age five for both acute and chronic conditions	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 Therapy for congenital defects and birth abnormalities are covered for children up to age five for both acute and chronic conditions
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

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

Part B: Summary of Benefits (continued)

	HMO #1	HMO #2	HDHP
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 home-based hospice care. Not covered outside the Service Area	20% coinsurance for home-based hospice care, after deductible is met. Not covered outside the Service Area	20% coinsurance for home-based 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
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

Kaiser Permanente

	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
Part C: Limitations and Exclusions			
32. Period during which Pre-Existing Conditions are not covered[10]	Not applicable; plan does not impose limitation periods for pre-existing conditions	Not applicable; plan does not impose limitation periods for pre-existing conditions	Not applicable; plan does not impose limitation periods for pre-existing conditions
33. Exclusionary Riders: Can an individual's pre-existing condition be entirely excluded from the policy?	No	No	No
34. How does the policy define a "Pre-Existing Condition?"	Not applicable; plan does not exclude coverage for pre-existing conditions	Not applicable; plan does not exclude coverage for pre-existing conditions	Not applicable; plan does not exclude coverage for pre-existing conditions
35. What treatments and conditions are excluded under this policy?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy

Part D: Using the Plan	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
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

Kaiser Permanente

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.

Kaiser Permanente Health Savings Account (HSA) Option

Kaiser Permanente's High Deductible Health Plan (HDHP) qualifies you to contribute to an HSA plan. You may use an HSA with Kaiser's HSA partner or you use any HSA plan of your choice. You also have the option of enrolling in this High Deductible Health Plan and not contributing to 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: • 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	No deductible	$100
b. Family	No deductible	$200
c. Accumulation Period	N/A	Calendar Year
Annual Maximum Benefit	None	$1,500
Covered Providers	CIGNA Dental Care HMO Providers	CIGNA Dental PPO Network
Office Visits	$5 copay (in addition to any other copay)	Included in benefit for procedure
Diagnostic and Preventive	$0 to $155 copay	100% covered (not subject to deductible)
Restorative (Fillings)	$0 to $100 copay	80% covered after deductible
Endodontics (Root Canals)	$11 to $375 copay	80% covered after deductible
Periodontics (Gum Treatment)	$30 to $430 copay	80% covered after deductible
Oral Surgery (Extractions)	$11 to $105 copay	80% covered after deductible
Crowns and Bridges	$41 to $480 copay	50% covered after deductible
Prosthodontics (Dentures)	$39 to $675 copay	50% covered after deductible
Implants	Not covered	50% covered after deductible up to $1,500 lifetime maximum
Missing Tooth Limitation	No limitation	For the first 24 months of coverage, limitation applies
Orthodontics (Braces)	$1,872 copay for children; $2,184 copay for adults	50% covered after deductible up to $1,500 lifetime maximum

Comparing the Dental Plans

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

Delta Dental

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

Considering the Delta Dental PPO Plan

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

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

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

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

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: 1301 Pennsylvania Street, Denver
1120 W. 122nd Avenue, Westminster
303-832-9550 • 1-800-759-PERA (7372)
www.copera.org

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