PERACARE

2022

HEALTH PLAN DESCRIPTIONS

For Active Members

PERACARE®

PERACare Plan Contact Information/Resources

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

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

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

VSP
Group #12144626
1-800-877-7195
www.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)
www.copera.org
Email via the "Contact Us" link on the PERA home page

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
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

	HMO #1	HMO #2	HDHP
Part A: Type of Coverage	**In-Network Only (Out-of-Network care is not covered except as noted)**		
1. Type of Plan	Health Maintenance Organization (HMO)		
2. Out-of-Network Care Covered?[1]	Only for urgent and emergency care		
3. Plan Availability	Plan is available in the metro area from Fort Collins to Pueblo, as determined by ZIP code		

Part B: Summary of Benefits

Important Note: This booklet is not a contract; it is only a summary. The contents of this booklet 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 PCP, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

4. Annual Deductible[2]			
a. Individual	No deductible	$1,000 per year	$3,500 per year
b. Family	No deductible	$3,000 per year	$7,000 per year
5. Out-of-Pocket Maximum[3]			
a. Individual	$4,000 per year	$3,000 per year	$6,050 per year
b. Family	$10,000 per year	$6,000 per year	$12,100 per year
c. Is deductible included in the Out-of-Pocket Maximum?	Not applicable	Yes	Yes
6A. 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
6B. With respect to network plans, are all the providers listed in 6A accessible to me through my PCP?	Yes. Referrals are not required for most services	Yes. Referrals are not required for most services	Yes. Referrals are not required for most services
7. Medical Office Visits[4]			
a. Primary Care Physicians	$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	$45 copay per specialist care office visit, not subject to deductible	20% coinsurance per specialist care office visit, after deductible is met
	Line 12 may apply for procedures performed during an office visit	20% coinsurance for procedures received during an office visit, after deductible is met	20% coinsurance for procedures received during an office visit, after deductible is met
8. Preventive Care			
a. Children's Services	No charge (100% covered)	No charge (100% covered), not subject to deductible	No charge (100% covered), not subject to deductible
b. Adults' Services	No charge (100% covered)	No charge (100% covered), not subject to deductible	No charge (100% covered), not subject to deductible

Part B: Summary of Benefits (continued)	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
9. Maternity			
a. Prenatal Care	No charge (100% covered)	20% coinsurance after deductible is met	20% coinsurance after deductible is met
b. Delivery & Inpatient Well Baby Care[5]	$1,000 copay per admission	20% coinsurance after deductible is met	20% coinsurance after deductible is met
10. Prescription Drugs[6] Level of Coverage and Restrictions on Prescriptions	*Retail (30-day supply):* $15 Generic $40 Brand $60 Non-Preferred Brand 20% up to $250 Specialty *Mail Order (90-day supply):* $30 Generic $80 Brand $120 Non-Preferred Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center	*Retail (30-day supply):* $15 Generic $40 Brand $60 Non-Preferred Brand 20% up to $250 Specialty *Mail Order (90-day supply):* $30 Generic $80 Brand $120 Non-Preferred Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center	After deductible is met: *Retail (30-day supply):* $10 Generic $30 Brand 50% Non-Preferred Brand 20% up to $250 Specialty *Mail Order (90-day supply):* $20 Generic $60 Brand 50% Non-Preferred Brand Certain drugs limited to a 30-day supply. For drugs on our approved list, please contact your Clinical Pharmacy Call Center
11. Inpatient Hospital	$1,000 copay per admission	20% coinsurance after deductible is met	20% coinsurance after deductible is met
12. Outpatient/Ambulatory Surgery	$300 copay per visit if performed at an Ambulatory Surgery Center; $600 copay if performed at a hospital	$500 copay per visit if performed at an Ambulatory Surgery Center; 20% coinsurance after deductible if performed at a hospital	10% coinsurance after deductible if performed at an Ambulatory Surgery Center; 20% coinsurance after deductible if performed at a hospital
13. 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 and Therapeutic X-ray: 20% coinsurance after deductible is met	Diagnostic lab: 20% coinsurance after deductible is met Diagnostic and Therapeutic X-ray: 20% coinsurance after deductible is met
b. MRI, Nuclear Medicine, and Other High-Tech Services	MRI/CT/PET: $100 copay per procedure	MRI/CT/PET: 20% coinsurance after deductible is met	MRI/CT/PET: 20% coinsurance after deductible is met
14. Emergency Care[7]	$250 copay per visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient Line 13b 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

Part B: Summary of Benefits (continued)	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
15. Ambulance	20% coinsurance up to a maximum of $500 per trip	20% coinsurance up to a maximum of $500 per trip	20% coinsurance after deductible is met
16. Urgent, Non-Routine After Hours Care	$50 copay per after hours visit at designated Kaiser Permanente medical offices	$45 copay per after hours visit at designated Kaiser Permanente medical offices, not subject to deductible	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
17. Mental Health Care	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
18. Alcohol & Substance Abuse	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness	Coverage is no less extensive than the coverage provided for a physical illness
19. Physical, Occupational, and Speech Therapy	For inpatient services, up to 60 days per condition per Accumulation Period Inpatient: $1,000 copay per admission Outpatient: $25 copay per visit for up to 20 visits per year for each type of therapy Therapy for congenital defects and birth abnormalities is covered for children up to age 5 for both acute and chronic conditions	For inpatient services, up to 60 days per condition per Accumulation Period 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 5 for both acute and chronic conditions	For inpatient services, up to 60 days per condition per Accumulation Period 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 5 for both acute and chronic conditions
20. Durable Medical Equipment	No charge (100% covered)	20% coinsurance	20% coinsurance
21. Oxygen	No charge (100% covered)	20% coinsurance, subject to deductible	20% coinsurance after deductible is met
22. 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	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	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

Part B: Summary of Benefits (continued)	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
23. Home Health Care	No charge (100% covered) for prescribed medically necessary part-time home health services	20% coinsurance for prescribed medically necessary part-time home health services, after deductible is met	20% coinsurance for prescribed medically necessary part-time home health services, after deductible is met
24. Hospice Care	No charge (100% covered) for home-based hospice care	No charge (100% covered) for home-based hospice care	20% coinsurance for home-based hospice care, after deductible is met
25. 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	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	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
26. Dental Care	Not covered	Not covered	Not covered
27. Vision Care	$25 copay per vision exam, including refraction test Hardware not covered	$25 copay per vision exam; 20% coinsurance after deductible for refraction test Hardware not covered	20% coinsurance after deductible for vision exam and refraction test Hardware not covered
28. Chiropractic Care	$25 copay per visit up to 20 visits each calendar year	$25 copay per visit up to 20 visits per year	20% coinsurance for up to 20 visits, after deductible is met

Part C: Limitations and Exclusions	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
29. Significant Additional Covered Services	Virtual care options including email, e-visits, chat online, phone, video, and on-demand video are available at no cost. When traveling, urgent and emergency care are available 24/7 worldwide. Additionally, visiting member services from another Kaiser regional health plan are available, subject to the terms and conditions of the member's home plan. Contact the "Away from Home Travel Line" at 951-268-3900 or online at www.kp.org/travel for more information. A limited benefit is also available to dependents, up to age 26, receiving care outside any Kaiser regional health plan service area. The Dependent Out-of-Area benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and approved prescription drug fills.	Virtual care options including email, e-visits, chat online, phone, video, and on-demand video are available at no cost. When traveling, urgent and emergency care are available 24/7 worldwide. Additionally, visiting member services from another Kaiser regional health plan are available, subject to the terms and conditions of the member's home plan. Contact the "Away from Home Travel Line" at 951-268-3900 or online at www.kp.org/travel for more information. A limited benefit is also available to dependents, up to age 26, receiving care outside any Kaiser regional health plan service area. The Dependent Out-of-Area benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and approved prescription drug fills.	Virtual care options, including email, e-visits, and chat online are available at no cost. Phone, video, and on-demand video visits with a Kaiser provider are no cost only after the deductible is met. When traveling, urgent and emergency care are available 24/7 worldwide. Additionally, visiting member services from another Kaiser regional health plan are available, subject to the terms and conditions of the member's home plan. Contact the "Away from Home Travel Line" at 951-268-3900 or online at www.kp.org/travel for more information. A limited benefit is also available to dependents, up to age 26, receiving care outside any Kaiser regional health plan service area. The Dependent Out-of-Area benefit is limited to certain office visits, diagnostic X-rays, physical, occupational, and speech therapy, and approved prescription drug fills.
30. What treatments and conditions are excluded under this policy?	Experimental and investigational services are not covered. Other 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.	Experimental and investigational services are not covered. Other 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.	Experimental and investigational services are not covered. Other exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or plan sponsor. Review the list to see if a service or treatment you may need is excluded from the policy.

Part D: Using the Plan	HMO #1	HMO #2	HDHP
	In-Network Only (Out-of-Network care is not covered except as noted)		
31. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No	No
32. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes	Yes
33. If the provider charges more for a covered service than the plan pays, does the enrollee have to pay the difference?	No	No	No
34. What is the main customer service phone number?	303-338-3800 or 1-800-632-9700	303-338-3800 or 1-800-632-9700	303-338-3800 or 1-800-632-9700
35. Whom do I write/call if I have a complaint or want to file a grievance?[8]	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
36. 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
37. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small, or large group; and if it is a short-term policy.	Policy forms: LGEOC-DENCOS (01-09) and GA-Large-DENCOS (01-09) Large Group	Policy forms: DEDEOC-DENCOS (01-09) and GA-Large-DENCOS (01-09) Large Group	Policy forms: LGHDEOC-DENCOS (01-09) Large Group
38. Does the plan have a binding arbitration clause?	Yes	Yes	Yes

Endnotes

1. **"Network"** refers to a specified group of physicians, hospitals, 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.

3. **"Out-of-Pocket Maximum"** means the maximum amount you will have to pay for allowable covered expenses under a health plan.

4. **"Medical office visits"** include physician, mid-level practitioner, and specialist visits.

5. **"Well baby care"** includes an In-hospital newborn pediatric visit and newborn hearing screening. The hospital copay applies to mother and well-baby together; there are not separate copays.

6. **"Prescription drugs"** otherwise excluded are not covered, regardless of whether generic, brand, non-preferred brand, or specialty.

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. **"Grievances"** or grievance procedures are required by all plans by Colorado law. Write the Colorado Division of Insurance for a copy of those procedures.

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 www.cigna.com or call 1-877-635-7372	Search www.cigna.com or call 1-877-635-7372	Search www.deltadentalco.com or call Delta Dental at 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.

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 every 12 months		Covered once every 12 months			
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 every 12 months		Covered once every 24 months			
	$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 every 12 months		Covered once every 12 months		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, once every 12 or 24 months as noted above.

[3] Upgrade options are: an additional $70 frame allowance, an additional $40 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.

Premiums

Kaiser Permanente Plans

	HMO #1	HMO #2	HDHP
Employee Only	$743.00	$650.00	$400.00
Employee + Spouse	$1,483.00	$1,297.00	$797.00
Employee + Child(ren)	$1,373.00	$1,200.00	$739.00
Employee + Spouse + Child(ren)	$2,143.00	$1,872.00	$1,153.00

Cigna Dental Plans

	HMO	PPO
Employee Only	$16.00	$40.06
Employee + Spouse	$32.01	$80.13
Employee + Child(ren)	$36.83	$92.15
Employee + Spouse + Child(ren)	$51.23	$128.21

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
www.copera.org

5/43 (REV 10-21)