

Enrollment Information

For Retirees Eligible for Medicare



About This Brochure

Your employer has selected The Local Choice Health Benefits Program to provide health care coverage for you and your eligible family members. This brochure provides important information about how to enroll and special provisions that apply to The Local Choice plans. Take time to review the other materials in your enrollment package as well:

- ▲ **Benefits Summary** — Your package contains a Benefits Summary of the Medicare plan offered by your employer. The Benefits Summary outlines the benefits and general information about the plan.
- ▲ **Enrollment/Waiver Form** — This form must be used to enroll yourself and any other eligible family members in a plan. You must also complete this form if you choose to waive coverage (Part A of form). Whatever your decision, you must return this form to your former employer's Benefits Administrator.

About The Local Choice Health Benefits Program

The Local Choice is a unique health benefits program managed by the Commonwealth of Virginia's Department of Human Resource Management (DHRM). It was created especially for local governments, school boards, and constitutional officers seeking affordable health care benefits for their employees and retirees. No matter which plan you join, you will be served by customer service and claims processing professionals dedicated to serving Local Choice members.

A One-Time Opportunity To Enroll Yourself

You have a one-time opportunity to enroll in The Local Choice Health Benefits Program. That opportunity is now if you are currently eligible for Medicare, or at the appropriate time in the future when you become Medicare eligible.

Your Benefits Administrator is prepared to help you enroll and will assist you with enrollment procedures. In this brochure you will find more enrollment information and guidelines for making changes at other times of the year.

You must decide now to enroll or to waive coverage in The Local Choice program *for retirees*.

- ▲ **If you decide to waive enrollment**, you or your eligible family members will not be able to join at a later date.
- ▲ **If you decide to enroll**, eligible family members also may enroll now or they may be added at a future Open Enrollment. To take advantage of this one-time enrollment opportunity, simply complete the enclosed Enrollment/Waiver Form and return it to your Benefits Administrator.

The Local Choice is the only program that your employer offers to retirees. If your employer currently sponsors a health benefits program or plan for retirees, it will end as of the effective date of The Local Choice program.

Types Of Membership

Single Membership

Each person eligible for Medicare has his or her own individual membership in Advantage 65, Medicare Complementary, Dental/Vision, or the Drug Only plan, administered by Trigon Blue Cross Blue Shield.

Membership When Other Family Members Enroll

The following types of membership are available if you wish to enroll yourself and eligible family members:

- ▲ Retiree with Medicare and Dependent(s) with Regular (Non-Medicare) Coverage
- ▲ Retiree with Regular Coverage and Dependent(s) with Medicare
- ▲ Both Retiree and Dependent(s) with Medicare

You and your dependent(s) must enroll under the same type of plan—either a Trigon administered or a fully insured regional Health Maintenance Organization (HMO), or a Point of Service (POS) plan. For example, if you are eligible for Medicare but your spouse is not:

- ▲ If you choose one of the Trigon-administered plans, your spouse must enroll under a Trigon Blue Cross Blue Shield plan available to active employees.

Retiree Plus One Or Family Membership

If you have one or more dependents who are not eligible for Medicare, contact your Benefits Administrator for assistance.

Why Your Eligible Family Members Should Enroll Now

It's important to enroll family members now. Otherwise you must wait until the next annual Open Enrollment period set by your employer to add family members or change your type of membership, unless you experience an event such as marriage or divorce or death of an enrolled family member. Please see the complete list of life events on page 3. Always contact your Benefits Administrator when any of these changes occur.

Your Benefits Administrator has Enrollment/Waiver Forms. You must complete and return a form to your Benefits Administrator within 31 days of the life event.

The following family members are eligible to enroll:

- ▲ Your spouse;
- ▲ Your unmarried children, biological or legally adopted;
- ▲ Your unmarried stepchildren who live with you in a parent-child relationship and are dependent upon you for federal income tax purposes; and
- ▲ Other children if a court orders the eligible employee or retiree to assume permanent, court-ordered custody of the child.

The age limit for unmarried dependent children who are not self-supporting is the last day of the calendar year in which the child reaches age 23.

A dependent child, regardless of age, may continue membership if he or she is incapable of self-support because of a severe physical or mental handicap diagnosed while the child is enrolled under the plan. Application to continue coverage must be completed and returned to the Benefits Administrator at least 31 days before the child becomes ineligible due to age. The physical or mental handicap must have existed prior to the end of the year in which the child reached age 23.

A child who is self-supporting or married loses eligibility.

How To Enroll

Your Benefits Administrator will answer questions and assist you with enrollment procedures. To enroll in a Local Choice plan, simply complete, sign, and return the enclosed Enrollment/Waiver form to your Benefits Administrator.

To receive maximum benefits, your non-Medicare eligible dependents must select a primary care physician from the Key Advantage and Cost Alliance Provider Directory and write the name of the PCP on the Enrollment/Waiver Form. The directory is available from your Benefits Administrator.

If you decide not to enroll now or at any time in the future, you must sign and date Part A of the form, and return it to your former employer's Benefits Administrator.

Your Benefits Administrator can give you guidance, but cannot make decisions for you. Remember, it's your responsibility to ensure that your Enrollment/Waiver form is returned by the deadline set by your employer.

Life Events

These events may permit an election change outside the annual Open Enrollment period. Most allow you to change your membership. To be allowed, changes must be consistent with and on account of the life event. If you fail to submit an Enrollment/Waiver Form to your Benefits Administrator within 31 days of the life event, you will not be allowed to make a change until the next Open Enrollment Period. If you have questions about these events, contact your Benefits Administrator.

Events Which Allow You To Change Your Membership Outside Of The Open Enrollment Period

- ▲ Marriage, divorce, or death of a spouse
- ▲ Birth or adoption*
- ▲ Death of a covered child
- ▲ Covered child exceeds plan's age limit
- ▲ Covered child marries
- ▲ Court order to cover a child
- ▲ Gains or loses eligibility for a government-sponsored plan
- ▲ Spouse or covered child begins/ends employment
- ▲ Spouse or covered child begins/ends leave without pay
- ▲ Spouse or covered child begins/ends family medical leave
- ▲ Annual enrollment or changes allowed under another employer's plan
- ▲ Moves in or out of a plan's service area

*Pre-adoptive placements may be approved under certain circumstances.

If you have any questions about life events or need assistance for changing your type of membership, contact your Benefits Administrator.

If You Need More Information

Your Benefits Administrator will assist you when you have questions. You may also visit The Local Choice Web site at www.thelocalchoice.state.va.us or call Trigon Member Services at (804) 355-8506 in Richmond or 1-800-552-2682 outside Richmond.

Questions And Answers

I have health benefits already. Why should I enroll?

If you are enrolled in a health benefits plan sponsored by your employer for retirees, it will be canceled when The Local Choice program becomes effective. That means unless you complete and return an Enrollment/Waiver Form, you will not be covered and will not be able to join at a later date.

If you are enrolled in another program which is not sponsored by your employer, compare the benefits available. If the other program ends at any time for any reason, and you are not a member of your employer's retiree plan, you will not be able to join at a later date. **Remember, this is a one-time opportunity.**

Are there waiting periods?

The Local Choice health benefits plans do not have waiting periods or pre-existing condition restrictions.

Is it important to choose Medicare participating physicians?

Yes. It is extremely important for you to be enrolled in both Medicare Part A and Part B and to select a Medicare participating physician. Here's why:

Doctors have the option to sign a participating agreement with Medicare. A doctor who signs this agreement "accepts assignment" for all services furnished to Medicare patients. This means the doctor files your Part B claims for you and accepts Medicare's payment for covered services. It also means your copayment is limited to a percentage of the Medicare-approved charge.

▲ Advantage 65 pays your Medicare Part B copayment in full up to the Medicare-approved charge, after you meet the \$100 Medicare Part B calendar year deductible.

▲ With Medicare Complementary, you pay out of pocket the first \$1,000 of Medicare-approved Part B expenses. Then the plan pays your copayment in full up to the Medicare-approved charge.

On the other hand, if you go to a physician who does not accept assignment for Medicare, you are responsible for any amounts above the Medicare-approved charge. However, the amount may not exceed 115% of the Medicare-approved charges.

Call your nearest Social Security office for more information about Medicare participating physicians.

Will I receive other information?

Yes. Before your coverage becomes effective, you receive an identification card to be used (along with your Medicare card) each time you receive health care services. Also, you receive a Member Handbook which provides complete information about your health benefits plan.

What if my claim is denied and I disagree?

Any plan you choose during this one-time enrollment opportunity has an appeals procedure. The appeals procedure is outlined in detail in the Member Handbook. If all or part of a claim is denied, you have the right to appeal the plan's decision. All requests for an appeal must be made in writing. Address your appeals request to the department indicated and the address shown in the Member Handbook. If Medicare denies a claim, the appeals procedure is handled in the manner prescribed by the Social Security Administration.