Medicare

2013 PERACare Health Benefits Program

PERACare Plan Contact Information/Resources

Anthem Blue Cross and Blue Shield
Group #195331
1-877-PERABLU (737-2258)
www.anthem.com

Caremark
Group #PERA
1-800-378-0755
www.caremark.com

CIGNA Dental
Dental HMO
Group #10080104
Dental PPO
Group #3171792
1-877-635-PERA (7372)
www.cigna.com

Delta Dental
Group #9426
1-800-610-0201
www.deltadentalco.com

Kaiser Permanente
Group #1804
Denver/Boulder: 303-338-3800 or
1-800-632-9700
Southern Colorado: 1-888-681-7878
www.kaiserpermanente.org

Rocky Mountain Health Plans
Group #00550000
1-888-251-1330 (pre-enrollment)
1-888-281-0720 (post-enrollment)
www.rmhp.org

UnitedHealthcare
Group—PERACare
1-800-610-2660 (pre-enrollment)
1-800-457-8506 (post-enrollment)
www.uhcretiree.com

VSP
Group #12144626
1-800-877-7195
www.vsp.com

Centers for Medicare and Medicaid Services (CMS)
1-800-MEDICARE (633-4227)
www.medicare.gov

Social Security Administration
1-800-772-1213
www.socialsecurity.gov

SilverSneakers
1-888-423-4632
www.silversneakers.com

PERAFit
1-877-550-PERA (7372)
www.perafit.org

PERACare QuitLine
1-855-261-2636

PERA Contact Information

Colorado Public Employees' Retirement Association
Mailing Address
Colorado PERA
PO Box 5800
Denver, CO 80217-5800

Denver Main Office
1301 Pennsylvania Street
Denver, CO 80203-5011

Denver Main Office Hours (Mountain time)
7:30 a.m.–4:30 p.m. Monday–Friday

Westminster Office
1120 W. 122nd Avenue
Westminster, CO 80234

Westminster Office Hours (Mountain time)
7:30 a.m.–4:30 p.m. Monday, Tuesday, Thursday, and Friday
1:00 p.m.–4:30 p.m. Wednesday

Customer Service Center Phone Hours (Mountain time)
7:00 a.m.–5:30 p.m. Monday–Thursday
7:00 a.m.–4:30 p.m. Friday

Phone
303-832-9550 or
1-800-759-7372 (PERA)
303-863-3727 (Fax)

Web site/e-mail
www.copera.org (e-mail via "Contact Us" link on the PERA home page)

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PERACare Program Enrollment Guidelines

Who is Eligible to Enroll in PERACare?

PERA benefit recipients and their eligible dependents may enroll in PERACare.

"Benefit recipient" means a retiree, spouse, cobeneficiary, qualified child, or dependent parent receiving a monthly full service or reduced service retirement, disability retirement, or survivor benefit.

The individual receiving the PERA benefit (the benefit recipient) must be enrolled in order for any dependents to be enrolled. If the benefit recipient is enrolled, he/she may enroll the following dependents:

- Spouse;
- Domestic partner; and
- Unmarried, dependent children under age 25, certain mentally or physically incapacitated adult children, and dependent parents. (Any child claimed as a dependent for income tax purposes who lives with the benefit recipient and meets these guidelines also is eligible.)

  Federal guidelines that require some employer plans to offer coverage to all children under age 26 do not apply to PERACare's retiree-only plans.

In addition, the following individuals are eligible to be enrolled in PERACare:

- Guardians of children receiving PERA survivor benefits, as long as the children also are enrolled.
- Surviving spouses of deceased retirees who chose single-life annuity options (Option 1 under the PERA benefit structure, or Options A or B under the DPS benefit structure), if the surviving spouse was enrolled in the PERACare program when the retiree's death occurred.*
- Divorced spouses of retirees who are not receiving PERA benefits, but were enrolled in the PERACare program when the divorce from the PERA retiree occurred.*

* *If a surviving spouse or divorced spouse discontinues coverage, re-enrollment is not allowed.*

When Can I Enroll, Change Plans, or Add Dependents?

If you are enrolling in PERACare when you retire, you have 30 days from your first benefit payment date to submit your enrollment form. If you do not enroll when you retire, you are eligible to enroll, change plans, or add dependents based on certain "life events" and annually during the open enrollment period. See the PERACare Enrollment Eligibility Chart on page 4.

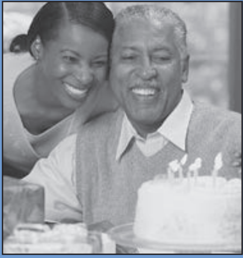
The "life event" of turning age 65 may allow you to enroll in PERACare. You must have other coverage immediately prior to your Medicare eligibility. (If you were without coverage, your enrollment can be accepted during the next annual open enrollment period.)

Note that if you are adding PERACare coverage anytime other than when you are first eligible or during the annual open enrollment period, the effective date of your PERACare coverage must coincide with the end of your other coverage.

PERACare coverage is effective on the first day of the month. Any additions or changes can only be effective on the first day of the month.

ENROLLING IN PERACARE

You must complete a *PERACare Enrollment/Change Form* in order to enroll in PERACare. Enrollment in PERACare is not automatic, even if you are choosing PERACare coverage under the same health plan you had with a prior employer or group.



BEFORE YOUR 65TH BIRTHDAY

Three months before your 65th birthday, PERA will send you a booklet containing information about your PERACare Medicare plan options. Plan information is also available on PERA's Web site at www.copera.org.

You must be enrolled in Medicare Part B to be in a PERACare health plan once you turn 65. You are not required to have, or to purchase, Medicare Part A.

See pages 6-8 for definitions of Medicare terms.

What Happens When I Turn Age 65?

You become eligible for Medicare when you turn age 65 (or earlier in some instances based on disability or disease). The Social Security Administration determines your eligibility for Medicare, even if you never worked under Social Security. Contact Social Security at 1-800-772-1213 three months before your 65th birthday to determine your eligibility for Medicare. If you are receiving a Social Security benefit, you will automatically be enrolled in Medicare. If you are not receiving a benefit from Social Security, you will have to enroll in Medicare through Social Security. You must enroll before you turn age 65 or you may be without any health care coverage once you turn 65.

When you turn age 65, you are no longer eligible to be enrolled in a PERACare pre-Medicare health plan. All of PERA's plans for individuals over age 65 work with Medicare. You must enroll in Medicare Part B and maintain Part B coverage. If you choose to delay enrolling in Medicare, you will likely delay your eligibility to be enrolled in a PERACare health plan.

Note that all PERACare Medicare plans provide replacement Part A benefits for individuals who do not have Medicare Part A. Further, all PERACare Medicare plans have a prescription drug benefit that is comparable to, or better than, Medicare's prescription drug benefit (Medicare Part D). If you want to be enrolled in a PERACare Medicare plan, you cannot be enrolled in another Part D plan outside of PERACare.

If you become eligible for Medicare before age 65 because of a medical condition or disability, you are no longer eligible to be enrolled in a PERACare pre-Medicare health plan. You should request PERACare Medicare plan information from PERA so that you may make a Medicare plan selection.

Checklist for Enrolling in a PERACare Medicare Plan

✓ If you are new to Medicare, your first stop is Social Security. Apply for Medicare and get your Medicare Part B in place. Enroll in Medicare Part A if you are eligible to receive it at no cost. Send PERA a copy of your Medicare card.

✓ Review the plans and premiums on the following pages and choose a plan. Your options will depend upon the plans available where you live. PERA's Anthem Blue Cross and Blue Shield plans are available worldwide. See pages 14 and 15 for the HMO plans' service areas.

✓ If you are already enrolled in PERACare, you will receive information from PERA explaining the steps you need to take. You should submit a *PERACare Enrollment/ Change Form* to PERA at least 30 days in advance of your Medicare effective date if you want to have coverage in a Medicare HMO plan or if you are in an Anthem pre-Medicare plan and wish to be enrolled in Anthem's Medicare Supplement #2 or #3. (If you are enrolled with Anthem, you will be transitioned to Medicare Supplement #1 unless you submit a form requesting a different plan.)

✓ If you are not already enrolled in PERACare, you may be able to enroll at age 65. Check the PERACare Enrollment Eligibility chart on page 4. Complete a *PERACare Enrollment/Change Form* and a *Certification of Previous Health Care Coverage* form, if applicable.

✓ All enrollees in a PERACare Medicare plan, including spouse and children, must be enrolled in Medicare. If any of your dependents are not eligible for Medicare, see "Options for Combination Coverage" on page 3.

Options for Combination Coverage

Combination coverage applies if you want to cover your spouse and/or children, but you are over 65 and they are under 65. Your options for combination coverage are the plans with Anthem Blue Cross and Blue Shield and Kaiser Permanente. (Note that Kaiser Permanente's combination coverage is not available in its Northern Colorado service area in 2013, but is expected to be available in 2014.) With combination coverage, you choose the carrier and your Medicare plan, then you choose a pre-Medicare plan with the same carrier for your spouse and or/children.

If you are interested in combination coverage, contact PERA and request the *PERACare Combination Coverage Premium Information/Enrollment Form*. You may also download combination coverage information from PERA's Web site at www.copera.org.

Moving

If you move, notify PERA promptly of your new address and PERA will advise your health care, dental, and/or vision carrier.

If you move your permanent residence outside of the service area of the HMO plan in which you are enrolled, your coverage must be canceled. You will have 30 days from the date you move to enroll in another plan by completing a *PERACare Enrollment/Change Form*.

Note that you do not have to change plans during the open enrollment period in anticipation of a move during the following year. You can make the change at the time of your move, as long as you are no longer eligible to be enrolled in your HMO because of your new address.

Traveling

If you are traveling and have a medical emergency while you are outside of your plan's service area (either within the United States or in a foreign country), all of the PERACare HMO plans cover your emergency and urgent care. In most cases, you would need to pay the bill yourself, and then file your claims with your plan for reimbursement. The HMO plans do not cover non-emergency care (routine care) when you are traveling outside of the plan's service area.

If you are enrolled in one of the Anthem Medicare Supplement plans, you have worldwide coverage for both emergency and routine care while you are traveling. Through the Blue Cross and Blue Shield BlueCard network, you have access to an extensive network of hospitals and doctors throughout the United States and in more then 200 countries and territories.

Cancellation of Coverage

You may cancel coverage for yourself and/or any dependent with 30-days advance written notice to PERA. Be sure to sign and date your cancellation request.

PERA may cancel coverage if you and/or any dependents are no longer eligible to participate in PERACare or if your premium payments are not current.

SEE A TERM YOU DON'T UNDERSTAND?

See the Glossary on the inside back cover for key terms used in this booklet.

HOW TO ENROLL

The *PERACare Enrollment/Change Form* is a separate document accompanying this booklet. You may also download the *PERACare Enrollment/Change Form* from the PERA Web site ("Forms & Publications" section) or call PERA's Customer Service Center to request one. You can submit your form in person, via U.S. mail, or by fax. You may also enroll electronically by logging on to your account through the PERA Web site.

PERACare Enrollment Eligibility Chart

The chart below summarizes the different times that a benefit recipient is eligible to enroll in PERACare, or add or change coverage. Your request must be received within 30 days of the Enrollment Eligibility Events listed below.

ENROLLMENT ELIGIBILITY EVENTS	PROOF REQUIRED	WHO CAN BE ENROLLED OR ADDED	CHANGE(S) YOU CAN MAKE
When you are first eligible to enroll			
• Within 30 days of the date of your first PERA benefit payment (as a retiree, cobeneficiary, or survivor benefit recipient)	None for the benefit recipient*	Yourself, your spouse, and children*; your guardian (if benefit recipient is a child)	Enroll
Open enrollment			
• During the PERACare annual fall open enrollment period	None for the benefit recipient*	Yourself, your spouse, and children*	Enroll, add coverage for spouse or children, or change plans
Life events when you can enroll or change			
• Marriage	Copy of marriage certificate	Your new spouse	Add coverage for spouse
• Birth or adoption of child(ren)	Copy of birth certificate or adoption papers*	Your new child(ren)*	Add coverage for children
• Moving out of your HMO's service area	Address change notice to PERA	Yourself, your spouse, and children* (if they were covered under PERA's plan prior to move)	Change from HMO to another plan
• Turning age 65 (you or your spouse)	*CPHC*** and a copy of Medicare card(s)	Yourself, your spouse, and children*	Enroll, add coverage for spouse or children, or change health care plans
• Loss of other employer/group coverage, either your own or your spouse's	*CPHC*** and a copy of employer certification***	Yourself, your spouse, and children* (if they were covered in the employer's plan)	Enroll yourself, your spouse, and children (if they were covered in the employer's plan)
• Loss of individual coverage	*CPHC*** and a copy of insurer's cancellation or market exit letter***	Yourself, your spouse, and children* (if they were covered in the plan)	Enroll yourself, your spouse, and children (if they were covered in the plan)
• Completion of COBRA coverage period (18, 29, or 36 months)	*CPHC*** and a copy of employer certification or COBRA letter***	Yourself, your spouse, and children* (if they were covered in the employer's plan)	Enroll yourself, your spouse, and children (if they were covered in the employer's plan)
• Divorce	*CPHC***	Yourself (if you were covered by your former spouse's plan)	Enroll

* If children are being enrolled, proof of dependent status may be required.

** *CPHC*—PERA's *Certification of Previous Health Care Coverage* form.

*** Loss of coverage must be a non-voluntary event. If you remain eligible for coverage but choose not to pay premiums or select a new plan, you are not eligible to enroll in PERACare.

Plan Benefit Choices

What Plans Does PERACare Offer?

PERACare includes health care, dental, and vision plans. You may enroll in any or all of these types of coverage. You may also enroll any eligible dependents in any of the plans in which you are enrolled.

- PERACare's Medicare health plan partners are Anthem Blue Cross and Blue Shield (Anthem), Kaiser Permanente, Rocky Mountain Health Plans, and UnitedHealthcare.
- PERACare's dental plan partners are CIGNA Dental and Delta Dental.
- PERACare's vision plan partner is VSP.

Online Provider Directories

Provider directories for all of the health, dental, and vision plans in PERACare are available online through PERA's Web site. These directories can help you find physicians and other providers who contract with the plans offered in PERACare. Log on to www.copera.org and click on "PERACare," then choose "Provider Directories."

If you do not have Internet access, call the plan directly for assistance or to request a printed directory. Phone numbers and plan group numbers for each of the plans are listed on the inside front cover of this booklet.

Medicare Health Plans

PERACare offers Medicare health plans for retirees, benefit recipients, and their dependents who are age 65 and/or eligible for Medicare. Depending on where you live, you may have choices of one, two, or three HMO plans, as well as PERA's three Medicare Supplement plans administered by Anthem. Note that PERACare offers coverage options for you, even if you have never contributed to Medicare or Social Security.

All of the Medicare plans available through PERACare pay some or all of the Medicare deductibles, pay some or all of covered charges not paid by Medicare, include prescription drug coverage, and include some benefits in addition to what Medicare covers.

What Types of Plans are Available?

HMO Plans

In an HMO plan, you have a comprehensive set of benefits, including preventive care benefits. You use doctors and hospitals in the plan's network, and generally have no coverage if you see a non-network provider. You pay your copay or coinsurance to the provider at the time of the service, and the remaining charges are handled between the provider and the health plan. (Rocky Mountain Health Plans handles copays slightly differently in some areas.)

In PERACare, Kaiser Permanente, Rocky Mountain Health Plans, and UnitedHealthcare each offer a Medicare HMO plan.

PERACARE FORMS

You may download and print the following forms from the PERA Web site (in the "Forms & Publications" section):

- *PERACare Enrollment/Change Form* (may be completed online by logging on to your account)
- *Certification of Previous Health Care Coverage*
- *PERACare Program Cancellation*

The forms also may be obtained by calling PERA's Customer Service Center at 303-832-9550 or 1-800-759-7372.

WHAT ABOUT PRE-EXISTING CONDITIONS?

None of the PERACare health plans exclude coverage for, or impose limitation periods on, pre-existing conditions.

Medicare Supplement Plans

In a Medicare Supplement plan, you have all of Original Medicare's benefits. Some plans, like PERA's, include additional benefits such as prescription drug and out-of-country benefits. Your providers submit their claims to Medicare, which is your "primary" payer. Your supplement plan pays next, and your providers will bill you for any remaining amounts that you must pay.

In PERACare, PERA's plans administered by Anthem are Medicare Supplement plans. In these plans, you may use any doctor you wish—you do not need to designate a primary care physician or go to any specific network of doctors. If you use providers who accept Medicare assignment, you will reduce costs to yourself and the plan. Note that if you do not have Medicare Part A, your hospital benefit is administered by Anthem rather than Medicare.

Medicare Terms

Centers for Medicare & Medicaid Services (CMS)

This division of the U.S. Department of Health and Human Services oversees the Medicare and Medicaid programs.

End Stage Renal Disease (ESRD)

If you have End Stage Renal Disease (ESRD), Medicare places certain restrictions on your enrollment in Medicare plans. Contact Medicare for more information.

Medicare

Medicare is the federal health insurance program for people age 65 and over, and for some disabled people under age 65.

Part A Coverage

Medicare Part A covers inpatient hospital care, skilled nursing facility care, some home health services, and hospice care. Part A has a deductible ($1,184.00 in 2013) that is paid (fully or partially) by all plans in PERACare.

You are entitled to Medicare Part A at no cost if you have 40 credits (quarters) of Social Security or Medicare coverage. In some cases, you may also be entitled to Medicare Part A at no cost if your spouse is entitled to Medicare Part A, or if your former or deceased spouse was/is entitled to Medicare Part A. If you are not entitled to Medicare Part A and choose to purchase it, the cost in 2013 is $441.00 per month. PERACare offers plans that replace Part A, so you are not required to purchase Part A from Medicare.

Part B Coverage

Medicare Part B covers doctors and other outpatient health services. Part B has a calendar year deductible ($147.00 in 2013), which is covered (fully or partially) by all PERACare plans. You are eligible to enroll in Part B at age 65 even if you have not paid into Social Security.

Medicare charges everyone a monthly Part B premium. In 2013, the standard premium is $104.90. Your Part B premium is separate from any PERACare premiums and is deducted from your Social Security benefit. If you do not have a Social Security benefit, Social Security will bill you for your Part B premium. PERA can deduct Part B premiums from your PERA benefit and send payment to CMS for you, if you request this service. You may request an *Authorization for Medicare Part B Premium Deduction* by calling PERA or downloading it from the PERA Web site.

Part D Coverage

Medicare Part D covers outpatient prescription drugs. Part D coverage is sold by private insurance companies, subject to government approval and oversight.

All of PERA's Medicare plans include a prescription drug benefit that qualifies as Part D or creditable coverage to replace Part D. If you or your dependent purchases a Part D plan outside PERACare, you cannot remain enrolled in a PERACare Medicare plan.

Medicare's Enrollment Periods

You are eligible to enroll in Medicare at age 65. Note that you should sign up early (two to three months before your birthday month) if you want to have PERACare coverage when you turn 65.

If you do not enroll when you are first eligible, you may be eligible to enroll later during a "special enrollment period" based on loss of employer coverage that you had at age 65. You also may enroll during an annual general enrollment period. See CMS's 12-page Tip Sheet–*Understanding Medicare Enrollment Periods* (CMS Product No. 11219) for detailed information.

Medicare Card

After enrolling, you will receive a card that lists your Medicare claim number and the effective date of your coverage. (The letter at the end of your Medicare number indicates the manner in which you became eligible for Medicare; it does not relate to whether or not you have Part A or Part B.)

Medicare Assignment

A physician or other health care provider who agrees to "accept Medicare assignment" waives any charges above the Medicare approved amount. For a list of providers who accept Medicare assignment, check with libraries and senior centers who may have a copy that you can review, or the Medicare Web site for its online participating provider directory. A link to the Medicare Web site is provided on PERA's Web site. You may also call the providers' offices to learn if they accept assignment.

By federal law, most health care providers who do not accept assignment may charge no more than 15 percent above the Medicare approved amount. Durable Medical Equipment (DME) providers are not subject to this limit.

Medicare Supplement Plan

A Medicare Supplement plan usually pays all or part of the Medicare deductibles and some of the charges not paid by Medicare. With a supplement plan, your claim is sent to Medicare by your physician or provider. After Medicare has paid its approved amounts, the supplement pays part or all of any remaining cost. The plans administered by Anthem are Medicare Supplement plans.

Medicare Advantage Plan

In a Medicare Advantage plan, you assign your Medicare benefits to the plan that has contracted with Medicare to provide all of your health care needs. The plan is paid a monthly fee by Medicare, regardless of the actual cost of your care or how often you receive services. Enrollees cannot receive reimbursement from Medicare for any services not authorized by the plan. Kaiser Permanente's Senior Advantage plan and UnitedHealthcare are Medicare Advantage plans.

FOR MORE INFORMATION ABOUT MEDICARE

- Call Social Security toll-free at 1-800-772-1213
- Visit the Social Security Web site at www.socialsecurity.gov
- Call Medicare toll-free at 1-800-MEDICARE (1-800-633-4227)
- Visit the Medicare Web site at www.medicare.gov

PRESCRIPTION BENEFITS

For questions about prescription benefits, you may call the following carriers directly:

- Caremark *(for those enrolled in PERA's Anthem Medicare Supplement plans only)* 1-800-378-0755
- Kaiser Permanente Denver/Boulder: 303-338-4503 Southern Colorado: 1-866-244-4119
- Rocky Mountain Health Plans 1-888-281-0720
- UnitedHealthcare 1-866-622-8055

PERA's Group Numbers with each of the carriers are on the inside front cover.

Medicare Cost Plan

In a Medicare Cost plan, your Medicare benefits are administered by the Cost plan. If you receive medical services from a non-network provider who is enrolled in Medicare, the services are covered under Original Medicare. You would be responsible for the Part A and Part B coinsurance and deductibles, unless the services are urgent or emergent, or if you received prior authorization from the Cost plan. The non-network providers will bill Medicare directly for you. Rocky Mountain Health Plans' Medicare plan is a Medicare Cost plan.

Medicaid

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources.

Medigap

Medigap policies are Medicare supplemental health insurance policies sold to individuals by private insurance companies.

Prescription Drug Coverage

All of the health plans offered through PERACare include prescription drug coverage. Benefits, copayments, deductibles, and coverage levels vary between plans. Formularies (lists of preferred drugs) are used by most plans; there may be limited or no coverage for drugs that are not included on the formulary.

In efforts to control costs and premiums, plans use a number of cost-containment designs. Most plans require that generic drugs be dispensed whenever possible. Some plans have closed formularies and will cover only those drugs that are on their formulary. Some plans use three-tier copay structures, with higher copays for brand-name drugs that are not on the plan's preferred drug list. Some plans have a fourth tier for high cost drugs. Most plans use a prior authorization process for some types of medications.

Most plans have special procedures and cost-sharing for specialty pharmacy. Specialty pharmacy includes high-cost pharmaceutical products that are generally biotech in nature. Most require injection or other unique methods of administration and refrigeration or special handling.

If you are enrolled in one of PERA's self-insured plans administered by Anthem, you have a comprehensive prescription drug benefit through Caremark, a national pharmacy benefit manager. You may get your prescriptions filled at local retail pharmacies and through the Caremark mail order pharmacies. If you are enrolled in Kaiser Permanente Denver/Boulder, your prescription drug benefit is an integral part of your Kaiser Permanente plan, and you get your prescriptions filled when you visit your Kaiser Permanente facility. Kaiser Permanente also offers a home delivery option which is similar to mail order. If you are enrolled in Kaiser Permanente Southern Colorado, Rocky Mountain Health Plans, or UnitedHealthcare, you have both retail and mail order options through those plans' prescription benefit managers.

Fitness and Wellness Programs

Fitness and wellness benefits have been proven to improve health and reduce health care costs. If you enroll in a PERACare health plan, you will receive information about the following value-added benefits once your coverage becomes effective.

SilverSneakers

All of PERA's plans with Anthem, Kaiser Permanente, and UnitedHealthcare include membership in the SilverSneakers® Fitness Program. With SilverSneakers, you receive a free basic fitness center membership to over 9,000 participating locations nationwide. You also have access to SilverSneakers classes, Senior Advisors℠, health education, and social activities.

PERAFit

Enrollees in PERA's Anthem plans also have access to PERAFit, a fitness and wellness program developed by National Jewish Health in Denver. It is a medically sound program that focuses on healthy behaviors, exercise, and long-term weight management. It was designed for enrollees to exercise on their own, but can be combined with SilverSneakers for the added benefit of exercise and classes in a fitness center.

Silver&Fit

PERA's plan with Rocky Mountain Health Plans offers the Silver&Fit Basic program, which includes a free fitness center membership to over 12,000 network fitness centers. For members who prefer an at-home program, members can order two home fitness kits such as walking, exercise, and Tai Chi.

PERACare QuitLine—Retire the Habit

The PERACare QuitLine gives enrollees in Anthem, Kaiser Permanente, Rocky Mountain Health Plans, and United Healthcare access to a team of dedicated coaches who can help you cope with common barriers to quitting tobacco. You can also receive free nicotine replacement therapy through the PERACare QuitLine. Call the PERACare QuitLine at 1-855-261-2636 to take the first step toward being tobacco free.

Plan Descriptions

The following pages provide summaries of the health care, dental, and vision plans available in PERACare for individuals with Medicare (over age 65).

For health care, PERACare offers a total of six options: three plan options with Anthem Blue Cross and Blue Shield, and three HMO plan options with Kaiser Permanente, Rocky Mountain Health Plans, and UnitedHealthcare. The three Anthem plans are available worldwide. The three HMO plans are available in select geographic areas in Colorado. Because all of the plans work with Medicare, they generally cover the same types of services, but differ in the amount that you pay for services.

For dental care, PERACare offers three plan options: CIGNA Dental HMO, CIGNA Dental PPO, and Delta Dental PPO.

For vision care, PERACare offers three plan options with VSP (Vision Service Plan).

Medicare Supplement Plans Benefit Highlights—Administered by Anthem Blue Cross and Blue Shield

(Must be enrolled in Medicare Part B)

For claims incurred on or after January 1, 2010, there is a lifetime maximum benefit of $1,000,000 per individual. The lifetime maximum benefit applies only to claim amounts paid by PERA's Anthem plan. Claim amounts paid by Medicare do not count toward the maximum.

Part A Services	Medicare Pays	Medicare Supplement #1 You Pay
HOSPITAL STAYS *Covered costs include semiprivate room, meals, general nursing, other hospital services and supplies*		
Days 1-60 each benefit period	Costs above first $1,184 (in 2013)	20% of Part A deductible
Days 61-90 each benefit period	Costs above $296/day	$0
Days 1-60 of "lifetime reserve days"	Costs above $592/day	$0
Any additional days	$0	All charges
SKILLED NURSING FACILITY *Covered costs follow a 3-day hospital stay*		
Days 1-20 each benefit period	All covered costs	$0
Days 21-100 each benefit period	Costs above $148/day	50% of charges not covered by Medicare
Days over 100 in a benefit period	$0	All charges
HOME HEALTH CARE *Covered costs include part-time skilled nursing care, therapy, and home health services*	All covered costs	$0
HOSPICE CARE *Covered services include home care and inpatient*	All covered costs except some copayments	$0
BLOOD	Covered costs after first 3 pints	$0

PERA's Replacement Part A Benefit

*Benefits for Participants **without** Part A coverage* *PERA's Replacement Part A Benefit covers services that would be covered under Medicare Part A if the participant had Part A. PERA's Replacement Part A Benefit is structured similar to its pre-Medicare PPO (Preferred Provider Organization) benefit.*	$0	*In Network:* $1,500 deductible then 30% of allowable charges up to $4,500 Annual-Out-of-Pocket Maximum, then $0 for additional charges
		Out-of-Network: $3,000 deductible, then 50% of allowable charges up to $9,000 Annual Out-of-Pocket Maximum, then $0 for additional charges

Medicare Supplement #2 You Pay	Medicare Supplement #3 You Pay
← 50% of Part A deductible →	
← $0 →	
← $0 →	
← All charges →	
← $0 →	
← 50% of charges not covered by Medicare →	
← All charges →	
← $0 →	
← $0 →	
← $0 →	
In Network: $3,000 deductible then 30% of allowable charges up to $9,000 Annual Out-of-Pocket Maximum, then $0 for additional charges	*In Network:* $4,500 deductible then 30% of allowable charges up to $13,500 Annual Out-of-Pocket Maximum, then $0 for additional charges
Out-of-Network: $6,000 deductible, then 50% of allowable charges up to $18,000 Annual Out-of-Pocket Maximum, then $0 for additional charges	*Out-of-Network:* $9,000 deductible, then 50% of allowable charges up to $27,000 Annual Out-of-Pocket Maximum, then $0 for additional charges

Medicare Supplement Plans Benefit Highlights— Administered by Anthem Blue Cross and Blue Shield

(Must be enrolled in Medicare Part B)

For claims incurred on or after January 1, 2010, there is a lifetime maximum benefit of $1,000,000 per individual. The lifetime maximum benefit applies only to claim amounts paid by PERA's Anthem plan. Claim amounts paid by Medicare do not count toward the maximum.

Part B Services	Medicare Pays	Medicare Supplement #1 You Pay
DOCTORS' SERVICES Includes doctors' visits, some preventive care, outpatient hospital, outpatient blood, some home health care, laboratory services, emergency care, mental health care	After $147 annual Part B deductible, 80% of Medicare-approved amount for most services or 65% of Medicare-approved amount for mental health care	20% of $147 annual Part B deductible, then 20% of any Excess Charges up to $2,000 Annual-Out-of-Pocket Maximum
DURABLE MEDICAL EQUIPMENT (DME)	80% of Medicare-approved amount for DME	20% of amount between Medicare-approved amount and Anthem's Allowable Charge and anything over Anthem's Allowable Charge
Additional Services		
PRESCRIPTION DRUGS *(Administered by Caremark)* *Outpatient prescription drugs* *Prescription drug deductibles and copays do not apply toward the Out-of-Pocket Maximum*	$0	Retail (30-day supply): $200 deductible, then 50% coinsurance; $75 maximum copay Mail Order (90-day supply): $20 copay for Generic $60 copay for Brand
CARE OUTSIDE THE U.S. *Emergency*	$0	$250 copay per visit then 20% of charges up to $10,000 annual benefit, then all additional charges
Non-emergency	$0	$1,500 deductible then 50% of charges up to $50,000 annual benefit, then all additional charges
Annual Out-of-Pocket Maximum		
Applies to Replacement Part A Benefits, Part A Deductible, and Part B Services only. *No out-of-pocket maximum for skilled nursing facility, outpatient prescription drugs, and services not covered by Medicare or PERA's plan.*	N/A	$2,000 for participants with Medicare Parts A and B; $4,500 for participants with Replacement Part A Benefits if only In-Network providers are used; $9,000 for participants with Replacement Part A Benefits if both In- and Out-of-Network providers are used

Medicare Supplement #2 You Pay	Medicare Supplement #3 You Pay
50% of $147 annual Part B deductible, then 50% of the Medicare-approved amount not paid by Medicare, then any Excess Charges up to $4,000 Annual Out-of-Pocket Maximum	50% of $147 annual Part B deductible, then 100% of the Medicare-approved amount not paid by Medicare, then any Excess Charges up to $6,000 Annual Out-of-Pocket Maximum
20% of amount between Medicare-approved amount and Anthem's Allowable Charge and anything over Anthem's Allowable Charge	50% of amount between Medicare-approved amount and Anthem's Allowable Charge and anything over Anthem's Allowable Charge

Retail (30-day supply): $300 deductible, then 50% coinsurance; $80 maximum copay Mail Order (90-day supply): $25 copay for Generic $65 copay for Brand	Retail (30-day supply): $350 deductible, then 50% coinsurance; $85 maximum copay Mail Order (90-day supply): $30 copay for Generic $70 copay for Brand
$500 copay per visit then 20% of charges up to $9,000 annual benefit, then all additional charges	$750 copay per visit then 20% of charges up to $8,000 annual benefit, then all additional charges
$3,000 deductible then 50% of charges up to $40,000 annual benefit, then all additional charges	$4,500 deductible then 50% of charges up to $30,000 annual benefit, then all additional charges

$4,000 for participants with Medicare Parts A and B; $9,000 for participants with Replacement Part A Benefits if only In-Network providers are used; $18,000 for participants with Replacement Part A Benefits if both In- and Out-of-Network providers are used	$6,000 for participants with Medicare Parts A and B; $13,500 for participants with Replacement Part A Benefits if only In-Network providers are used; $27,000 for participants with Replacement Part A Benefits if both In- and Out-of-Network providers are used

Medicare HMO Plans Benefit Highlights

Features	Kaiser Permanente
Annual deductible	None
Lifetime maximum benefit	None
Out-of-pocket annual maximum	$2,500
Where available? *(Note: Emergency care is covered worldwide. See page 3.)*	Denver/Boulder as determined by ZIP code and in Southern Colorado in the following counties: El Paso, Fremont, Pueblo, and Teller
Out-of-network services covered?	Only for emergency care

Benefits

Benefits	Kaiser Permanente
Preventive Care	All Medicare-covered preventive care covered with $0 copay
Outpatient Services (per visit or procedure)	
Primary care office visit	$20 copay
Specialty care office visit	$30 copay
Ambulatory surgery	$200 copay
Diagnostic lab and X-ray	No charge
Therapeutic X-ray; MRI, PET, CT	$100 copay per procedure
Durable medical equipment	20% copay
Oxygen	No charge
Physical, occupational, and speech therapy	$20 copay
Home health care	No charge
Hospice care	No charge
Vision care	$20 copay for exam; $100 credit for frames, lenses, or contacts; additional charge for contact lens fitting
Hearing services	$20 copay for exam every 12 months; $500 hearing aid allowance every 36 months
Chiropractic care	$20 copay; limited to 20 visits per year
Inpatient Care	
Hospital care and professional visits	$250 per day; maximum $500 per admit
Skilled nursing facility care	No charge
Emergency and Urgent Care	
Emergency room visit (waived if admitted)	$50 copay
After-hours care	$30 copay
Ambulance service	$100 copay
Prescription Drugs	
Pharmacy (up to a 30-day supply)	$15 generic; $40 brand
Mail order (up to a 90-day supply)	$30 generic; $80 brand

<table>
<tr><th>Rocky Mountain Health Plans</th><th>UnitedHealthcare</th></tr>
<tr><td colspan="2">None</td></tr>
<tr><td colspan="2">None</td></tr>
<tr><td>None</td><td>$6,700</td></tr>
<tr><td>Throughout Colorado
EXCEPT in Baca County</td><td>In the following counties in Colorado: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Fremont, Jefferson, Larimer, Pueblo, and Teller</td></tr>
<tr><td>Yes, but see page 8 for details</td><td>Only for emergency care</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">All Medicare-covered preventive care covered with $0 copay</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">$20 copay</td></tr>
<tr><td colspan="2">$30 copay</td></tr>
<tr><td colspan="2">$200 copay</td></tr>
<tr><td colspan="2">Lab: No charge; X-ray: $20 copay</td></tr>
<tr><td>$100 copay per visit</td><td>$60 copay per visit</td></tr>
<tr><td colspan="2">20% copay</td></tr>
<tr><td colspan="2">20% copay</td></tr>
<tr><td>$15 copay</td><td>$30 copay</td></tr>
<tr><td colspan="2">No charge</td></tr>
<tr><td colspan="2">No charge</td></tr>
<tr><td>$30 copay for exam; $80 frame or contact lens allowance every 24 months through VSP providers</td><td>$30 copay for exam; $70 frame allowance and $105 contact lens allowance every 24 months</td></tr>
<tr><td>$20 copay for exam once per year;
$500 hearing aid allowance every 36 months</td><td>No charge for exam every 12 months;
$500 hearing aid allowance every 36 months</td></tr>
<tr><td>$20 copay; limited to 12 visits per year for services not covered by Medicare. 20% coinsurance for Medicare-covered services</td><td>$20 copay; limited to 12 visits per year</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">$500 per admit</td></tr>
<tr><td colspan="2">No copay days 1-20
$75 copay per day days 21-100</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">$50 copay</td></tr>
<tr><td colspan="2">$30 copay</td></tr>
<tr><td colspan="2">$100 copay</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">$15 generic/$45 preferred brand/$60 non-preferred brand/$75 specialty</td></tr>
<tr><td colspan="2">$30 generic/$90 preferred brand/$120 non-preferred brand/$150 specialty</td></tr>
</table>

Dental Plan Highlights

Features	CIGNA Dental HMO	CIGNA Dental PPO	Delta Dental PPO
Individual plan annual deductible[1]	None	$100	$100
Family plan annual deductible[1]	None	$200	$200
Annual benefit maximum (per individual)	None	$1,500	$1,500
Lifetime benefit maximums:			
Implants (per individual)	Not covered	$1,500	$1,500
Orthodontics (per individual)	No limitation	$1,500	$1,500
Provider network	CIGNA Dental HMO	CIGNA Dental PPO Core Network	Delta Dental PPO
How to find a dentist	Search www.cigna.com or call 1-800-CIGNA24 (1-800-244-6224)	Search www.cigna.com or call 1-800-CIGNA24 (1-800-244-6224)	Search www.deltadentalco.com or call Delta Dental at 1-800-610-0201
Areas where plan is available	Metro Denver, Front Range, and major metro areas in many states	Nationwide	Nationwide

Covered Services	Covered in-network only	Covered in- and out-of-network	
Diagnostic and Preventive	**Your Copay**	**What you pay if you use a network dentist[2]**	
Office visit	$5 copay	Nothing	Nothing
Oral exams and regular cleanings	$0 to $45 copay	Nothing	Nothing
X-rays	$0 copay	Nothing	Nothing
Sealants	$10 per tooth	Nothing	Nothing
Basic Services			
Basic restorative (fillings)	$0 to $100 copay	20% of PPO Contracted Fee	20% of PPO Contracted Fee
Oral surgery (extractions)	$11 to $105 copay	20% of PPO Contracted Fee	20% of PPO Contracted Fee
Endodontics (root canal therapy)	$11 to $375 copay	20% of PPO Contracted Fee	20% of PPO Contracted Fee
Periodontics (gum disease treatment)	$30 to $430 copay	20% of PPO Contracted Fee	20% of PPO Contracted Fee
Major Services			
Prosthodontics (dentures, bridges)	$39 to $675 copay	50% of PPO Contracted Fee	50% of PPO Contracted Fee
Special restorative (crowns, bridges)	$41 to $480 copay	50% of PPO Contracted Fee	50% of PPO Contracted Fee
Orthodontics (braces)	$61 to $2,184 copay	50% of PPO Contracted Fee	50% of PPO Contracted Fee
Implants	Not covered	50% of PPO Contracted Fee	50% of PPO Contracted Fee
Missing tooth limitation	None	Applies for first 24 months	None

[1] *Deductible applies to Basic and Major Services, but not Diagnostic and Preventive.*

[2] *In both the CIGNA Dental and Delta Dental PPO plans, you have the greatest savings if you use a PPO dentist. If you see a dentist who does not participate in the plan's PPO network, you will pay the difference between the PPO contracted fee and the fee charged by the dentist, in addition to any deductible and coinsurance.*

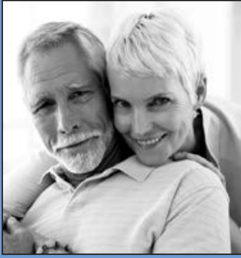
In the Delta Dental plan, if you see a dentist who does not participate in the PPO network, but does participate in the Premier network, you will have greater savings than seeing an out-of-network dentist, but you will pay the difference between the PPO contracted fee and the Premier contracted fee, in addition to any deductible and coinsurance.

Vision Plan Highlights

	Vision PPO #1		Vision PPO #2		Vision PPO #3	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Network Coverage	For some services, but patient pays more for Out-of-Network care		For some services, but patient pays more for Out-of-Network care		For some services, but patient pays more for Out-of-Network care	
Plan Availability	Nationwide		Nationwide		Nationwide	
WellVisionExam® (Every 12 months)	$10 copay, then covered in full	$10 copay, then covered up to $35	$25 copay, then covered in full	$25 copay, then covered up to $45	$10 copay, then covered in full	$10 copay, then covered up to $35
Prescription Glasses[1]	$25 copay for lenses and frame		$25 copay for lenses and frame		20% discount off complete pair of glasses only; no discount for lenses only, frame only, or replacement parts or repairs	Not covered
Lenses	Covered once every 12 months		Covered once every 24 months			
Single Vision	Covered in full	Covered up to $25	Covered in full	Covered up to $35		
Lined Bifocal	Covered in full	Covered up to $40	Covered in full	Covered up to $50		
Lined Trifocal	Covered in full	Covered up to $55	Covered in full	Covered up to $65		
Frame	Covered once every 24 months		Covered once every 24 months			
	$130 retail allowance	Covered up to $40	$105 retail allowance	Covered up to $50		
Contacts[1]	Covered once every 12 months		Covered once every 24 months		15% discount for evaluation, fitting, and lenses; no discount for lenses only	Not covered
	$130 allowance for evaluation, fitting, and lenses	$105 allowance for evaluation, fitting, and lenses	$105 allowance for evaluation, fitting, and lenses	$105 allowance for evaluation, fitting, and lenses		
Lens Options	Discounts average 35%	Not covered	Discounts average 35%	Not covered	20% discount	Not covered
Additional Glasses (Including sunglasses)	20% discount	Not covered	20% discount	Not covered	20% discount	Not covered
Laser Vision Correction	15% discount	Not covered	15% discount	Not covered	15% discount	Not covered
VSP Network Doctors *See VSP directory for a complete list of current doctors*	Nationwide access to thousands of private practice VSP doctors	Non-VSP providers licensed or certified to provide covered benefits	Nationwide access to thousands of private practice VSP doctors	Non-VSP providers licensed or certified to provide covered benefits	Nationwide access to thousands of private practice VSP doctors	Non-VSP providers licensed or certified to provide covered benefits
VSP Member Services	1-800-877-7195 or www.vsp.com		1-800-877-7195 or www.vsp.com		1-800-877-7195 or www.vsp.com	

[1] *You may choose prescription glasses or contacts, but not both, once every 12 or 24 months as noted above.*

Premiums



PREMIUM PAYMENT

Premiums for health, dental, and vision are deducted from your monthly benefit. If your monthly benefit is not large enough to accommodate this, PERA will contact you to arrange direct payment.

Premium Information

Your health care premium is determined by:

- The plan(s) you select,
- The number of people you enroll, and
- Your PERA subsidy.

How does the PERA health care subsidy work?

PERA provides a health care subsidy to help offset your health care premium. The subsidy amount is set in State law, and is applied toward your health care premium (but by law cannot be applied to dental or vision premiums).

The subsidy is based upon your years of service credit (including projected service credit, if applicable). Purchased service credit for a refunded account or for employment not covered by PERA is also considered for retirees under the PERA benefit structure and for retirees under the Denver Public Schools (DPS) benefit structure who retire on or after January 1, 2010. The subsidy is paid for retirees only under the DPS benefit structure, and for all benefit recipients (retirees, cobeneficiaries, and survivors) under the PERA benefit structure.

The maximum subsidy is paid for retirees with 20 or more years of service credit. If you have less than 20 years of service credit, the subsidy is reduced by 5 percent per year less than 20.

The maximum subsidy is $115 for most Medicare (over age 65) retirees. For Medicare retirees under the DPS benefit structure who do not have Medicare Part A, the maximum subsidy is $230 (see chart on page 21), which was designed to help offset their higher plan premiums. For all other Medicare retirees, the premium is the same whether or not they have Medicare Part A.

You may use the PERACare calculator on the PERA Web site at www.copera.org to calculate your net health care premium. You do not need to log on to your account to access the calculator menu.

Calculating Your Health Care Premium

After you have selected a health plan and chosen a level of coverage from the preceding pages, you are ready to calculate your premium for that plan.

The premiums on page 20 and subsidy chart below apply to all benefit recipients except benefit recipients under the 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 page 21 for premiums and subsidy chart to calculate your health care premium.

A. Enter the total premium amount .... A. $ ______
(from the premium chart on page 20 or 21)

B. Enter your Medicare Benefit Recipient Subsidy .... B. $ ______
(from the subsidy chart on page 19 or 21)

C. Subtract line B from line A (A – B) .... C. $ ______

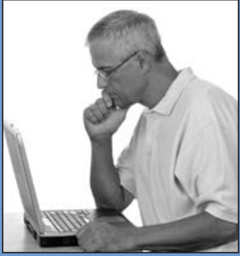
This is your monthly health care premium.

Medicare Benefit Recipient (BR) Subsidy Chart

YEARS OF SERVICE	MEDICARE BR SUBSIDY
20+	$115.00
19	109.25
18	103.50
17	97.75
16	92.00
15	86.25
14	80.50
13	74.75
12	69.00
11	63.25
10	57.50
9	51.75
8	46.00
7	40.25
6	34.50
5	28.75
4	23.00
3	17.25
2	11.50
1	5.75

MEDICARE PART B PREMIUMS

Remember that you need to have Medicare Part B in place to be enrolled in a PERACare health care plan. If you receive a premium notice from Social Security, don't ignore it or they may cancel your coverage.



PLANS AND PREMIUMS
Plans and premiums on this page are for Medicare coverage only. If you are enrolling dependents who are under age 65, contact PERA to request the *PERACare Combination Coverage Premium Information/ Enrollment Form.*

Health Care Plans—Monthly Premiums

For Medicare Enrollees

Notes: See separate premium chart on page 21 if you are a retiree under the DPS benefit structure and do not have Medicare Part A.

If you wish to add coverage for a spouse under age 65 or dependent children, contact PERA to request the *PERACare Combination Coverage Premium/Enrollment Form.*

If you wish to add coverage for a disabled dependent child with Medicare benefits, the child can be added to your plan for an additional single ("retiree only") premium.

The premiums below show the monthly premiums for coverage, before deduction for the PERA subsidy. Find the right premium—"Retiree only" (single coverage) or "Retiree plus spouse" (couple coverage). Subtract your PERA subsidy (see chart on page 19) from the premium below to get your premium. See the sample calculation at the top of page 19.

	Anthem Medicare Supplement #1	Anthem Medicare Supplement #2	Anthem Medicare Supplement #3
Retiree only	$324.00	$193.00	$152.00
Retiree plus spouse	648.00	386.00	304.00

	Kaiser Permanente	Rocky Mountain Health Plans	UnitedHealthcare
Retiree only	$199.00	$212.00	$153.00
Retiree plus spouse	398.00	424.00	306.00

Dental and Vision Plans—Monthly Premiums

Dental and vision premiums are the same for everyone, regardless of age. Dental and vision coverage is independent of health care coverage, that is, you do not need to be enrolled in health care in order to have dental and/or vision coverage.

Dental Plans	CIGNA Dental HMO	CIGNA Dental PPO	Delta Dental PPO
Retiree only	$17.79	$36.99	$36.47
Retiree plus spouse	35.59	73.98	72.93

Vision Plans	VSP PPO #1	VSP PPO #2	VSP PPO #3
Retiree only	$7.47	$4.94	$0.78
Retiree plus spouse	11.94	7.94	1.27

Monthly Premiums for Retirees Under the DPS Benefit Structure Without Medicare Part A

If you are receiving benefits under the DPS benefit structure, please read these notes to help determine your premium:

PERA's plans all provide coverage for Medicare Part A services (hospital services). If you are a retiree under the DPS benefit structure and have Medicare Parts A and B, see pages 19 and 20 for your premiums and subsidy. If you are a DPS benefit structure retiree and do not have Medicare Part A, see below for your premiums and subsidy.

The premiums below show the monthly premiums for coverage, before deduction of the PERA subsidy.

1. Find the right premium—"Retiree only" (single coverage) or "Retiree plus spouse" (couple coverage).
2. Subtract your PERA subsidy from the premium below to get your premium.

	Anthem Medicare Supplement #1	Anthem Medicare Supplement #2	Anthem Medicare Supplement #3
Retiree only	$754.00	$390.00	$339.00
Retiree plus spouse	1,508.00	780.00	678.00

	Kaiser Permanente	Rocky Mountain Health Plans	UnitedHealthcare
Retiree only	$716.00	$564.00	$598.00
Retiree plus spouse	1,432.00	1,128.00	1,196.00

DPS Benefit Structure Subsidy Chart—Retirees Without Medicare Part A

YEARS OF SERVICE	SUBSIDY	YEARS OF SERVICE	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

Glossary of Key Terms

The health care terms listed below are used in this booklet, and are defined here in the context of their usage by PERA. The definitions are not meant to be comprehensive, but rather to be helpful to your understanding of PERA's program and plans. (For a list of Medicare terms see pages 6-8.)

Carrier
Insurance company or administrator offering coverage.

Coinsurance
The percentage of covered medical expenses that you pay. For example, if you are in PERA's Anthem Medicare Supplement #1 plan, your coinsurance for a hospital stay is 20 percent of the Medicare deductible. You will pay 20 percent of the deductible and the plan will pay the other 80 percent. Your coinsurance equates to $236.80 in 2013.

Copay or Copayment
The dollar amount that you pay to a provider for a covered service. For example, if your copay for a hospital stay is $500, you would pay $500 and the plan would pay all remaining charges.

Deductible
What you must pay for covered expenses each year before the plan starts to pay.

Formulary
A list of covered drugs. Also called preferred drug list. Includes drugs that you can receive through the plan, and includes both generic and brand-name drugs.

HMO or Health Maintenance Organization
Members receive care from the HMO's provider network, but do not have access to providers who are outside of the plan's network. HMOs typically use the "gatekeeper" approach, where a patient's care is managed by his/her PCP.

Out-of-Network Provider
A doctor, hospital, or other provider who does not contract with your health plan. In HMO plans, you generally cannot receive any plan benefits if you see an out-of-network provider.

Out-of-Pocket Costs
The actual costs you pay when you receive health care services.

Out-of-Pocket Maximum
The most you may have to pay in a plan year for covered services. Depending on the plan, it may include your deductible, copays, and coinsurance. Once the amount you have paid for your covered services has reached the amount of the out-of-pocket maximum, the plan pays 100 percent for all of your covered services for the rest of the calendar year. Note that most plans specify that some types of services are not included in the out-of-pocket maximum, for example, your payments for prescription drugs are typically not included in the calculation.

PBM or Pharmacy Benefit Manager
Also called prescription benefit manager. Company that administers a plan's prescription drug benefit.

PCP or Primary Care Provider
The doctor who works with you and other doctors to provide, prescribe, approve, and coordinate your medical care and treatment. An HMO plan may require you to see your PCP before you can see a specialist.

PPO or Preferred Provider Organization
A network of providers (physicians, hospitals, specialty providers, ancillary services) that offers discounted charges, in exchange for a benefit structure that channels patients to network providers. PPO plans do not require you to see providers in their network, but they generally cover less of your costs if you see a provider outside the network.

Premium
The amount you are charged each month for your coverage.

Specialist
A doctor who has special training in a specific kind of medical care, like a cardiologist or neurologist.

This booklet provides information about PERA's health benefits program. Your rights, benefits, and obligations as a Colorado PERA member are governed by Title 24, Article 51 of the Colorado Revised Statutes, and the Rules of the Colorado Public Employees' Retirement Association, which take precedence over any interpretations in this booklet.

Colorado Public Employees' Retirement Association
1301 Pennsylvania Street
Denver, Colorado 80203-5011
www.copera.org

2/104 (REV 01-13) 10M