COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

Group Administrator Memo #06-02

To: Group Benefits Administrators

From: Mary P. Habel, Director
State and Local Health Benefits Programs

Date: March 24, 2006

Re: Creditable Coverage Disclosure

As promised during the TLC Regional Meetings, enclosed you will find guidance in filing your Creditable Coverage Notice with the Centers for Medicare and Medicaid Services (CMS). CMS requires that all employers file this form electronically by 03/31/2006.

The CMS on-line Creditable Coverage Disclosure form is available at https://www.cms.hhs.gov/apps/ccdisclosure/default.asp . Additional detailed guidance is available by clicking on the link found at the top of the Disclosure form.

Key points to consider when completing the form include:

- Your Group is the Entity Offering Coverage, therefore your group name, address, phone number and Federal ID number must be listed.
- Under type of coverage, TLC groups are considered Local Governments.
- How many Prescription Drug Options are offered refers to the number of plans your group offers to active employees. Key Advantage Expanded, Key Advantage 200, Key Advantage 300, Key Advantage 500 and Kaiser are each considered one (1) option. For example, if your group offers Key Advantage Expanded and Key Advantage 500, you would list two (2) in this section.
- All TLC plans are Creditable.
- Plan Year references are to the current fiscal year and would be 07/01/2005 through 06/30/2006 for government groups. Certain School Group plan years may be 10/1/2005 through 9/30/2006. You are required to file again within two months after the end of the current plan year (by 08/31/2006 or 11/30/2006 for certain school groups).

- You must next estimate the number of Medicare Part D eligible individuals you expect to be covered under the plans. This is the number of covered employees and dependents that are over age 65, disabled, or Medicare Eligible.
- There should be no one covered under a Union Retiree Group Health plan.
- On 11/02/2005, we sent you Numbered Memo 05-09 asking that you send a creditable coverage letter to your participants. You must complete the form to indicate when you sent that letter.
- Since this is your initial Disclosure this filing would not be a change.
- Finally, your Executive's name, Title and e-mail address should be listed and the date you submit the form completed. It is required that you file by 03/31/2006.

Should you have questions, please feel free to contact Walter E. Norman, TLC Program Manager at (804) 786-6460 or via email at walter.Norman@dhrm.virginia.gov .

Enclosures

CMS Centers for Medicare & Medicaid Services

Creditable Coverage Disclosure to CMS Website

Please refer to the Disclosure to CMS Guidance at http://www.cms.hhs.gov/CreditableCoverage/ for detailed information when completing this form.

Complete the following information for each Type of Coverage offered by the Entity/Plan Sponsor:

Name of Entity Offering Coverage
Your Group NAme

Entity Federal ID Number Your ID ex: xx-xxxxxxx

Street Address of Entity Your Address

City Your Address State Zip Code

Phone Number of Entity Your pHone# ex: xxx-xxx-xxxx

Type of Coverage (Choose One):

GROUP HEALTH PLAN:
- ○ Employer Sponsored Plan
- ○ Union/Taft Hartley Sponsored Plan
- ○ Church
- ○ Federal Government
- ○ State Government
- X Local Government
- ○ Other Entity

STATE-SPONSORED PLANS:
- ○ Medicaid
- ○ State Pharmacy Assistance Program (SPAP)
- ○ State High Risk Pool
- ○ Other State-Sponsored Plan:

MEDIGAP (Medicare Supplement) PLAN (as defined under §403.205):
- ○ Standardized Plan (H, I, J)
- ○ Pre-standardized Plan
- ○ Waiver State Plan
- ○ Innovative Benefit Rider

- ○ INDIVIDUAL HEALTH INSURANCE (Non-Medigap Plans)
- ○ VETERANS COVERAGE (under Chapter 17 of Title 38 U.S.C.)
- ○ MILITARY COVERAGE (under Chapter 55 of Title 10, U.S.C., including TRICARE)
- ○ INDIAN HEALTH SERVICE
- ○ TRIBE OR TRIBAL ORGANIZATION
- ○ URBAN INDIAN ORGANIZATION
- ○ OTHER TYPE OF COVERAGE OFFERED TO MEDICARE PART D ELIGIBLE INDIVIDUALS

Please Fill in Type of Plan:

* Based on # of Active plans offered.

How many Prescription Drug Options offered under this Coverage? [*]

* KA+, KA200, KA300, KA500 and Kaiser each count as 1 option.

Please Select **One** of the following and an additional box will appear for you to complete the required disclosure information.

- (X) **All Options Offered Are Creditable.**
- ( ) **All Options Offered Are Non-Creditable.**
- ( ) **There are some Creditable or Non-Creditable Options Offered.**

You have select All Options Offered Are Creditable.

Period covered by this Disclosure:

- Plan Year Beginning Date (MM/DD/YYYY) [07/01/2005] Plan Year Ending Date (MM/DD/YYYY) [06/30/2006] School Groups may be 10/01/2005-09/30/2006
- Total Number of Medicare Part D Eligible Individuals expected to be covered under these Option(s) as of the Plan Year Beginning Date stated above: [Estimate # of covered Actives and Dependents Age 65, disabled or Medicare eligible.]
- Estimated number of those Medicare Part D Eligible individuals stated above expected to be covered through an Employer/Union **Retiree** Group Health Plan [0]
- Date that the Annual Creditable Coverage Disclosure to Part D Eligible Individuals requirement was completed by the entity (MM/DD/YYYY) [Date you sent our letter of 11/2/2005 - Numbered memo 05-09]
- Is this a change to a previous disclosure of creditable coverage status provided to CMS? Yes ( ) No (X)
  - If yes, include the effective date(s) of this change (MM/DD/YYYY) [ ]
  - If yes, date Entity completed the disclosure to Medicare Part D Eligible Individuals of this change in Creditable Coverage(MM/DD/YYYY) [ ]

I understand and agree to the following statements:

- That this submission supersedes any previous submission of this information with dates prior to the date below;
- That the entity/plan sponsor agrees to disclose to CMS and all Medicare Part D eligible individuals any changes that would affect the creditable status of the above coverage as outlined under §423.56.
- That I am authorized to supply this disclosure of creditable coverage on behalf of the Entity; and
- That the information provided in this disclosure is true, correct, and complete to the best of my knowledge and belief.

[Your Executive] (Name of Entity's Authorized Individual)

[Your Executive's Title] (Title)

[Your Executive's E-mail] (Email of Entity's Authorized Individual)

[Date Submitted] Date (MM/DD/YYYY)

Submit the form | Clear All Fields