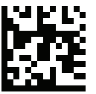
PERACare Enrollment/Change Form

Combination Pre-Medicare and Medicare Coverage—2022

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



Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Complete and return this form if you want to enroll in, change, or cancel 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 Information

Name ____
Last First MI

Permanent Residence Street Address ______________________________
(PO Box is not allowed)

City ____________________ State __________ ZIP Code __________

Daytime Phone Number (____) __________ Email Address ____________________

Sign up for electronic delivery of PERA information? ❑ Yes ❑ No

Sign Here ➔ **Your Signature** ______________________________ **Date** __________

Sign Here ➔ **Spouse's Signature** ______________________________ **Date** __________
(Spouse's signature only required if spouse is enrolling in a Medicare health plan)

Effective Date

I would like to request my effective date to enroll in, change, or cancel coverage to be ____________________ 1, 2022.* This *Enrollment/Change Form* must be signed prior to the requested effective date, but cannot be signed more than 90 days in advance.

* 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 Medicare Coverage* booklet.

Dependent Enrollment Information

Complete this section if you are adding coverage(s) for your dependent(s). Be sure that your spouse signs above if they are enrolling in a Medicare plan.

Spouse's Last Name	First Name	MI	Birthdate	SSN	M/F
			/ /		

Child's Last Name	First Name	MI	Birthdate	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.***

Check this box if you have not received your Medicare number(s) yet: ❑ **PENDING**

My Medicare No. ____________________ ❑ Both Medicare Parts A and B ❑ Part B Only

My Spouse's Medicare No. ____________________ ❑ Both Medicare Parts A and B ❑ Part B Only

My Child's Medicare No. ____________________ ❑ Both Medicare Parts A and B ❑ Part B Only

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Your Name ______________________________ **Your SSN** ____________________

Health Plan Selection

Complete this section to enroll in, change, or cancel health care coverage

1. What do you want to do? (Check only one box.)

❑ **Do not change** PERACare health care coverage
❑ **Enroll** or **change** coverage as indicated below
❑ **Cancel** current PERACare health care coverage

2. Check yes or no to the following important medical questions for all enrollees:

Will any enrollees have additional medical coverage outside of Medicare and PERACare? ❑ Yes ❑ No
Will any enrollees have prescription drug coverage outside of Medicare and PERACare? ❑ Yes ❑ No

3. Select a coverage level, and then → **4. Select a health plan:**

Medicare Advantage (MA)

❑ Benefit Recipient (BR)+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

❑ UMR PPO #1/UnitedHealthcare MA #1
❑ UMR PPO #2/UnitedHealthcare MA #1
❑ UMR PPO #1/UnitedHealthcare MA #2
❑ UMR PPO #2/UnitedHealthcare MA #2
❑ Kaiser Permanente Deductible HMO/Med HMO
❑ Kaiser Permanente HDHP/Med HMO

Dental Plan Selection

Complete this section to enroll in, change, or cancel dental coverage

1. What do you want to do? (Check only one box.)

❑ **Do not change** PERACare dental coverage
❑ **Enroll** or **change** coverage as indicated below
❑ **Cancel** current PERACare dental coverage

2. Select a coverage level, and then → **3. Select a dental plan:**

❑ Benefit Recipient (BR) only
❑ BR+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

❑ Cigna Dental PPO
❑ Cigna Dental HMO*
❑ Delta Dental PPO

* If you are enrolling in the Cigna Dental HMO, indicate the six-digit DHMO office number(s) below. To obtain this number, call Cigna at 1-877-635-PERA (7372) or visit www.copera.org and click the appropriate "Provider Directory" from the "PERACare Carriers" page under the "PERACare" drop-down menu.

Cigna Dental HMO Office Number(s):

Benefit Recipient	Spouse	Child(ren)

Vision Plan Selection

Complete this section to enroll in, change, or cancel vision coverage

1. What do you want to do? (Check only one box.)

❑ **Do not change** PERACare vision coverage
❑ **Enroll** or **change** coverage as indicated below
❑ **Cancel** current PERACare vision coverage

2. Select a coverage level, and then → **3. Select a vision plan:**

❑ Benefit Recipient (BR) only
❑ BR+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

❑ VSP PPO #1
❑ VSP PPO #2
❑ VSP PPO #3

Note: If you select a coverage level but do not select a plan, you will be enrolled in VSP PPO #1.

Signature Certification

By signing the attached form, I certify and agree with the following: 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. By joining a PERACare Medicare plan, I acknowledge that the Medicare 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. Finally, I agree that, if I wish to cancel this coverage, I must provide PERA with a 30-day written notice.

PERACare Combination Coverage Premium Information

If you or your spouse is over age 65 and has Medicare, but one of you is Pre-Medicare, you have several options for combination coverage. UMR/UnitedHealthcare and Kaiser Permanente offer both Pre-Medicare and Medicare coverage. Detailed information about Pre-Medicare and Medicare coverage in PERACare can be found in the *Medicare* and *Pre-Medicare PERACare 2022 Health Benefits Program* booklets.

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 reverse for premiums and subsidy chart to calculate your health care premium.

UMR/ UnitedHealthcare Monthly Premiums

BR=Benefit Recipient S=Spouse C=Child(ren)

	PPO #1/MA #1	PPO #1/MA #2	PPO #2/MA #1	PPO #2/MA #2
BR+S	$1,400.00	$1,300.00	$882.00	$782.00
BR+C	1,151.00	1,051.00	737.00	637.00
BR+S+C	2,399.00	2,299.00	1,467.00	1,367.00

Kaiser Permanente Monthly Premiums

BR=Benefit Recipient S=Spouse C=Child(ren)

	Deductible HMO/Med HMO	HDHP/Med HMO
BR+S	$1,491.00	$963.00
BR+C	1,227.00	804.00
BR+S+C	2,550.00	1,599.00

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

Years of Service	Pre-Medicare BR Subsidy	Medicare BR Subsidy
20+	$230.00	$115.00
19	218.50	109.25
18	207.00	103.50
17	195.50	97.75
16	184.00	92.00
15	172.50	86.25
14	161.00	80.50
13	149.50	74.75
12	138.00	69.00
11	126.50	63.25

Years of Service	Pre-Medicare BR Subsidy	Medicare BR Subsidy
10	$115.00	$57.50
9	103.50	51.75
8	92.00	46.00
7	80.50	40.25
6	69.00	34.50
5	57.50	28.75
4	46.00	23.00
3	34.50	17.25
2	23.00	11.50
1	11.50	5.75

PERACare Combination Coverage Premiums for Retirees Under the DPS Benefit Structure Without Medicare Part A

These combination coverage premiums are for one enrollee without Medicare Part A and one or more Pre-Medicare (under age 65) enrollees. If you are under the DPS benefit structure and have Medicare Parts A and B, see the reverse for premiums and subsidy chart to calculate your health care premium.

UMR/ UnitedHealthcare Monthly Premiums

BR=Benefit Recipient *S=Spouse* *C=Child(ren)*

	PPO #1/MA #1	PPO #1/MA #2	PPO #2/MA #1	PPO #2/MA #2
BR+S	$1,829.00	$1,625.00	$1,311.00	$1,107.00
BR+C	1,580.00	1,376.00	1,166.00	962.00
BR+S+C	2,828.00	2,624.00	1,896.00	1,692.00

Kaiser Permanente Monthly Premiums

BR=Benefit Recipient *S=Spouse* *C=Child(ren)*

	Deductible HMO/Med HMO	HDHP/Med HMO
BR+S	$1,918.00	$1,390.00
BR+C	1,654.00	1,231.00
BR+S+C	2,977.00	2,026.00

DPS Benefit Structure Retiree Without Medicare Part A Subsidy Chart

Years of Service	Retiree Subsidy
20+	$230.00
19	218.50
18	207.00
17	195.50
16	184.00
15	172.50
14	161.00
13	149.50
12	138.00
11	126.50

Years of Service	Retiree Subsidy
10	$115.00
9	103.50
8	92.00
7	80.50
6	69.00
5	57.50
4	46.00
3	34.50
2	23.00
1	11.50