Making Changes

As a retiree, may I make changes to my plan or membership level?

Changes in plan and membership can be made under certain circumstances as addressed below:

Both Medicare and Non-Medicare Retiree Group Enrollees may make membership level changes which are consistent with the occurrence of certain Life events (Qualifying Mid-Year Events). These include:

Events that are consistent with Increasing Membership

- *Marriage*
- *Birth, adoption, or placement for adoption*
- *Eligible family member loses eligibility for Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), or other government plan*
- *Eligible family member loses employer eligibility*
- *Judgment, decree or order requiring coverage of an eligible child*
- *Sole permanent custody of eligible child granted*
- *Spouse or eligible child's open enrollment or significant change under another employer's plan resulting in termination of coverage*
- *HIPAA Special Enrollment due to:*
    - *Loss of eligibility for other coverage for which the State Program was declined*
    - *Eligible family member also becomes eligible for Medicaid or CHIP premium assistance subsidy*
    - *Eligible family member loses coverage in Medicaid or the State Children's Health Insurance Program (CHIP)*

Events that are consistent with Decreasing Membership

Retiree group Enrollees may reduce membership prospectively at any time, but some events allow for extending coverage beyond the termination event date per the Extended Coverage provisions of the Public Health Service Act. Refer to your General Notice, Member Handbook or Benefits Administrator for more information.

- *Divorce from Enrollee*
- *Death of covered family member*
- *Covered child loses eligibility under plan provisions*
- *Judgment, decree or order to remove child*
- *Covered family member gains eligibility for Medicare or Medicaid*
- *Covered family member gains employer eligibility*
- *Covered family member's open enrollment or significant change under another employer's plan resulting in eligibility for coverage*
- *Enrollment in Marketplace Exchange Health Plan*

Allowable Changes for Non-Annuitant Survivors

Non-annuitant surviving spouses may be covered until remarriage, obtaining alternate health insurance coverage, or death. 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).

Non-annuitant survivors may not add new dependents. Non-annuitant surviving spouses who lose eligibility will lose coverage at the end of the month in which the loss-of-eligibility event occurs. Non-annuitant surviving children will also lose coverage at the end of the month in which they lose eligibility, but they may elect Extended Coverage. There is no Extended Coverage qualifying event for Non-Annuitant Surviving Spouses who lose eligibility for the program.

Event that would allow a Plan Change

- *Move affecting eligibility for plan (non-Medicare plans only)*

The following limitations apply:

Notification: Submit an Enrollment Form within 60 days of the Life Event/ Qualifying mid-year event (see "Effective Date of Change" below). Late notification may result in loss of premium, loss of the opportunity to add eligible family members, suspension of coverage (due to allowing coverage of an ineligible family member) and/or retraction of claim payments.

Consistency: Election changes based on qualifying mid-year events must be consistent with the event involved. For example, divorce would be consistent with removing a spouse; marriage would be consistent with adding a spouse.

Effective Date of Change: Generally, election changes will be effective the first of the month following notification of the event, provided that it is made within 60 days of the event (60 days begin on the day of the event). This means that you must submit an Enrollment Form within 60 days of the applicable qualifying mid-year event, and the date of the requested change will be effective the first of the month after receipt of the election. However, election changes for the birth, adoption, or placement for adoption of a child will be effective on the first day of the month in which the event occurs, as long as notice is given within 60 days of the event. Family members who lose eligibility in the plan will cease to be covered at the end of the month in which the loss-of-eligibility event takes place, regardless of the date of notification. See your Member Handbook for additional information.

Reducing Membership or Canceling Coverage: Retiree group Enrollees may reduce membership or cancel coverage prospectively (going forward) at any time, but retirees and survivors who cancel coverage may not re-enroll in the future. (See ***Retiree Fact Sheet #11*** for more information about VSDP LTD Enrollees.)

Some policies apply specifically to either Medicare or non-Medicare Retiree Group Enrollees:

Non-Medicare Retiree Group Enrollee Rules:

Open Enrollment: Non-Medicare Retiree Group Enrollees may make membership and/or plan changes at open enrollment, including adding Medicare-eligible family members. Enrollees must live in the service area of the plan they elect.

Service Area Changes: A change in plans must be made if an Enrollee moves out of a plan's service area (e.g., Kaiser HMO or Sentara Health Vantage HMO).

Medicare Eligibility: Retiree Group Enrollees and their covered family members must elect a Medicare-coordinating plan immediately upon eligibility for Medicare. NOTE: Failure of retiree group Enrollees and their covered family members to enroll in a Medicare-coordinating plan and Medicare Parts A and B immediately upon Medicare eligibility will result in retraction of primary claim payments made in error and can result in a gap in coverage since Advantage 65 will not pay for services that would have been paid by Medicare had proper enrollment in Medicare Parts A and B occurred.

For Retiree Group Enrollees in the Tricare supplement, Medicare eligibility of any family member (and loss of eligibility for the Tricare supplement), would allow return of covered family members to other state program options. A family group may not be split between the Tricare supplement and other state program plans.

Medicare Retiree Group Enrollee Rules:

Plan Changes: Enrollees in Medicare-coordinating plans do not have an annual open enrollment period, so the opportunity for plan changes is limited. Advantage 65 and Advantage 65 Medical Only (both with or without Dental/Vision) are the only Medicare-coordinating plans available to new Medicare-eligible retiree group participants or those existing participants newly eligible for Medicare. Coverage under Advantage 65 may be canceled prospectively (going forward) at any time, but once canceled by the Enrollee, coverage may not be reinstated in the future. The cancellation of a retiree group Enrollee's coverage will result in termination of any family members covered by virtue of the retiree's/LTD participant's/survivor's membership.

Retirees or Survivors who are currently enrolled in Option II (Medicare Supplemental) may elect Advantage 65 coverage prospectively at any time. However, if they cancel coverage in Option II to elect Advantage 65, they may not enroll in Option II in the future.

Dental/Vision coverage may be added to a Medicare-coordinating plan at any time, or it may be canceled at any time (prospectively). However, once it has been elected and canceled once, Enrollees may not re-enroll in the future.

Membership Changes: Medicare-eligible retiree group Enrollees may add eligible family members only upon the occurrence of a consistent qualifying mid-year event. Medicare-eligible retiree group Enrollees do not have an open enrollment period.

To facilitate coordination of benefits with Medicare, Medicare-eligible retiree group Enrollees and their covered family members have separate ID numbers.

However, even though their coverage is under separate contracts, the family member's coverage will end immediately upon the termination of the retiree group Enrollee through whom the family member's eligibility is obtained.

If I am eligible to make a change, where do I send my completed enrollment form?

You may send your completed paper enrollment form to your Benefits Administrator as follows:

If You Are A:	***Your Benefits Administrator is:***
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Participant	The Virginia Retirement System 888-827-3847 www.varetire.org PO Box 2500 Richmond, VA 23218-2500
Local or Optional Retirement Plan Retiree	Your Pre-Retirement Agency Benefits Administrator
Non-Annuitant Survivor (a survivor of an employee or retiree, not receiving a VRS benefit)	Department of Human Resource Management 888-642-4414 www.dhrm.virginia.gov 101 N. 14th Street, 13th Floor Richmond, VA 23219

Who is authorized to make plan or membership changes?

Changes can be made only by the Retiree or other plan member who is the eligible Enrollee through whom family members are eligible for coverage (e.g., the retiree, survivor or LTD Enrollee). Family Members may not submit plan or membership changes. This means that the original Enrollee, not covered family members, must sign any enrollment form requesting changes.

***What should I do If my address changes*?**

Having your correct name and address on file ensures that you receive claim information and communications about your health plan coverage. You will miss important information if you do not update your mailing address. Failure of Enrollees to provide up-to-date address information will not be considered as an adequate reason to allow enrollment or changes outside of designated time limitations. Administrators (medical, dental, prescription drug, behavioral health) will not send replacement cards to Enrollees whose address has been

determined to be incorrect. Enrollees must change their address with their Benefits Administrators, and the Benefits Administrators will ensure that the claim administrator's system is updated. Once their system is updated, you may request replacement cards from the claims administrator.

If you are a VRS Retiree/Survivor/LTD Enrollee

Contact VRS to request a **Name/Address Change Form** (Form VRS-58). This form is also available on the VRS Web site at **http://www.varetire.org.**

Allow 30 days for your name or address change to become effective. Retirees whose monthly benefit is direct deposited need only call VRS at (804) 649-8059 in Richmond or toll free at 1-888-827-3847 to report address changes.

If you are an ORP Enrollee or Local Retiree

Notify your pre-retirement agency's Benefits Administrator (not VRS) of your name or address change.

If you are a Non-Annuitant Survivor (not receiving a VRS benefit)

Mail your name/address changes to: Department of Human Resource Mgmt., Office of State and Local Health Benefits, Attn: Retiree Services, 101 N. 14th Street, 13th Floor, Richmond, VA 23219