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## Commonwealth of Virginia Retiree Health Benefits Program

### 2009 Annual Premium Rate Notification for Medicare-Eligible Participants

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***NOTE—NEW DISTRIBUTION:*** Only Enrollees (Retirees, Survivors and Long-Term Disability Participants) will receive this package. Medicare-eligible covered dependents will no longer receive annual premium rate notification materials directly, even if they have separate coverage under their own ID numbers. This means that Enrollees must share this information with their Medicare-eligible covered dependents. Only Enrollees can request coverage changes for covered dependents since the dependents are covered based on the Enrollee's eligibility. If you are an Enrollee who is not eligible for Medicare but are covering a Medicare-eligible dependent, you are receiving this package for the Medicare-eligible dependent whom you cover.





**COMMONWEALTH OF VIRGINIA**  
*DEPARTMENT OF HUMAN RESOURCE MANAGEMENT*

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To: **State Retiree Health Benefits Program Enrollees Eligible for Medicare or Enrollees who cover Medicare-Eligible Dependents**

From: **Office of State and Local Health Benefits Programs**

Date: **November 5, 2008**

**IMPORTANT INFORMATION**

**This notification includes information about coverage for Medicare-eligible participants in 2009. Be sure to read these materials carefully to ensure that you understand program changes and coverage options. Receipt of benefit-specific information in this package does not guarantee those benefits.**

***Your 2009 Premium Cost***

**❖ *How much will my health plan cost in 2009, and what is the reason for the change?***

Your 2009 Medicare-coordinating plan monthly premium cost is listed on page two and will go into effect on January 1. In addition to a side-by-side comparison to your 2008 premium, you will find a chart breaking down the cost of each type of benefit included in your total monthly premium for 2009.

Premium changes reflect only a small increase in overall medical expense for the Advantage 65 and Medicare Supplemental/Option II Plans and resulted in a minimal increase (\$2 for Advantage 65 and \$8 for Option II) for the medical supplement portion of the total premium. However, increased medical claims experience for the Medicare Complementary/Option I Plan resulted in a premium increase of \$26 per month for the medical supplement portion of that plan's total premium.

Lower total claim cost for those with the optional dental/vision coverage resulted in a \$6.00 per month decrease in the cost of that portion of the total premium.

For those plans that include the enhanced Medicare Part D/outpatient prescription drug coverage (all but the Advantage 65—Medical Only Plans), a decrease in claims expense resulted in a \$9.00 decrease in the prescription drug portion of the total premium (from \$151 to \$142). However, to ensure adequate funding for the program in 2009, you will note an increase in the generic and preferred brand co-payment levels for 2009 (see page four), which shifts higher cost to those who use these benefits more often. More information about changes in the Medicare Part D program is included on pages 4—6 and in the updated Member Handbook Prescription Drug insert. In addition, the *Open Forum* newsletter (enclosed for participants who have the state program’s Medicare Part D prescription drug coverage) contains information about drug coverage options. The Department of Human Resource Management’s Office of State and Local Health Benefits Programs strongly encourages you to review these materials to ensure that you are making a sound prescription drug plan decision for 2009.

**The following chart provides a comparison of 2008 premium rates to your new January 1, 2009, premium rates:**

<b>Plan – Single Membership</b>	<b>Current (2008) Monthly Premium</b>	<b>Monthly Premium for 2009</b>
Advantage 65	\$277	<b>\$270</b>
Advantage 65 + Dental/Vision	\$308	<b>\$295</b>
Medicare Complementary (Option I)	\$237	<b>\$254</b>
Medicare Supplemental (Option II)	\$319	<b>\$318</b>
Option II + Dental/Vision	\$350	<b>\$343</b>
Advantage 65—Medical Only*	\$126	<b>\$128</b>
Advantage 65—Medical Only + Dental/Vision*	\$157	<b>\$153</b>

\*Does not include outpatient prescription drug/Medicare Part D coverage.

All State Medicare-coordinating plan medical, dental and vision benefits are administered by Anthem Blue Cross and Blue Shield. For plans that include prescription drug coverage (all but the Advantage 65—Medical Only Plans), the drug benefit is administered by Medco and is an enhanced Medicare Part D plan.

**The following chart breaks down 2009 monthly premiums by type of benefit within each plan.**

<b>Plan – Single Membership</b>	<b>Medical Supplement Cost</b>	<b>Dental/Vision Option Cost</b>	<b>Prescription Drug Option Cost</b>	<b>TOTAL 2009 PREMIUM</b>
Advantage 65	\$128	NA	\$142	<b>\$270</b>
Advantage 65 + Dental/Vision	\$128	\$25	\$142	<b>\$295</b>
Medicare Complementary (Option I)	\$112	Included in medical	\$142	<b>\$254</b>
Medicare Supplemental (Option II)	\$176	NA	\$142	<b>\$318</b>
Option II + Dental/Vision	\$176	\$25	\$142	<b>\$343</b>
Advantage 65—Medical Only	\$128	NA	NA	<b>\$128</b>
Advantage 65—Medical Only + Dental/Vision	\$128	\$25	NA	<b>\$153</b>

❖ **If I qualify with Social Security for extra help with my prescription drug costs (the Low Income Subsidy), how will my premium be affected?**

If you have qualified through the Social Security Administration for extra help (low income subsidy or LIS) with paying the cost of your Medicare Part D coverage, your premium will be reduced for each month you are approved for the subsidy as follows:

If your subsidy is:	Your 2009 monthly premium will be reduced by*:
100%	\$30
75%	\$23
50%	\$15
25%	\$8

\*The state program rounded the reductions defined by Medicare up to the next whole dollar.

Those participants who have qualified for extra help should explore other Medicare Part D plan options outside of the state program. While your state program premium is reduced due to your subsidy (see chart above), you are still paying the balance for an enhanced Medicare Part D benefit that may not be providing you with additional coverage. The Medicare Web site ([www.medicare.gov](http://www.medicare.gov)) or 1-800- MEDICARE can provide you with a summary of additional plans and benefits that are available to you.

If you would like more information about the low income subsidy, contact the Social Security Administration at 800-772-1213.

❖ **When will I begin paying my new 2009 premium?**

For participants whose premiums are deducted from a VRS retirement benefit, the new January premium will be reflected in the February retirement benefit payment. If the premium increase means that your retirement benefit will no longer support your premium deduction, you will be moved to direct billing from Anthem Blue Cross and Blue Shield. Direct billing occurs prior to the coverage month while deduction occurs at the end of the coverage month.

For those who already pay through direct billing, the new January premium will be reflected in your December bill (or later based on the date of any request for change). For those who are paying through automatic bank draft, your first deduction in the new premium amount will take place in your January draft.

## ***Your 2009 Benefits***

### ***❖ Will medical, dental and vision benefits change for 2009?***

There will be no change in the supplemental medical benefits under any of the state's Medicare-coordinating plans for 2009. There will also be no change in benefits for those participants who are enrolled in plans that include routine dental and vision coverage.

Review your *Medicare and You 2009* publication regarding any changes to your Medicare coverage for 2009.

### ***❖ Will prescription drug benefits change for 2009?***

**Note: Medical-Only Plan participants may skip this section and go to “Your 2009 Options—What Do You Need To Do?” on page six.**

If you choose to maintain prescription drug coverage under the state program's enhanced Medicare Part D plan, be sure to review the following changes for 2009:

**Formulary** – (This is your list of covered drugs.) Medco will provide all participants with a new partial formulary for 2009 as a part of your *Annual Notice of Change* package (ANOC). Your ANOC will also include a list of formulary changes that will become effective on January 1, 2009. Some formulary tier changes can result in substantial increased cost to participants. In addition, some drugs are being removed from the formulary for 2009. Be sure to review your ANOC and 2009 formulary carefully to determine if any drugs that you are taking will change tiers, be removed from the formulary or have additional coverage limits for 2009. Your ANOC and *Evidence of Coverage* also provide options for addressing formulary changes.

For additional information, contact Medco customer service at 1-800-572-4098. You may also go to the Commonwealth of Virginia-specific Web site that will be available until December 31, 2008, at:

**<http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html>**.

This link takes you to the Department of Human Resource Management Web site—then just click on the *Medco—Medicare Part D Plan* quick link. Starting January 1, 2009, you may go to **[www.medco.com](http://www.medco.com)** for complete formulary information.

Certain changes can be made to the formulary during the year, such as adding or removing drugs from the formulary; adding prior authorizations, quantity limits and/or step therapy restrictions on a drug; or, moving a drug to a higher or lower cost-sharing tier.

Generally, however, if drugs are removed, coverage limitations are imposed or a drug is moved to a higher cost-sharing tier during the year (after January 1) and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year. Exceptions would include drugs replaced with a new generic or changes as a result of new information on a drug's safety or effectiveness. In those cases, you may be affected by the change. Section two of your *Evidence of Coverage* provides additional information regarding formulary changes. The Centers for Medicare and Medicaid Services has reviewed and approved your formulary.

**Deductible** – Your annual outpatient prescription drug deductible will increase from \$275 to \$295 in 2009. However, there will still be no deductible for covered generics.

**Co-payments/Coinsurance** – Co-payments for Tier 1 (generics) and Tier 2 (preferred brand) drugs will change effective January 1, 2009, as follows:

<b>Covered Tier 1 (generic) Drugs</b>	<b>2009 Co-payment</b>
A one-month (up to 34-day) supply at a retail network pharmacy	\$7
A 90-day supply at a retail network pharmacy	\$21
A 90-day supply through the mail-order pharmacy	\$7

<b>Covered Tier 2 (preferred brand) Drugs</b>	<b>2009 Co-payment</b>
A one-month (up to 34-day) supply at a retail network pharmacy	\$25
A 90-day supply at a retail network pharmacy	\$75
A 90-day supply through the mail-order pharmacy	\$50

There will be no change in coinsurance for covered Tier 3 (non-preferred brand-name) or Tier 5 (specialty) drugs in 2009.

**Catastrophic Coverage** – In 2009, after your annual true out-of-pocket drug expense (not including the cost of non-covered or excluded drugs) reaches \$4,350, you will pay either a \$2.40 co-payment (generics or drugs treated as generics) or \$6.00 co-payment (brand-name drugs) or 5% coinsurance, whichever is greater. For any months during which you use your coverage, you will receive an Explanation of Benefits directly from Medco which will track your covered drug costs.

**Notice of Creditable Coverage** – The outpatient prescription drug coverage that is available through the State Retiree Health Benefits Program to its Medicare-eligible retiree group participants is a Medicare Part D plan. As such, no Notice of Creditable Coverage is required to be provided to participants. However, beneficiaries will not have to pay a higher premium for any period that they are enrolled in this plan if they decide later to enroll in other Medicare Part D coverage, as long as there is not a break in creditable coverage (including this plan) of 63 or more days.

**Enrolling in Part D Plans Outside of the State Program** – Your enrollment in a Part D plan outside of the state program will result in your disenrollment from the state program's Medicare Part D plan. If you do not notify the state program of your election outside of the program, Medicare will do so. Once you have enrolled in Medicare Part D coverage outside of the state program, you may not re-enroll in the state's Part D plan.

Enrollment in the state's enhanced Medicare Part D plan for outpatient prescription drug coverage is contingent upon approval by the Centers for Medicare and Medicaid Services.

The State Retiree Health Benefits Program must remove prescription drug coverage from the plan of any participant whom Medicare has advised is not eligible for this coverage. This could be due to conflicting coverage in another Medicare Part D plan, loss of eligibility for Medicare, or any reason determined by Medicare. You will be notified if Medicare disenrolls you from the state-sponsored Medicare Part D plan and you will be moved to either the Advantage 65—Medical Only Plan or the Advantage 65—Medical Only Plan with Dental/Vision (depending on your existing dental/vision enrollment status). There is no medical-only plan option under the Medicare Supplemental/Option II or Medicare Complementary/Option I Plans.

❖ ***Is the state program's prescription drug coverage the best plan for me?***

As Medicare Part D, the Medicare outpatient prescription drug benefit, approaches its fourth year, the state program continues to provide information to ensure that participants understand that there are other Medicare Part D options available to them. Please take a few moments to read your enclosed *Open Forum* newsletter which includes information to assist you in your Medicare Part D plan decision for 2009.

***Your Options for 2009 – What Do You Need To Do?***

**If you wish to maintain your current benefit plan, no action on your part is required. If you continue to be eligible, your new monthly premium will automatically be deducted or billed.**

**If you wish to make an allowable plan change for January 1, 2009, you must request the change by taking one of the following actions:**

Obtain an enrollment form from your Benefits Administrator (see page ten), or from the Web at [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov) and submit your request to your Benefits Administrator no later than December 15, 2008. An abbreviated enrollment form specifically designed for January 1, 2009, changes is available. (Requests received after December 15, 2008, but before January 1, 2009, will be effective on January 1, but there may be a delay in implementing the change and updating your premium.)

Request changes on-line no later than December 31, 2008, by using EmployeeDirect at [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov) (click on the EmployeeDirect link). To use EmployeeDirect, you must have a personal e-mail address listed in the state's eligibility system. (A state e-mail address will not allow EmployeeDirect access for retiree group participants.) If you do not already have an e-mail address in your eligibility file, you may contact your Benefits Administrator to update your record. NOTE: January 1 changes using EmployeeDirect must be requested during the month of December. If you request an

allowable change through EmployeeDirect in November, it will generally become effective on December 1.

Changes requested after December 31, 2008, will be effective the first of the month after the request is received per program policy. **All Enrollment Forms must be signed by the Enrollee (Retiree, Survivor or LTD Participant); forms signed by a covered dependent will not be accepted.**

The following options are available to you for January 1:

**You may keep your current benefit plan (no action required).**

You may make a plan change as follows:

- You may elect Medical-Only coverage (no outpatient prescription drug coverage). If you drop your prescription drug coverage, you may not elect Medicare-coordinating prescription drug coverage under the state program again in the future.
- If you are in Advantage 65, Medicare Supplemental—Option II or Advantage 65—Medical Only (and have not previously elected the Dental/Vision option), you may add Dental/Vision coverage one time and terminate it one time. Once you have terminated Dental/Vision coverage, you may not add it again.
- If you are in Medicare Complementary—Option I or Medicare Supplemental—Option II, you may move between those two plans on a prospective basis (the first of the month after your request is received) at any time. You may also change to the Advantage 65 Plan (including Advantage 65—Medical Only) at any time on a prospective basis. The effective date of these plan changes is generally the first of the month after your enrollment form is received. Once you have left either the Option I or Option II plan to enroll in any Advantage 65 plan, you may not re-enroll in Option I or Option II. If you are an Option I or Option II participant, please read the enclosed information regarding your plan premium and choices.

Retirees, Survivors and LTD Participants may cancel dependent coverage at any time on a prospective basis. However, once dependents of a Medicare-eligible participant have been cancelled, they may only be added within 31 days of the occurrence of a consistent qualifying mid-year event (e.g., loss of eligibility for other employer coverage) that would allow the addition. Medicare-eligible Enrollees do not have an annual Open Enrollment opportunity.

All Medicare-eligible covered family members (e.g., retiree and spouse) may make separate plan elections.

State coverage as an Enrollee may be cancelled completely, but you will not have the opportunity to return to the program at any time in the future. This will also result in the cancellation of coverage for any covered dependents.

**NOTE:** Medical-Only Plan participants may not enroll in any state-sponsored Medicare-coordinating plan that includes outpatient prescription drug coverage.

## ***Other Important Retiree Program Information***

### ***❖ Can I enroll in a Medicare Advantage Plan?***

Some state program participants in Advantage 65, Medicare Complementary/Option I and Medicare Supplemental/Option II plans have also enrolled in Medicare Advantage plans. The state's Medicare-coordinating plans specifically exclude services or supplies that are received through Medicare Advantage plans. State program participants may terminate their state program Medicare supplemental coverage prospectively at any time (no return to the program). If you wish to enroll in a Medicare Advantage plan, please consider submitting an enrollment form to your Benefits Administrator to terminate your state program coverage. (This would also result in termination of coverage for any covered dependents.) Consider carefully whether you wish to continue paying for state program coverage that may provide minimal, if any, medical benefits to those enrolled in Medicare Advantage plans. Also, if your Medicare Advantage plan includes prescription drug coverage, it will likely result in your disenrollment from the state program's Medicare Part D plan (no return to that coverage).

### ***❖ Will I get a new ID card for 2009?***

If you do not make a plan change for 2009, you may continue to use your current identification (ID) card or cards (Anthem and Medco as appropriate to your election) after December 31, 2008. If you change your medical plan (including adding or deleting dental/vision coverage), but it does not change your outpatient prescription drug coverage, you may continue to use your Medco card, but you will receive a new Anthem card. If you enroll in medical-only coverage or enroll in a non-state-program Medicare Part D plan for 2009, your 2008 Medco card will not be functional for prescription drug claims after December 31, 2008.

### ***❖ Will I get a new Member Handbook for 2009?***

Please continue to use your existing Member Handbook and Dental/Vision insert (if applicable to your election) dated January 2006. Those participants currently enrolled in the state program's Medicare-coordinating outpatient prescription drug/Medicare Part D plan will receive a new Prescription Drug Benefits insert with this notification. If you decide to terminate your drug coverage for 2009, your insert will no longer apply. However, those who maintain drug coverage in 2009 should destroy their old insert and maintain the new insert as a resource for plan benefit information.

## ❖ **How does Medicare eligibility prior to age 65 affect program participation?**

When an Enrollee (Retiree, Survivor, LTD participant) or a covered dependent becomes eligible for Medicare prior to age 65, an enrollment form must be submitted immediately to elect a Medicare-coordinating plan. While this letter is being directed to Enrollees and/or their dependents already enrolled in Medicare-coordinating plans, we provide this information to ensure that other covered family members who may be in non-Medicare plans are also moved to a plan that coordinates with Medicare immediately upon eligibility. It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so could result in significant coverage deficits.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B in order to get the full benefit of any state-plan-sponsored Medicare supplemental coverage since Medicare becomes the primary payer of claims. If you wish to obtain prescription drug coverage through the state program, enrollment for Medicare Part D will be automatic (pending approval by Medicare) if you enroll in the Advantage 65 or Advantage 65 with Dental/Vision Plan immediately upon eligibility for Medicare. If you wish to stay in the state program but obtain your prescription drug benefit from another Medicare Part D plan, you should enroll in Medicare Part D when you enroll in Parts A and B.

If it is determined that a retiree group participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in the Advantage 65 with Dental/Vision plan immediately. If participants have declined Medicare coverage, it could result in a delay in enrollment and a critical gap in coverage until Medicare coverage goes into effect. The state program will not pay any claims that should have been paid by Medicare had the participant been properly enrolled in Medicare coverage.

## ❖ **What happens if I fail to pay my premium?**

Plan participants are responsible for timely payment of their monthly premiums (either through annuity deduction or by direct payment to the billing administrator). Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Once an Enrollee and his/her dependents have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except in extreme circumstances and at the discretion of the Department of Human Resource Management. Direct-bill participants may enroll for automatic deduction of their monthly premium from their bank accounts and may make on-line check payments. Contact Anthem for more information.

Participants are responsible for understanding their premium obligation and for notifying the program within 31 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee (Retiree,

Survivor, LTD Participant) to advise the program of membership reductions may result in loss of the overpaid premium amount.

### ❖ **What resources are available for information about the State Retiree Health Benefits Program?**

In addition to your Benefits Administrator and your Member Handbook (and applicable insert/s), there are many resources available at the Department of Human Resource Management's Web site to provide information to retiree group participants about their State Retiree Health Benefits Program coverage.

Go to <http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html>.

### ❖ **What should I do if my address changes**

Was this package forwarded to you from an old address? If so, be sure to contact your Benefits Administrator immediately to make an address correction. Failure to update your address can result in your missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss because their address of record has not been corrected. The Department's only means of communicating important information to retiree group participants is through the mail. You may also update personal information by using EmployeeDirect on-line (see page six for more information about EmployeeDirect). Please let your Benefits Administrator know when you move!

### ❖ **Who is my Benefits Administrator?**

***If you have questions about eligibility and enrollment, contact:***

<b><i>If You Are A:</i></b>	<b><i>Contact This Benefits Administrator</i></b>
<b>Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Enrollee</b>	The Virginia Retirement System 1-888-827-3847 <a href="http://www.varetire.org">www.varetire.org</a>
<b>Local or Optional Retirement Plan Retiree/Survivor or a non-VSDP LTD participant</b>	Your Pre-Retirement Agency Benefits Administrator