

Medicare and the State Retiree Health Benefits Program

What is Medicare?

Medicare is the federal government health insurance program for:

- Most people turning age 65
- Some people under age 65 who have a disability
- People with End-Stage Renal Disease who need dialysis or a transplant

Medicare covers a wide variety of medical services provided by hospitals, doctors and certain other facilities and health professionals. On January 1, 2006, Medicare added an outpatient prescription drug benefit. Visit your local Social Security office for more information about Medicare eligibility and benefits. Information is also available on the Medicare Web site at www.medicare.gov or by calling 1-800-MEDICARE.

What is Advantage 65?

Under the State Retiree Health Benefits Program, there are several options available to new Medicare-eligible retiree group members and their Medicare-eligible covered dependents or current retiree group members and their covered dependents who are newly eligible for Medicare. (Along with retirees, the “retiree group” includes Long-Term Disability participants and Survivors.) These plan options will be referred to as the **Advantage 65 Plans** and include:

- **Advantage 65** – A Medicare supplemental plan that pays secondary to Medicare and covers most Medicare coinsurance/co-payments for covered services. Generally, Advantage 65 will not pay for services that are not covered by Medicare unless specifically indicated in the Member Handbook. Advantage 65 also includes an enhanced Medicare Part D benefit for outpatient prescription drug coverage, contingent upon approval of enrollment by Medicare.
- **Advantage 65 with Dental/Vision** – Adds coverage for certain basic dental and routine vision services to the Advantage 65 coverage described above. However, it does not include coverage for prosthetic and complex restorative dental services.

- **Advantage 65—Medical Only** – Provides the same medical benefits as the Advantage 65 Plan described above but **does not include outpatient prescription drug coverage**. If this plan is elected, outpatient prescription drug coverage should be obtained through a non-state-sponsored Medicare Part D plan or other creditable coverage such as Tricare, Veterans Benefits or coverage through a spouse’s active employment. Upon eligibility for Part D coverage, failure to enroll or to have other creditable coverage for a period of 63 or more days may result in a higher Part D premium if enrolling at a later date.
- **Advantage 65—Medical Only + Dental/Vision** – Adds coverage for certain basic dental and routine vision services to the Advantage 65—Medical Only coverage described above. However, it does not include coverage for prosthetic and complex restorative dental services.

The *Medicare Plan Options Brochure* provides a summary of the Advantage 65 Plans’ benefits, including coordination with Medicare. You may review this brochure by going to:

<http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html>

and clicking on “Plan Summary of Benefits” or you may request a copy from your Benefits Administrator.

Following is a basic overview:

Brief Summary of Advantage 65 Benefits*

	<i>Medicare Pays (2008)</i>	<i>Advantage 65 Pays</i>
Hospital Inpatient (Part A)	All but \$1,024 for days 1--60 All but \$256 per day for days 61--90 All but \$512 per day for 60 Lifetime Reserve Days \$0 for any additional days	Part A Deductible/Copayment except first \$100 up to 90 days 100% of the Allowable Charge for days 91--120 Part A Copayment for Lifetime Reserve Days
Physician and Other Services (Part B)	Generally 80% of Medicare-Approved Amount after \$135 Deductible	Part B Coinsurance, but not Deductible
Outpatient Prescription Drug (Part D)	Basic or enhanced benefit, if enrolled	Enhanced Part D plan (<i>if Medical Only Plan selected, no outpatient prescription drug benefit*</i>)
Dental Benefits	\$0	Optional Benefit
Routine Vision Benefits	\$0	Optional Benefit

*Medical (and Dental/Vision, if elected) benefits are the same under the Advantage 65 Plans and the Advantage 65-Medical Only Plans.

How does the State Retiree Health Benefits Program coordinate with Medicare?

- If you choose to maintain coverage under the State Retiree Health Benefits Program when you and/or your covered dependents become eligible for Medicare, you must enroll in Medicare Parts A and B to receive supplemental medical benefits under any of the Advantage 65 Plans. (Optional dental and routine vision benefits, if elected, do not coordinate with Medicare since Medicare generally does not pay any level of benefits for those services.)
- If you are eligible for Medicare, the Advantage 65 Plans will generally only pay your medical claims after Medicare pays its benefit. Medicare is primary (it pays first) and Advantage 65 is secondary (it pays the supplemental benefit). Enrollment in Medicare Part A is usually automatic for participants who are not working or not covered due to a working spouse, and there is usually no cost to the participant. However, if you do not enroll in or you decline Medicare Part B, valuable benefits may be lost because the state plan will not pay for medical services that should have been covered by Medicare, regardless of whether you have exercised your right to enroll. It is the retiree group participant's responsibility to ensure enrollment in Medicare Parts A and B immediately upon eligibility. If you are eligible for Medicare at the time of retirement (or start of long-term disability), you must notify the Social Security Administration of your change in employment status so that it will properly coordinate your Medicare benefits. Medicare will become your primary coverage (with limited exceptions) upon your termination of active employment. This also includes your Medicare-eligible dependents' coverage that is based on your current employment.
- If you elect the Advantage 65 or Advantage 65 + Dental/Vision Plans, you will be submitted for enrollment in the enhanced Medicare Part D (outpatient prescription drugs) plan that is a part of that coverage, and your premium will include that coverage. However, the enrollment must be approved by Medicare. The state is unable to override a denial of coverage by Medicare, so if Medicare denies your state Medicare Part D plan enrollment, or disenrolls you at any time, you will be moved to a Medical-Only plan, and your premium will be adjusted accordingly. To facilitate a successful enrollment in the state program's Medicare Part D plan, be sure to carefully complete your enrollment form to include the information that appears on your red, white and blue Medicare ID card. Failure of the state plan's submission to match the information at Medicare will often result in denial of coverage. Be sure to confirm your current Medicare Claim Number (on your Medicare ID card) and include it in the designated section of your enrollment form. If you enroll in a Medicare Part D plan outside of the state-sponsored coverage, you may not maintain the state's Part D coverage.
- If you elect the Advantage 65—Medical Only or Advantage 65—Medical Only + Dental/Vision Plans, you will not have any outpatient prescription drug

coverage under the state program. If you do elect one of those two plans, you are encouraged to seek other, non-state-sponsored Medicare Part D coverage or other creditable coverage to ensure that you do not have to pay a higher premium for Part D coverage when you do enroll.

- If you enroll in one of the Medical-Only Plans, you may not elect state-sponsored coverage that includes outpatient prescription drug/Part D benefits at a later time.

How do I Enroll in Medicare and Advantage 65?

Three months before any retiree group enrollee or covered dependent becomes eligible for Medicare, take the following steps:

Medicare Enrollment

- Visit your local Social Security office or call 1-800-772-1213 for information about enrolling in the Original Medicare Plan. As a Medicare-eligible retiree group participant, you must be sure that Medicare coverage is effective immediately upon eligibility (or immediately upon retirement or start of LTD coverage if you are eligible for Medicare prior to or upon that date). If you are already eligible for Medicare at the time of retirement or start of LTD, be sure to advise the Social Security Administration (1-800-772-1213) and Medicare (1-800-MEDICARE) of the date that your coverage as an active employee will end so that your coverage as a retiree group participant will be correctly coordinated. Failure to notify Social Security of your change in employment status could result in a gap in your supplemental coverage. You may direct any coordination of Medicare benefits problems to the Medicare Coordination of Benefits Contractor at 1-800-999-1118.
- Be sure to carefully coordinate your enrollment in Medicare Parts A and B with enrollment in the State Retiree Health Benefits Program's Advantage 65 Plans so that coverage starts at the same time. Your Medicare Initial Enrollment Period (IEP) lasts for seven months (starting three months before your eligibility month); however, waiting until the last four months of your IEP may result in a waiting period for coverage to begin in Medicare Part B. Be sure that you discuss your enrollment responsibilities with the Social Security Administration so that you do not miss your opportunity to enroll.
- You may get your Medicare Part D prescription drug coverage through the state program by electing the Advantage 65 or Advantage 65 + Dental/Vision Plan (contingent upon approval by Medicare). If your enrollment in the state's Part D plan is denied by Medicare, you will be moved to a Medical-Only plan, and your premium will be adjusted accordingly. The state program cannot override a denial by Medicare. If you elect the Advantage 65—Medical Only or Advantage 65—Medical Only + Dental/Vision Plan, you will not have outpatient prescription drug coverage under the state program and should

consider other options. If you enroll in a non-state-sponsored Medicare Part D plan, you will be disenrolled from the state's plan and may not return to that coverage at a later date.

- **Medicare and You**, a helpful guide to Medicare coverage, and other subject-specific Medicare publications are available by calling 1-800-MEDICARE or by visiting the Medicare Web site at www.medicare.gov.
- If you enroll in a Medicare Advantage Plan, including Medicare Private Fee-For-Service Plans, HMOs, PPOs and Special Needs Plans (instead of the Original Medicare Plan), no Advantage 65 Plan will pay for services received through those plans. If you leave the state program to enroll in any other Medicare supplemental coverage, you may not return to the state program.

Advantage 65 Enrollment

- New retiree group participants are required to enroll within 31 days of their retirement date (or loss of active coverage due to start of LTD). However, early application for coverage will facilitate a smooth transition from active to retiree group coverage. All retiree group participants and their covered dependents who are eligible for Medicare must select one of the Advantage 65 Plans to ensure coordination with Medicare. If you are electing an Advantage 65 Plan that includes outpatient prescription drug coverage, your enrollment must be approved by Medicare (see "Medicare Enrollment" above).
- Enrollment in Advantage 65 is automatic if:
 - you are already enrolled in the State Retiree Health Benefits Program when you (or a covered dependent) become eligible for Medicare at age 65; and,
 - you do not decline Advantage 65 coverage or leave the program.
- If you are enrolled in the State Retiree Health Benefits Program, you will receive notification of the effective date for your Advantage 65 coverage before your 65th birthday month. You will also receive information regarding your other options, including declining coverage and electing a medical-only plan. If you do not decline coverage or make another plan choice, you will automatically receive your Advantage 65 ID card. If Medicare approves your enrollment, you will receive your prescription drug card. If your state-sponsored Medicare Part D coverage is denied by Medicare, you will be moved to medical-only coverage, and your premium will be adjusted to reflect that plan change.
- If you or any covered retiree group dependents become eligible for Medicare before age 65 and wish to continue coverage under the State Retiree Health Benefits Program:

- Enroll in Medicare-coordinating coverage by submitting an Enrollment Form prior to your Medicare eligibility date to the appropriate recipient listed on page 9.
- It is your responsibility to notify VRS, or the Benefits Administrator who administers your eligibility, if you become eligible for Medicare prior to turning age 65. **Failure to do so will result in retraction of primary payments made in error** (when Medicare should have been the primary payer) **and a gap in your coverage until you can enroll in Medicare Parts B and D. You may also lose your opportunity to enroll in the state's Part D plan.**
- You can obtain a Retiree Enrollment Form from the Virginia Retirement System by calling 1-888-827-3847 or by going to the VRS Web site at www.varetire.org. Forms are also available at the Department of Human Resource Management Web site at www.dhrm.virginia.gov.
- Once you have enrolled in or defaulted to coverage under the Advantage 65 Plan, you will receive a new ID card for your medical coverage from Anthem Blue Cross and Blue Shield and for your outpatient prescription drug coverage from Medco (if your enrollment is approved by Medicare). However, if you elect one of the medical-only plans, you will receive only an Anthem card since you will not have outpatient prescription drug coverage through the state program.
- Your behavioral health supplementary coverage will be administered by Anthem. If you elect dental and vision coverage, those benefits will also be administered by Anthem. You will not have benefits administered by Delta Dental or ValueOptions under any Advantage 65 plan.

What are the consequences if I don't enroll in Medicare when I become eligible?

As a retiree, survivor or LTD participant (or covered dependent in the retiree group), you are no longer covered by virtue of current employment. Therefore, per Medicare Secondary Payer Guidelines*, Medicare becomes your primary coverage. An important provision of the State Retiree Health Benefits Program requires that participants enroll in a Medicare-coordinating plan immediately upon ELIGIBILITY for Medicare if they wish to maintain state program participation. If it is determined that a retiree group participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in Medicare-primary status immediately. In addition, primary payments made in error by the state program will be retracted back to either the Medicare claim filing limit, the date of Medicare eligibility or the date that retiree group coverage began, whichever is later. It will then be the responsibility of the participant to arrange for submission of retracted claims to Medicare. If participants have declined their Medicare Part B coverage, it could result in a

delay in Part B enrollment, a higher Part B premium, and a critical gap in coverage until Part B goes into effect. The state plan will not pay any claims that should have been paid by Medicare had the participant properly enrolled in Medicare coverage. In addition, failure to enroll in Medicare Part D upon initial eligibility could also result in a delay in drug coverage, a higher Part D premium, a gap in coverage and the loss of eligibility for state-sponsored prescription drug coverage.

*Some exceptions exist when eligibility for Medicare is due to End Stage Renal Disease. See your Benefits Administrator or contact Medicare for more information.

I was covered by COVA Care immediately before Medicare eligibility. Will my claims administrators remain the same under the Advantage 65 Plans?

When moving from COVA Care to any of the Advantage 65 Plans, you will experience some change in your claims administration.

- Your medical claims should be submitted first to Medicare for primary coverage and then submitted to Anthem for secondary coverage. This includes any claims for behavioral health. (ValueOptions will no longer administer your behavioral health claims.) In most cases (except as specifically designated in your Member Handbook), claims denied by Medicare will not be eligible for any benefit.
- If you enroll in dental and vision coverage, your claims should be submitted directly to Anthem since dental and routine vision services are generally not covered by Medicare. (Delta Dental will no longer administer your dental claims.) Dental coverage that is available through any Advantage 65 plan is equivalent to the basic dental coverage under the COVA Care Plan and does not include coverage for prosthetic or complex restorative services.
- If you elect the Advantage 65 or the Advantage 65 + Dental/Vision Plans, your outpatient prescription drug coverage will be administered by Medco. However, enrollment in this enhanced Medicare Part D plan must be approved by Medicare (see “Medicare Enrollment”).
- If you enroll in the Advantage 65—Medical Only Plan or the Advantage 65—Medical Only + Dental/Vision Plan, you will no longer have outpatient prescription drug coverage through the state program, and you will not have the opportunity to add this coverage again in the future. Under those circumstances, you are encouraged to enroll in a non-state-sponsored Part D plan or other creditable coverage to avoid a higher Part D premium if you enroll in Part D at a later date.

I am covering my entire family. Can I continue to cover non-Medicare-eligible family members after I become eligible for Medicare?

In the retiree group, all plan choices are based on Medicare eligibility. For example, if two family members are covered and one is eligible for Medicare and one is not, the Medicare-eligible family member must choose a Medicare-coordinating plan and the non-Medicare-eligible member must choose a non-Medicare plan. However, no family group will be required to pay more than the family membership premium level for the COVA Care Plan in which the non-Medicare-eligible family members are enrolled.

Be sure to review the ***Eligibility, Enrollment and Plan Choices, Fact Sheet # 2***, for more information on plans and enrollment guidelines.

If I live or travel outside of the United States, will I have coverage under any of the Advantage 65 Plans?

The Advantage 65 Plans provide an out-of-country major medical benefit. Please see your Medicare-Coordinating Plans Member Handbook for more information. However, participants who live abroad are not eligible for Medicare Part D since they do not reside in a Part D service area and, therefore, are restricted to coverage under the Advantage 65—Medical Only plans.

The Original Medicare Plan generally does not cover health care while you are outside of the United States. (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States.) There are some rare exceptions that provide coverage for inpatient hospital services that are received in Canada or Mexico. Contact 1-800-MEDICARE for more information.

What is the Premium Cost for the Advantage 65 Plans?

All Medicare-coordinating plan memberships are single; that is, every participant has his or her own single membership and ID number. Following are the premium rates for January 1—December 31, 2008.

Plan	2007 Monthly Premium
Advantage 65	\$277
Advantage 65 + Dental/Vision	\$308
Advantage 65—Medical Only	\$126
Advantage 65—Medical Only + Dental/Vision	\$157

What are Options I and II?

Options I and II (Medicare Complementary and Medicare Supplemental) are Medicare supplemental plans that have been replaced by the Advantage 65 Plans. Only existing participants may maintain coverage in these two plans. Option I and Option II

participants have the same prescription coverage as participants in the Advantage 65 and Advantage 65 with Dental/Vision plans. Option I and Option II participants who wish to get prescription drug coverage outside of the state program may elect the Advantage 65—Medical Only Plans, thereby maintaining only their medical supplemental coverage (and dental/vision if applicable) through the state program. There is no medical-only coverage available under Option I or Option II. If any Option I or Option II member is disenrolled from the state-sponsored Medicare Part D plan, he or she will be moved to an Advantage 65—Medical Only Plan.

If I Need to Enroll in Advantage 65 or Make any Allowable Change, Where Do I Send My Enrollment Form?

If You Are:	Send Completed Form To:
A New Retiree, New Survivor of a State employee, or New LTD participant	Your Former Agency Benefits Administrator
A Current VRS Retiree, Current Survivor or Current VSDP LTD participant	Virginia Retirement System P. O. Box 2500 Richmond, VA 23219-2500
A Non-Annuitant Survivor (not receiving a VRS survivor annuity)	Department of Human Resource Management - OHB 101 N. 14 th Street, 13 th floor Richmond, VA 23219
All Other Retirees (e.g., ORP or Local Retirees)	Your Pre-Retirement Agency Benefits Administrator

Suggested Attachment:

Medicare Plan Options Brochure

(available at www.dhrm.virginia.gov/hbenefits/retiree.html or from your Benefits Administrator)