

**University of Denver Health Plan Comparison Chart 2006 Plan Year**

Benefits	Kaiser Permanente	Kaiser Permanente			PPO Traditional Plan	
	HMO Plan	(POS) Point-of-Service Plan				
<b>Provider Arrangement</b>	Kaiser Network providers only	<u><b>Kaiser Network</b></u> Use Kaiser providers	<u><b>Preferred Network</b></u> Self refer (no PCP)	<u><b>Out-of-Network</b></u> Use any provider	<b>PHCS Network</b> Self refer (no PCP)	<u><b>Out-of-Network</b></u> Use any provider
<b>Deductible</b>	None None	None None	\$500 Individual \$1500 Family	\$600 Individual \$1800 Family	\$500 individual \$1000 Family	\$1000 individual \$2000 Family
<b>Coinsurance</b>	100% covered by plan	100% covered by plan	Ded/20%	Ded/50%	Ded / 20%	Ded / 40%
<b>Annual Out of Pocket Maximum</b>	\$2,000 Individual \$4,500 Family	\$2,000 Individual \$4,500 Family	\$4,000 Individual \$8,000 Family	\$7,000 Individual \$14,000 Family	\$4,000 Individual \$8,000 Family	\$8,000 Individual \$16,000 Family
<b>Lifetime Maximum</b>	Unlimited	Unlimited	\$1,000,000 combined maximum		\$2,000,000 in & out of network	
<b>Office Visits</b>	\$20 PCP / \$30 Specialist	\$20 PCP / \$30 Specialist	\$25 PCP / \$40 Specialist	Ded / 50%	\$25 PCP / \$40 Specialist	40% coinsurance, deductible waived
<b>Preventive Care</b>	\$10 copay	\$10 copay	\$25 copay per visit	50%, ded waived	\$25 copay, deductible waived	40% coinsurance, deductible waived
<b>Children's Services</b>	\$10 copay	\$10 copay	\$25 copay per visit	50%, ded waived	\$25 copay, deductible waived	40% coinsurance, deductible waived
<b>Maternity</b>	\$10 per visit copay	\$10 per visit copay	\$25 copay per visit	Ded / 50%	\$25 copay, deductible waived	40% coinsurance, deductible waived
<b>Prenatal Delivery &amp; inpatient well baby care</b>	\$10 per visit copay \$300 copay per admit/Individual	\$10 per visit copay \$300 copay per admit/Individual	\$25 copay per visit Ded / 20%	Ded / 50% Ded / 50%	\$25 copay, ded waived Ded / 20%	40%, ded waived Ded / 40%
<b>Inpatient Hospital</b>	\$300 per admit	\$300 per admit	Ded / 20% - Pre-cert is required.	Ded / 50% - Pre-cert is required	Ded / 20% - Pre-cert is required.	Ded / 40% - Pre-cert is required.
<b>Outpatient/Ambulatory Surgery</b>	\$100 copay per visit	\$100 copay per visit	Ded / 20% - Pre-cert is required.	Ded / 50% - Pre-cert is required	Ded / 20% - Pre-cert is required.	Ded / 40% - Pre-cert is required.
<b>Ambulance</b>	20% up to \$500 per trip	20% up to \$500 per trip	Covered as in-network	Covered as in-network	Ded / 20%	Ded / 40%
<b>Emergency Room</b>	\$100 per incident (waived if admitted)	\$100 per incident (waived if admitted)	Covered as in-network	Covered as in-network	Ded / 20%	Ded / 40%
<b>X-Ray &amp; Labs</b>	Diagnostic: 100% covered; Therapeutic: \$30 per visit copay; MRI/CAT/ PET: \$100/per procedure	Diagnostic: 100% covered; Therapeutic: \$30 per visit copay; MRI/CAT/ PET: \$100/per procedure	Ded / 20% - Pre-cert is required is for MRI, CAT or PET.	Ded / 50% - Pre-cert is required for MRI, CAT or PET.	Ded / 20% - Pre-cert is required is for MRI, CAT or PET.	Ded / 40% - Pre-cert is required for MRI, CAT or PET.
<b>Prescriptions</b>	\$10 generic \$20 brand at KP facility	\$10 generic \$20 brand at KP facility - 60-day supply	\$25 generic \$35 brand - 30-day supply @ Med-Impact Pharmacies.  Rx @ KP = In-	Ded / 50% - 30-day supply. Rx @ KP = In-network copay. Rx @ MedImpact = Pre-	\$15 Pref generic \$40 Pref brand - 30-day supply; Ded / 20% for diabetic supplies & Lupron	No coverage at non-MedImpact Pharmacies

			network copay	ferred Network rate	Mail: 2x copay-90 days	
<b>Vision</b>	\$20 per visit for exam (materials not covered)	\$20 per visit for exam (materials not covered)	Covered as in-network	Covered as in-network	\$25 copay exam every 2 yrs (no hardware)	Ded / 40% exam every 2 yrs (no hardware)
<b>Inpatient Mental Illness*</b> <i>(non-biologically based)</i>	\$300 copay per admit to 45 days per calendar yr	\$300 copay per admit to 45 days per calendar yr	Covered as in-network	Covered as in-network	Ded / 20% to 45 inpatient days per calendar yr.	Ded / 40% to 45 inpatient days pr calendar yr.
<b>Outpatient Mental Illness*</b> <i>(non-biologically based)</i>	\$20 copay per visit up to 20 visits per calendar year	\$20 copay per visit up to 20 visits per calendar year	\$40 copay per visit up to 20 visits per calendar yr combined w/ non-net	Ded / 50% to 20 visits per calendar year combined w/ non-net	\$40/visit to 20 visits per calendar year in & out of net. combined	Ded / 40% to 20 visits per calendar yr max in & out of network combined
<b>Inpatient Alcohol/ Substance Abuse</b>	\$300 copay per admit for Medical Detox. Residential Rehab \$300 copay per admit up to 45 days per calendar yr.	\$300 copay per admit for Medical Detox. Residential Rehab \$300 copay per admit up to 45 days per calendar yr.	Medical detox. covered in KP HMO only. Residential Rehab covered in-network only	Medical detox. covered in KP HMO only. Residential Rehab covered in-network only	Ded / 20% for Medical Detox. Max 5 days per stay to max of 2 stays. Residential Rehab not covered.	Ded / 40% for Medical Detox. Max 5 days per stay to max of 2 stays. Residential Rehab not covered.
<b>Outpatient Alcohol/ Substance Abuse</b>	\$20 copay per visit up to 20 visits per calendar year	\$20 copay per visit up to 20 visits per calendar year	Covered in KP HMO only	Covered in KP HMO only	\$40/visit to 20 visits per calendar year in & out of net. combined	Ded / 40% to 20 visits per calendar yr max in & out of network combined
<b>Chiropractic Care</b>	\$20 copay per visit maximum 20 visits	\$20 copay per visit maximum 20 visits	\$40 copay per visit up to 20 visits per calendar yr	Not covered	\$25 copay to 20 visits per calendar year	Not covered
<b>Durable Medical Equipment</b>	20% copay within service area. \$2,000 annual benefit max per contract yr. Prosthetic arms & legs covered at 20% copay with no annual max. See policy	20% copay within service area. \$2,000 annual benefit max per contract yr. Prosthetic arms & legs covered at 20% copay with no annual max. See policy	Covered in-network only, except prosthetic arms & legs covered at Ded / 20% with no annual max. See policy	Covered in-network only, except prosthetic arms & legs covered at Ded / 20% with no annual max. See policy	20% - \$2,000 annual benefit max per calendar yr. Prosthetic arms & legs covered at 20% with no annual max. See policy	40% - \$2,000 annual benefit max per calendar yr. Prosthetic arms & legs covered at 20% with no annual max. See policy

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.

\*\* HSA: A separate Health Savings Account (HSA) can be established where contributions can be made on a pre-tax basis. When funds are used for medical, dental or vision expenses, they are tax-free. Unused contributions carryover to following year.