

**University of Denver Non-Medicare Health Plan Comparison Chart 2010-2011 Plan Year**

	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente	PPO Traditional Plan	PPO Traditional Plan
Medical Plans:	HMO Plan	(POS) Point-of-Service (a.k.a. Triple Option) Plan	(POS) Point-of-Service (a.k.a. Triple Option) Plan	(POS) Point-of-Service (a.k.a. Triple Option) Plan	PPO Traditional Plan	PPO Traditional Plan
Provider Arrangement	<u>Kaiser Network</u> providers only	<u>Kaiser Network</u> Using Kaiser providers only	<u>PHCS-Preferred Network</u> Self refer (no PCP)	<u>Out-of-Network</u> Use any provider	<u>PHCS-Preferred Network</u> Self refer (no PCP)	<u>Out-of-Network</u> Use any provider
Calendar Year Deductible	None	None	\$1,000 Individual \$3,000 Family	\$1,200 Individual \$3,600 Family	\$500 individual \$1000 Family	\$1000 individual \$2000 Family
Member Coinsurance <i>(portion of expenses you pay after ded./copays)</i>	100% covered by plan	100% covered by plan	20% of eligible expenses after deductible/copays	50% of eligible expenses after deductible/copays	20% of eligible expenses after deductible/copays	40% of eligible expenses after deductible/copays
Calendar Year Out of Pocket Maximum	\$2,000 Individual \$4,500 Family	\$2,000 Individual \$4,500 Family	\$4,000 Individual \$8,000 Family <i>Does not include ded.</i>	\$7,000 Individual \$14,000 Family <i>Does not include ded.</i>	\$4,000 Individual \$8,000 Family <i>Does not include ded.</i>	\$8,000 Individual \$16,000 Family <i>Does not include ded.</i>
Lifetime Maximum Benefit	Unlimited (except for transplants)	Unlimited (except for transplants)	\$1,000,000 in & out of network combined	\$1,000,000 in & out of network combined	\$2,000,000 in & out of network combined	\$2,000,000 in & out of network combined
Office Visits	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist	\$25 PCP / \$40 Specialist	50% after deductible	\$25 PCP / \$40 Specialist	40% after deductible
Preventive Care	\$10 copay	\$10 copay	\$25 copay per visit (limited adult services)	\$70 copay per visit (limited adult services)	\$25 copay per visit (limited adult services)	\$70 copay per visit (limited adult services)
Maternity	\$10 per visit copay	\$10 per visit copay	\$25 copay per visit	50% after deductible	\$25 per visit copay	40% after deductible
<i>Prenatal Delivery &amp; inpatient well baby care</i>	\$10 per visit copay \$500 copay per admission	\$10 per visit copay \$500 copay per admit/Individual	\$25 copay per visit 20% after deductible	50% after deductible 50% after deductible	\$25 per visit copay 20% after deductible	40%, after deductible 40% after deductible
Inpatient Hospital	\$500 per admit	\$500 per admit	20% after deductible Pre-cert is required	50% after deductible Pre-cert is required	20% after deductible; Pre-cert is required.	40% after deductible; Pre-cert is required.
Outpatient/Ambulatory Surgery	\$100 copay per visit	\$100 copay per visit	20% after deductible Pre-cert is required	50% after deductible Pre-cert is required	20% after deductible; Pre-cert is required.	40% after deductible; Pre-cert is required.
Ambulance	20% up to \$500 per trip	20% up to \$500 per trip	Covered as in-network	Covered as in-network	20% after deductible	40% after deductible
Emergency Care	\$100 per incident (waived if admitted)	\$100 per incident (waived if admitted)	Covered as in-network	Covered as in-network	20% after deductible	40% after deductible
X-Ray & Labs	Diagnostic: Plan Pays 100%; Therapeutic: \$40 per visit copay; MRI/CAT/PET: \$100/per procedure	Diagnostic: Plan Pays 100%; Therapeutic: \$40 per visit copay; MRI/CAT/ PET: \$100/per procedure	20% after deductible (pre-cert is required for MRI/CT/PET)	50% after deductible (pre-cert is required for MRI/CT/PET)	20% after deductible (pre-cert is required for MRI/CT/PET)	40% after deductible (pre-cert is required for MRI/CT/PET)
Prescriptions	\$15 generic \$25 brand at KP facility (up to a 30-day supply) <i>Mail-order: 2x copay for a 90-day supply</i>	\$15 generic 25 brand at KP facility (up to a 30-day supply) <i>Mail-order: 2x copay for a 90-day supply</i>	\$25 generic \$35 brand at MedImpact Pharmacies up to a 30-day supply <i>Mail-order: 2x copay for a 90-day supply</i>	\$25 generic \$35 brand at MedImpact Pharmacies up to a 30-day supply <i>Mail-order: 2x copay for a 90-day supply</i>	\$15 generic \$40 brand at MedImpact Pharmacies up to a 30-day supply <i>Mail-order: 2x copay for a 90-day supply</i>	<i>Not Covered</i>

<b>Vision</b>	Exam: \$25 per visit ( <i>with an optometrist</i> ); hardware & contact lens exam not covered	Exam: \$25 per visit ( <i>with an optometrist</i> ); hardware & contact lens exam not covered	Covered in Kaiser network only	Covered in Kaiser network only	Exam: \$25 copay (every 2 years); hardware not covered	Exam: 40% after deductible (every 2 years); hardware not covered
<b>Chiropractic Care</b>	\$20 copay per visit maximum 20 visits per <i>plan</i> year	\$25 copay per visit maximum 20 visits per <i>calendar</i> year	\$40 copay per visit up to 20 visits per <i>calendar</i> year	Not covered	\$25 copay per visit maximum 20 visits per <i>calendar</i> year	<i>Not covered</i>

This summary of health insurance benefits is provided to assist you in comparing plans. It is not a complete description of plan benefits; additional restrictions and limitations may apply. The group contracts between the University of Denver and the health plans take precedence in case of any dispute. Please refer to plan description and certificates of coverage for full details of coverage, limitations, exclusions, etc.

\*Any biologically-based Mental Illness is paid the same as any other illness.