Virginia Department of
HUMAN RESOURCE
MANAGEMENT

Commonwealth of Virginia
Retiree Health Benefits Program

Annual Premium Rate Notification Materials for Medicare-Eligible Participants Enrolled in Plans that do not include Outpatient Prescription Drug Coverage

This Rate Notification Booklet includes:

Also enclosed:

- **Medicare-Coordinating Plans Member Handbook Amendment (for all recipients)**

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 for the Medicare-eligible family member covered through your eligibility.***

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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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: **October 15, 2014**

Important Information Regarding Your Health Benefits

This notification booklet includes information about coverage for Medicare-eligible participants in 2015. Be sure to read these materials carefully to ensure that you understand your options.

Your 2015 Premium Cost

- ***How much is my health plan premium for 2015?***

Monthly premiums for medical-only plans (no outpatient prescription drug coverage) are provided below. Increased claims cost for Medicare supplemental coverage resulted in a higher premium for 2015. In addition, as discussed in the rate materials for 2014, an adjustment at that time based on an accumulated surplus of the Medicare-coordinating plans resulted in a smaller premium increase for 2014. Consequently, the percentage of increase from the adjusted 2014 premium to the new 2015 premium is artificially high. Without the 2014 premium adjustment, the 2015 premium would be the same, but the percentage of increase would be lower.

2015 Premiums

Plan – Single Membership	2014 Premium	2015 Premium Effective 1/1/15	% Change
Advantage 65—Medical Only	**$131**	**$145**	**10.7%**
Advantage 65—Medical Only + Dental/Vision	**$164**	**$179**	**9.1%**

All State Medicare-coordinating plan supplemental medical and routine vision benefits are administered by Anthem Blue Cross and Blue Shield. Dental benefits are administered by Delta Dental of Virginia.

▪ ***When will I begin paying my new 2015 premium?***

For participants whose premiums are deducted from a VRS retirement benefit, the new January 2015 premium will be deducted from the retirement benefit payment you receive in February. If a premium increase means that your retirement benefit is no longer enough to support the deduction, you will be moved to direct billing from Anthem Blue Cross and Blue Shield. It is important to note that direct billing is mailed before the coverage month while deduction occurs at the end of the coverage month.

For those who already pay through direct billing, the new premium will be billed in December 2014. 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 automatic bank draft, your first deduction in the new premium amount will take place in your January 2015 draft.

Your 2015 Benefits

▪ ***Will my medical benefits change for 2015?***

The Medicare supplemental benefit under any Advantage 65 Plan will not change for 2015.

Consult your "*Medicare and You 2015"* publication to determine if there are any changes to your primary Medicare coverage for 2015.

▪ ***Will my dental and vision benefits change for 2015?***

Participants enrolled in the Advantage 65 Medical Only Plan with Dental/ Vision will experience no changes in their optional dental and routine vision benefits for 2015.

Your Options for 2015 – 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 for your current plan will automatically be deducted or billed.

If you wish to make an allowable plan change for January 1, 2015, you must request the change by taking one of the following actions:

- Obtain an enrollment form from your Benefits Administrator (see page 6), or from the web at www.dhrm.virginia.gov and submit your request to your Benefits Administrator no later than December 1, 2014. (Requests received after December 1, 2014, but before January 1, 2015, will be effective on January 1, but there may be a delay in implementing the change and updating your premium.)

- Request changes online no later than December 31, 2014, by using EmployeeDirect at www.dhrm.virginia.gov (click on the EmployeeDirect link).

    - To use EmployeeDirect, you must have a personal e-mail address listed in the state's eligibility system. (A state e-mail address will not allow access to EmployeeDirect for retiree group participants.) If you do not already have an e-mail address in your eligibility file, you may contact your Benefits Administrator to update your record.
    - Your ID number appears on your plan ID cards and is a seven-digit number, which is followed by XU. For EmployeeDirect, use only the seven-digit number, not the three-letter prefix or the XU suffix that appears on your Anthem ID card.
    - NOTE: January 1 changes using EmployeeDirect must be requested during the month of December. If you request an allowable change through EmployeeDirect in November, it will generally become effective on December 1.

Allowable changes requested after December 31, 2014 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).**

- If you have never enrolled in the Dental/Vision option as a Medicare-eligible retiree group participant, 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 a consistent qualifying mid-year event (e.g., loss of eligibility for other group coverage) that would allow the addition. Medicare-eligible Enrollees do not have an annual Open Enrollment opportunity. Open Enrollment to increase membership is not available based on non-Medicare-eligible family participants.

- 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.

Other Important Retiree Program Information

▪ *As a Medicare Beneficiary, will my benefits change due to the introduction of the Health Insurance Marketplace?*

You have probably heard about the Health Insurance Marketplace, which is a key part of the Affordable Care Act. Regardless of how you get Medicare (Original Medicare or a Medicare Advantage Plan), you still have the same Medicare benefits you have now, and you won't have to make any changes. If you want additional information about the Marketplace, visit www.HealthCare.gov.

▪ *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, if allowed by Medicare, 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. In some cases, enrollment in a Medicare Advantage plan or other Medicare supplemental coverage could conflict with your state program enrollment. ***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 ID card for 2015?*

New cards will only be issued if you make a change that requires updating the information on your existing ID card(s).

▪ *Will I get a new Member Handbook for 2015?*

Enclosed is an amendment to your January 2011 Medicare-Coordinating Plans Member Handbook that includes all updates since its original publication. The only change for January 1, 2015 is termination of the Medicare Complementary/Option I Plan.

Except for deletion of references to the Medicare Complementary/Option I Plan, there are no changes to the Dental/Vision Member Handbook insert for those enrolled in that optional coverage. This deletion is noted on your Medicare-Coordinating Plans Member Handbook amendment. Your existing January

2011 insert, along with the January 2013 and 2014 amendments, reflect up-to-date information for these benefits.

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

In addition to your Benefits Administrator and your Member Handbook (and applicable insert/s), 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 http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html.

▪ ***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 and/or their family members already enrolled 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 could 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. This also provides an opportunity for enrollment in the state program's Medicare Part D plan as a part of the Advantage 65 or Advantage 65 with Dental/Vision Plan (pending approval by Medicare).

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 for automatic deduction of their monthly premium from their bank accounts and may make online check payments. 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. You can update personal information by using EmployeeDirect online (see page three for more information about EmployeeDirect). 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 1-888-827-3847 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 of an employee or retiree—not receiving a VRS benefit)	The Department of Human Resource Management 1-888-642-4414 www.dhrm.virginia.gov