## 2017 Denver Employees Retirement Plan
## Non-Medicare Medical Plan Summary

| | Denver Health Medical Plan HDHP* | Kaiser Permanente Colorado HDHP | United Healthcare HDHP** | Denver Health Medical Plan DHMO* | Kaiser Permanente Colorado DHMO | United Healthcare Navigate (Colorado only) |
|---|---|---|---|---|---|---|
| **Annual Deductible** | | | | | | |
| **Single** | $1,350 | $1,350 | $1,350 | $500 | $500 | $500 |
| **Family** | $2,700 | $2,700 | $2,700 | $1,500 | $1,500 | $1,500 |
| **Out-of-Pocket Maximum** | | | | | | |
| **Single** | $2,700 per individual | $2,700 per individual | $2,700 per individual | $3,000 per individual | $3,000 per individual | $2,500 per individual |
| **Family** | $5,400 per family | $5,400 per family | $5,400 per family | $6,000 per family | $6,000 per family | $5,000 per family |
| **Preventive** | **No Charge** | **No Charge** | **No Charge** | **No Charge** | **No Charge** | **No Charge** |
| **PCP Office Visit** | 10% after deductible | 20% after deductible | 20% after deductible | $25 copay | $30 copay | $25 copay |
| **Specialist Office Visit** | 10% after deductible | 20% after deductible | 20% after deductible | $50 copay | $50 copay | $50 copay |
| **Urgent Care** | 10% after deductible | 20% after deductible | 20% after deductible | $75 copay | $75 copay | $75 copay |
| **Emergency Room** | 10% after deductible | 20% after deductible | 20% after deductible | $300 copay | $200 copay | $300 copay |
| **Ambulance** | 10% after deductible | 20% after deductible | 20% after deductible | 20% after deductible | 20% coinsurance up to $500 | 20% after deductible |
| **Inpatient Hospital** | 10% after deductible | 20% after deductible | 20% after deductible | $150 **and** 20% coinsurance after deductible | 20% after deductible | $150 **and** 20% coinsurance after deductible |
| **Physicians Fees for Surgical/Medical Services** | 10% after deductible | 20% after deductible | 20% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| **Outpatient Surgery** | 10% after deductible | 20% after deductible | 20% after deductible | $150 **and** 20% coinsurance after deductible | 20% after deductible | $75 **and** 20% coinsurance after deductible |
| **Lab and X-ray** | 10% after deductible | 20% after deductible | 20% after deductible | 20% after deductible | **Lab:** No Charge **X-ray:** 20% after deductible | 20% after deductible |
| **MRI/CAT/CT/PET** | 10% after deductible | 20% after deductible | 20% after deductible | $150 copay | 20% after deductible | $150 copay |
| **Mental Health/ Substance Abuse Outpatient Services** | 10% after deductible | 20% after deductible | 20% after deductible | $50 copay | $30 copay | $50 copay |
| **Physical, Occupational and Speech Therapy** | 10% after deductible; maximum of 20 visits per year | 20% after deductible; maximum of 20 visits per year | 20% after deductible; maximum of 20 visits per year | $25 copay maximum of 20 visits per year | $30 copay maximum of 20 visits per year | $25 copay maximum of 20 visits per year |
| **Routine Vision Exams** | n/a | 20% after deductible | 20% after deductible; one exam per 24 months | $25 copay, one exam per 24 months | $30 copay per exam with Optometrist | $25 copay, one exam per 24 months |
| **Chiropractic** | 10% after deductible; maximum of 20 visits per year | 20% after deductible; maximum of 20 visits per year | 20% after deductible; maximum of 20 visits per year | $50 copay maximum of 20 visits per year | $30 copay maximum of 20 visits per year | $50 copay maximum of 20 visits per year |
| **Durable Medical Equipment** | 10% after deductible; maximum of $2,000 per year | 20% after deductible | 20% after deductible | 20% after deductible; maximum of $2,500 per calendar year | 20% after deductible | 20% after deductible; maximum of $2,500 per calendar year |

| | Denver Health Medical Plan HDHP* | Kaiser Permanente Colorado HDHP | United Healthcare HDHP** | Denver Health Medical Plan DHMO* | Kaiser Permanente Colorado DHMO | United Healthcare Navigate (Colorado only) |
|---|---|---|---|---|---|---|
| Oxygen and Oxygen Equipment | Oxygen fully covered; 10% after deductible for equipment | 20% after deductible | see Durable Medical Equipment | Oxygen fully covered; 20% after deductible for equipment | 20% after deductible | see Durable Medical Equipment |
| Home Health Care | Fully covered for prescribed medically necessary services | 20% after deductible | 20% after deductible; maximum of 60 visits per year | 20% after deductible; maximum of 60 visits per year | 20% after deductible | 20% after deductible; maximum of 60 visits per year |
| Hospice Care | Fully covered | 20% after deductible | 20% after deductible | 20% after deductible | 20% after deductible | 20% after deductible |
| Skilled Nursing Facility Care | Fully covered; maximum of 100 days per calendar year | 20% after deductible; maximum of 100 days per year | 20% after deductible; maximum of 60 visits per year | 20% after deductible; maximum of 60 days per year | 20% after deductible; maximum of 100 days per year | 20% after deductible; maximum of 60 days per year |
| Hearing Aids | $1,500 benefit maximum every 5 years | n/a | 20% after deductible; maximum of $2,500 benefit every three years | maximum of $2,500 benefit maximum every five years | n/a | 20% after deductible; maximum of $2,500 benefit every three years |
| **Prescription Drugs** | **30-day supply** | **30-day supply** | **30-day supply** | **30-day supply** | **30-day supply** | **30-day supply** |
| Generic | $10 after deductible | $10 after deductible | $10 after deductible | $12 | $20 | $15 |
| Preferred Brand | $15 after deductible | $35 after deductible | $35 after deductible | $40 | $40 | $45 |
| Non-Preferred Brand | $30 after deductible | $60 after deductible | $60 after deductible | $50 | $60 | $60 |
| **Prescription Drugs** | **90-day supply by mail** | **90-day supply by mail** | **90-day supply by mail** | **90-day supply by mail** | **90-day supply by mail** | **90-day supply by mail** |
| Generic | $20 after deductible | $25 after deductible | $25 after deductible | $24 | $40 | $37.50 |
| Preferred Brand | $30 after deductible | $87.50 after deductible | $87.50 after deductible | $80 | $80 | $112.50 |
| Non-Preferred Brand | $60 after deductible | $150 after deductible | $150 after deductible | $100 | $120 | $150 |

## 2017 Non-Medicare Plans-Monthly Premiums

| | Denver Health Medical Plan HDHP* | Kaiser Permanente Colorado HDHP | United Healthcare HDHP** | Denver Health Medical Plan DHMO* | Kaiser Permanente Colorado DHMO | United Healthcare Navigate (Colorado only) |
|---|---|---|---|---|---|---|
| Member only | **$463.65** | **$397.90** | **$623.76** | **$588.23** | **$493.32** | **$653.13** |
| Member and Spouse | **$1,020.03** | **$875.38** | **$1,372.30** | **$1,294.12** | **$1,085.30** | **$1,436.90** |
| Member and Child(ren) | **$927.30** | **$795.80** | **$1,247.55** | **$1,176.47** | **$986.63** | **$1,306.30** |
| Member and Family | **$1,483.69** | **$1,273.28** | **$1,996.03** | **$1,882.35** | **$1,578.61** | **$2,090.38** |

***NOTE:*** **The Denver Health HDHP and DHMO plans also have benefits with its national Cofinity Network. The benefits are different than what is listed here. For detailed information on these coverages, please call our office and request a Denver Health brochure.**

****NOTE:*** **The United Healthcare HDHP plan has a nationwide network as well as out-of-network benefits. These out-of-network benefits are different than what is listed here. For detailed information on these coverages, please call our office and request a United Healthcare brochure.**

## 2017 Denver Employees Retirement Plan
## Medicare Medical Plan Summary

| | Humana Medicare Advantage HMO | Kaiser Permanente Colorado Senior Advantage HMO | Humana Medicare Advantage PPO *Option M* | Humana Medicare Advantage PPO *Option R* |
|---|---|---|---|---|
| **Annual Deductible** | N/A | N/A | N/A | $250 |
| **Out-of-Pocket Maximum** | $3,000 | $2,500 | $2,500 | $3,500 |
| **Preventive** | **No Charge** | **No Charge** | **No Charge** | **No Charge** |
| **PCP Office Visit** | $15 copay | $15 copay | $15 copay | Deductible then $15 copay |
| **Specialist Office Visit** | $30 copay | $30 copay | $30 copay | Deductible then $30 copay |
| **Urgent Care** | $30 copay | $30 copay | $30 copay | $30 copay |
| **Emergency Room** | $65 copay | $65 copay | $65 copay | $75 copay |
| **Ambulance** | 20% coinsurance up to $500 per trip | 20% coinsurance up to $500 per trip | $50 copay | $50 copay |
| **Inpatient Hospital** | $300 copay | $300 copay | $300 copay | Deductible then $150 copay per day for days 1-5 |
| **Outpatient Surgery** | $150 copay | $150 copay | $125 copay | Deductible then $200 copay |
| **Lab and X-ray** | No Charge | No Charge | No Charge | Deductible then fully covered |
| **MRI/CAT/CT/PET** | $100 copay | $100 copay | $50 copay | Deductible then $50 copay |
| **Mental Health/Substance Abuse Inpatient Services** | $300 copay | $300 copay | $300 copay | Deductible then $150 copay per day for days 1-5 |
| **Mental Health/Substance Abuse Outpatient Services** | $30 copay | $15 copay | $30 copay | Deductible then $50 copay |
| **Physical, Occupational and Speech Therapy** | $30 copay | $15 copay | $30 copay | Deductible then $40 copay |
| **Vision Care** | $30 copay per exam; Medicare covered services only; no routine exams | $15-$30 copay per exam; Up to $200 materials benefit every 2 years | $30 copay per exam; Medicare covered services only; no routine exams | Deductible then $30 copay per exam; Medicare covered services only; no routine exams |
| **Chiropractic** | $15 copay maximum of 20 visits per year | $15 copay maximum of 20 visits per year | $20 copay | Deductible then $20 copay |
| **Durable Medical Equipment** | No Charge | No Charge | No Charge | Deductible then No Charge |
| **Oxygen** | No Charge | No Charge | No Charge | Deductible then No Charge |
| **Home Health Care** | No Charge | No Charge | No Charge | Deductible then No Charge |
| **Hospice Care** | Covered through Original Medicare | Covered through Original Medicare | Covered through Original Medicare | Covered through Original Medicare |
| **Skilled Nursing Facility Care** | No Charge; maximum of 100 days per calendar year | No Charge; maximum of 100 days per calendar year | $0 copay days 1-20; $50 copay per day days 21-100 | Deductible then $0 copay days 1-20; $50 copay per day days 21-100 |
| **Hearing Exam** | $30 copay; Medicare covered services only | $15 copay | $30 copay; Medicare covered services only | $30 copay; Medicare covered services only |
| **Hearing Aids** | N/A | $500 credit per ear every 36 months | N/A | N/A |
| **Prescription Drugs** | **30-day supply** | **30-day supply** | **30-day supply** | **30-day supply** |
| **Generic** | $20 copay | $15 copay | see schedule below* | $15 copay |
| **Preferred Brand** | $40 copay | $40 copay | see schedule below* | $30 copay |
| **Non-Preferred Brand** | $40 copay | $40 copay | see schedule below* | $50 copay |
| **Specialty** | $60 copay | $40 copay | see schedule below* | $80 copay |

| | Humana Medicare Advantage HMO | Kaiser Permanente Colorado Senior Advantage HMO | Humana Medicare Advantage PPO ***Option M*** | Humana Medicare Advantage PPO ***Option R*** |
|---|---|---|---|---|
| **Prescription Drugs** | **90-day supply by mail** | **90-day supply by mail** | **90-day supply by mail** | **90-day supply by mail** |
| **Generic** | $40 copay | $30 copay | see schedule below* | $25 copay |
| **Preferred Brand** | $80 copay | $80 copay | see schedule below* | $75 copay |
| **Non-Preferred Brand** | $80 copay | $80 copay | see schedule below* | $125 copay |
| **Specialty** | N/A | N/A | N/A | N/A |

## *Humana PPO Low Rx Plan (Option M)

**This prescription drug plan has different costs based on what *phase* a member is in.**

### *Initial Coverage Limit (ICL) Phase*

**A member will be in the ICL Phase until the drug cost (the amount the member pays plus the amount Humana pays) reaches $3,700 during the calendar year.**

| | 30-day supply | 90-day supply by mail |
|---|---|---|
| **Generic** | $5 copay | $10 copay |
| **Preferred Brand** | $15 copay | $30 copay |
| **Non-Preferred Brand** | $25 copay | $50 copay |
| **Specialty** | $40 copay | N/A |

### *Coverage Gap Phase*

**A member will be in the Coverage Gap Phase when the total drug cost exceeds $3,700 (Humana and the member's combined costs). A member will remain in this phase until the MEMBER'S drug cost reaches $4,950 during the calendar year. (NOTE: Please refer to the Humana Evidence of Coverage for details on the Coverage Gap Phase.)**

| | 30-day supply | 90-day supply by mail |
|---|---|---|
| **Generic** | $5 copay | $10 copay |
| **Preferred Brand** | 40% coinsurance | 40% coinsurance |
| **Non-Preferred Brand** | 40% coinsurance | 40% coinsurance |
| **Specialty** | 40% coinsurance | N/A |

### *Catastrophic Phase*

**A member will be in the Catastrophic Phase when the drug cost exceeds $4,950 during the calendar year and will remain in this phase for the rest of the calendar year.**

| | |
|---|---|
| **30-day Supply** | Greater of $3.30 for generic/multiple source drugs ($8.25 for all others) or 5% coinsurance |
| **90-day Supply by Mail** | Greater of $3.30 for generic/multiple source drugs ($8.25 for all others) or 5% coinsurance |

## 2017 Medicare Plans-Monthly Premiums

| | Humana Medicare Advantage HMO | Kaiser Permanente Colorado Senior Advantage HMO | Humana Medicare Advantage PPO - ***Option M*** | Humana Medicare Advantage PPO - ***Option R*** |
|---|---|---|---|---|
| **Per Person** | **$237.42** | **$226.33** | **$276.51** | **$332.12** |

## 2017 Denver Employees Retirement Plan
## CIGNA Dental Plan Summary

| | CIGNA DHMO | CIGNA PPO Low | | CIGNA PPO High | |
|---|---|---|---|---|---|
| | | In-network | Out-of-network | In-network | Out-of-network |
| **Annual Deductible** | | | | | |
| **Single** | N/A | $25 | $25 | $25 | $25 |
| **Family** | N/A | $75 | $75 | $75 | $75 |
| **Annual Maximum Benefit** | N/A | $1,000 | $1,000 | $1,500 | $1,500 |
| **Covered Providers** | **CIGNA Dental Care HMO Providers** | **CIGNA Dental PPO Network** | **CIGNA Dental PPO Network** | **CIGNA Dental PPO Network** | **CIGNA Dental PPO Network** |
| **Diagnostic & Preventive** | $0 to $240 copay | No Charge | No Charge | No Charge | No Charge |
| **Restorative (Fillings)** | $0 to $115 copay | 30% after deductible; up to annual maximum benefit | 30% after deductible*; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit |
| **Crowns & Bridges** | $12 to $245 copay | 50% after deductible; up to annual maximum benefit | 50% after deductible*; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit |
| **Endodontics (Root Canals)** | $12 to $245 copay | 30% after deductible; up to annual maximum benefit | 30% after deductible*; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit |
| **Periodontics (Gum Treatment)** | $24 to $430 copay | 30% after deductible; up to annual maximum benefit | 30% after deductible*; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit |
| **Prosthetics (Dentures)** | $14 to $425 copay | 50% after deductible; up to annual maximum benefit | 50% after deductible*; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit |
| **Oral Surgery (Extractions)** | $8 to $185 copay | 30% after deductible; up to annual maximum benefit | 30% after deductible*; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit |
| **Orthodontics (Braces)** | $50 to $1,584 copay for children (to age 19); $50 to $2,328 copay for adults | 50% after deductible; available only to children up to age 19; $1,000 lifetime maximum benefit | 50% after deductible*; available only to children up to age 19; $1,000 lifetime maximum benefit | 50% after deductible; available only to children up to age 19; $1,250 lifetime maximum benefit | 50% after deductible; available only to children up to age 19; $1,250 lifetime maximum benefit |
| **Anesthetics** | $73 to $190 copay | 30% after deductible; up to annual maximum benefit | 30% after deductible*; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit |
| **Implants** | not covered | 50% after deductible; up to annual maximum benefit | 50% after deductible*; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit | No charge after deductible; up to annual maximum benefit |

***If you use a non-network, non-participating provider, you may be "balance billed" by your dentist for any charges above Cigna's contracted PPO fee schedule.**

## 2017 CIGNA Dental Plan Monthly Premiums

| | CIGNA DHMO | CIGNA PPO Low | CIGNA PPO High |
|---|---|---|---|
| **Member only** | $34.84 | $39.46 | $51.58 |
| **Member + 1 dependent** | $70.08 | $78.19 | $102.43 |
| **Member + 2 or more dependents** | $105.26 | $120.78 | $158.36 |

# 2017 Denver Employees Retirement Plan
# Delta Dental Plan Summary

| | Delta EPO | Delta PPO Low | | Delta PPO High | |
|---|---|---|---|---|---|
| **Annual Deductible** | | | | | |
| **Single** | N/A | $25 | $25 | $25 | $25 |
| **Family** | N/A | $75 | $75 | $75 | $75 |
| **Annual Maximum Benefit** | N/A | $1,250 | $1,250 | $2,000 | $2,000 |
| **Covered Providers** | **Delta Dental PPO Network-Colorado Residents Only** | **Delta Dental PPO Network-Nationwide** | **Delta Dental Premier Network-Nationwide** | **Delta Dental PPO Network-Nationwide** | **Delta Dental Premier Network-Nationwide** |
| **Diagnostic & Preventive** | $0 to $10 copay | No charge after deductible | 20% after deductible; up to annual maximum benefit | No charge after deductible | No charge after deductible |
| **Restorative (Fillings)** | $21 to $73 copay | 20% after deductible; up to annual maximum benefit | 50% after deductible; up to annual maximum benefit | 10% after deductible; up to annual maximum benefit | 20% after deductible; up to annual maximum benefit |
| **Crowns & Bridges** | $0 to $295 copay | 50% after deductible; up to annual maximum benefit | 50% after deductible; up to annual maximum benefit | 40% after deductible; up to annual maximum benefit | 50% after deductible; up to annual maximum benefit |
| **Endodontics (Root Canals)** | $10 to $297 copay | 20% after deductible; up to annual maximum benefit | 50% after deductible; up to annual maximum benefit | 10% after deductible; up to annual maximum benefit | 20% after deductible; up to annual maximum benefit |
| **Periodontics (Gum Treatment)** | $23 to $284 copay | 20% after deductible; up to annual maximum benefit | 50% after deductible; up to annual maximum benefit | 10% after deductible; up to annual maximum benefit | 20% after deductible; up to annual maximum benefit |
| **Prosthetics (Dentures)** | $16 to $377 copay | 50% after deductible; up to annual maximum benefit | 50% after deductible; up to annual maximum benefit | 40% after deductible; up to annual maximum benefit | 50% after deductible; up to annual maximum benefit |
| **Oral Surgery (Extractions)** | $22 to $100 copay | 20% after deductible; up to annual maximum benefit | 50% after deductible; up to annual maximum benefit | 10% after deductible; up to annual maximum benefit | 20% after deductible; up to annual maximum benefit |
| **Orthodontics (Braces)** | $35 to $1,980 copay | 50%; no deductible; $1,000 lifetime maximum benefit | | 50%; no deductible; $1,000 lifetime maximum benefit | |
| **Anesthetics** | $8 to $56 copay | No charge after deductible | 20% after deductible; up to annual maximum benefit | No charge after deductible | No charge after deductible |
| **Implants** | not covered | 50% after deductible; up to annual maximum of $1,000 | 50% after deductible; up to annual maximum of $1,000 | 40% after deductible; up to annual maximum of $1,000 | 50% after deductible; up to annual maximum of $1,000 |

**NOTE: If you use a non-participating dentist (one that is not a Delta PPO or a Premier dentist), then payment is based on the the non-participating Maximum Plan Allowance (MPA). Members are responsible for the difference between the non-participating MPA and the full fee charged by the dentist. You will receive the best benefit by choosing a PPO dentist.**

## 2017 Delta Dental Plan Monthly Premiums

| | Delta EPO | Delta PPO Low | Delta PPO High |
|---|---|---|---|
| **Member only** | $49.87 | $43.25 | $58.01 |
| **Member + 1 dependent** | $92.61 | $85.49 | $112.96 |
| **Member + 2 or more dependents** | $149.60 | $132.30 | $179.12 |

# 2017 Denver Employees Retirement Plan
# Vision Plan Summary

| | VSP | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **Comprehensive Exam** | | |
| **Optometrist (OD)** | Covered in full after $10 copay | $45 allowance |
| ***One exam per 12 months*** | | |
| **Standard Lenses (Per Pair)** | | |
| **Single Vision** | Covered in full after $25 copay | $30 allowance |
| **Bifocals** | Covered in full after $25 copay | $50 allowance |
| **Trifocals** | Covered in full after $25 copay | $65 allowance |
| ***One pair of lenses per 12 months*** | | |
| **Contact Lenses (Per Pair)** | | |
| **Medically Necessary** | Covered in full | $210 allowance |
| **Elective - (Cosmetic)** | $160 allowance | $145 allowance |
| **Standard Contact Lens Fitting Fee** | Up to $60 copay | Not Covered |
| **Frames-Standard** | $160 allowance | $70 allowance |
| ***One pair of frames per 24 months*** | | |
| | ***NOTE: Contact lenses are in lieu of eyeglass lenses and frames benefit.*** | |

## 2017 Vision Plan Monthly Premiums

| | VSP |
|---|---|
| **Member only** | $4.97 |
| **Member and Spouse** | $10.12 |
| **Member and Child(ren)** | $9.33 |
| **Member and Family** | $17.05 |

# 2017 Denver Employees Retirement Plan
# Insurance Premium Reduction

**The *Insurance Premium Reduction Benefit* is a benefit in which the Denver Employees Retirement Plan contributes a portion of a member's monthly insurance premium, provided the member is enrolled in a group insurance offered by DERP. The monthly amount DERP contributes toward insurance is established by the Retirement Board based on credited service with the City/DHHA.**

**Effective January 1, 2017, the Plan will continue a monthly contribution of $6.25 for each year of credited service for Medicare-eligible members, and $12.50 monthly for each year of credited service for members who are not yet Medicare-eligible.**

**Surviving spouses and dependents who continue insurance coverage, but do not receive a monthly benefit from the Plan, must pay the full monthly premium. Persons in this category, or those whose retirement benefits are not large enough to pay their portion of the insurance premium, are required to have any remaining premiums automatically deducted from a checking or savings account.**

***Please note:*** **The medical, dental and vision benefits contained in this brochure are a summary of benefits. For more detailed information, please contact DERP Membership Services and ask for an enrollment packet for your preferred insurance options.**

# 2017 Denver Employees Retirement Plan
# Kaiser Multi-Site Plan Monthly Premiums
# Non-Medicare Plans

| | Northern California | Southern California | Hawaii |
|---|---|---|---|
| Member only | $778.07 | $778.07 | $801.02 |
| Member + 1 dependent | $1,556.14 | $1,556.14 | $1,602.04 |
| Member + 2 or more dependents | $2,201.94 | $2,201.94 | $2,403.06 |

| | Mid-Atlantic States | NW Oregon/SW Washington |
|---|---|---|
| Member only | $792.00 | $705.08 |
| Member + 1 dependent | $1,639.00 | $1,410.16 |
| Member + 2 or more dependents | $2,281.00 | $2,115.24 |

# 2017 Denver Employees Retirement Plan
# Kaiser Multi-Site Plan Monthly Premiums
# Medicare Plans

| | Northern California | Southern California | Hawaii |
|---|---|---|---|
| Per Person | $269.11 | $269.11 | $364.03 |

| | Mid-Atlantic States | NW Oregon/SW Washington |
|---|---|---|
| Per Person | $266.53 | $287.79 |

***Please contact DERP Membership Services if you are interested in one of the Kaiser Multi-Site plans.***