

Medicare-Eligible Letter
Revised for 0114

Address to the Retiree, Survivor or LTD participant, not any dependent

Our records indicate that (you/your covered family member) will be eligible for Medicare effective (date). Since your coverage in the State Retiree Health Benefits Program is no longer based on current employment, Medicare should be the primary payer of claims for any Medicare-eligible covered family members. As such, all Medicare-eligible covered family members must be moved to a Medicare-coordinating plan in order to remain in the state program, or you may request termination of coverage.

In order to make a Medicare-coordinating plan election (or terminate coverage), you must submit the enclosed enrollment form to (insert name and address of Benefits Administrator) no later than (insert date to accommodate keying of the election prior to the 23rd of the month prior to the effective date). If a plan selection or request for termination is not made by that date, the Medicare-eligible participant will be moved to the Advantage 65 with Dental/Vision plan effective (insert effective date). If you request termination of your own coverage, it will result in the termination of all covered family members. However, you may terminate a dependent's coverage and maintain your own coverage as the eligible Enrollee.

Following are the Medicare-coordinating plan selections that are available to participants in the Commonwealth of Virginia Retiree Health Benefits Program.

Plan	Description	2013 Monthly Premium
Advantage 65	This is a Medicare supplement plan that is administered by Anthem Blue Cross and Blue Shield. It includes enrollment in the program's enhanced Medicare Part D outpatient prescription drug coverage which is administered by Express Scripts (contingent upon approval by Medicare).	\$247
Advantage 65 + Dental/Vision*	This plan adds dental and routine vision benefits to the Advantage 65 plan described above. Dental benefits are administered by Delta Dental and vision benefits are administered by Anthem Blue Cross and Blue Shield/Blue View Vision. The Medicare-eligible family member will default to this plan if no election is submitted.	\$279
Advantage 65 – Medical Only*	This plan includes the same Medicare supplemental benefits as those provided under the Advantage 65 plan but does not include enrollment in the state program's Medicare Part D plan. If you select this coverage, be sure to consider the family member's enrollment in Part D coverage outside of the state program.	\$131
Advantage 65 – Medical Only + Dental/Vision*	This plan adds dental and routine vision benefits to the Advantage 65 – Medical Only plan described above. Dental benefits are administered by Delta Dental and vision benefits are administered by Anthem Blue Cross and Blue Shield/Blue View Vision.	\$164

*If medical-only coverage is elected, enrollment in the state program's Medicare Part D plan will not be allowed at a later date. If you have already enrolled in a Medicare Part D plan outside of the state program, enrollment in the state program's Medicare Part D plan can result in disenrollment from your other plan. Be sure to send your Medical-Only Plan election by the date indicated above to avoid this conflict. If the dental/vision option is elected, be sure to review your new Member Handbook inserts to ensure understanding of your new plan provisions.

Unless you terminate coverage, the move to Medicare-coordinating coverage will take place regardless of whether Medicare Part A and B enrollment has occurred. However, if Medicare coverage is not in effect at the time of the plan change, there will be a gap in your coverage. Please contact the Social Security Administration at 1-800-772-1213 immediately if Medicare enrollment has not been completed. The state program's Advantage 65 plans will only coordinate with the Original Medicare Plan. Enrollment in a Medicare Advantage Plan (instead of Original Medicare) will generally exclude secondary medical benefits under any Advantage 65 plan. Also, subsequent enrollment in a non-state-program-sponsored Medicare Part D plan or other Medicare prescription drug coverage will result in disenrollment from the state program's Medicare Part D plan.

If the Medicare-eligible family member (you or a dependent) does enroll (or default) in an Advantage 65 plan, he or she will receive a new ID card from Anthem Blue Cross and Blue Shield. If he or she elects or defaults to a plan that includes the state program's Medicare Part D coverage, Express Scripts will also issue an ID card for prescription drug coverage (pending approval by Medicare). If the dental/vision option is elected, Delta Dental will issue a new dental identification card, and your Anthem card will reflect your vision benefits.

If you are enrolling in a plan that includes prescription drug coverage and your Medicare Claim Number is anything other than your own Social Security Number followed by an A, you must notify your Benefits Administrator by submitting the enclosed enrollment form to include this information. Your Medicare Claim Number can be found on your red, white and blue Medicare card, or you may contact 1-800-MEDICARE. Providing an accurate claim number is critical to a successful enrollment in prescription drug coverage. Submission of an incorrect claim number could result in loss of eligibility for the program's Medicare Part D coverage.

If your premium is paid through direct billing (instead of deduction from your retirement benefit), there will be a delay in your premium reduction for one month due to timing issues associated with billing in advance. This will be adjusted in the second month of your plan change. If you overpay your premium, you will be credited for the overpayment. If you wish to pay your new premium for the first month of the plan change, you may do so, even if your bill has not yet been adjusted.

(Insert if applicable) If the effective date of your Medicare eligibility is prior to the date of your move to an Advantage 65 plan and primary claim payments have been paid by the state program in error, you may be contacted by SSDC Disability Services regarding reprocessing of your claims. SSDC is a company that contracts with the State Retiree Health Benefits Program to identify Medicare-eligible participants and correct coordination of benefits errors. You may be asked to sign an authorization form allowing SSDC to act on your behalf to coordinate these recoveries. SSDC will work directly with hospitals, doctors and Medicare to facilitate submission of claims to Medicare for appropriate primary coverage payments.

More information regarding Medicare and the State Retiree Health Benefits Program and Prescription Drug Coverage for Medicare-Eligible Retirees can be found at <http://www.dhrm.virginia.gov/hbenefits/retirees/factsheet.html>. A Member Handbook describing your new coverage will be mailed to you. It is important that you understand the changes in your coverage

Thank you for your attention to this important benefits information.

Enclosure: Enrollment Form
Retiree Fact Sheets (If you include the fact sheets, you can remove the reference to them in the last full paragraph above)