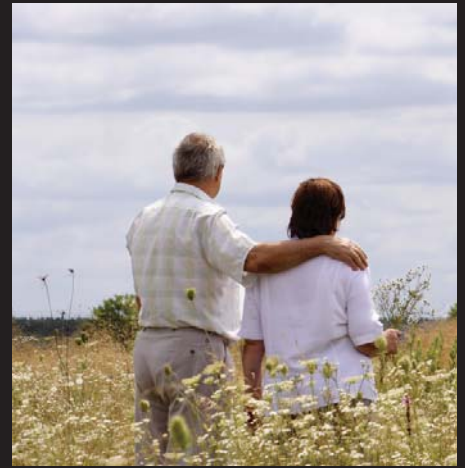




2008 Health Benefits Program



Pre-Medicare Coverage



Personal.
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PERACare Plan Contact Information/Resources

Anthem Blue Cross and Blue Shield

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

Caremark

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

CIGNA Dental

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

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

Centers for Medicare and Medicaid Services (CMS)

1-800-MEDICARE (633-4227)
www.medicare.gov

Social Security Administration

1-800-772-1213
www.socialsecurity.gov

PERA Contact Information

Colorado Public Employees' Retirement Association

Mailing Address

Colorado PERA
PO Box 5800
Denver, CO 80217-5800
Denver Main Office
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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PERACare Program Enrollment Guidelines

Who is Eligible to Enroll in PERACare?

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

There are three types of benefit recipients:

- PERA retirees;
- Individuals who are receiving survivor benefits; and
- Cobeneficiaries of deceased PERA retirees who selected an Option 2 or 3 benefit.

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

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

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

- Guardians of children receiving PERA survivor benefits, as long as the children also are enrolled.
- Surviving spouses of deceased retirees who are not receiving PERA benefits but were enrolled in the PERACare program when the retiree's death occurred.*
- Former spouses of retirees who are not receiving PERA benefits but were enrolled in the PERACare program when the divorce from the PERA retiree occurred.*

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

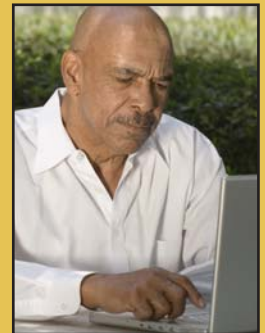
When Can I Enroll, Change Plans, or Add Dependents?

You may enroll in PERACare within 30 days of when you are first eligible or during the annual open enrollment period. In addition, you may become eligible to enroll, change plans, or add dependents based on certain "life events." These enrollment times are summarized in the chart on page 3.

PERACare coverage is effective on the first day of the month in which you are first eligible, unless you request a different date. If you are enrolling at retirement, you may choose an effective date up to six months in the future, as long as you remain covered by your employer's plan in the interim. The effective date of your PERACare coverage must coincide with the end of your other coverage.

What Happens When I Turn Age 65 and/or Become Eligible for Medicare?

You become eligible for Medicare when you turn age 65 (or earlier in some instances based on disability or disease). The Social Security Administration determines your eligibility for Medicare, even if you never worked under Social Security.



Enrolling in PERACare

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

Before Your 65th Birthday

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



When you turn 65 and/or become eligible for Medicare, you may enroll in, or remain in, PERACare. PERACare includes health plans designed to supplement, coordinate with, or replace Original Medicare. You cannot be enrolled in a pre-Medicare plan once you are eligible for Medicare, but you can enroll in one of the PERACare Medicare plans. You are eligible to add PERACare coverage (health care, dental, or vision) if you had other similar coverage, either privately or through another group plan, immediately prior to your Medicare eligibility. (See Enrollment Eligibility chart on page 3.) Otherwise, you have to wait for the next open enrollment to add coverage.

When you turn 65 or otherwise become eligible for Medicare, you must enroll in Medicare Part B to be in a PERACare health plan. You are not required to have, or to purchase, Medicare Part A.

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

Options for Combination Coverage

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

Traveling

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

Moving

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

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

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

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

Cancellation of Coverage

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

PERACare Enrollment Eligibility

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

	Proof Required	Who Can Be Enrolled or Added	Change(s) You Can Make
Events when you are first eligible to enroll			
• Retirement	None for the benefit recipient*	Yourself, your spouse, and children*	Enroll
• Becoming a PERA benefit recipient (PERA member or retiree has died and you are eligible to receive a monthly survivor or continuing benefit)	None for the benefit recipient*	Yourself, your spouse, and children*; your guardian (if benefit recipient is a child)	Enroll
Other times when you can enroll or change			
• Marriage	Copy of marriage certificate	Your new spouse	Add coverage for spouse
• Birth or adoption of child(ren)	Copy of birth certificate or adoption papers*	Your new child(ren)*	Add coverage for children
• During PERA's annual open enrollment period (October 1–November 15 each year)	None for the benefit recipient*	Yourself, your spouse, and children*	Enroll, add coverage for spouse or children, change plans
• Moving out of your HMO's service area	Address change notice to PERA	Yourself, your spouse, and children* (if they were covered under PERA's plan prior to move)	Change from HMO to another plan
• Turning age 65/becoming eligible for Medicare (you or your spouse)	CPHC** and a copy of Medicare card(s)	Yourself, your spouse, and children*	Enroll, add coverage for spouse or children, change plans
• Loss of other employer/group coverage, either your own or your spouse's	CPHC** and a copy of HIPAA certificate or employer letter***	Yourself, your spouse, and children* (if they were covered in the employer's plan)	Enroll yourself and your spouse and children (if they were covered in the employer's plan)
• Loss of individual coverage	CPHC** and a copy of insurer's cancellation or market exit letter***	Yourself, your spouse, and children* (if they were covered in the plan)	Enroll yourself and your spouse and children (if they were covered in the plan)
• Completion of COBRA coverage period (18, 29, or 36 months)	CPHC** and a copy of HIPAA certificate or COBRA letter***	Yourself, your spouse, and children* (if they were covered in the employer's plan)	Enroll yourself and your spouse and children (if they were covered in the employer's plan)
• Divorce	CPHC**	Yourself (if you were covered by your former spouse's plan)	Enroll

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

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

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

Plan Benefit Choices

What Plans Does PERACare Offer?

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

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

PERACare's dental plan partner is CIGNA Dental.

PERACare's vision plan partner is VSP.

How Should I Choose a Health Plan?

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

Your location

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

Your current coverage

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

Your doctor(s)

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

Your usage of health services

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

Your prescription drug needs

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



Online Provider Directories

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

Premiums

Consider all of your potential health care costs—not just your premium—when you evaluate costs. Look at deductibles, copays, and out-of-pocket maximums when estimating your total health care costs. Plans with higher premiums are more likely to have lower copays; plans with lower premiums have more cost-sharing for you. Premium information starts on page 29.

Pre-Medicare Health Plans

PERACare offers a variety of pre-Medicare (under age 65) health plan options. The following types of plans are available through PERACare in 2008. (See pages 8-26 for more specific plan information.)

HMO Plans

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

PPO Plans

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

HDHP and HSA Plans

Created by federal law in late 2003, a High Deductible Health Plan (HDHP) is usually a variation of a PPO plan, and it must meet specific requirements set forth in the law. You can enroll in an HDHP alone, or you can enroll in an HDHP and then set up a Health Savings Account (HSA) to set aside funds to cover your deductible and out-of-pocket costs on a tax-deductible basis. In an HDHP, you have the same type of benefits as in other plans, but you must meet the plan's high deductible before the plan starts to pay for those benefits. An HDHP can offer first-dollar coverage for some preventive services, but for most health care needs, including prescription drugs, you pay 100 percent of costs until you have met the plan's deductible. After you meet the plan's deductible, you share in costs through coinsurance and/or copays.

If you are participating in an HDHP, you are eligible to contribute to an HSA. For 2008, you can contribute \$2,900 (plus \$900 "catch up" if you are age 55 or older) no matter what your HDHP plan's deductible is, and your contributions can be tax-deductible. Funds in your HSA are invested and earnings accumulate tax-free. If you withdraw HSA funds for qualified health care expenses, they can remain tax-free upon distribution. You may establish an HSA with your bank, credit union, or any financial institution of your choice, including the bank that has an arrangement with your carrier's HDHP. You are not required to contribute to an HSA if you enroll in an HDHP, but many individuals choose an HDHP so they can contribute to an HSA.



Questions About Prescription Benefits?

- If you are enrolled in PERA's Anthem Blue Cross and Blue Shield plans, call Caremark at 1-800-378-0755.
- If you are enrolled in Kaiser Permanente plans, call Kaiser Permanente at 303-338-4503.

Prescription Drug Coverage

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

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

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

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

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

Plan Descriptions

Colorado Health Plan Description Forms

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

Dental and Vision Plan Descriptions

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

Endnotes for the Health Plan Descriptions are found on page 20 (Anthem) and page 26 (Kaiser Permanente). Premium information begins on page 29.



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

Part B: Summary of Benefits

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

4. Annual Deductible²			
a. Individual	No deductible	\$1,500, excludes copays	\$3,000
b. Family	No deductible	\$3,000, excludes copays	\$6,000
		Cross accumulates between In-Network and Out-of-Network	Cross accumulates between In-Network and Out-of-Network
5. Out-of-Pocket Maximum³			
a. Individual	\$10,000	\$10,000	\$20,000
b. Family	\$20,000 Excludes payments for prescription drugs, other mental health care, and alcohol and substance abuse	\$20,000 Excludes copays, excludes payments for prescription drugs, other mental health care, and alcohol and substance abuse. Cross accumulates between In-Network and Out-of-Network	\$40,000 Excludes payments for prescription drugs, other mental health care, and alcohol and substance abuse. 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	\$2,500,000 per individual In-Network and Out-of-Network combined for all covered services	\$2,500,000 per individual In-Network and Out-of-Network combined for all covered services
7A. Covered Providers	HMO Colorado managed care network. See provider directory for complete list of current providers	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers	All providers licensed or certified to provide covered benefits
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes	Yes

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

\$6,000	\$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	\$5,250	\$10,500
\$32,000 Excludes payments for prescription drugs, other mental health care, and alcohol and substance abuse. Cross accumulates between In-Network and Out-of-Network	\$64,000 Excludes payments for prescription drugs, other mental health care, and alcohol and substance abuse. Cross accumulates between In-Network and Out-of-Network	\$10,500 Cross accumulates between In-Network and Out-of-Network	\$21,000 Excludes payments for other mental health care, and alcohol and substance abuse. Cross accumulates between In-Network and Out-of-Network
Yes	Yes	Yes	Yes
\$2,500,000 per individual In-Network and Out-of-Network combined for all covered services	\$2,500,000 per individual In-Network and Out-of-Network combined for all covered services	\$2,500,000 per individual In-Network and Out-of-Network combined for all covered services	\$2,500,000 per individual In-Network and Out-of-Network combined for all services
Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers	All providers licensed or certified to provide covered benefits	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers	All providers licensed or certified to provide covered benefits
Yes	Yes	Yes	Yes

	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
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 Plan pays 80% for all other services that are not billed as an office visit	\$40 copay per visit (not subject to deductible) Plan pays 80% after deductible for all other services that are not billed as an office visit	Plan pays 60% after deductible
9. Preventive Care			
a. Children's Services (Up to age 13) Exam	\$25 copay per visit for PCP \$40 copay per visit for specialist Plan pays 100% up to \$150 per year for all services that are not billed as an office visit	\$25 copay per visit for PCP (not subject to deductible) \$40 copay per visit for specialist (not subject to deductible) Plan pays 80% (not subject to deductible) up to \$150 per year for all services that are not billed as an office visit	Plan pays 60% (not subject to deductible) for exam Other services not covered
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 Plan pays 100% up to \$150 per year for all services that are not billed as an office visit	\$25 copay per visit for PCP (not subject to deductible) \$40 copay per visit for specialist (not subject to deductible) Plan pays 80% (not subject to deductible) up to \$150 per year for all services that are not billed as an office visit	Not covered
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%	Plan pays 100% (not subject to deductible)	Not covered
Colonoscopy	Plan pays 80% after \$500 copay	Plan pays 80% after deductible	Not covered

PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Plan pays 80% (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 \$150 per year for all services that are not billed as an office visit		Plan pays 80% (not subject to deductible) up to \$150 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 \$150 per year for all services that are not billed as an office visit		Plan pays 80% (not subject to deductible) up to \$150 per year for all services that are not billed as an office visit	
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)	Not covered	Plan pays 80% (not subject to deductible)	Not covered
Plan pays 80% after deductible	Not covered	Plan pays 80% after deductible	Not covered

	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
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 prescriptions	Retail (30-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) Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum	Retail (30-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) Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum	
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^{6,7}	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 Care⁸	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
19. Other Mental Health Care			
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
Retail (30-day supply): \$500 deductible (per person), then 50% covered; \$15 minimum; \$80 maximum after deductible Mail order (90-day supply): \$30 for Generic, \$160 for Brand (not subject to deductible) Prescription drug copays, deductibles, and coinsurance do not apply toward the Out-of-Pocket Maximum		Plan pays 80% after deductible	Plan pays 80% after deductible
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
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
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 year. 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

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>
Covered as a medical service	Covered as a medical service	Covered as a medical service	Covered as a medical service
<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>
<p>Plan pays 80% after deductible with benefits limited to a maximum payment of \$3,000 per year. 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</p>	Not covered	<p>Plan pays 80% after deductible with benefits limited to a maximum payment of \$3,000 per year. 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</p>	Not covered
Plan pays 80% after deductible	Not covered	Plan pays 80% after deductible	Not covered

	HMO	PPO #1	
		In-Network	Out-of-Network
Part B: Summary of Benefits (continued)			
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 an 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
28. Dental Care	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 80%	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 80% after deductible	Not covered unless result of an accident in which other significant bodily injuries outside the mouth or oral cavity were sustained, then plan pays 60% after deductible
29. Vision Care	Not covered	Not covered	Not covered
30. Chiropractic Care	\$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"> • One smoking cessation program up to a maximum lifetime payment of \$150 • 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. One smoking cessation education program up to a maximum lifetime payment of \$150	Members who desire another professional opinion may obtain a second surgical opinion

PPO #2		HDHP	
In-Network	Out-of-Network	In-Network	Out-of-Network
Plan pays 80% after deductible	Not covered	Plan pays 80% after deductible	Not covered
Plan pays 80% after deductible	Not covered	Plan pays 80% after deductible	Not covered
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
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. One smoking cessation education program up to a maximum lifetime payment of \$150	Members who desire another professional opinion may obtain a second surgical opinion	Members who desire another professional opinion may obtain a second surgical opinion. One smoking cessation education program up to a maximum lifetime payment of \$150	Members who desire another professional opinion may obtain a second surgical opinion

	HMO	PPO #1	
		In-Network	Out-of-Network
Part C: Limitations and Exclusions			
32. Period during which Pre-Existing Conditions are not Covered.⁹	Not applicable; plan does not impose limitation periods for pre-existing conditions	Not applicable; plan does not impose limitation periods for pre-existing conditions	
33. Exclusionary Riders Can an individual's specific pre-existing condition be entirely excluded from the policy?	No	No	
34. How does the Policy define a "Pre-Existing Condition?"	Not applicable; plan does not exclude coverage for pre-existing conditions	Not applicable; plan does not exclude coverage for pre-existing conditions	
35. What treatments and conditions are excluded under this policy?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier or plan sponsor. Review them to see if a service or treatment you may need is excluded from the policy	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier or plan sponsor. Review them to see if a service or treatment you may need is excluded from the policy	

Part D: Using the Plan

36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining the preauthorization	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
39. What is the main customer service number?	1-877-PERABLU (877-737-2258)		1-877-PERABLU (877-737-2258)
40. Whom do I write/call if I have a complaint or want to file a grievance?¹⁰	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 1-877-PERABLU (877-737-2258)		Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 1-877-PERABLU (877-737-2258)
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800		Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s 98770_HMO Group—all sizes		Policy form #'s _PPO1 Group—all sizes
43. Does the plan have a binding arbitration clause?	Yes		Yes

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

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

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. **“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.
7. **“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.
8. **“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.
9. **“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.
10. **“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 (1-877-737-2258)
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 Deductible²			
a. Individual	No deductibles	\$1,000 per year	\$3,000 per year
b. Family	No deductibles	\$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 Maximum³			
a. Individual	\$4,000 per year	\$3,000 per year	\$5,600 per year
b. Family	\$10,000 per year	\$6,000 per year	\$11,200 per year
c. Is deductible included in the Out-of-Pocket Maximum?	Not applicable	No, the Out-of-Pocket Maximum excludes deductible and copays	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. Are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes	Yes
8. Routine Medical Office Visits⁴			
a. Primary Care Providers	\$25 copay per primary care office visit	\$25 copay per primary care office visit, not subject to deductible	20% coinsurance per primary care office visit, after deductible is met
b. Specialists	\$40 copay per specialist care office visit Line 13 may apply for procedures performed during an office visit	\$45 copay per specialist care office visit, not subject to deductible 20% coinsurance for procedures received during an office visit, after deductible is met	20% coinsurance per specialist care office visit, after deductible is met 20% coinsurance for procedures received during an office visit, after deductible is met
9. Preventive Care			
a. Children's services	\$25 copay per visit	No charge (100% covered), not subject to deductible	No charge (100% covered), not subject to deductible
b. Adults' services	\$25 copay per visit	No charge (100% covered), not subject to deductible	No charge (100% covered), not subject to deductible
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

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

Part B: Summary of Benefits (continued)

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 Medical Office Pharmacist	\$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 Medical Office Pharmacist	\$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 Medical Office Pharmacist
12. Inpatient Hospital	\$1,000 copay per admission	20% coinsurance after deductible is met 20% coinsurance for inpatient professional visits, after deductible is met	20% coinsurance after deductible is met 20% coinsurance for inpatient professional visits, after deductible is met
13. Outpatient/Ambulatory Surgery	\$300 copay per visit for outpatient surgery performed in any setting other than inpatient	20% coinsurance after deductible is met for outpatient surgery performed in any setting other than inpatient	20% coinsurance after deductible is met for outpatient surgery performed in any setting other than inpatient
14. Diagnostics a. Laboratory & X-ray	Diagnostic lab and X-ray: No charge (100% covered) Therapeutic X-ray: \$40 copay per visit	Diagnostic lab: No charge (100% covered), not subject to deductible Diagnostic X-ray, including therapeutic: 20% coinsurance after deductible is met	Diagnostic lab: 20% coinsurance after deductible is met Diagnostic X-ray, including therapeutic: 20% coinsurance after deductible is met
b. MRI, nuclear medicine, and other high-tech services	MRI/CAT/PET: \$100 copay per procedure	MRI/CAT/PET: 20% coinsurance after deductible is met	MRI/CAT/PET: 20% coinsurance after deductible is met
15. Emergency Care^{7,8}	\$150 copay per visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient. Line 14b procedures will generate a separate copay per procedure	20% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met	20% coinsurance at a Kaiser Permanente designated Plan or non-Plan emergency room, after deductible is met
16. Ambulance	20% coinsurance up to a maximum of \$500 per trip	20% coinsurance up to \$500 per trip, not subject to deductible, does not apply toward Out-of-Pocket Maximum	20% coinsurance, after deductible is met
17. Urgent, Non-Routine After Hours Care	\$150 copay per visit at a designated Kaiser Permanente emergency room \$25 copay per visit at a Kaiser Permanente medical office during office hours \$50 copay per after hours visit at designated Kaiser Permanente medical offices	20% coinsurance at a designated Kaiser Permanente emergency room, after deductible is met \$25 copay per visit at a Kaiser Permanente medical office during office hours, not subject to deductible; 20% coinsurance for procedures received during the visit, after deductible is met \$45 copay per after hours visit at designated Kaiser Permanente medical offices, not subject to deductible; 20% coinsurance for procedures received during the visit, after deductible is met	20% coinsurance at a designated Kaiser Permanente emergency room, after deductible is met 20% coinsurance at a Kaiser Permanente medical office during office hours, after deductible is met; 20% coinsurance for procedures received during the visit, after deductible is met 20% coinsurance per after hours visit at designated Kaiser Permanente medical offices, after deductible is met; 20% coinsurance for procedures received during an office visit, after deductible is met
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

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>19. Other Mental Health Care</p> <p>a. Inpatient Care</p>	<p>Inpatient: \$1,000 copay per admission—up to 45 days each calendar year</p>	<p>Inpatient: 20% coinsurance—up to 45 days each calendar year, after deductible is met</p>	<p>Inpatient: 20% coinsurance—up to 45 days each calendar year, after deductible is met</p>
<p>b. Outpatient Care</p>	<p>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>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>Outpatient: 20% coinsurance each visit up to 20 visits each calendar year, after deductible is met</p>
<p>20. Alcohol & Substance Abuse</p> <p>a. Inpatient</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</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</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 up to 30 days each calendar year, after deductible is met</p>
<p>b. Outpatient</p>	<p>Outpatient Chemical Dependency: \$25 copay per visit. 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>Outpatient Chemical Dependency: 50% coinsurance each visit, not subject to deductible, does not apply toward Out-of-Pocket Maximum</p>	<p>Outpatient Chemical Dependency: 20% coinsurance each visit, after deductible is met</p>
<p>21. Physical, Occupational & Speech Therapy</p>	<p>For conditions subject to significant improvement within two months Inpatient: \$1,000 copay per admission</p> <p>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</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 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: 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 is 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 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 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>

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

Part B: Summary of Benefits (continued)

23. Oxygen	No charge (100% covered)	20% coinsurance, not subject to deductible, does not apply toward Out-of-Pocket Maximum	20% coinsurance, after deductible is met
24. Organ Transplants	Applicable inpatient and outpatient copays apply—no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver Transplant lifetime maximum \$1,000,000 per individual	20% coinsurance after deductible is met—no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. 20% coinsurance for inpatient professional visits after deductible is met Transplant lifetime maximum \$1,000,000 per individual	20% coinsurance after deductible is met—no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea, liver, small bowel, and small bowel/liver. 20% coinsurance for inpatient professional visits, after deductible is met Transplant lifetime maximum \$1,000,000 per individual
25. Home Health Care	No charge (100% covered) for prescribed medically necessary part-time home health services. Not covered outside the Service Area	20% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area	20% coinsurance for prescribed medically necessary part-time home health services, after deductible is met. Not covered outside the Service Area
26. Hospice Care	No charge (100% covered) for 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	No dental benefits are available	No dental benefits are available
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	No chiropractic benefits are available	No chiropractic benefits are available
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 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

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 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

Part D: Using the Plan

36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes	Yes
38. If the provider charges more for a covered service than the plan pays, does the enrollee have to pay the difference?	No	No	No
39. What is the main customer service phone number?	Denver: 303-338-3800 or 1-800-632-9700 Colorado Springs: 1-888-681-7878	Denver: 303-338-3800 or 1-800-632-9700 Colorado Springs: 1-888-681-7878	Denver: 303-338-3800 or 1-800-632-9700 Colorado Springs: 1-888-681-7878
40. Whom do I write/call if I have a complaint or want to file a grievance?¹¹	Member Services 2500 S. Havana Street Aurora, CO 80014 303-338-3800	Member Services 2500 S. Havana Street Aurora, CO 80014 303-338-3800	Member Services 2500 S. Havana Street Aurora, CO 80014 303-338-3800
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800	Write to: Colorado PERA Insurance Division PO Box 5800 Denver, CO 80217-5800
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small, or large group; and if it is a short-term policy.	Policy forms LGEOC-DENCOS (01-08) and GA-Large-DENCOS (01-08) Large Group	Policy forms DEDEOC-DENCOS (01-08) and GA-Large-DENCOS (01-08) Large Group	Policy forms LGHDEOC-DENCOS (01-08) Large Group

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 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	\$100
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, and major metropolitan areas in many other states	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	\$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	
Lenses	Covered once every 12 months	Covered up to \$25	Covered once every 24 months	Covered up to \$35		Not covered
Single Vision		Covered up to \$40		Covered up to \$50		Not covered
Lined Bifocal		Covered up to \$55		Covered up to \$65		Not covered
Lined Trifocal		Covered up to \$80		Covered up to \$90		Not covered
Lenticular		Covered up to \$40		Covered up to \$50		Not covered
Frame	Covered up to \$120 retail allowance once every 24 months		Covered up to \$105 retail allowance once every 24 months		20% discount off complete pair of glasses only; no discount for lenses only, frame only or replacement parts or repairs	
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
Other Services (Add to lens price above)	Discounts average 20%	Not covered for any of the services listed	Discounts average 20%	Not covered for any of the services listed	Discounts average 20%	Not covered for any of the services listed
Progressive no-line bifocals						
Anti-reflective coating						
Scratch coating						
Lens tinting						
Photochromic						
UV coating						
Polycarbonate lenses						
Glass lenses						
Additional Glasses	20% discount	Not covered	20% discount	Not covered	20% discount for 12-month period following exam	Not covered
Laser Vision Correction	25% discount at approved laser centers	Not covered	25% discount at approved laser centers	Not covered	25% discount at approved laser centers	Not covered
VSP Network Doctors	VSP PPO providers See VSP directory for a complete list of current doctors	All providers licensed or certified to provide covered benefits	VSP PPO providers See VSP directory for a complete list of current doctors	All providers licensed or certified to provide covered benefits	VSP PPO providers See VSP directory for a complete list of current doctors	All providers licensed or certified to provide covered benefits
VSP Member Services	1-800-877-7195		1-800-877-7195		1-800-877-7195	

Premiums

Premium Information

Your health care premium is determined by:

- The plan(s) you select,
- The number of people you enroll, and
- The years of service for your retirement benefit.

PERACare uses four “tiers” of coverage.

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

How does the PERA health care subsidy work?

PERA provides a health care subsidy based upon the number of years of PERA service credit on which the PERA retirement benefit is based. The subsidy is up to \$230 monthly for pre-Medicare benefit recipients. The full subsidy is paid for 20 years of service credit; the subsidy is reduced 5 percent for each year of service credit less than 20. For example, a retiree with 10 years of service receives 50 percent of the subsidy or \$115.

Calculating Your Health Care Premium

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

A. Enter the total premium amount A. \$
 (from the premium chart on page 30)

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

C. Subtract line B from line A (A - B) C. \$
This is your monthly health care premium.

Pre-Medicare Benefit Recipient (BR) Subsidy Chart

Years of Service	Pre-Medicare BR Subsidy	Years of Service	Pre-Medicare BR Subsidy
20+	\$230.00	10	\$115.00
19	218.50	9	103.50
18	207.00	8	92.00
17	195.50	7	80.50
16	184.00	6	69.00
15	172.50	5	57.50
14	161.00	4	46.00
13	149.50	3	34.50
12	138.00	2	23.00
11	126.50	1	11.50

The PERA health care subsidy is applied toward the PERACare health care premium, and any remaining premium is deducted from the PERA monthly benefit. The subsidy does not apply to dental and vision coverage.

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

Anthem Monthly Premiums

	HMO	PPO #1	PPO #2	HDHP
BR	\$654.00	\$571.00	\$299.00	\$507.00
BR+S	1,308.00	1,142.00	598.00	1,014.00
BR+C	1,177.00	1,028.00	538.00	913.00
BR+S+C	1,831.00	1,599.00	837.00	1,420.00

Kaiser Permanente Monthly Premiums

	HMO #1	HMO #2	HDHP
BR	\$602.00	\$514.00	\$304.00
BR+S	1,203.00	1,028.00	607.00
BR+C	1,083.00	926.00	547.00
BR+S+C	1,685.00	1,440.00	850.00

CIGNA Dental Monthly Premiums

	HMO	PPO
BR	\$14.50	\$24.89
BR+S	28.75	49.89
BR+C	30.81	57.36
BR+S+C	48.50	80.05

VSP Monthly Premiums

	PPO #1	PPO #2	PPO #3
BR	\$7.84	\$5.29	\$0.84
BR+S	12.54	8.50	1.36
BR+C	12.80	8.69	1.39
BR+S+C	20.64	14.00	2.23

BR = Benefit Recipient

S = Spouse

C = Children

To calculate your net health care premium, subtract your PERA subsidy from the above health care premium. You may use the formula on page 29 or the PERACare calculator on the PERA Web site at www.copera.org.

Glossary of Key Terms

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

Carrier

Insurance company or administrator offering coverage.

Coinsurance

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

Copay or Copayment

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

Deductible

Individual Deductible

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

Family Deductible

Limits a family's potential costs by not requiring all family members to satisfy their individual deductibles. Once two or three family members satisfy their individual deductibles, the family has met the family deductible. Other family members would not need to meet any deductible. Note that in Kaiser Permanente's HDHP, family members must meet the family deductible; the individual deductible does not apply.

Formulary

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

HDHP or High Deductible Health Plan

HSA or Health Savings Account

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

HMO or Health Maintenance Organization

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

Out-of-Network Provider

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

Out-of-Pocket Costs

The actual costs you pay when you receive health care services.

Out-of-Pocket Maximum

The most you may have to pay in a plan year for covered services. Generally includes your deductible, copays, and coinsurance. Once you have reached your out-of-pocket maximum, the plan pays 100% for all of your covered services for the rest of the calendar year. Note that most plans specify that some types of services are not included in the out-of-pocket maximum. In Kaiser Permanente's HDHP, family members must meet the family out-of-pocket maximum; the individual amount does not apply.

PBM or Pharmacy Benefit Manager

Also called prescription benefit manager. Company that administers a plan's prescription drug benefit.

PCP or Primary Care Provider

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

PPO or Preferred Provider Organization

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

Premium

The amount you are charged each month for your coverage.

Specialist

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



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

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