COLORADO PERA

Pre-Medicare

2013 PERACare Health Benefits Program

PERACare

PERACare Plan Contact Information/Resources

Anthem Blue Cross and Blue Shield
Group #195096
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
Northern Colorado: 1-800-632-9700
Southern Colorado: 1-888-681-7878
www.kaiserpermanente.org

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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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 benefit for a 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 3.

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.

If you are enrolling at retirement, you may choose an effective date up to six months in the future, as long as you remain covered by your employer's plan in the interim.

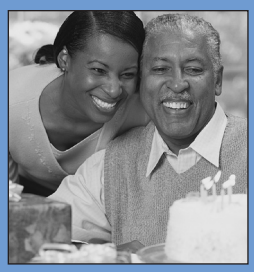
ENROLLING IN PERACARE

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.

If I'm Enrolled in a Pre-Medicare Plan, What Happens When I Turn Age 65?

When you turn age 65, you are no longer eligible to be enrolled in a PERACare pre-Medicare health plan. Instead, you become eligible to enroll in a PERACare Medicare health plan. Three months before your 65th birthday, you should contact Social Security and enroll in Medicare Part B. (You are eligible for Medicare Part B even if you never worked under Social Security or contributed to Medicare.) With your Medicare Part B in place, you can enroll in any of the PERACare Medicare plans for which you are eligible (see the PERACare Enrollment Eligibility Chart on page 3). Note that you are not required to have, or to purchase, Medicare Part A, but you should enroll in Part A if you are eligible to receive it at no cost.

If you become eligible for Medicare before age 65 because of a medical condition or disability, you should request Medicare plan information from PERA.



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.

Options for Combination Coverage

If you want to cover your spouse in PERACare and you are not **both** under age 65, you can enroll in PERA's combination coverage option. 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 pre-Medicare plan, and then you choose a Medicare plan with the same carrier for your spouse. For information and rates, see the *PERACare Combination Coverage Premium Information/Enrollment Form*.

Traveling

If you are traveling and have a medical emergency, all PERACare plans cover your emergency and urgent care services at the in-network benefit level, even if the facility is not part of your plan's network. If you are traveling and wish to receive non-emergency care (routine care), you should check with your plan first. Anthem's HMO plan has no out-of-network coverage for routine care; Kaiser Permanente plans have coverage at other Kaiser Permanente facilities throughout the United States; and Anthem's PPO plans have both in- and out-of-network coverage worldwide.

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 are enrolled in an HMO health plan (with either Anthem or Kaiser Permanente) and move outside of the plan's service area, your HMO coverage must be canceled. You can continue to have PERACare coverage by submitting a *PERACare Enrollment/Change Form* to enroll in one of Anthem's PPO plans within 30 days of your move date.

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.

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.

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.

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 PERA 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.

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 health plan partners for pre-Medicare coverage are Anthem Blue Cross and Blue Shield (Anthem) and Kaiser Permanente.
- PERACare's dental plan partners are CIGNA Dental and Delta Dental.
- PERACare's vision plan partner is VSP.

How Should I Choose a Health Plan?

This may not be an easy decision, especially because you have a number of good plans from which to choose. Here are some of the factors that you should use in your decision:

Your location

Depending on where you live, some or all of the plans will be available to you. Your choices could be as few as three if you live outside of Colorado, or as many as seven if you live in Colorado and along the Front Range.

Your current coverage

Think about whether you like the kind of plan you have now or whether you want to make a change. PERACare offers three kinds of plans: HMO, PPO, and HDHP/HSA. See the descriptions on page 5 for more information about each type of plan. If you like the plan you have now, and a similar plan is available through PERACare, you might want to enroll in that plan.

Your doctor(s)

If you have a doctor whom you would like to continue to use when you enroll in a PERACare plan, you will want to choose a plan that either contracts with that doctor or has an out-of-network benefit that allows you to see that doctor. Anthem has a large network of contracted providers, so it is likely that your doctor will be in Anthem's network. If not, you might choose one of the Anthem PPO plans that provide for out-of-network coverage. If you are in a Kaiser Permanente plan now, you will probably want to enroll in one of PERA's Kaiser Permanente plans so that you can continue to see your Kaiser Permanente doctors.

Your usage of health services

If you're healthy, have minimal prescription expenses, and rarely see a doctor, you might choose a plan like PPO #2 or HMO #2. These plans have lower premiums, but higher out-of-pocket costs when you use the plan. If you have the need for frequent and/or expensive health care services, you might be better served in a plan with higher premiums and more generous benefits like PPO #1 or HMO #1.

Your prescription drug needs

If you take any prescription drugs, you may want to compare the coverage and costs in different plans. Each plan has a formulary or preferred drug list, and may or may not cover drugs not on their formulary. You may want to review the formularies on the plan Web sites or you may call the plans (see "Questions About Prescription Benefits" on page 6).

ONLINE PROVIDER DIRECTORIES

Provider directories for all of the health, dental, and vision plans in PERACare are available online through PERA's Web site. Log on to www.copera.org and click on "PERACare." From this page you can 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.

Premiums

Consider all of your potential health care costs—not just your premium—when you evaluate costs. Look at deductibles, copays, and out-of-pocket maximums when estimating your total health care costs. Plans with higher premiums are more likely to have lower copays; plans with lower premiums have more cost-sharing when you use services. Premium information starts on page 16.

Pre-Medicare Health Plans

PERACare offers a variety of pre-Medicare (under age 65) health plan options. The following types of plans are available through PERACare. (See pages 8-13 for more specific plan information.)

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 a specified copayment and/or coinsurance for each office visit and the plan pays the rest. You generally don't have to worry about filing claims or dealing with bills from providers.

PPO Plans

In a PPO plan, you have more flexibility for accessing benefits than in an HMO plan. The network of preferred/participating providers is usually larger, and often covers a broader geographic area. You have the ability to use non-network providers in a PPO plan and receive some level of coverage, but your cost-share will be higher. You are subject to deductibles and coinsurance and/or copays.

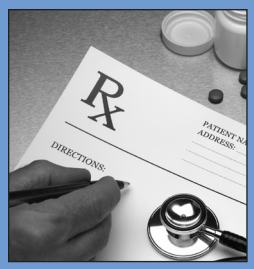
HDHP and HSA Plans

A High Deductible Health Plan (HDHP) is usually a variation of an HMO or PPO plan, and it must meet specific requirements set forth in federal law. You can enroll in an HDHP alone, or you can enroll in an HDHP and then set up a Health Savings Account (HSA) to set aside funds to cover your deductible and out-of-pocket costs on a tax-deductible basis. In an HDHP, you have the same type of benefits as in other plans, but you must meet the plan's deductible before the plan starts to pay for those benefits. An HDHP can offer first-dollar coverage for some preventive services, but for most health care needs, including prescription drugs, you pay 100 percent of costs until you have met the plan's deductible. After you meet the plan's deductible, you share in costs through coinsurance and/or copays.

If you are participating in an HDHP, you are eligible to contribute to an HSA. For 2013, you can contribute $3,250 (plus $1,000 "catch up" if you are age 55 or older) no matter what your HDHP plan's deductible is, and your contributions can be tax-deductible. Funds in your HSA are invested and earnings accumulate tax-free. If you withdraw HSA funds for qualified health care expenses, they can remain tax-free upon distribution. You may establish an HSA with your bank, credit union, or any financial institution of your choice. You are not required to contribute to an HSA if you enroll in an HDHP, but many individuals choose an HDHP so they can contribute to an HSA.

SEE A TERM YOU DON'T UNDERSTAND?

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



QUESTIONS ABOUT PRESCRIPTION BENEFITS?

- If you are enrolled in PERA's Anthem Blue Cross and Blue Shield plans, call Caremark at 1-800-378-0755.
- If you are enrolled in Kaiser Permanente plans, call Kaiser Permanente at one of the following phone numbers:

  Denver/Boulder
  303-338-4503

  Northern Colorado
  303-338-4503

  Southern Colorado
  1-866-244-4119

Prescription Drug Coverage

All of the health plans offered through PERACare include prescription drug coverage. Benefits, copayments, deductibles, and coverage levels vary between plans. If you use high-cost prescriptions and/or a number of different drugs, you will want to compare the different plans' coverage and costs carefully.

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 or Northern Colorado, you may get your prescriptions filled at a Kaiser Permanente Medical Office, contracted local retail pharmacies, and through Kaiser Permanente's mail pharmacy service.

Fitness and Wellness Programs

Fitness and wellness benefits have been proven to improve health and reduce health care costs. If you enroll in an Anthem or Kaiser Permanente 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 and Kaiser Permanente include membership in the SilverSneakers® Fitness Program. With SilverSneakers, you receive a free basic fitness center membership to over 9,000 participating locations nationwide, including Curves® locations. You can use any of the fitness center's amenities that come with a basic membership. You also have access to SilverSneakers classes, Senior Advisors℠, health education, and social activities.

Healthways SilverSneakers® Fitness Program

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 now it can be combined with SilverSneakers for the added benefit of exercise and classes in a fitness center.

PERA Fit
Take the Fitness Challenge

PERACare QuitLine– Retire the Habit

The PERACare QuitLine gives enrollees in Anthem and Kaiser Permanente access to a team of dedicated coaches who can help you cope with common barriers to quitting, such as dealing with stress, fighting cravings, and coping with irritability. You can also receive free nicotine replacement therapy, such as gum or patches, through the PERACare QuitLine. It all starts with a phone call. Call the PERACare QuitLine at 1-855-261-2636 to take the first step toward being tobacco free.

PERACare QuitLine
Retire the Habit

Plan Descriptions

The following pages provide summaries of the health care, dental, and vision plans available in PERACare for individuals under age 65.

For health care, PERACare offers a total of seven options: four plan options with Anthem Blue Cross and Blue Shield and three plan options with Kaiser Permanente. All plans cover the same types of services, but differ in the amount that you pay for services. (The only exception is chiropractic care, which is covered in all plans except Kaiser Permanente's HMO #2 and HDHP.)

PERACare offers four plan options with Anthem Blue Cross and Blue Shield:

HMO

- Available within Colorado.
- Anthem's HMO Colorado managed care network of doctors and facilities.
- No up-front deductible.

PPO #1

- Available worldwide.
- Anthem's PPO provider network within Colorado.
- Blue Cross and Blue Shield Association's worldwide network outside of Colorado.
- $1,500 deductible, but preventive care and routine doctor visits are not subject to the deductible.

HDHP (High Deductible Health Plan)

- Same worldwide availability and network as PPO #1.
- $3,500 deductible, but preventive care is not subject to the deductible. Prescription drug costs are subject to the deductible.
- Designed as a lower cost alternative and for those who want to contribute to a Health Savings Account (HSA).

PPO #2

- Same worldwide availability and network as in PPO #1.
- $6,000 deductible, but preventive care is not subject to the deductible.
- Designed as a lower cost alternative for those with minimal health care expenses.

PERACare offers three plan options with Kaiser Permanente. All are available in Kaiser Permanente's Colorado service areas: Denver/Boulder, Northern Colorado, and Southern Colorado.

HMO #1

- A traditional HMO plan with copays for most services and no up-front deductible.

HMO #2

- A lower cost alternative with both copays and coinsurance, depending on the service.
- $1,000 deductible, but preventive care, routine office visits, and some other services are not subject to the deductible.

HDHP (High Deductible Health Plan)

- $3,500 deductible, but preventive care is not subject to the deductible. Prescription drug costs are subject to the deductible.
- Designed as a lower cost alternative and for those who want to contribute to a Health Savings Account (HSA).

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).

WHAT ABOUT PRE-EXISTING CONDITIONS?

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

Anthem Benefit Highlights

The information below is for using in-network providers. See the notes on page 10 for out-of-network information.

Features	HMO In-Network Only	PPO #1 In-Network
Annual In-Network Deductible[1]		
Individual	None	$1,500
Family	None	$3,000
Annual Out-of-Pocket Maximum[1]		
Individual	$10,000	$10,000
Family	$20,000	$20,000
Lifetime Benefit Maximum (per individual)	$2,500,000, including $1,000,000 transplant lifetime benefit	

Benefits

Preventive Care—Covered In-Network only and not subject to deductible

Exam	No charge	
Screenings	No charge	
Immunizations	No charge	
Colonoscopy	$300 copay	

Outpatient Services (per visit or procedure)—Subject to deductible unless otherwise noted

Primary care office visit	$30 copay	$30 copay[2]
Specialty care office visit	$45 copay	$45 copay[2]
Ambulatory surgery	$600 copay plus 20% coinsurance	20% coinsurance
Diagnostic lab and X-ray	20% coinsurance	
Therapeutic X-ray; MRI, PET, CT	$200 copay plus 20% coinsurance	20% coinsurance
Durable medical equipment[3]	20% coinsurance	
Oxygen	20% coinsurance	
Physical, occupational, and speech therapy[3]	$45 copay	20% coinsurance
Home health care	20% coinsurance	
Hospice care	20% coinsurance	
Chiropractic care[3]	$30 copay	20% coinsurance
Vision care	Not covered	
Dental care	Not covered unless resulting from an accident in which other significant injuries occurred	

Inpatient Care

Hospital care and professional visits	$1,200 copay plus 20% coinsurance	20% coinsurance
Skilled nursing facility care[3]	20% coinsurance	

[1] *In PPO #1 and PPO #2, your payments for services not subject to the deductible do not accumulate toward the deductible and out-of-pocket maximum.*

[2] *Not subject to deductible.*

[3] *Maximum benefit may be limited.*

HDHP In-Network	PPO #2 In-Network
$3,500	$6,000
$7,000	$12,000
$6,050	$16,000
$12,100	$32,000
$2,500,000, including $1,000,000 transplant lifetime benefit	
No charge	
No charge	
No charge	
$300 copay	
20% coinsurance	
20% coinsurance	
20% coinsurance	
20% coinsurance	
20% coinsurance	
20% coinsurance	
20% coinsurance	
20% coinsurance	
20% coinsurance	
20% coinsurance	
20% coinsurance	
Not covered	
Not covered unless resulting from an accident in which other significant injuries occurred	
20% coinsurance	
20% coinsurance	

Continued on next page

Anthem Benefit Highlights

Emergency and Urgent Care	HMO In-Network Only	PPO #1 In-Network
Emergency room visit	$250 copay plus 20% coinsurance; copay waived if admitted	20% coinsurance
After-hours care	$60 copay plus 20% coinsurance	20% coinsurance
Ambulance service	20% coinsurance	
Prescription Drugs		
Retail pharmacy (up to a 30-day supply)	$300 deductible, then 50% coinsurance maximum copay is $75	
Caremark mail order (up to a 90-day supply)	Generic: $35 copay Brand: $125 copay	Generic: $35 copay Brand: $150 copay

Note: For inpatient and outpatient services, if lab and other professional services are billed separately, they are subject to the deductible, if any, and 20 percent coinsurance.

Out-of-Network Information

Emergency room visits, urgent care, and ambulance services are covered at the in-network benefit level in all Anthem plans, even if you use providers who are not part of Anthem's network.

If you are enrolled in Anthem's HMO plan, you must use providers in Anthem's Colorado HMO network for routine (non-emergency) services.

If you are enrolled in Anthem's PPO #1, HDHP, or PPO #2, you may use doctors and other providers who do not contract with Anthem ("out-of-network" providers) for some services. But if you use providers outside of Anthem's PPO network, you will have higher costs when you use services, and you will be subject to the following costs:

- A separate out-of-network deductible that is two times the in-network deductible shown on pages 8 and 9
- A separate out-of-pocket maximum that is two times the in-network out-of-pocket maximum shown on pages 8 and 9
- Coinsurance of 40 percent

In all Anthem plans, you must use network providers in order to receive a benefit for the following services:

- Preventive care
- Oxygen
- Durable medical equipment
- Organ transplants
- Mail-order prescription drugs

HDHP In-Network	PPO #2 In-Network
←20% coinsurance→	
←20% coinsurance→	
←20% coinsurance→	

20% coinsurance (after plan deductible is met)	$500 deductible, then 50% coinsurance; maximum copay is $100
20% coinsurance (after plan deductible is met)	Generic: $35 copay Brand: $175 copay

Some important benefits and features of PERA's Anthem plans when using in-network providers:

- You have access to large, worldwide networks of doctors and facilities, including all hospitals in Colorado
- Preventive care is covered at no charge to you, except for colonoscopies
- No referrals are needed to see a specialist
- Routine doctor visits are not subject to the deductible in PPO #1 (you pay a copay)
- You have the option of seeing out-of-network providers in the PPO and HDHP plans

The **Benefit Highlights** chart summarizes and compares the features and benefits of the four plans.

The chart shows the amounts that you will be paying when you receive care or services. For many services, your share of costs is the same for all plans. The shaded blocks help to compare your cost-share.

For example, many of the services are subject to "20 percent coinsurance." This means that you will pay 20 percent of the charges and PERA's Anthem plan will pay the other 80 percent of charges. Note that in the PPO and HDHP plans, for some services, you have deductibles to meet before the plan begins to share in costs. Until you meet the deductible, you are paying all charges after Anthem's network discounts have been applied.

Other services are subject to copays. For example, a "$30 copay" means that you will pay your doctor $30 at the time of your visit, and your doctor will bill PERA's Anthem plan for the rest of the charges. If your doctor also bills Anthem for services such as blood work or X-rays, you will have additional coinsurance to pay once Anthem applies its network discounts and processes the charges. If you have not yet met your deductible, your coinsurance will be 100 percent until the deductible is satisfied, then it will be 20 percent.

Questions about what services are covered?

If you enroll, you will receive a benefits booklet from Anthem which describes the terms and conditions of your coverage in detail. You may also call Anthem's Customer Service Center at 1-877-737-2258 if you have questions about benefits or coverage.

Kaiser Permanente Benefit Highlights

Features	HMO #1 In-Network Only	HMO #2 In-Network Only
Individual plan annual deductible	None	$1,000
Family plan annual deductible[1]	None	$3,000[1]
Individual plan annual out-of-pocket maximum[1]	$4,000	$3,000
Family plan annual out-of-pocket maximum[1]	$10,000	$6,000
Lifetime benefit maximum (per individual)	$1,000,000 for transplants; no other lifetime maximum	
Benefits		
Preventive Care—Not subject to deductible		
Exam	$25 copay	No charge
Screenings	No charge	
Immunizations	No charge	
Colonoscopy	$70 copay	
Outpatient Services (per visit or procedure)		
Primary care office visit	$25 copay	$25 copay[2]
Specialty care office visit	$40 copay	$45 copay[2]
Ambulatory surgery	$300 copay	20% coinsurance
Diagnostic lab and X-ray	No charge	Lab: No charge; X-ray: 20% coinsurance
Therapeutic X-ray; MRI, PET, CT	$40 copay; $100 copay	20% coinsurance
Durable medical equipment[3]	No charge	20% coinsurance[2]
Oxygen	No charge	20% coinsurance[2]
Physical, occupational, and speech therapy[3]	$25 copay	$25 copay[2]
Home health care	No charge	20% coinsurance
Hospice care	No charge	20% coinsurance
Vision care	$25/$40 copay	$25/$45 copay[2]
Chiropractic care[3]	$25 copay	Not covered
Inpatient Care		
Hospital care and professional visits	$1,000 copay	20% coinsurance
Skilled nursing facility care[3]	No charge	20% coinsurance
Emergency and Urgent Care		
Emergency room visit (waived if admitted)	$150 copay	20% coinsurance
After-hours care	$50 copay	$45 copay[2]
Ambulance service	20% coinsurance (up to $500 per trip)	
Prescription Drugs		
Pharmacy (up to a 30-day supply)	Generic: $15 copay Brand: $40 copay	Generic: $15 copay Brand: $40 copay[2]
Mail order (up to a 90-day supply)	Generic: $30 copay Brand: $80 copay	Generic: $30 copay Brand: $80 copay[2]

HDHP In-Network Only
$3,500
$7,000[1]
$6,050
$12,100[1]
$1,000,000 for transplants; no other lifetime maximum
No charge
No charge
No charge
$70 copay
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
Not covered
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
20% coinsurance
Generic: $10 copay Brand: $25 copay[4]
Generic: $20 copay Brand: $50 copay[4]

The **Benefit Highlights** chart summarizes and compares the features and benefits of the three plans.

The chart shows the amounts that you will be paying when you receive care or services. For some services, your share of costs is the same in two or all of the plans. The shaded blocks help to compare your cost-share.

Some services are covered at no charge to you; for other services you will pay a portion of the costs (either a fixed dollar copay or a percentage coinsurance).

A "$25 copay" means that you will pay Kaiser Permanente $25 at the time of your visit, and PERA's Kaiser Permanente plan will pay the rest.

A "20 percent coinsurance" means that you will pay 20 percent of the charges, and PERA's Kaiser Permanente plan will pay the other 80 percent of charges.

For some services and procedures received during an office visit in HMO#2, you will pay 20 percent coinsurance in addition to the office visit copay. Services subject to coinsurance are also subject to the plan deductible.

Except for emergency care, there are no out-of-network benefits with Kaiser Permanente. You must use Kaiser Permanente's network of physicians and providers.

Questions about what services are covered?

If you enroll, you will receive an Evidence of Coverage (benefits booklet) from Kaiser Permanente which describes the terms and conditions of your coverage. You may also call Kaiser Permanente's Customer Service Center if you have questions about benefits or coverage. Call 303-338-3800 or 1-800-632-9700 if you are in Kaiser Permanente's Denver/Boulder or Northern Colorado service areas, or 1-888-681-7878 for their Southern Colorado service area.

[1] *For family memberships in HMO #2, each enrollee is responsible for meeting the individual deductible or out-of-pocket maximum until the family limit is met. For family memberships in the HDHP, the family deductible and out-of-pocket maximum must be met by one or more family members. Individual amounts do not apply.*

[2] *Not subject to deductible, and not applicable to the out-of-pocket maximum.*

[3] *Maximum benefit may be limited.*

[4] *Copays for prescription drugs in the HDHP apply after the plan deductible is met.*

Dental Plan Highlights

Features	CIGNA Dental HMO	CIGNA Dental PPO	Delta Dental PPO
Individual plan annual deductible[1]	None	$100	
Family plan annual deductible[1]	None	$200	
Annual benefit maximum (per individual)	None	$1,500	
Lifetime benefit maximums:			
Implants (per individual)	Not covered	$1,500	
Orthodontics (per individual)	No limitation	$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.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	

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	
Oral exams and regular cleanings	$0 to $45 copay	Nothing	
X-rays	$0 copay	Nothing	
Sealants	$10 per tooth	Nothing	
Basic Services			
Basic restorative (fillings)	$0 to $100 copay	20% of PPO Contracted Fee	
Oral surgery (extractions)	$11 to $105 copay	20% of PPO Contracted Fee	
Endodontics (root canal therapy)	$11 to $375 copay	20% of PPO Contracted Fee	
Periodontics (gum disease treatment)	$30 to $430 copay	20% of PPO Contracted Fee	
Major Services			
Prosthodontics (dentures, bridges)	$39 to $675 copay	50% of PPO Contracted Fee	
Special restorative (crowns, bridges)	$41 to $480 copay	50% of PPO Contracted Fee	
Orthodontics (braces)	$61 to $2,184 copay	50% of PPO Contracted Fee	
Implants	Not covered	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 Information

Your health care premium is determined by:

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

PERACare uses four "tiers" of coverage.

- Retiree/benefit recipient only (BR)
- Retiree/benefit recipient plus spouse (BR+S)
- Retiree/benefit recipient plus child(ren) (BR+C)
- Retiree/benefit recipient plus spouse plus child(ren) (BR+S+C)

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 $230 for pre-Medicare (under age 65) retirees.

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.

Calculating Your Health Care Premium

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

A. Enter the total premium amount ..... A. $ _____
(from the premium chart on page 18)

B. Enter your Pre-Medicare Benefit Recipient Subsidy ..... B. $ _____
(from the subsidy chart below)

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

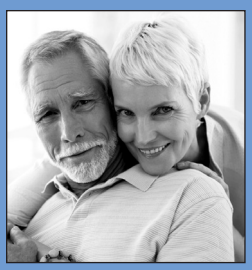
This is your monthly health care premium.

Pre-Medicare Benefit Recipient (BR) Subsidy Chart

YEARS OF SERVICE	PRE-MEDICARE BR 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
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

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.



PLANS AND PREMIUMS

Plans and premiums on this page are for pre-Medicare coverage only. If you are enrolling dependents who are age 65 or over or have Medicare, contact PERA to request the *PERACare Combination Coverage Premium Information/ Enrollment Form.*

Anthem Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	HMO	PPO #1	HDHP	PPO #2
BR	$826.00	$696.00	$657.00	$325.00
BR+S	1,652.00	1,392.00	1,314.00	650.00
BR+C	1,487.00	1,253.00	1,182.00	585.00
BR+S+C	2,313.00	1,949.00	1,839.00	910.00

Kaiser Permanente Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	HMO #1	HMO #2	HDHP
BR	$772.00	$646.00	$383.00
BR+S	1,542.00	1,291.00	764.00
BR+C	1,389.00	1,164.00	689.00
BR+S+C	2,159.00	1,809.00	1,071.00

CIGNA Dental Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	HMO	PPO
BR	$17.79	$36.99
BR+S	35.59	73.98
BR+C	40.92	85.09
BR+S+C	56.93	118.37

Delta Dental Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	PPO
BR	$36.47
BR+S	72.93
BR+C	83.87
BR+S+C	116.70

VSP Monthly Premiums

(BR = Benefit Recipient S = Spouse C = Children)

	PPO #1	PPO #2	PPO #3
BR	$7.47	$4.94	$0.78
BR+S	11.94	7.94	1.27
BR+C	12.20	8.11	1.30
BR+S+C	19.67	13.08	2.08

To calculate your net health care premium, subtract your PERA subsidy from the above health care premium. You may use the formula on page 17 or the PERACare calculator on the PERA Web site at www.copera.org.

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.

Carrier
Insurance company or administrator offering coverage.

Coinsurance
The percentage of covered medical expenses that you pay. For example, if your coinsurance for a hospital stay is 20 percent, you would pay 20 percent of the charges and the plan would pay the other 80 percent.

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 $1,000, you would pay $1,000 and the plan would pay all or a percentage of remaining charges.

Deductible
Individual Deductible
What you must pay for covered expenses each year before the plan starts to pay. In some plans, you must pay the deductible before the plan pays for any covered services. In other plans, some routine and preventive services (those referenced as "not subject to the deductible") are covered before you have met the deductible.

Family Deductible
Limits a family's potential costs by not requiring all family members to satisfy their individual deductibles.

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.

HDHP or High Deductible Health Plan
HSA or Health Savings Account
An HDHP meets the definitions of federal law and can be used alone or in conjunction with an HSA. (See page 5.)

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 PPO plans, you can see an out-of-network provider and receive some plan benefits, but your share of costs will be higher. 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 you have eached your 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.

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

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