PERACARE

2023

HEALTH PLAN DESCRIPTIONS

For Active Members

PERACARE®

PERACare Plan Contact Information/Resources

Cigna Dental
Group #3171792
1-877-635-PERA (7372)
cigna.com

Delta Dental
Group #11869
1-800-610-0201
deltadentalco.com

Kaiser Permanente
Group #1804
303-338-3800 or 1-800-632-9700
kp.org

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

Colorado PERA Contact Information

Mailing Address
Colorado PERA
PO Box 5800
Denver, CO 80217-5800

Phone/Website/Email
1-800-759-7372 (PERA)
copera.org
Email via the “Contact Us” link on the PERA homepage

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

Denver Main Office
1301 Pennsylvania Street
Denver, CO 80203

Lone Tree Office
10457 Park Meadows Drive, Suite 102
Lone Tree, CO 80124

Westminster Office
1120 W. 122nd Avenue, Suite 200
Westminster, CO 80234

Contents

PATIENT PROTECTION NOTICE

Kaiser Permanente (Kaiser) generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in your plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. You may contact Kaiser for more information on PCPs. Please see the inside front cover for contact information.

You do not need prior authorization from Kaiser or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in your plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your plan at the telephone number and/or website shown on the inside front cover.

Kaiser Permanente Plans Benefit Highlights

	HMO #1	HMO #2	HDHP
Plan Availability	Plan is available in the metro area from Fort Collins to Pueblo, as determined by ZIP code		
Annual Deductible	$0	$1,000 individual/$3,000 family	$3,500 individual/$7,000 family
Annual Out-of-Pocket Maximum	$4,000 individual/$10,000 family	$3,000 individual/$6,000 family	$6,050 individual/$12,100 family
Lifetime Benefit Maximum (per individual)	None		
Out-of-Network Services Covered?	Emergency and urgent care are covered at the in-network level		
Preventive Care—Not subject to deductible			
Exams, Screenings, Immunizations	No charge		
Physician Services			
Primary Care Office Visit	$25 copay	$25 copay, not subject to deductible	20% coinsurance
Specialist Office Visit	$40 copay	$45 copay, not subject to deductible	20% coinsurance
Virtual Care	No charge	No charge	20% coinsurance
Urgent Care[1]	$50 copay	$45 copay, not subject to deductible	20% coinsurance
Outpatient Services			
Office-Administered Medication	20% coinsurance		
Outpatient Surgery	$300 copay, not subject to deductible, at ambulatory surgery center; $600 copay, not subject to deductible, at hospital	$500 copay, not subject to deductible, at ambulatory surgery center; 20% coinsurance at hospital	10% coinsurance at ambulatory surgery center; 20% coinsurance at hospital
Diagnostic Lab	No charge	No charge	20% coinsurance
X-ray	No charge	20% coinsurance	20% coinsurance
Therapeutic X-ray; MRI, PET, CT	$40; $100	20% coinsurance	20% coinsurance
Durable Medical Equipment	No charge	20% coinsurance	20% coinsurance
Oxygen	No charge	20% coinsurance	20% coinsurance
Physical, Occupational, and Speech Therapy	$25 copay, up to 20 visits per year for each type of therapy	$25 copay, not subject to deductible, up to 20 visits per year for each type of therapy	20% coinsurance, up to 20 visits per year for each type of therapy
Home Health Care	No charge	20% coinsurance	20% coinsurance
Hospice Care	No charge	No charge	20% coinsurance
Vision Care	$25 copay, includes refraction test Hardware is not covered	$25 exam, 20% coinsurance for refraction test Hardware is not covered	20% coinsurance for exam and refraction test Hardware is not covered
Chiropractic Care	$25 copay/20 visits	$25 copay/20 visits	20% coinsurance/20 visits

[1] These prices are available at designated Kaiser medical offices

Kaiser Permanente Plans Benefit Highlights

	HMO #1	HMO #2	HDHP
Inpatient Care			
Inpatient Hospitalization	$1,000 copay	20% coinsurance	20% coinsurance
Skilled Nursing Facility Care	No charge up to 100 days	20% coinsurance up to 100 days	20% coinsurance up to 100 days
Emergency Care			
Emergency Room Visit	$250 copay per visit, waived if admitted	20% coinsurance	20% coinsurance
Ambulance Services	20% coinsurance, up to $500	20% coinsurance, up to $500	20% coinsurance
Prescription Drugs			
Pharmacy Copay (up to a 30-day supply)	Preferred Generic $15 Preferred Brand $40 Non-Preferred $60 Specialty 20% coinsurance ($250 max)	Preferred Generic $15 Preferred Brand $40 Non-Preferred $60 Specialty 20% coinsurance ($250 max)	After deductible is met: Preferred Generic $10 Preferred Brand $30 Non-Preferred 50% Specialty 20% coinsurance ($250 max)
Mail-Order Copay (up to a 90-day supply)	Preferred Generic $30 Preferred Brand $80 Non-Preferred $120	Preferred Generic $30 Preferred Brand $80 Non-Preferred $120	After deductible is met: Preferred Generic $20 Preferred Brand $60 Non-Preferred 50%

See page 5 for premium details

Dental Plan Highlights

Network Information	Cigna Dental HMO	Cigna Dental PPO	Delta Dental PPO
Provider Network	Cigna Dental Care Access	Cigna Dental DPPO Advantage Network	Delta Dental PPO Network
How to Find a Dentist	Search cigna.com or call 1-877-635-7372	Search cigna.com or call 1-877-635-7372	Search deltadentalco.com or call 1-800-610-0201
Plan Availability	Metro Denver, Front Range, and major metro areas in many states	Nationwide	Nationwide
Features			
Individual Plan Annual Deductible[1]	None	$100	$100
Family Plan Annual Deductible[1]	None	$200	$200
Annual Benefit Maximum[2] (per individual)	None	$1,500	$1,500
Lifetime Benefit Maximums for Orthodontics (per individual)	No limitation	$1,500	$1,500

Covered Services	Covered in-network only	Covered in- and out-of-network	
Diagnostic and Preventive	**Your Copay**	**What you pay if you use a network dentist[3]**	
Office Visit	$0 copay	Nothing	Nothing
Oral Exams and Regular Cleanings	$0 copay	Nothing	Nothing
X-rays	$0 copay	Nothing	Nothing
Sealants	$12 per tooth	Nothing	Nothing
Basic Services			
Basic Restorative (fillings)	$0 to $115 copay	20% of PPO Contracted Fee	20% of PPO Contracted Fee
Oral Surgery (extractions)	$13 to $125 copay	20% of PPO Contracted Fee	20% of PPO Contracted Fee
Endodontics (root canal therapy)	$14 to $430 copay	20% of PPO Contracted Fee	20% of PPO Contracted Fee
Periodontics (gum disease treatment)	$42 to $430 copay	20% of PPO Contracted Fee	20% of PPO Contracted Fee
Major Services			
Prosthodontics (dentures, bridges)	$43 to $715 copay	50% of PPO Contracted Fee	50% of PPO Contracted Fee
Special Restorative (crowns, bridges)	$13 to $500 copay	50% of PPO Contracted Fee	50% of PPO Contracted Fee
Orthodontics (braces)	$67 to $2,376 copay	50% of PPO Contracted Fee	50% of PPO Contracted Fee
Implants	$82 to $1,015 copay	50% of PPO Contracted Fee	50% of PPO Contracted Fee

[1] Deductible applies to Basic and Major Services, but not Diagnostic and Preventive.

[2] Benefits paid for preventive care do not apply to the Annual Benefit Maximum.

[3] You have the lowest cost if you use a DPPO Advantage dentist under Cigna or a PPO dentist for Delta Dental. If you see a dentist who does not participate in the plan's network, you may be balance billed, meaning you will pay the difference between the PPO contracted fee and the fee charged by the dentist, in addition to any deductible and coinsurance.

See page 5 for premium details

Vision Plan Highlights

	Vision PPO #1		Vision PPO #2		Vision PPO #3	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Availability	Nationwide					
VSP Network Doctors See VSP Choice Network directory for a complete list of current doctors	Nationwide access to thousands of private practice VSP doctors	Non-VSP providers licensed or certified to provide covered benefits	Nationwide access to thousands of private practice VSP doctors	Non-VSP providers licensed or certified to provide covered benefits	Nationwide access to thousands of private practice VSP doctors	Non-VSP providers licensed or certified to provide covered benefits
Well Vision Exam (Every 12 months)	$10 copay, then covered in full	$10 copay, then covered up to $45	$25 copay, then covered in full	$25 copay, then covered up to $45	$10 copay, then covered in full	$10 copay, then covered up to $45
Prescription Glasses	$25 copay for lenses and frame		$25 copay for lenses and frame		20% discount off complete pair of glasses only; no discount for lenses only, frame only, or replacement parts or repairs	Not covered
Lenses	Covered once per calendar year		Covered once per calendar year			
Single Vision	Covered in full	Covered up to $30	Covered in full	Covered up to $30		
Bifocal	Covered in full	Covered up to $50	Covered in full	Covered up to $50		
Trifocal	Covered in full	Covered up to $65	Covered in full	Covered up to $65		
Frame[1]	Covered once per calendar year		Covered once every other calendar year			
	$160 allowance, $180 on featured frame brands	Covered up to $70	$115 allowance, $165 on featured frame brands	Covered up to $70		
Contacts[2]	Covered once per calendar year		Covered once per calendar year		15% discount for evaluation and fitting, no discount for lenses	Not covered
	$160 allowance for evaluation, fitting, and lenses	$105 allowance for evaluation, fitting, and lenses	$105 allowance for evaluation, fitting, and lenses	$105 allowance for evaluation, fitting, and lenses		
Lens Options	Standard progressives covered in full. Discounts for all other options average 30%	Not covered	Standard progressives covered in full. Discounts for all other options average 30%	Not covered	20% discount	Not covered
Easy Options Upgrades	Select one upgrade[3]	Not covered	Not covered	Not covered	Not covered	Not covered
Additional Glasses (Including Sunglasses)	20% discount	Not covered	20% discount	Not covered	20% discount	Not covered
Laser Vision Correction	15% discount	Not covered	15% discount	Not covered	15% discount	Not covered

[1] Frame allowance is higher if Marchon featured frame brands are selected.

[2] You may choose prescription glasses or contacts, but not both.

[3] Upgrade options are: $230 to $250 frame allowance, a $200 contact lens allowance, fully-covered premium or custom progressive lenses, fully-covered light-reactive lenses, or fully-covered anti-glare coating.

VSP partners with TruHearing to offer VSP enrollees in PERACare special discounts on hearing tests and hearing aids. Call 1-866-929-3827 and tell them you are with Colorado PERA to schedule a hearing test and learn if you need a hearing aid.

See page 5 for premium details

Premiums

Kaiser Permanente Plans

	HMO #1	HMO #2	HDHP
Employee Only	$750.00	$656.00	$404.00
Employee + Spouse	$1,496.00	$1,309.00	$804.00
Employee + Child(ren)	$1,385.00	$1,211.00	$745.00
Employee + Spouse + Child(ren)	$2,162.00	$1,889.00	$1,163.00

Cigna Dental Plans

	HMO	PPO
Employee Only	$16.48	$41.78
Employee + Spouse	$32.97	$83.58
Employee + Child(ren)	$37.94	$96.11
Employee + Spouse + Child(ren)	$52.77	$133.72

Delta Dental Plan

	PPO
Employee Only	$38.06
Employee + Spouse	$76.08
Employee + Child(ren)	$87.50
Employee + Spouse + Child(ren)	$121.75

VSP Vision Plans

	PPO #1	PPO #2	PPO #3
Employee Only	$8.85	$4.70	$0.77
Employee + Spouse	$14.19	$7.58	$1.20
Employee + Child(ren)	$14.47	$7.74	$1.24
Employee + Spouse + Child(ren)	$23.36	$12.46	$2.00

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 in understanding 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 is 20%, you would pay 20% of the charges and the plan would pay the other 80%.

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

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

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

Formulary
A list of covered drugs that you can receive through the plan, including generic, brand-name, and specialty drugs.

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

Health Maintenance Organization (HMO)
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, but your share of costs will be higher. 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 calendar year for covered services. Depending on the plan, it may include 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.

Pharmacy Benefit Manager (PBM)
The company that administers a plan's prescription drug benefit; also called prescription benefit manager.

Primary Care Physician (PCP)
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.

Preferred Provider Organization (PPO)
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 advanced education and training in a specific area of medicine, such as a cardiologist or neurologist.

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

Colorado Public Employees' Retirement Association
PO Box 5800
Denver, Colorado 80217-5800
copera.org

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