

The State Retiree Health Benefits Program

The Retiree Group

Participants in this program (the retiree group) include retirees, survivors, long-term disability participants (referred to as Enrollees) and their eligible covered family members. In general, these are former employees and their family members who are covered based on that former (not current) employment. Coverage based on former employment is an important distinction that will be discussed later in this section as it relates to coordination of benefits with Medicare.

Specifically, the retiree group includes:

Type of Participant*	Agency No.	Group
VRS Service Retiree	005	001
VRS Disability Retiree	005	002
Optional Retirement Plan Retiree	007	008
Local Retirees	007	007
Annuitant Survivors of Service Retirees	005	001
Annuitant Survivors of Disability Retirees	005	002
Non-Annuitant Survivors	006	006
VSDP LTD Participants	005	004
Other LTD Participants	007	004

*Also includes their eligible family members

Retiree group participants' Agency Number defines their Benefits Administrator. Retiree group Enrollees should be directed to their appropriate Benefits Administrator for assistance as follows:

- Agency 005 = Benefits Administrator is the Virginia Retirement System
- Agency 006 = Benefits Administrator is the Department of Human Resource Management's Office of Health Benefits
- Agency 007 = Benefits Administrator is their Pre-Retirement Agency

This Section of the HBP Administrative Manual Includes:

This section of the Health Benefits Program (HBP) Administration Manual generally discusses retiree coverage. Many policies for retirees also apply to survivors and LTD participants. Refer to the following sections for additional enrollee-specific information:

- Survivor Coverage
- Long-Term Disability (LTD) – Virginia Sickness and Disability Plan and Other LTD Programs

These sections are available at:

<http://www.dhrm.virginia.gov/hbenefits/HPBAdminManual/hbpadminmanualtransitionmatrix.html>

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Eligibility for Retiree Coverage

VRS Retirees (not including Optional Retirement Plan (ORP) Participants):

To enroll in the State Retiree Health Benefits Program, certain eligibility criteria must be met. The retiree must:

- Be a retiring state employee who is eligible for a monthly retirement benefit from the Virginia Retirement System (VRS), **and**
- Start receiving (do not defer) his/her retirement benefit immediately upon retirement*, **and**
- Be employed by the state until retirement (full-time or part-time as long as there is eligibility for immediate retirement), **and**
- Be eligible for (even if he/she were not enrolled) coverage as an active employee in the State Health Benefits Program until his/her retirement date (not including Extended Coverage/COBRA), **and**
- Enroll within 31 days of the retirement date.

*For VRS retirees, this also means that your employing agency reported a retirement contribution or leave without pay status for retirement in the month immediately prior to your retirement date. Some faculty members may also be eligible if they are paid on an alternate pay cycle but maintain eligibility for active coverage until their retirement date.

Optional Retirement Plan (ORP) Participants:

Effective January 01, 2017, ORP participants must meet the following requirements to be eligible for enrollment in the State Retiree Health Benefits Program**. The ORP Retiree must:

- Be a terminating state employee who participates in one of the qualified Optional Retirement Plans; **and**
- Be employed by the Commonwealth of Virginia until termination; **and**
- Be eligible for (even if he/she were not enrolled) coverage in the State Employee Health Benefits Program for active employees at the time of his/her termination; **and**
- Meet the age and service requirements for an immediate retirement benefit under the non-ORP Virginia Retirement System plan that he/she would have been eligible for on his/her date of hire had he/she not elected the ORP; **and**
- Enroll in the State Retiree Health Benefits Program no later than 31 days from the date he/she lose coverage (or lose eligibility for coverage) in the State Health Benefits Program for active employees due to his/her termination of employment.

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*This change applies to ORP terminations effective January 1, 2017, or later. Eligibility for those who terminated employment prior to January 1 should be determined based on the policy in place at the time of their termination.

NOTE: References to retirement below will also apply to terminating ORP participants who meet the above requirements for enrollment in the State Retiree Health Benefits Program.

The only exceptions which allow for enrollment after 31 days from your retirement date are:

- State retirees who properly waive retiree coverage within 31 days of their retirement date to enroll as an eligible family member on their spouse's active employee or retiree state health benefits membership may enroll in the retiree group within 31 days of the loss of that coverage. Failure of the retiree to submit a waiver at the time of retirement may result in lack of documentation to support continuous eligibility for the state program, which could preclude future retiree enrollment. To waive coverage, submit an enrollment form indicating the waiver. To ensure continuous coverage, the retiree should enroll in the spouse's plan in time to generate an effective date equal to his/her retirement date.
- Certain involuntarily-terminated state employees with at least 20 years of creditable service who defer retirement may enroll at a later date.
- Under certain circumstances, retroactive approval of a disability retirement may allow for enrollment within 31 days of the approval notification letter.

Enrollment

New retirees can enroll by submitting a *State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants* to their Benefits Administrator within 31 days of their retirement date. This should be keyed into the retiree group in BES by the employing agency. Benefits Administrators should also encourage eligible new retirees who do not wish to enroll in retiree coverage to complete this form to confirm that they have declined coverage, which will avoid potential conflicts later. However, failure to enroll within the 31-day window effectively ends eligibility for enrollment in the retiree group.

A Retiree Fact Sheet entitled *Planning for Retirement – State Retiree Health Benefits Program Coverage Options* is available at the link below and includes useful information for employees interested in health benefits available at retirement. There are also other subject-specific fact sheets available to address retiree-related issues.

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

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Effective Date of Coverage

If it is determined that a retiree is eligible, and enrollment occurs within 31 days of the retirement date, retiree coverage will begin on the first day of the first full month of retirement—no break in coverage (or eligibility for coverage). Enrollment in retiree coverage is not prospective to the date of enrollment.

Generally, No Retroactive Changes to Retirement Elections

Elections for retiree coverage may not be changed after the coverage is in effect. This means that, even though eligible retiring employees have 31 days from their retirement date to elect coverage, if they elect prior to the retirement date and the coverage goes into effect (including declining coverage), it may not be changed retroactively, even if it is within the 31 days after retirement. Elections made prior to the retirement date may be changed until the coverage goes into effect. When assisting retiring employees in advance of their retirement date, remind them to ensure that their election is accurate prior to its effective date.

Elections can be changed prospectively due to consistent qualifying mid-year events, at open enrollment (non-Medicare only), or based on law or specific policy. Certain HIPAA special enrollments can be effective retroactively.

Extended Coverage

If an employee retires and loses active health plan coverage, he/she must be offered Extended Coverage/COBRA since retirement is a termination of employment, and loss of the employer contribution toward the cost of coverage is a change in the terms and conditions of coverage and, therefore, a loss of coverage. While it is generally, but not always, beneficial to elect retiree coverage instead of Extended Coverage (due to additional Extended Coverage administrative cost and a finite coverage period), offer of retiree coverage does not relieve the requirement to offer Extended Coverage. Failure to offer Extended Coverage under these circumstances can result in significant liability to the program.

Family Member Eligibility

Eligibility criteria for spouses and children of retirees are the same as those for active employees. See section “*Survivor Coverage*” for more information about family members’ coverage after a retiree’s death.

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Retiring from Leave Without Pay

To avoid deferred retirement status and loss of eligibility for retiree coverage, employees who retire while on a Leave Without Pay must continue to be reported to VRS up until the time of retirement.

Retiring from Military Leave Without Pay

Employees on approved Military Leave Without Pay who are eligible for and elect to take an immediate service retirement (not deferred) from the Virginia Retirement System (or who meet the age and service requirements for an immediate benefit under the non-ORP Virginia Retirement System plan that he/she would have been eligible for on his/her date of hire had he/she not elected the ORP) may enroll in the State Retiree Health Benefits Program within 60 days of their retirement date, regardless of whether they actively returned to work at the end of the leave. Retiring employees must have been eligible for coverage under the State Health Benefits Program prior to the start of their leave. Enrollees must be otherwise eligible for the retiree program and adhere to all program provisions after enrollment. Medicare-eligible retirees must select a plan that coordinates with Medicare. If enrollment is not completed within 60 days of the retirement date, there will be no future opportunity to enroll. If eligible and properly enrolled, the effective date of retiree coverage will be equal to the retirement date.

Local Retirees

Based on contract or legislative provisions, some retirees are eligible for coverage in the State Retiree Health Benefits Program even though they are covered under a locality's retirement program. Those covered under these special provisions are identified in BES (agency 007, group 007) and continue to be administered by their employing entity after retirement.

Plan Choices

Retiree plan choices are dependent on whether the retiree and/or his/her covered family members are eligible for Medicare. Non-Medicare retirees/family members may choose from the same plans as those offered to active employees, including the TRICARE supplement (see special rules regarding this coverage later in this section).

Medicare-eligible retirees/family members must choose a plan that coordinates with Medicare. Those include:

- Advantage 65 – a Medicare supplement plan that includes a Medicare Part D prescription drug benefit but not routine dental and vision coverage.

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- Advantage 65 with Dental/Vision – the same Medicare supplement plan described above, including Medicare Part D, with the addition of routine dental and vision benefits.
- Advantage 65 Medical Only – the same Advantage 65 Medicare supplement plan benefits, but with no outpatient prescription drug coverage
- Advantage 65 Medical Only with Dental/Vision – adds routine dental and vision benefits to the Advantage 65 Medical Only Plan

The Medicare-Coordinating Plans Member Handbook, along with the inserts for Outpatient Prescription Drug Coverage and Dental/Vision Coverage, describes the specific benefits of these plans.

Initial Enrollment Limitations

- Except as specifically allowed, if an enrollment form is not submitted to the designated Benefits Administrator within 31 days of the non-deferred retirement date, the opportunity to enroll in the retiree program is lost.
- Once an enrollment has gone into effect (including declining coverage), there can be no change to that enrollment, except as specifically allowed by the program, even if it is within the initial 31-day enrollment window.
- If initial enrollment is in an Advantage 65 Medical Only Plan, enrollment in the state program's Medicare Part D plan will not be an option at a later date. (This also applies to any termination of the Part D plan.)
- Enrollment in the Advantage 65 plan's dental/vision option is allowed one time. Once an enrollment and disenrollment has occurred, there may not be any additional enrollment in the dental/vision option.

Option II (Medicare Supplemental) Plan

This plan was replaced by the Advantage 65 plans. Only current enrollees may elect this plan. New retiree group participants or newly Medicare-eligible existing retiree group participants may not elect this plan. However, existing participants may make the following plan change prospectively at any time:

- They may elect any Advantage 65 Plan, but once they have discontinued participation in Option II, they may not return to that plan at a later date.

The Medicare-Coordinating Plans Member Handbook includes specific benefits under Option II. The dental and vision benefits are the same under this plan and are optional benefits.

Changes Allowed at Retirement

New eligible retirees may maintain their existing plan (unless they or their covered family members are eligible for Medicare) and/or membership or make the following changes:

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- Decrease membership (no increase unless there is a consistent qualifying mid-year event that would allow the addition)
- Enroll from active waive into single coverage
- Change plans
- Waive to be covered as a family member in the state program (until Medicare eligibility results in a split contract)
- Decline coverage (no return to the program)

Required Change at Retirement

If any new retiree group participant (enrollee or covered family member) is eligible for Medicare, he/she must select a plan that coordinates with Medicare, and Medicare becomes the primary payer (except in limited circumstances where the beneficiary is eligible due to End Stage Renal Disease and is still in the coordination period). Medicare will adjudicate all primary claims for Medicare-covered services. (If the dental/vision option is elected, the state plan will remain primary for those services since Medicare does not generally cover routine dental and vision.) More information about Medicare is provided later in this section.

Waiving Coverage at Retirement

Generally, failure to enroll in retiree coverage within 31 days of the retirement date will result in loss of eligibility for the retiree program. However, new retirees who are eligible to be covered as a family member under the active employee plan or through the membership of another retiree can waive coverage, thereby maintaining his/her own eligibility. This allows two state program enrollees to get the benefit of dual or family membership instead of the additional cost associated with two single memberships, a single and a dual, etc. When family member eligibility is lost, the retiree may re-enroll in the retiree program in his/her own right only within 31 days of the loss of that status with no break in state program coverage.

When a retiree becomes eligible for Medicare, he or she will be moved back to his or her own membership since all Medicare memberships are single and, therefore, there is no premium benefit to maintaining family member status. Also, BES will not accommodate two participant records, so there can't be a linked record and a waive record in BES. If the linked record is established, the waive record will be lost along with the continuous eligibility trail.

Be sure to get an enrollment form requesting the waiver within 31 days of the retirement date and establish the waive record in BES.

When moving a retiree from family member to retiree status in his/her own right, be sure to confirm continuous program enrollment. A break in coverage will result in loss of eligibility to enroll in the retiree program.

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Changes Allowed After Enrollment in the Retiree Group

- Membership can be cancelled at any time prospectively—no return to the program.
- Membership can be reduced (family members dropped) at any time prospectively.
- Eligible family members can be added based on consistent qualifying mid-year events, including HIPAA Special Enrollments, if the request is made within 60 days of the event.
- Eligible family members can be added at Open Enrollment by non-Medicare retiree group enrollees. (Medicare-eligible enrollees do not have an open enrollment except that they may make an open enrollment election to add eligible non-Medicare family members effective July 1 if their initial move to Medicare-primary coverage is also July 1. After that, there is no open enrollment available for making membership increases.)
- Medicare-eligible participants can terminate prescription drug coverage, but they may not re-enroll at a later date.
- Dental/Vision can be added one time prospectively, any time, but once it has been added and deleted, it may not be added again.
- Option II participants may move to an Advantage 65 Plan prospectively at any time. Once coverage in Option II has been terminated, that plan may not be elected again.

Retiree Group Participant Who Becomes Eligible for Coverage as an Active Employee

In most cases, retiree group participants who become eligible for coverage as active employees must leave the retiree program and enroll in active employee coverage. This will require completion of an enrollment form or the use of EmployeeDirect. For those eligible for Medicare, it will result in moving from a Medicare-coordinating plan to a non-Medicare plan. Some examples are listed below:

- **Retirees** enrolled in the State Retiree Health Benefits Program who return to work in a part-time classified position will be required to enroll in the active plan if they wish to continue coverage under the state program. This will result in a pre-tax benefit for those whose pay supports the full amount of their premium by payroll deduction. If the employee's part-time pay is not sufficient to cover the premium obligation, the premium will need to be paid directly to the agency payroll office. Those individuals who have been enrolled in a Medicare-coordinating plan based on their retiree coverage would be covered in a non-Medicare plan by virtue of their coverage as current, active employees. Under those circumstances, employees may wish to contact Medicare to discuss suspension of their Part B coverage. Upon retirement from the part-time classified position,

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re-enrollment in retiree coverage must be completed within 31 days of the loss of active coverage. At that time, all retiree eligibility criteria and retiree program provisions will again apply.

- ***Covered spouses** in the retiree group who are hired as part-time classified employees must enroll in the active plan in order to continue their state coverage. The retiree may choose to waive his/her retiree coverage to be covered as a family member under the active spouse's plan or may choose to remain in retiree coverage. Under these circumstances, retirees should review the benefits of active versus retiree coverage. If the spouse is hired as a full-time employee, eligibility for the employer contribution would suggest that coverage as a family member is generally to the retiree's advantage, and a waiver of retiree coverage would allow re-enrollment in the retiree group within 31 days of the loss of that coverage.
- ***Covered children** in the retiree group who are hired as full-time or part-time classified employees must enroll in the active plan in order to continue their state coverage. The only exception would be if the child were covered in a family contract of four or more family members, and dropping one family member would not decrease the family membership level. In that case, the employee would be allowed to waive coverage in the active group until his/her termination in the family membership would result in a lower retiree premium.
- **A retiree who has waived his/her own retiree coverage** to be a covered family member of his/her spouse who is also a state retiree and then resumes employment on a part-time classified basis may choose to be covered in his/her own right as a retiree or continue his/her waiver as a family member under the active spouse's coverage. Under these circumstances, retirees should review the benefits of active versus retiree coverage.
- **Survivors** covered under the State Retiree Health Benefits Program who accepts positions as full-time or part-time classified employees must terminate their retiree group coverage and enroll in the active employee plan. However, upon termination of employment, they will be allowed to re-enroll as survivors as long as they do so within 31 days of their loss of active coverage; have maintained continuous coverage in the state program; and, are otherwise eligible for coverage based on the eligibility provisions for annuitant or non-annuitant survivors, as applicable. If they accrue enough service to retire, and they meet all of the other eligibility requirements for retiree coverage, they may, of course, enroll in their own right as retirees.

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*Some exceptions may apply if enrollment in the active group results in a higher premium cost.

Retirees in Plans with Health Reimbursement Arrangements (HRA)

If an employee enrolled in the COVA HealthAware Plan retires and remains in that plan, any HRA balance existing at the time of retirement follows him/her into the retiree program, and future funding of the HRA will continue per plan provisions. However, if that employee enrolls in retiree coverage but chooses another plan at retirement, any HRA balance will be held for one year. If the employee/retiree does not re-enroll in the COVA HealthAware Plan within that period, any HRA balance will be lost. (This does not include any access created by the election of Extended Coverage.)

If a retiree in the COVA HealthAware Plan becomes eligible for Medicare and enrolls in the state program's Medicare-coordinating coverage, any available HRA balance may be used to pay for the new Medicare-coordinating plan's premium until exhausted; however, all funds must be exhausted within one year.

If a retiree leaves the program with a remaining HRA balance, the balance would be lost.

The Office of Health Benefits will monitor retiree participation in the COVA HealthAware Plan to ensure appropriate administration of any HRA funds.

Medicare and the State Retiree Health Benefits Program

Once a Medicare-eligible participant in the State Health Benefits Program ceases to be covered based on current employment (e.g., at retirement, survivorship, long-term disability), Medicare will be the primary payer of Medicare-covered claims, and a Medicare-coordinating plan must be chosen. These plans include:

Advantage 65 – a Medicare supplement plan that pays after Medicare's primary payment for Medicare-covered services. It includes an enhanced Medicare Part D prescription drug plan (subject to Medicare approval), and it also includes some additional benefits that are not covered by Medicare. These additional benefits are specifically explained in the Member Handbook and include out-of-country major medical benefits and at-home recovery care and visits.

Advantage 65 with Dental/Vision – the same Medicare supplemental coverage listed above, but also including routine dental and vision care. This is the default plan when the state identifies Medicare eligibility and the participant makes no plan election.

Advantage 65 Medical Only – the same Medicare supplemental coverage listed above, but no outpatient prescription drug coverage. Once enrolled in this plan,

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participants may not elect outpatient prescription drug coverage later under the state's Medicare-coordinating plans.

Advantage 65 Medical Only with Dental/Vision – adds routine dental and vision benefits to the Advantage 65 Medical Only Plan.

Medicare Supplemental – Option II – this Medicare supplement plan is no longer available to new retiree group participants or existing participants who are newly eligible for Medicare. Only existing enrollees may maintain coverage in this plan.

Specific plan benefits are described in the Medicare-Coordinating Plans Member Handbook and relevant inserts (Dental/Vision and Prescription Drugs). The Medicare Plan Options Brochure provides a good overview of how the state program's Medicare-coordinating plans work with Medicare. Handbooks and the Options brochure are available on the DHRM web site—see links at the end of this section.

A few more notes about Medicare-coordinating plans:

- These plans are not available to active employees or their eligible family members who are also eligible for Medicare (see “Medicare Benefits for Active Employees” section of this manual).
- Routine dental and vision coverage are not covered by Medicare, so any claims for these benefits should be filed directly with the plan's carrier for those who have elected this option.
- The dental benefits under the dental/vision option available to Medicare-eligible retiree group participants are not the same as those covered under the non-Medicare plan options. A description of these benefits is available in the Dental/Vision Medicare-Coordinating Plans Member Handbook Insert. A pre-treatment estimate is always advisable, especially for basic and major dental care.
- All Medicare-coordinating plan memberships are single so that they coordinate with the individual's Medicare eligibility.
- Medicare eligibility due to age is the first of the month in which a beneficiary turns age 65 or the first of the previous month if the date of birth is on the first of the month.
- Services not covered by Medicare as primary payer, will not be covered by the plans except as specifically described in the Member Handbook (e.g., Out-of-Country Major Medical benefits). If Medicare denies the claim and the plan does not specifically cover the service, the claim will be denied by the state plan for secondary payment.
- Two Retiree Fact Sheets discussing coordination with Medicare are available at the DHRM web site, one regarding Medicare coverage in general and the other regarding Medicare prescription drug coverage offered by the state program. These are written in question-and-answer format and intended for

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use by new Medicare-eligible retiree group participants or existing participants newly eligible for Medicare.

- To enroll in Medicare, beneficiaries must contact the Social Security Administration by calling 800-772-1213 or going to www.ssa.gov.

Notification of Move to a Medicare Plan Immediately Upon Eligibility

DHRM tracks Medicare eligibility for retiree group participants and employees. Retirees who become eligible due to age are identified based on birthdate, and Benefits Administrators are notified in advance so that participants can be provided plan options, default coverage, fact sheets and premiums. A sample letter is provided for your use at <http://www.dhrm.virginia.gov/resources/benefitsadmin/notices.html> (click on Medicare Eligibility Letter). This letter, along with the related Retiree Fact Sheets (see link at end of this section) provides a good overview of the program.

Since DHRM has a voluntary data sharing agreement with Medicare, retiree group participants who are eligible due to disability are also identified. DHRM contacts those individuals and arranges to update their record to reflect their chosen (or default) Medicare-primary plan (or termination).

Communications received from Medicare

Agencies receiving any requests for employee health plan information from the Centers for Medicare and Medicaid Services (CMS), the Medicare Secondary Payer Recovery Contractor (MSPRC), or any of their contractors, including collection agencies, should forward them immediately to DHRM's Office of Health Benefits for handling. This includes Primary Payment Notices, which provide an opportunity to resolve Medicare Secondary Payer Debts (the result of incorrect coordination of benefits information at Medicare) before they move to a collection status.

Split Contracts and Linked Family Members

Because all Medicare-coordinating plans include only single memberships, covered family members in the retiree group who are eligible for Medicare or who are covered based on the eligibility of a Medicare-eligible enrollee/original participant must have their own membership and their own ID number. These family members are "linked" (e.g., linked child, linked spouse) in the Benefits Eligibility System to the original participant (the Enrollee through whom eligibility is obtained), and this is called a split contract. Despite their own ID numbers, they are still treated as family members and rely on eligibility of the original participant to remain covered.

Family groups that are split between Medicare and non-Medicare plans must pay the appropriate premium for each plan except that a family group will not have to

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pay a total premium that is greater than the family membership level for the non-Medicare plan. For example, a family in which one member is eligible for Medicare and three members are not eligible for Medicare will pay only the family premium for the non-Medicare plan.

Health Insurance Claim Numbers (HICNs)

This is the ID number found on a beneficiary's red, white and blue Medicare card. Often it is the beneficiary's Social Security Number with a suffix which indicates the origin of Medicare eligibility. For example, a suffix of A after a beneficiary's Social Security Number indicates that eligibility is based on the contributions of the beneficiary him/herself. However, there are many suffixes that identify eligibility, and sometimes the HICN can be someone else's Social Security Number (for example, the beneficiary's spouse). There may also be prefixes that identify someone who gets Railroad Retirement Benefits instead of Social Security.

Providing a correct HICN when keying movement into one of the Medicare-coordinating plans is critical to successful enrollment if the participant elects prescription drug coverage. If an incorrect HICN is submitted to the prescription drug plan administrator and it is unable to resolve the matter, the Centers for Medicare and Medicaid Services (CMS) will generally deny the enrollment. In this case, the participant will be moved to a medical-only plan. This can also result in an enrollment date that is after the retirement or Medicare eligibility date and a break in coverage, which effectively precludes enrollment in the program.

Coordination of Benefits with Original Medicare

For Medicare-eligible participants, the State Retiree Health Benefits Program coordinates with Original Medicare. This includes Part A (hospital insurance) and Part B (medical insurance). It does not coordinate with Part C, which generally includes the Medicare Advantage plans. The state program's Medicare-coordinating plans specifically exclude services covered by a Medicare Advantage Plan, so if a participant enrolls in Part C, there will generally be minimal if any value to their Advantage 65 coverage.

When a Medicare beneficiary is no longer covered based on current employment and enrolls in the state retiree program, failure to enroll in Original Medicare will result in a gap in coverage since Advantage 65 will not pay any benefit for services that would have been covered by Medicare had the participant been enrolled. Usually, the question is whether to enroll in Part B since there is a premium for that coverage. For most individuals, there is no cost for Medicare Part A. The following enrollment rules generally apply to Part B, but beneficiaries enrolled in the retiree group should always ensure that enrollment for both A and B are completed.

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Enrollment in Original Medicare

Most individuals are eligible for Medicare on the first of the month in which they turn age 65. (If their date of birth is the first of the month, eligibility is the first of the prior month.) A beneficiary who is eligible due to age has a seven-month Initial Enrollment Period (IEP) that starts three months before the month of eligibility, includes the month of eligibility and three months after. Participants in the retiree group (Enrollees and covered family members) who become eligible for Medicare and wish to stay in the state program must enroll in Parts A and B to effectively use the available supplemental benefits. Failure to do so will result in a gap in coverage since Advantage 65 will not pay for any services that would have been covered by Medicare had the beneficiary been properly enrolled.

The state program tracks Medicare due to age and will contact retiree group Enrollees prior to their or their family member's eligibility month. If another election is not made or coverage is not terminated, the new Medicare beneficiary will automatically be moved to the Advantage 65 with Dental and Vision Plan (the default plan).

If a new retiree was already eligible for Medicare prior to his/her retirement date and declined coverage in Medicare Part B because he/she was covered based on current employment, he/she must enroll in Original Medicare upon retirement. If Medicare was properly declined based on coverage due to current employment, and the coverage was uninterrupted, the beneficiary can exercise a Special Enrollment Period (SEP) at any time they continue to be covered based on current employment or within the eight months after that coverage ends. If a beneficiary fails to exercise those enrollment rights, they will have to wait until the annual General Enrollment Period (GEP) that occurs each January through March, but coverage will not begin until the following July. Also, a break between coverage based on current employment and Medicare enrollment can result in a late enrollment penalty that can increase the Part B premium forever (or until eligibility due to age if later than original enrollment).

In any case, retirees should be sure to contact the Social Security Administration (800-772-1213) well in advance of the date they wish to be enrolled in Medicare. Waiting until the end of the IEP or SEP can result in a delayed enrollment and a gap in primary coverage.

Finally, if a beneficiary declines enrollment during his/her IEP, he/she may not exercise a SEP until the end of the original IEP. Also, a delay in coverage start dates during the last months of the IEP can result in a gap in primary coverage. Beneficiaries should be careful in declining Medicare coverage during the IEP if retirement is being considered. The state program will not allow coverage in a non-Medicare plan if a retiree fails to exercise an enrollment opportunity that ensures Medicare coverage coincident with his/her retirement date.

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Medicare Eligibility due to Disability/End Stage Renal Disease (ESRD)

Eligibility for Medicare can occur prior to age 65 based on Disability. Regardless of the reason for Medicare eligibility, retiree group participants, including their covered family members, must enroll in a Medicare-coordinating plan immediately upon eligibility for Medicare if they wish to remain in the state program. This is because Medicare should become the primary payer when coverage in a large group health plan is no longer based on current employment. It is to the advantage of the Enrollee to notify the retiree program immediately upon Medicare eligibility. If the Enrollee fails to do so, the state program will eventually be notified of Medicare eligibility through our data sharing agreement with Medicare. If it is determined that Medicare should have been the primary payer, the state program will retract primary payments made in error, and the beneficiary will need to file for primary claim payments with Medicare retroactively. DHRM contracts with a vendor to assist with recovery of overpayments and, if eligibility is due to disability, with Medicare Part B enrollments.

When eligibility is due to ESRD, there is a 30-month coordination period before Medicare becomes the primary payer. This period may straddle active and retiree coverage periods. The state program also tracks these coordination periods to ensure that the program is not paying for claims that should be absorbed by Medicare as primary payer.

Medicare Part D

This is the Medicare prescription drug benefit that was introduced in 2006. The State Retiree Health Benefits Program offers an enhanced Part D plan that can be elected or declined by Medicare-eligible participants. Participants have the flexibility to get their Medicare A and B supplement through the state program but to obtain their Part D coverage elsewhere. This is accomplished by enrolling in one of the Advantage 65 Medical Only plans and drug coverage outside of the state program. However, once the state program's prescription drug coverage has been declined or terminated, it may not be elected at a later time.

At this time, Express Scripts administers the State Retiree Health Benefits Program's Medicare Part D plan.

The Member Handbook and subject-specific Retiree Fact Sheet provide coverage specifics, but following are some basic provisions:

Evidence of Coverage and Summary of Benefits – Express Scripts annually publishes these documents to provide a resource for specific plan policies and provisions, as well as those governing all Medicare Part D plans. These will be sent to participants upon initial approval of enrollment and along with their Annual Notice of Changes.

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Formulary – All Medicare Part D plans have a formulary, or list of covered drugs. In general, drugs not included in the plan’s formulary will not be covered by the plan. However, when it is determined to be medically necessary for a beneficiary to take a non-formulary drug, a formulary exception may be granted that will allow coverage of a non-formulary drug in the non-preferred brand tier. All Medicare Part D plan formularies must be approved by Medicare to ensure that they will meet the needs of beneficiaries. When a beneficiary is moving from a non-Medicare plan to an Advantage 65 Plan that includes drug coverage, they should consult the formulary to ensure that drugs they are taking are covered. Also, in some cases, new coverage rules may apply.

A current formulary is sent upon approval of initial enrollment and each year to plan participants as a part of their Annual Notice of Changes. In addition, a complete on-line formulary and a paper formulary for printing are available at:

<http://www.dhrm.virginia.gov/hbenefits/retirees/medicarenotification2017.html>

Exceptions/Appeals – Exceptions may be granted based on medical necessity. The Evidence of Coverage and Summary of Benefits includes information on how to request an exception to the plan (e.g., a formulary or tiering exception). A formulary exception will allow a non-formulary drug to be covered in the non-preferred tier. A tiering exception may be granted to allow preferred brand coverage for a non-preferred brand. There will be no exceptions allowed for specialty drugs or for generic coverage of a preferred tier drug.

All appeal opportunities are included in the Evidence of Coverage.

Deductible – The State Retiree Health Benefits Program’s Medicare Part D plan has an annual deductible for brand drugs. The Evidence of Coverage and Summary of Benefits will include specific information.

Tiers – The State Retiree Health Benefits Program’s Medicare Part D plan provides benefits for covered drugs based on tiers. The tier of the covered drug indicates the amount of co-payment or coinsurance:

- Tier 1 – generics
- Tier 2 – preferred brands
- Tier 3 – non-preferred brands
- Tier 4 – specialty drugs

Generally, the higher the tier, the higher the out-of-pocket expense. The Evidence of Coverage and Summary of Benefits include specific benefit information.

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Excluded Drugs – Coverage for certain categories of drugs are excluded by Medicare. They are also not covered by the state program. Excluded drugs are generally not allowed a formulary exception. Following are drugs that are excluded by Medicare and the state program:

- Drugs for anorexia, weight loss or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs for symptomatic relief of cough and colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered part D drugs)
- Non-prescription drugs, also known as over-the-counter drugs
- Drugs for treatment of sexual or erectile dysfunction
- Over-the-counter diabetic supplies
- Federal Legend Part B medications such as oral chemotherapy agents

Coverage Stages – Along with the co-payment or coinsurance indicated by the tier of the covered drug, the coverage stage also dictates the level of benefit.

- **Deductible Stage** – The beneficiary pays the full cost of any covered brand drug until the full deductible amount has been paid. There is no deductible for covered generic drugs.
- **Initial Coverage Stage** – After any required deductible is met, beneficiaries will move into the Initial Coverage Stage during which the designated coinsurance or co-payment is paid for covered drugs based on the drug's tier.
- **Coverage Gap Stage** – Once the total drug cost (what the plan and the beneficiary pays) reaches a designated level, the Medicare Coverage Gap Discount Program pays half the cost of any covered drug that is manufactured by a participant in the program. The coinsurance or co-payment indicated by the drug tier is then paid by the beneficiary. Any remaining cost will be absorbed by the plan. In most cases, the out-of-pocket cost between the Initial Coverage Stage and the Coverage Gap Stage will be the same. However, the out-of-pocket cost for covered Non-Preferred Brands will generally decrease at this level. The discount program helps to control plan costs and, therefore, premium costs. This stage continues until the total out-of-pocket costs reach the designated level to move into the Catastrophic Stage.
- **Catastrophic Stage** – Once the beneficiary's total out-of-pocket cost reaches the designated catastrophic level, the benefit for covered drugs increases to 95% or a designated minimal co-payment, whichever is greater.

The amount of cost and out-of-pocket expense that defines each of these coverage stages is included in the Evidence of Coverage and Summary of

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Benefits. Also, the “*Prescription Drugs – Medicare-Eligible Participants*” Retiree Fact Sheet includes plan-specific information.

Medicare Part D plans outside of the state program may be reviewed and compared by calling 800-MEDICARE or going to www.medicare.gov.

Medicare Part D Late Enrollment Penalty

Medicare beneficiaries who are eligible for but do not enroll in Part D and do not have creditable coverage during any period of eligibility will be subject to a Late Enrollment Penalty (LEP).

Medicare requires notification of a possible LEP whenever a beneficiary enrolls in Part D coverage when their initial enrollment is after their initial eligibility. This would generally apply to anyone who became eligible for Medicare while still working and who did not enroll in a Medicare Part D plan at that time. If the beneficiary had creditable drug coverage (coverage at least as good as Medicare’s standard coverage) during that period, the penalty would not apply. The prescription drug vendor is required to contact anyone whose Medicare Part D start date is after their eligibility date. DHRM will then get the opportunity separately to attest to the creditable coverage if the beneficiary was enrolled in the state program (all state program drug plans are creditable). Unfortunately, this means that many new enrollees will receive an LEP letter. If questioned, Benefits Administrators should respond to questions regarding the LEP letter by indicating that DHRM will generally be able to resolve this matter without any action on their part. The LEP letter from Express Scripts will explain:

“Since you were eligible for Medicare prior to your enrollment in Express Scripts Medicare Prescription Plan (PDP) for the Commonwealth of Virginia Retiree Health Benefits Program, the Centers for Medicare & Medicaid Services must have proof that you had creditable prescription drug coverage (coverage at least as good as Medicare Part D) for the period that you were eligible but were not enrolled in a Part D plan. Express Scripts Medicare Prescription Plan is required to send you this notice, but the Commonwealth of Virginia will also be notified of the need for attestation of your creditable coverage. If you had continuous coverage through the Commonwealth of Virginia Health Benefits Program since your Medicare eligibility, the Commonwealth of Virginia Department of Human Resource Management will attest to your coverage, and you may disregard this notice. However, if you did not have coverage through the state program, you will need to provide proof of creditable coverage from your previous plan(s) for the period listed.”

If an Enrollee receives more than three letters regarding this matter, and they have been continuously covered by a state program drug plan, contact the Office of Health Benefits for assistance.

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Resources Regarding Medicare

There are two Retiree Fact Sheets available to assist retirees with transitioning to Medicare primary coverage:

- *Medicare and the State Retiree Health Benefits Program*
- *Prescription Drugs – Medicare-Eligible Participants*

These are available at the link below and include contact information for the Centers for Medicare and Medicaid Services and the Social Security Administration:

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

The *Medicare Plan Options Brochure* is also a useful tool to learn about the coordination of Medicare with Advantage 65, and the Medicare-Coordinating Plans Member Handbook and inserts (Prescription Drugs, Dental/Vision) are also available for review at:

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

Premium Cost

Retirees pay the full cost of coverage. Some retirees may be eligible for the VRS Health Insurance Credit Program, which is administered by VRS and does not reduce the premium. However, it does reimburse a part of the premium based on the program's eligibility criteria.

Retiree premiums will be deducted from the monthly retirement benefit if the benefit will accommodate the premium. The only exception would be Tricare, which is discussed later in this section. If the benefit is too low, or if there is no monthly VRS benefit (e.g., ORP retirees or other retiree group enrollees such as non-annuitant survivors or LTD participants), the enrollee may be direct billed. The billing agents are as follows:

Plan	Billing Agent
COVA Care Plans	Anthem Blue Cross and Blue Shield
COVA HealthAware Plans	Payflex
Kaiser Permanente	Kaiser
Advantage 65 Plans	Anthem Blue Cross and Blue Shield

Direct bills go out on approximately the tenth (depending on the day of the week on which the tenth falls) of the month prior to the coverage month and are due the first of the coverage month.

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As stated in the Member Handbooks, premiums not paid within 31 days of the due date will result in termination of coverage with no reinstatement. The termination process does result in some additional grace period before the actual termination occurs.

For plans billed by Anthem Blue Cross and Blue Shield, Enrollees may enroll for automatic bank draft of their monthly premium, which occurs at the beginning of each coverage month. If the draft fails, a bill is generated.

For plans billed by Payflex, Enrollees will receive monthly payment coupons to remit their payment. Note: Automatic Bank draft is not an offered option for these plans.

Premiums are subject to change at the beginning of each plan year. Non-Medicare plans run on the fiscal year (July 1 through June 30), while the Medicare plans run on the calendar to coordinate with Medicare.

Links to premium costs for Medicare-coordinating and non-Medicare plans are provided at the end of this section.

Medicare Part D Low Income Subsidy (LIS)

Some Medicare-eligible retiree group participants who are enrolled in a plan that includes Medicare Part D coverage may be entitled to a low income subsidy (LIS), sometimes referred to as “Extra Help.” This is determined by Social Security. The amount of the premium reduction is determined by the subsidy level and will be administered by the Office of Health Benefits based on information received from Medicare. Benefits Administrators do not have the authority to make any changes related to the LIS. The annual rate notification booklet for Medicare-eligible participants contains additional information regarding the LIS. All participants receiving the LIS will be direct billed for their premium cost. **VRS does not deduct premiums reduced by the LIS.**

Disability Retirements

Employees who are enrolled in the traditional leave plan (not the Virginia Sickness and Disability Plan) may qualify for a Disability Retirement through the Virginia Retirement System. Coverage may be extended while awaiting adjudication of disability retirement through:

- Using Sick Leave Without Pay
- Enrolling in Extended Coverage/COBRA
- Converting to an individual policy
- If eligible, taking a service retirement and enrolling for retiree coverage*

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Disability retirees must enroll in retiree coverage within 31 days of losing coverage as an active employee or, if the disability retirement has not been approved, within 31 days of the date of the disability retirement notification letter. In the case of a retroactive disability retirement approval, the retiree can enroll retroactively to the date of the disability retirement approval, not to exceed 12 months for any statewide self-funded plans or two months for any insured plan. As an alternative, the retiree can enroll prospectively, effective the first of the month after the date of the notification letter. These enrollment opportunities would apply whether or not coverage was maintained during any break while waiting for disability retirement approval.

*If eligible, taking service retirement will provide coverage while waiting for the results of a disability retirement application. If the disability retirement is approved, the Health Insurance Credit and retirement benefit will be adjusted. If the disability retirement is denied, enrollment for health plan coverage as a service retiree will ensure that eligibility for retiree coverage is not lost. Otherwise, denial of disability retirement benefits will not allow enrollment in the State Retiree Health Benefits Program outside of the 31-day enrollment window. An exception would be an employee who is applying for disability retirement for a work-related disability. Under that circumstance, employees are not allowed by

VRS to apply for service retirement while awaiting the result of their disability application. In that case, the retiree may enroll in retiree coverage if he/she does so within 31 days of a denial date (not to exceed one year) if an application was received within 31 days of the loss of active coverage. Coverage would be effective either retroactively to the date active coverage was lost or the first of the month after the denial is received, at the retiree's choice.

If a disability retirement is recalled by VRS, retiree coverage will terminate at the end of the month in which the recall occurs. This is not an Extended Coverage qualifying event, but if it occurs less than 18 months after termination of employment, the employee may utilize any remaining Extended Coverage period. Except as allowed through Extended Coverage, coverage may not continue while the recall is being appealed.

If the recall of disability retirement is appealed and overturned, the retiree may re-enroll in retiree coverage back to the date of recall or, if never enrolled, may enroll in the plan retroactively or prospectively as would be allowed for any new disability retiree. In either case, a new enrollment form will be required.

TRICARE Supplement Eligibility and Enrollment

A TRICARE Supplement Plan became available to non-Medicare-eligible retiree group enrollees (retirees, survivors and LTD participants) and their family members, all of whom must also be entitled to TRICARE, effective October 1, 2011.

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Administration of the TRICARE supplement plan will be as follows:

- Initial enrollment can occur at open enrollment, within 60 days of new eligibility for TRICARE, and within the designated enrollment window at retirement or the start of LTD or Survivor coverage. Changes during TRICARE supplement enrollment will be administered by Selman & Company and reported back to OHB monthly for BES update.
- When eligibility for the TRICARE supplement is lost without return to the state program, the BES record should be terminated by OHB.
- It will officially be Selman & Company's responsibility to track Medicare eligibility for its enrollees, but OHB will still manage information received through the Voluntary Data Sharing Agreement or based on age.

When can the TRICARE supplement be dropped with return to the state program?

- At open enrollment--all TRICARE supplement-enrolled family members who are otherwise eligible for the state program can be returned to the program as long as the Enrollee/original participant returns. All Enrollees will receive open enrollment materials.
 - Family members added while in the supplement can be moved back to the state program if otherwise eligible.
 - Return to the state program will not be an event, in and of itself, that allows adding family members.
- Family group can return to the state program by enrolling within 60 days of Medicare eligibility of any covered family member (enrollee/original participant must return). An appropriate Medicare or non-Medicare plan must be elected by each participant. Family members may be dropped at that time, per appropriate policy, but not added. If Medicare eligibility is for a family member, he/she can be dropped from the supplement (e.g., enroll in TRICARE for Life as allowed by TRICARE), but if the enrollee/original participant becomes eligible for Medicare and fails to enroll in an Advantage 65 plan, family eligibility for the state program will be lost.
- If otherwise eligible, a family can return to the state program if a child loses eligibility under the TRICARE supplement (e.g., age 21 or 23) if enrollment is within 60 days of the event (enrollee/original participant must return). If the child loses eligibility and is dropped from the supplement or moves to TRICARE continuation coverage, remaining family members can maintain supplement coverage if otherwise eligible. An eligible child could come back at a later open enrollment if the state program has been resumed by the family.

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- If TRICARE eligibility is lost, the family group can return to the state program if requested within 60 days of the event. The effective date will be the first of the month after TRICARE eligibility is lost.

When will TRICARE supplement enrollees lose eligibility for the state program?

- If the enrollee/original participant becomes eligible for Medicare and fails to re-enroll in the state program within 60 days of the eligibility date, eligibility for the state program is lost (including all covered family members).
- If a non-annuitant survivor adds a spouse while enrolled in TRICARE supplement, he/she may not return to the state program.
- If a family group is terminated from the TRICARE supplement due to non-payment, they may not return to the state program based strictly on that termination event.

What is Continuation Coverage through TRICARE?

TRICARE is not subject to COBRA continuation and has its own continuation opportunities based on its specific eligibility criteria. The impact of continuation coverage on the state program will be as follows:

- Enrollment in any TRICARE continuation coverage (e.g., TYA or CHCPB) is not a part of the state program's TRICARE supplement voluntary benefit program. However, eligible children who enroll in these programs could be added to the state program at a later open enrollment if otherwise eligible and the Enrollee/original participant has resumed state program coverage.
- COBRA continuation coverage is not available for the TRICARE supplement (no Election Notice). If supplement coverage is lost by the enrollee/original participant and allowable re-enrollment in the state program is not exercised within the designated enrollment window, the retiree family group may not return to the state program in the future.
- No COBRA General Notice will be required for TRICARE supplement enrollment.

Survivors Enrolled in the TRICARE Supplement:

- Survivors enrolled in the TRICARE supplement can continue coverage in the state program, including the TRICARE supplement, based on standard eligibility criteria.

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TRICARE Supplement Premiums:

- Premiums will be billed or drafted by Selman & Company —no VRS deduction.
- Termination due to failure to pay TRICARE supplement premium will result in loss of eligibility to return to the state program.

The Benefits Administrator's Role at Retirement, Survivorship or LTD:

The employing agency's Benefits Administrator should assist eligible employees who are retiring with enrollment in the retiree group (including survivors of active employees and new long-term disability participants).

- Provide an enrollment form and relevant Retiree Fact Sheets to assist the employee in making coverage decisions. This is especially important if the employee is eligible for Medicare.
- Provide premium information and explain VRS deduction or direct billing as appropriate.
- Explain who will be the Benefits Administrator after retirement.
- If the retiree does not wish to enroll in retiree coverage, encourage him or her to indicate this on the enrollment form to document the offer and rejection.
- Once an election is made, the agency Benefits Administrator should key the enrollment in BES—see BES Systems Guide for assistance.
- A copy of the enrollment form should be sent to the new retiree Benefits Administrator to advise of the enrollment. This is especially critical for VRS retirees whose premium deduction, if applicable, will be set up based on the enrollment form.
- If the new retiree group Enrollee had coverage as an active employee, a COBRA Election Notice must be provided, even if retiree group coverage is available and elected—see Extended Coverage/COBRA section of this manual.
- When coverage is lost as an active employee, provide a HIPAA Certificate of Creditable Coverage to document coverage up to the point of termination of employment (upon request).
- Direct any questions regarding the Health Insurance Credit Program to VRS.

Health Insurance Credit Program

The Health Insurance Credit Program is administered by the Virginia Retirement System, and questions regarding the program should be directed to VRS. Generally, however, retirees or LTD participants who are eligible for this benefit and enrolled in the State Retiree Health Benefits Program will automatically be enrolled for Health Insurance Credit benefits. Enrollment in health plan coverage outside of the state program will require a positive enrollment to access Health Insurance Credit benefits.

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Faculty Members/Faculty Pay Cycles

Faculty Members with 12-month contracts should be allowed to enroll in Retiree coverage, regardless of their pay cycle, as long as they fulfill the eligibility criteria (Refer to the *Eligibility For Retiree Coverage* section at the beginning of this document).

Note that this pay-cycle distinction does not change the policy that excludes deferred retirees from the State Retiree Health Benefits Program participation but does clarify the definition of retirement deferral as it relates to eligibility for retiree health plan coverage affected by pay cycle.

It is also important to note that 10-month-paid faculty members who retire on June, July or August 1 may not maintain coverage as an active employee while receiving a retirement benefit even though their employment contract allows them to maintain coverage while not receiving pay or a VRS contribution. A retiree may not have active employee benefits unless they are receiving them through a layoff/WTA benefit.

Resources

The following retiree-specific resources are available at www.dhrm.virginia.gov:

Retiree Fact Sheets

Medicare Options Brochure

Premiums – Medicare Plans

Premiums – Non-Medicare Plans

Evidence of Coverage and Summary of Benefits for Medicare Part D