

# Eligibility, Enrollment and Plan Choices

## Who is eligible?

You are eligible to enroll in the State Retiree Health Benefits Program if:

- You are a retiring state employee who is eligible for a monthly retirement benefit from the Virginia Retirement System (VRS) or a periodic benefit from one of the qualified Optional Retirement Plan (ORP) vendors, **and**
- You start receiving (do not defer) your retirement benefit immediately upon retirement\*, **and**
- Your last employer before retirement was the Commonwealth of Virginia, **and**
- You were eligible (even if you were not enrolled) for coverage as an active employee in the State Health Benefits Program until your retirement date (not including Extended Coverage/COBRA), **and**
- **You enroll no later than 31 days after your retirement date.**

\*For VRS retirees, this 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.

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 a family member on their spouse's active or retiree state health benefits membership may enroll in the retiree group within 31 days of the loss of that family member coverage. Failure of the retiree to submit a waiver at the time of retirement may result in lack of documentation to support continuous coverage in 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. See your Benefits Administrator if you think this applies to you.

- Under certain circumstances, retroactive approval of a disability retirement may allow for enrollment within 31 days of the approval notification letter. See your Benefits Administrator for more information.

## **How do I enroll at retirement?**

To assure a smooth transition from active employee coverage to retiree coverage, contact your agency Benefits Administrator before your retirement date to complete your enrollment. Early enrollment will help to prevent problems during the transition from active to retiree coverage; however, you do have 31 days from your retirement date to enroll. After that enrollment window has been exhausted, you will not have another opportunity to enroll (see above exceptions).

Once your election is in effect (including waiver), you will not have an opportunity to make an election change except as allowed by the policies and procedures of the Department of Human Resource Management, even within the 31 days after your retirement date. If you enroll early, review your election prior to its effective date to make sure that it is accurate and complete.

If you are eligible for Medicare and wish to enroll in the State Retiree Health Benefits Program at retirement, be sure that your Medicare Parts A and B are active on the date of your retirement.

If you do not wish to enroll in retiree coverage, be sure to sign the “Cancel/Decline Coverage” portion of the Enrollment Form.

## **When does coverage begin?**

Coverage in the retiree group begins on the first day of the first full month of retirement if the retiree is eligible and enrolls within 31 days of his/her retirement date. Once you have enrolled in retiree coverage and the coverage begins, you may not terminate your coverage retroactively. **If you change your mind and decide not to enroll in retiree coverage, be sure to rescind your enrollment prior to the effective date of coverage.**

## **Who is not eligible?**

You are not eligible for the State Retiree Health Benefits Program if:

- You do not fulfill all eligibility criteria;
- You decline coverage when you retire;
- You fail to submit an enrollment form to your Benefits Administrator within 31 days of your retirement date;
- You defer retirement when you leave State employment;\*  
(Deferring retirement means that you will receive your retirement benefit at a later time, rather than directly after leaving eligible employment—as designated by VRS.)

- You cancel coverage at any time after enrollment.

*\*There are exceptions for certain involuntarily-terminated employees with 20 years of creditable service. See your Benefits Administrator for more information if you think this applies to you.*

## **What types of coverage are offered?**

The State Retiree Health Benefits Program is divided into two types of coverage:

- Plans available to retirees and covered family members who **are not eligible for Medicare, and**
- Plans available to retirees and covered family members who **are eligible for Medicare.**

All participants (retirees and family members) must choose a plan based on Medicare eligibility. Two or more non-Medicare-eligible family members must choose the same non-Medicare plan. All Medicare-eligible family members will have individual coverage and may choose different plans. However, no family will be required to pay a premium higher than the family membership premium for the non-Medicare plan in which the non-Medicare family members are enrolled.

The ***Medicare and the State Retiree Health Benefits Program, Fact Sheet #5***, is a good reference for more information about how your retiree health benefits work with Medicare.

See pages 8—9 for a list of Medicare and non-Medicare plans.

## **Can I enroll in the TRICARE supplement?**

Non-Medicare-eligible retiree group enrollees who are eligible for TRICARE can elect the TRICARE supplement within 31 days of retirement (if otherwise eligible), at open enrollment or with a consistent qualifying mid-year event (e.g., new eligibility for TRICARE). They can return to state program options at open enrollment or with a consistent qualifying mid-year event (e.g., loss of eligibility for TRICARE), upon Medicare eligibility of a covered family member, or upon loss of TRICARE eligibility of a covered child (e.g., reaching TRICARE's limiting age). Family groups may not split coverage between the TRICARE supplement and another state program plan. TRICARE supplement participants will be billed directly for their monthly premium; it may not be deducted from a retirement benefit. Consult your Benefits Administrator for additional information.

## **Who are my eligible family members?**

**Eligible Retiree Group Enrollees may cover the following family members:**

The Retiree Group Enrollee's Spouse (except for spouses of non-annuitant survivors—non-annuitant surviving spouses lose eligibility for coverage if they re-marry): The marriage must be recognized as legal in the Commonwealth of Virginia.

### The Retiree Group Enrollee's Children

Under the State Retiree Health Benefits Program (the program), the following eligible children may be covered to the end of the calendar year in which they turn age 26 (the program's limiting age). The age requirement is waived for adult incapacitated children:

#### Natural Children, Adopted Children, and Children Placed for Adoption

**Stepchildren:** A stepchild is the natural or legally adopted child of the Retiree Group Enrollee's legal spouse. Such marriage must be recognized by the Commonwealth of Virginia.

**Incapacitated Dependents:** Adult children who are incapacitated due to a physical or behavioral health condition, as long as the child was covered by the program and the incapacitation existed prior to the termination of coverage due to the child attaining the limiting age. The Retiree Group Enrollee must make written application, along with proof of incapacitation, prior to the child reaching the limiting age. Such extension of coverage must be approved by the Plan and is subject to periodic review. Should it be determined that the child no longer meets the criteria for coverage as an incapacitated child, the child's coverage will be terminated at the end of the month following notification from the Plan to the Retiree Group Enrollee. The child must live with the Retiree Group Enrollee as a member of his or her household, not be married, and be dependent upon the Retiree Group Enrollee for financial support. In cases where the natural or adoptive parents are living apart, living with the other parent will satisfy the condition of living with the Retiree Group Enrollee. Furthermore, the support test is met if either the Retiree Group Enrollee, the other parent, or combination of the Retiree Group Enrollee and the other parent provide over one-half of the child's financial support.

**Adding Adult Incapacitated Dependents as a Qualifying Mid-Year Event:** Adult incapacitated dependents that are enrolled on a parent's group employer coverage, or in Medicare or Medicaid, may be enrolled in the program with a consistent qualifying mid-year event (as defined by the Office of Health Benefits) if the dependent remained continuously incapacitated, eligibility rules are met, required documentation is provided, and the administrator for the plan in which the Retiree Group Enrollee is enrolled approves the adult dependent's condition as incapacitating. Eligibility rules require that the incapacitated dependent lives at home, is not married, and receives over one-half of his or her financial support from the Retiree Group Enrollee.

The following documentation is required by the claims administrator to approve the dependent's coverage:

- Evidence that the dependent has been covered continuously as an incapacitated dependent on a parent's group employer coverage or covered under Medicaid or Medicare since the incapacitation first occurred;
- Proof that the incapacitation commenced prior to the dependent attaining age 26; and,
- An enrollment form adding the dependent within 60 days of the qualifying mid-year event, accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset, and certifying that the dependent is not capable of financial self-support. The plan reserves the right to request additional medical information and to request an independent medical examination.

If an incapacitated dependent leaves the program and later wants to return, the review will take into consideration whether or not the same disability was present prior to reaching the limiting age and continued throughout the period that the child was not covered by the program. If the dependent was capable of financial self-support as an adult, and then became disabled, the disability is considered to have begun after the plan's limiting age, and the person cannot be added for coverage.

**Other Children:** An unmarried child for which a court has ordered the Retiree Group Enrollee (and/or the Retiree Group Enrollee's legal spouse) to assume sole permanent custody. The principal place of residence must be with the Retiree Group Enrollee, the child must be a member of the Retiree Group Enrollee's household, the child must receive over one-half of his or her support from the Retiree Group Enrollee, and custody was awarded prior to the child's 18<sup>th</sup> birthday.

Additionally, if the Retiree Group Enrollee or spouse shares custody with his or her minor child who is the parent of the "other child", then the other child may be covered. The other child, the parent of the other child, and the spouse, if the spouse is the one who has shared custody, must be living in the same household as the Retiree Group Enrollee.

When the minor child, who is the parent of the other child, reaches age 18, the Retiree Group Enrollee must obtain sole permanent custody of the other child and provide this documentation to the Benefits Administrator.

**Documentation Requirements:** The Retiree Group Enrollee must provide proof of a dependent's eligibility, as defined by the Department of Human Resource Management, when the Retiree Group Enrollee submits the enrollment request. The Benefits Administrator can provide specific requirements.

**Note:** Individuals may not be covered as family members unless they are US citizens, US resident aliens, US nationals, or residents of Canada or Mexico. However, there is an exception for certain adopted children. Retiree Group Enrollees who legally adopt a child who is not a US citizen, US resident alien, or US national, may cover the child if the child lived with the Retiree Group Enrollee as a member of his/her household all year. This exception also applies if the child was placed with the Retiree Group Enrollee for legal adoption.

## **Those not eligible for coverage:**

There are certain categories of persons who may not be covered as family members under the program. These include:

- Divorced spouses\*
- Parents
- Grandparents
- Aunts
- Uncles
- Dependent siblings\*\*
- Grandchildren\*\*
- Nieces\*\*
- Nephews\*\*

\*A court order to provide coverage for an ex-spouse does not make the ex-spouse eligible for coverage under this plan.

\*\*The Department of Human Resource Management may determine when children who normally would not be eligible satisfy the criteria for “other children.”

**Failure to remove ineligible family members within 60 days of a loss-of-eligibility event may result in suspension from the plan and/or retraction of claim payments.**

## **What are my plan choices?**

If you are eligible and decide to enroll in the State Retiree Health Benefits Program at the time of retirement, you are required to choose a plan based upon whether you **are** or **are not** eligible for Medicare. Available plans are listed on pages 8—9.

## **How does Medicare affect my coverage?**

If you are eligible for Medicare at the time of retirement and enroll in the State Retiree Health Benefits Program, or if you become eligible for Medicare as a retiree group participant (including covered family members), you must enroll in Medicare Parts A and B (Original Medicare) in order to coordinate with state program plan options. Medicare becomes the primary payer for Medicare beneficiaries once coverage is based on former (as opposed to current) employment. As a retiree group participant, failure to enroll in a Medicare-coordinating plan and Medicare Parts A and B immediately upon Medicare eligibility (or immediately upon retirement if the new retiree or any of his/her covered family members are already eligible for Medicare) will result in retraction of primary claim payments made in error and can result in a gap in coverage since the state program will not pay for services that would have been paid by Medicare had proper enrollment in Medicare Parts A and B occurred. Submission for enrollment in Medicare Part D (the Medicare prescription drug program) will be automatic upon enrollment in Advantage 65 or Advantage 65 + Dental/Vision. However, you may also choose medical-only coverage and obtain Medicare Part D outside of the state program.

It is strongly recommended that new retirees who are eligible for Medicare contact the Social Security Administration (1-800-772-1213) and Medicare (1-800-MEDICARE) at least three months prior to their retirement date to arrange/confirm enrollment and to ensure that Medicare is aware of the pending change in employment status, which drives correct coordination of benefits. Generally, coverage based on current employment dictates a large group health plan as the primary payer of claims, while coverage as a retiree means that Medicare becomes the primary payer. If you are covered by the state program as an active employee prior to retirement, explain that you will be losing that coverage and need to have your record updated to reflect your new retirement status.

If you enroll in Advantage 65 or Advantage 65 + Dental and Vision, which includes Medicare Part D prescription drug coverage, the state program will submit your enrollment for its state-program-sponsored Medicare Part D plan. However, if Part D coverage is denied by Medicare, participants will be moved to a medical-only plan (no prescription drug coverage). Be sure that the Medicare information you submit on your enrollment form, including your Medicare Claim Number, is accurate to avoid denial of Part D coverage. Enrollment in a non-state-program-sponsored Medicare Part D plan will result in denial of coverage or disenrollment from the state's Medicare Part D coverage. The state program generally cannot override a denial or disenrollment by Medicare.

Enrollment in Advantage 65—Medical Only will require separate enrollment in a Medicare Part D Plan (or other prescription drug coverage) not associated with the state program in order to facilitate drug coverage. Advantage 65—Medical Only does not provide any outpatient prescription drug benefit. Be sure to consult Medicare regarding your rights and obligations regarding enrollment in Medicare Part D outside of the state program. Once a Medicare-eligible participant declines or terminates drug coverage under either the Advantage 65 or the Advantage 65 + Dental/Vision Plan (or Option I or Option II for current participants), he/she may not enroll in drug coverage under any state-sponsored Medicare-coordinating plan in the future.

Retiree Fact Sheet #5, ***Medicare and the State Retiree Health Benefits Program***, has additional information regarding the coordination of these benefits.

### **When can I cancel coverage?**

Retiree group participants can request cancellation of coverage at any time, and it will be effective the first of the month after the request is received by their Benefits Administrator. However, once cancelled, there can be no return to the program. Cancellation of retiree coverage will result in cancellation of coverage for all covered family members.

## **Non-Medicare Plans**

*Plan Choices for Retirees and Family Members  
Not Eligible for Medicare*

### **Plans Available to All Non-Medicare Participants**

- *COVA Care with Preventive Dental*
- *COVA Care with Out-of-Network*
- *COVA Care with Expanded Dental*
- *COVA Care with Out-of-Network and Expanded Dental*
- *COVA Care with Vision, Hearing and Expanded Dental*
- *COVA Care with Out-of-Network, Vision, Hearing and Expanded Dental*
- *COVA HealthAware with Preventive Dental*
- *COVA HealthAware with Expanded Dental*
- *COVA HealthAware with Expanded Dental and Vision*
- *COVA HDHP (High Deductible Health Plan) with Preventive Dental*
- *COVA HDHP with Expanded Dental*

### **Regional Plan**

*Designated service area only:*

- *Kaiser Permanente HMO*

*Contact Kaiser for the specific cities and counties covered in their service area*

**A TRICARE supplement** is also available to non-Medicare-eligible retiree group participants who are eligible for TRICARE. For more information, see page three.

# **Medicare Plans**

## **Plan Choices for Retirees and Family Members Eligible for Medicare**

### **Plans Offered by the State Retiree Health Benefits Program**

You may choose one of these plans:

- **Advantage 65**
- **Advantage 65 + Dental/Vision**
- **Advantage 65—Medical Only**
- **Advantage 65—Medical Only + Dental/Vision**

Retirees or covered family members in the retiree group will be enrolled automatically in Advantage 65 + Dental/Vision upon attaining age 65 unless another election is made; an enrollment form is required only to make a different election. If you or a covered family member becomes eligible for Medicare before age 65, you must complete an Enrollment Form to select a Medicare-coordinating plan immediately upon Medicare eligibility.

The following plans are only available to existing enrollees who are not in an Advantage 65 Plan:

- **Option I - Medicare Complementary**
- **Option II - Medicare Supplemental**
- **Option II with Dental/Vision**

### **Plans Offered by Private Insurance Companies**

Medigap or Medicare Advantage Plans are examples of Medicare supplemental plans that, like the state's supplemental plans, are designed to cover gaps in Medicare coverage. Some may include prescription drug coverage. If you choose another plan and cancel your state Medicare-coordinating coverage, **you may not return** to the State Retiree Health Benefits Program. If you enroll in a Medicare Advantage Plan in addition to the state program's Medicare-coordinating plan, you will usually receive no benefit under the state program. If the Medicare Advantage plan also includes prescription drug coverage, it could result in termination of the state plan's prescription drug coverage since you may not have more than one Medicare drug plan.

### **Non-State-Sponsored Medicare Part D Plans**

If you choose one of the Advantage 65—Medical Only plans, you may obtain prescription drug coverage through separate Medicare Part D plans offered by various insurance companies. For more information about available plans and enrollment, or about Medicare in general, call 1-800-MEDICARE or go to [www.medicare.gov](http://www.medicare.gov). Note: once you have cancelled prescription drug coverage under any state-sponsored Medicare-coordinating plan, you may not add it under the state program later.

### **Note To Option I And II Enrollees**

Retirees currently enrolled in Medicare Complementary (Option I) and Medicare Supplemental (Option II) may continue enrollment in these plans. However, on July 1, 1997, these plans were closed to new enrollees and replaced by the Advantage 65 plan, which combines features of both plans. Option I and II enrollees may elect to participate in the Advantage 65 plan prospectively at any time, but they may not re-enroll in Option I or Option II after electing any Advantage 65 plan. Neither the Option I nor Option II plan offers medical-only coverage. If you are disenrolled from the state program's Medicare Part D coverage, you may not remain in Option I or Option II since they are not available without drug coverage. See your annual rate notification materials for additional information about Option I and Option II.