

**PERACare Enrollment/Change Form**  
**Combination Pre-Medicare and Medicare Coverage**

Colorado Public Employees' Retirement Association  
 PO Box 5800 Denver, Colorado 80217-5800  
 303-832-9550 or 1-800-759-7372 (PERA) • Fax: 303-863-3727 • www.copera.org



Complete and return this form if you want to add coverage(s), make changes, or cancel your coverage(s).

**Note:** This form is used for "combination coverage" only. Combination coverage applies when you are covering your spouse and/or child(ren) and one of you is on Medicare, but others are still under age 65.

**Your SSN**

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\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ ( ) \_\_\_\_\_  
 Last Name First Name MI Date of Birth Daytime Telephone Number

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Spouse's Signature** (if enrolling/changing) \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature Certification**

By signing the form, I am certifying and agreeing with the following: I have reviewed the information about PERACare. I am eligible to enroll in the Program, and if I am enrolling my spouse and/or dependents, I certify that they also are eligible to be enrolled. The information I provided on this form is correct and complete. If applicable, I authorize release of Medicare claims information to Anthem Blue Cross and Blue Shield to allow payment of any complementary benefit either to myself or to the party who accepts assignment. If applicable, by joining a Medicare HMO plan, I acknowledge that the Medicare HMO plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I authorize Colorado PERA to deduct from my monthly benefit the premium for my coverage. By the health plan election on this form, I authorize cancellation of any prior arrangements for coverage in the PERA Health Care Program and also agree that I will terminate any other Medicare coverage as of the effective date of my new election. Finally, I agree that, if I wish to cancel this coverage, I must provide Colorado PERA with a 30-day advance written notice.

**Effective Date**

I would like to request my effective date to enroll, make changes, or cancel coverage to be \_\_\_\_\_ 1, 2012.\*

\*If this date is not your retirement effective date, a *Certification of Previous Health Care Coverage* form may be required. See the PERACare Enrollment Eligibility Chart in the *PERACare Health Benefits Program Pre-Medicare or Medicare Coverage* booklets.

**Dependent Enrollment Information.** Complete this section if you are adding coverage(s) for your dependent(s) with Medicare (your spouse and/or dependent child) and be sure that your spouse signs above.

_____/_____/____	_____/_____/____	____	____	____	____
Spouse's Last Name	First Name	MI	Date of Birth	SSN	M/F
_____/_____/____	_____/_____/____	____	____	____	____
Child's Last Name	First Name	MI	Date of Birth	SSN	M/F

**Medicare Information.** Complete this section if you are enrolling in a health plan or changing health plans. You do not need to complete this section if you are adding only dental and/or vision plans. (Send a photocopy of your Medicare card[s] as soon as you receive it.)

I have or have applied for	<input type="checkbox"/> Medicare Part B only	<input type="checkbox"/> Both A and B	Medicare No. _____
My spouse has or has applied for	<input type="checkbox"/> Medicare Part B only	<input type="checkbox"/> Both A and B	Medicare No. _____
My child has or has applied for	<input type="checkbox"/> Medicare Part B only	<input type="checkbox"/> Both A and B	Medicare No. _____

**Important Additional Medical Questions for All Health Plan Enrollees** (If you answer "Yes" to any of the following questions, Colorado PERA may contact you to provide more information.)

1. Do any enrollees currently have End-Stage Renal Disease (ESRD) and receive routine dialysis treatment?  Yes  No
2. Will any enrollees have additional medical coverage (outside PERACare)?  Yes  No
3. Will any enrollees have other prescription drug coverage (outside PERACare)?  Yes  No

**Select your health, dental, and vision plans on the reverse**



## PERACare Combination Coverage Premium Information

### 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 (Anthem) offer both pre-Medicare and Medicare coverage worldwide. Kaiser Permanente also offers combination coverage in their Denver/Boulder and Southern Colorado service areas.

Detailed information about pre-Medicare and Medicare coverage in PERACare can be found in the *PERACare 2012 Health Benefits Program Pre-Medicare and Medicare Coverage* booklets.

### Calculating Your Health Care Premium

After you have selected a health plan and chosen a coverage combination, you are ready to calculate your premium. The premiums and subsidy chart below apply to all benefit recipients except benefit recipients under the Denver Public Schools (DPS) benefit structure who do not have Medicare Part A. If you are under the DPS benefit structure and do not have Medicare Part A, see the back page of this brochure.

A. Enter the premium amount (from the premium chart below or on the back page).....	A.	\$ <input style="width: 80%;" type="text"/>
B. Enter your Benefit Recipient Subsidy (from the subsidy chart below or on the back page).....	B.	\$ <input style="width: 80%;" type="text"/>
C. Subtract line B from line A (A - B) .....	C.	\$ <input style="width: 80%;" type="text"/>

**This is your monthly health care premium.**

#### Anthem Monthly Premiums\*

	HMO/MS #1	PPO #1/MS #1	PPO #2/MS #1	HDHP/MS #1
BR+S	\$1,079.00	\$957.00	\$609.00	\$920.00
BR+C	924.00	826.00	548.00	797.00
BR+S+C	1,699.00	1,479.00	853.00	1,413.00
	HMO/MS #2	PPO #1/MS #2	PPO #2/MS #2	HDHP/MS #2
BR+S	\$956.00	\$834.00	\$486.00	\$797.00
BR+C	801.00	703.00	425.00	674.00
BR+S+C	1,576.00	1,356.00	730.00	1,290.00
	HMO/MS #3	PPO #1/MS #3	PPO #2/MS #3	HDHP/MS #3
BR+S	\$918.00	\$796.00	\$448.00	\$759.00
BR+C	763.00	665.00	387.00	636.00
BR+S+C	1,538.00	1,318.00	692.00	1,252.00

#### Kaiser Permanente Monthly Premiums\*

	HMO #1/Medicare HMO	HMO #2/Medicare HMO	HDHP/Medicare HMO
BR+S	\$912.00	\$794.00	\$547.00
BR+C	766.00	673.00	475.00
BR+S+C	1,490.00	1,279.00	834.00

BR=Benefit Recipient, S=Spouse, C=Children

### Pre-Medicare and Medicare Benefit Recipient (BR) Subsidy Chart

Years of Service	Pre-Medicare BR Subsidy	Medicare BR Subsidy*	Years of Service	Pre-Medicare BR Subsidy	Medicare BR Subsidy*
20+	\$230.00	\$115.00	10	\$115.00	\$57.50
19	218.50	109.25	9	103.50	51.75
18	207.00	103.50	8	92.00	46.00
17	195.50	97.75	7	80.50	40.25
16	184.00	92.00	6	69.00	34.50
15	172.50	86.25	5	57.50	28.75
14	161.00	80.50	4	46.00	23.00
13	149.50	74.75	3	34.50	17.25
12	138.00	69.00	2	23.00	11.50
11	126.50	63.25	1	11.50	5.75

\*The premiums and subsidy amounts are different for retirees under the DPS benefit structure who do not have Medicare Part A. Please see the "PERACare Combination Coverage Premiums for Retirees Under the DPS Benefit Structure With Medicare Part B Only" on the back page.

## PERACare Combination Coverage Premiums for Retirees Under the DPS Benefit Structure With Medicare Part B Only

These combination coverage premiums are for one enrollee with Medicare Part B (no Part A coverage) and one or more pre-Medicare (under age 65) enrollees.

### Anthem Monthly Premiums

	HMO/MS #1	PPO #1/MS #1	PPO #2/MS #1	HDHP/MS #1
BR+S	\$1,482.00	\$1,360.00	\$1,012.00	\$1,323.00
BR+C	1,327.00	1,229.00	951.00	1,200.00
BR+S+C	2,102.00	1,882.00	1,256.00	1,816.00
	HMO/MS #2	PPO #1/MS #2	PPO #2/MS #2	HDHP/MS #2
BR+S	\$1,141.00	\$1,019.00	\$671.00	\$982.00
BR+C	986.00	888.00	610.00	859.00
BR+S+C	1,761.00	1,541.00	915.00	1,475.00
	HMO/MS #3	PPO #1/MS #3	PPO #2/MS #3	HDHP/MS #3
BR+S	\$1,093.00	\$971.00	\$623.00	\$934.00
BR+C	938.00	840.00	562.00	811.00
BR+S+C	1,713.00	1,493.00	867.00	1,427.00

### Kaiser Permanente Monthly Premiums

	HMO #1/Medicare HMO	HMO #2/Medicare HMO	HDHP/Medicare HMO
BR+S	\$1,403.00	\$1,285.00	\$1,038.00
BR+C	1,257.00	1,164.00	966.00
BR+S+C	1,981.00	1,770.00	1,325.00

BR=Benefit Recipient, S=Spouse, C=Children

### DPS Benefit Structure Medicare Part B Only Benefit Recipient (BR) Subsidy Chart

Years of Service	BR Subsidy	Years of Service	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