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To: State Retiree Health Benefits Program Enrollees Eligible for Medicare or Enrollees who cover Medicare-Eligible Family Members

From: Office of State and Local Health Benefits Programs

Date: November 19, 2021

Annual Benefit and Premium Rate Notification for 2022

This notification booklet includes information about coverage for Medicare-eligible participants enrolled in Medical-Only Plans* in 2022. Be sure to read these materials carefully to ensure that you understand your options.

*** No outpatient prescription drug/Medicare Part D coverage under the State Program**

If you wish to maintain your current plan, NO ACTION on your part is necessary. If you continue to be eligible, your new monthly premium will be automatically deducted or directly billed.

How much is my health plan premium for 2022?

All State Medicare-coordinating plan medical (including hearing), dental and routine vision benefits are administered by Anthem Blue Cross and Blue Shield.

Following is a summary of 2022 premiums:

Retiree group participants pay the full cost of their health plan coverage in the State Retiree Health Benefits Program. Premiums are based on the amount required to fund the costs of the program. This includes all claims and administrative cost.

Final total premiums are rounded to the nearest whole dollar.

Plan – Single Membership	2021 Premium	2022 Premium	% Increase
Advantage 65 – Medicare Only	**$170**	**$171**	**0.6%**
Advantage 65 – Medicare Only + Dental/Vision	**$204**	**$206**	**1.0%**

When will I begin paying the premium for 2022?

For participants whose premiums are deducted from a VRS retirement benefit, the new January 2022 premium will be deducted from the retirement benefit payment you receive in February. For those who already pay through direct billing, the new premium will be billed in December for January's premium.

If you have requested a change in coverage, the premium change may take place later depending on the date of your request. For those who are paying through Anthem automatic bank draft, your first deduction of the new premium amount will take place in your January draft. If you are paying through your financial institution, please ensure that you authorize the appropriate premium payment amount for January 1.

If a premium increase results in your VRS benefit no longer supporting your premium deduction, Anthem Blue Cross and Blue Shield will move you to direct billing. Direct billing notifications are mailed the month before the coverage month.

Your Benefit Options for 2022

Will my medical benefits change for 2022?

Your Medicare supplemental benefits and any other medical benefits under an Advantage 65 Plan will not change for 2022.

Consult your "*Medicare and You 2022"* publication to determine if there are any changes to your primary Medicare coverage for 2022.

Will my dental and vision benefits change for 2022?

For those enrolled in the dental/vision option, those benefits will not change for 2022.

Your Options for 2022 – What You Need To Do

If you wish to maintain your current plan, NO ACTION on your part is necessary. If you continue to be eligible, your new monthly premium will be automatically deducted or directly billed.

Making allowable plan changes for January 1, 2022: Online enrollment is not currently available. If you wish to make an allowable plan change, you must complete a State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants. You may obtain an enrollment form as follows:

- Contact your Benefits Administrator
- Online fillable forms are available on the DHRM website at **www.dhrm.virginia.gov**.

Once completed, be sure to sign the form and follow the mailing instructions to submit your request so that it is received by **December 16, 2021**. Forms received after **December 16, 2021, but before January 1, 2022,** will be effective on January 1, but there may be a delay in implementing the change and updating your premium.

Allowable changes requested after **December 31, 2021**, will be effective the first of the month after the request is received per program policy. **All Enrollment Forms must be signed by the Enrollee (Retiree, Survivor or LTD Participant); forms signed by a covered family member will not be accepted.**

The following options are available to you for January 1:

- **You may keep your current plan as long as you remain eligible (no action required).**
- You may make a plan change as follows:
  - If you are enrolled in Advantage 65—Medical Only and have not previously elected the Dental/Vision option, you may add Dental/Vision coverage one time and terminate it one time. Once you have terminated Dental/Vision coverage, you may not add it again.
- Retirees, Survivors and LTD Participants may cancel a family member's coverage at any time on a prospective basis (going forward). However, once family members of a Medicare-eligible participant have been cancelled, they may only be added within 60 days of the occurrence of an allowable qualifying mid-year event (e.g., loss of eligibility for other group coverage) that is consistent with the addition. Medicare-eligible Enrollees do not have an annual Open Enrollment opportunity. ***Non-Medicare eligible covered family members may not make an Open Enrollment election to increase membership.***

- All Medicare-eligible covered family members (e.g., retiree and spouse) may have separate plan elections, but only the Enrollee can request a change.

- State coverage as an Enrollee may be cancelled completely, but you will not have an opportunity to return to the program at any time in the future. This will also result in the cancellation of any covered family members.

NOTE: Medical-Only Plan participants **may not enroll** in any state-program-sponsored Medicare- coordinating plan that includes outpatient prescription drug coverage.

For Your Information…

Are there fitness benefits available under the Advantage 65 Plans?

None of the state program's Medicare-coordinating plans currently provide any fitness benefits such as fitness programs, memberships or general exercise equipment. In response to some participants who have asked about adding this type of benefit to the program, the Department of Human Resource Management's Office of Health Benefits (the Department) investigated programs that are offered under other plans and found the following:

- Even though the utilization of fitness programs is generally low, there would be an additional premium cost to ALL participants to add this type of benefit. If this benefit were offered as a stand-alone option, enrollment would generally be limited to those who would actually use the benefit. Since retiree group participants pay the full cost of their coverage, it would result in a premium cost that would basically be the full cost of the benefit.
- The provider network for the program is not fully developed in all areas where participants reside, so not all participants in the state program would have convenient access to a participating provider even though all participants would be sharing in the cost.

The Department considers very carefully any benefit change that increases the premium cost to retirees who pay the full cost of coverage. At this time, the additional premium cost, along with the network deficiencies in some areas, suggested that this was not a good enhancement for all participants.

Anthem does offer some fitness program discounts that are available to ALL members, regardless of plan or product. To view available discounts, login to **anthem.com** and select "Discounts" to get to the Special Offers and Discounts page. Members can only redeem the discounts by logging in to the member portal first, then clicking on the link for the discount they want to use. This is especially important because if a member does not click the link on the discounts page, they will not be recognized as eligible for the discount. This is not a reimbursement program so members cannot purchase a service or goods on their own, outside of the links on the discounts page, and then submit to Anthem for reimbursement. A summary of discount programs is included with this booklet.

Reminder to Non-Annuitant Survivors

Non-Annuitant Survivors are family members of employees or retirees who were covered under the State Health Benefits Program at the time of the employee's or retiree's death but are not beneficiaries of a VRS survivor annuity. There are specific eligibility guidelines for these participants, as follows:

- Non-annuitant surviving spouses may be covered until remarriage or obtaining alternate health insurance coverage. Coverage will be terminated at the end of the month in which the

loss-of-eligibility event occurs. There is no Extended Coverage/COBRA available to Non-Annuitant Surviving Spouses who lose eligibility for the program.

- Non-annuitant surviving children may be covered until the end of the year in which they turn age 26, and if they meet the eligibility criteria for an adult incapacitated dependent, they may be covered after age 26 until they are no longer incapacitated (see eligibility criteria for adult incapacitated children in Member Handbooks). They will lose coverage at the end of the month in which their loss-of-eligibility event occurs, but they may be offered Extended Coverage/COBRA due to losing dependent child status.

- Non-Annuitant Survivors may not increase membership.

Can I enroll in a Medicare Advantage Plan?

The state program's Medicare-coordinating plans specifically exclude services or supplies that are received through Medicare Advantage Plans, so enrolling in a Medicare Advantage Plan will generally result in loss of benefits under the state program's Medicare-coordinating plans. State program participants may terminate their state program Medicare- coordinating coverage prospectively at any time (no return to the program). If you wish to enroll in a Medicare Advantage Plan, consider cancelling your coverage in the state program. (This would also result in termination of any covered family members.) If you enroll in a Medicare Advantage Plan and do not cancel your state coverage, consider carefully whether you wish to continue paying for coverage that may provide minimal, if any, medical benefits. ***Please note that the Advantage 65 Plans are not Medicare Advantage plans.***

A new plan year and Medicare enrollment period are good times to review all plan options available to you as a Medicare beneficiary. There could be a plan outside of the state program that better meets your needs, either in types of benefits, cost levels or both. However, be sure that you understand the impact of enrolling in other plans if you still want to keep your state plan coverage. Some things to think about and compare include:

- Premium cost
- Benefits
- Out-of-pocket expenses such as deductible, copayments, or coinsurance

Will I get a new Member Handbook for 2022?

A new Medicare-Coordinating Plans Member Handbook is being finalized for printing. Until you receive your new handbook, continue to use your existing handbook, applicable insert, amendments, and this notice as your description of coverage. Following is a link to all of the existing materials on line:

https://www.dhrm.virginia.gov/employeebenefits/health-benefits/medicare-retirees
(click on Member Handbooks)

What resources are available for information about the State Retiree Health Benefits Program?

In addition to your Benefits Administrator and your Member Handbook (and insert if applicable), there are many resources available at the Department of Human Resource

Management's web site to provide information to retiree group participants about their State Retiree Health Benefits Program coverage. Go to:

https://www.dhrm.virginia.gov/employeebenefits/health-benefits/medicare-retirees
(click on Frequently Asked Questions)

How does Medicare eligibility prior to age 65 affect program participation?

When an Enrollee (Retiree, Survivor, LTD participant) or a covered family member becomes eligible for Medicare prior to age 65, an enrollment form should be submitted immediately to elect a Medicare-coordinating plan. While this letter is being directed to Enrollees already in Medicare-coordinating plans, this information is provided to ensure that other covered family members who may be in non-Medicare plans are also moved to Medicare-coordinating coverage immediately upon eligibility. It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so may result in significant coverage deficits.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B (Original Medicare) in order to get the full benefit of any state program Medicare-coordinating plan since Medicare becomes the primary payer of claims for those who are no longer covered based on current employment.

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 the Advantage 65 with Dental/Vision plan immediately. If participants have declined Medicare coverage, it could result in a delay in enrollment and a critical gap in coverage until Medicare goes into effect. The state program will not pay any claims that should have been paid by Medicare had the participant been properly enrolled in Medicare coverage. The state program tracks Medicare eligibility due to age and can generally identify eligibility prior to age 65, but it is in the best interest of the Enrollee to report eligibility as soon as it is determined.

What happens if I fail to pay my premium?

Plan participants are responsible for timely payment of their monthly premiums (either through retirement benefit deduction or by direct payment to the billing administrator). Monthly premiums that remain unpaid for 31 days after the due date will be processed for termination of coverage. Once an Enrollee and his/her family members have been terminated for non-payment of premiums, re-enrollment in the program is at the discretion of the Department of Human Resource Management.

Direct-bill participants may enroll to have an automatic deduction of their monthly premium from their bank accounts and may make payments on line or by phone. Contact Anthem for more information. Participants are responsible for understanding their premium obligation and for notifying the program within 60 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee (Retiree, Survivor, LTD Participant) to advise the program of membership reductions may result in loss of the overpaid premium amount.

What should I do if my address changes?

Was this package forwarded to you from an old address? If so, be sure to contact your Benefits Administrator immediately to make an address correction. Failure to update your address can result in missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss because their address of record has not been corrected. The Department's only means of communicating important information to retiree group enrollees is through the mail. Please let your Benefits Administrator know when you move!

How can I get information about HIPAA Privacy Protections?

The Office of Health Benefits Notice of Privacy Practice describes how the health plan can use and disclose your health information and how you can get access to this information. Participants can obtain a copy of the privacy notice at **www.dhrm.virginia.gov**.

Who is my Benefits Administrator?

If you have questions about eligibility and enrollment, contact:

If You Are A:	*Contact This Benefits Administrator*
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Enrollee	The Virginia Retirement System (888) 827-3847 **www.varetire.org**
Local or Optional Retirement Plan Retiree/ Survivor or a non- VSDP LTD participant	Your Pre-Retirement Agency Benefits Administrator
Non-Annuitant Survivor (surviving spouse or child or an employee or retiree – not receiving a VRS benefit)	The Department of Human Resource Management (888) 642-4414 **www.dhrm.virginia.gov**

NOTE: Receipt of benefit-specific information in this package does not guarantee those benefits. In family groups with multiple Medicare-eligible family members, Enrollees will receive information about all plans within their family group. (For example, if you are in a plan without dental and vision coverage, but you are covering a family member in a plan that includes dental and vision, you will receive dental and vision information.)

DISTRIBUTION: Only Enrollees (Retirees, Survivors and Long-Term Disability Participants) will receive this package. Medicare-eligible covered family members will not receive annual premium rate notification materials directly, even if they have individual ID numbers. This means that Enrollees must share this information with their Medicare-eligible covered family members. Only Enrollees can request coverage changes for covered family members. If you are an Enrollee who is not eligible for Medicare but you are covering a Medicare-eligible family member, you are receiving this package due to the Medicare-eligible family member covered through your eligibility.

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