



***PERACare Combination Coverage  
Premium Information/Enrollment Form***



## 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 Colorado Springs service areas.

Detailed information about pre-Medicare and Medicare coverage in PERACare can be found in the *PERACare 2009 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 below, you are ready to calculate your premium.

A. Enter the premium amount (from the premium chart below).....	A.	\$
B. Enter your Benefit Recipient Subsidy (from the subsidy chart below) .....	B.	\$
C. Subtract line B from line A (A - B) .....	C.	\$

**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	\$978.00	\$892.00	\$603.00	\$826.00
BR+C	843.00	774.00	543.00	722.00
BR+S+C	1,517.00	1,362.00	842.00	1,244.00
	HMO/MS #2	PPO #1/MS #2	PPO #2/MS #2	HDHP/MS #2
BR+S	\$855.00	\$769.00	\$480.00	\$703.00
BR+C	720.00	651.00	420.00	599.00
BR+S+C	1,394.00	1,239.00	719.00	1,121.00

### Kaiser Permanente Monthly Premiums

	HMO #1/Medicare HMO	HMO #2/Medicare HMO	HDHP/Medicare HMO
BR+S	\$753.00	\$665.00	\$455.00
BR+C	632.00	563.00	394.00
BR+S+C	1,234.00	1077.00	698.00

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

## PERACare Combination Pre-Medicare and Medicare Enrollment/Change Form Checklist

Check the following list to be sure you have completed all of the information needed for enrollment. Tear the enrollment form at the perforation and send it to PERA, or you may fax it to 303-863-3727.

- Is this enrollment for a combination of Medicare and pre-Medicare coverage? If not, use the appropriate *Pre-Medicare* or *Medicare Enrollment/Change Form*.
- Did you sign the form?
- If you are enrolling your spouse, did your spouse sign the form?
- If you are enrolling at a time other than retirement or open enrollment:
  - Is it within 30 days of the date you are losing coverage or 30 days of turning age 65?
  - Did you include a *Certification of Previous Health Care Coverage* form?
- If you are enrolling your spouse, did you complete the spouse enrollment information?
- If you and/or your spouse have Medicare, did you:
  - Include your Medicare number(s) on the form?
  - Send PERA a copy of your Medicare card(s)?
- If you are enrolling in a health plan, did you:
  - Select who you want to cover?
  - Select a plan?

*Note:* Rocky Mountain Health Plans and Secure Horizons do not offer combination coverage.
- If you are enrolling in the Anthem HMO plan, did you include a provider code for your Primary Care Physician (PCP) selection? (Provider codes are required for enrollment.)
- If you are enrolling in a dental or vision plan, did you:
  - Select who you would like to cover?
  - Select a plan?
  - Include a provider code if you are enrolling in CIGNA Dental HMO?
- If you are enrolling children, did you complete the dependent children enrollment information?

### 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 PERA to deduct from my monthly benefit the premium for my health care coverage, if applicable. By the health plan election on this form, I cancel any prior arrangements for coverage in the PERA health care program and also terminate any Medicare managed care coverage as of the effective date of my new election. Finally, I agree that, if I wish to cancel this coverage, I must provide PERA with a 30-day advance written notice.

# 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



Read the *PERACare 2009 Health Benefits Program—Pre-Medicare and Medicare Coverage* booklets before completing this form. The benefit recipient should complete this form to enroll in a PERACare plan or to make changes such as adding dependents or changing plans. This form is for benefit recipients who need combination pre-Medicare and Medicare coverage for health plans. There are other enrollment/change forms for benefit recipients who need only pre-Medicare or only Medicare plans. **If you are already enrolled in PERACare and are using this form to make a change, complete only the information that you wish to change. Any coverage that you are not changing will remain in place.**

### Your SSN

□ □ □ - □ □ - □ □ □ □

### SSN of Deceased PERA Member/Retiree (if you are not the PERA member)

□ □ □ - □ □ - □ □ □ □

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

### 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 PERA to deduct from my monthly benefit the premium for my health care coverage, if applicable. By the health plan election on this form, I cancel any prior arrangements for coverage in the PERA health care program and also terminate any Medicare managed care coverage as of the effective date of my new election. Finally, I agree that, if I wish to cancel this coverage, I must provide PERA with a 30-day advance written notice.

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

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

### Effective Date

I understand that my coverage will be effective January 1, 2009, if I am enrolling during open enrollment. If I am not enrolling during open enrollment, I am requesting that coverage be effective \* \_\_\_\_\_ 1, 2009.

\*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.

### Spouse Enrollment Information

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_(\_\_\_\_)\_\_\_\_\_  
Last Name First Name MI Date of Birth SSN M/F

### Medicare Information

Include a photocopy of your Medicare card(s) with this form.

I have/I have applied for  Medicare Part B only  Both A and B Medicare No. \_\_\_\_\_

My spouse has/My spouse has applied for  Medicare Part B only  Both A and B Medicare No. \_\_\_\_\_

### Important Additional Medical Questions for the Medicare Enrollee

If you answer "Yes" to any of the following questions, PERA may contact you to provide more information.

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



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

