



Virginia Department of
HUMAN RESOURCE
MANAGEMENT

Commonwealth of Virginia Retiree Health Benefits Program

Annual Open Enrollment May 1 through May 25, 2012

Your enclosed booklet:

<i>Open Enrollment</i>	<i>Page 1</i>
<i>ATTENTION – More Plan Options Available July 1</i>	<i>Page 2</i>
<i>COVA Care and COVA Connect Benefit Changes</i>	<i>Page 2</i>
<i>Medco Health Solutions is now Express Scripts/Medco</i>	<i>Page 3</i>
<i>COVA HDHP Benefit Changes</i>	<i>Page 3</i>
<i>Kaiser Permanente HMO Benefit Changes</i>	<i>Page 3</i>
<i>Monthly Premium Rates Effective July 1, 2012</i>	<i>Pages 3—4</i>
<i>Making Changes to your Coverage</i>	<i>Page 5</i>
<i>HIPAA Privacy</i>	<i>Page 6</i>
<i>Other Retiree Group News and Information</i>	<i>Pages 6—7</i>
<i>Notice – Women’s Health and Cancer Rights</i>	<i>Page 8</i>
<i>Resources</i>	<i>Page 8</i>

IMPORTANT INFORMATION: Be sure to read these materials carefully to ensure that you understand your coverage options and any changes for July 1, 2012.

Recipients of this Package: Retiree group Enrollees receiving this package include Retirees, Survivors and Long Term Disability Participants (not covered family members*).

****Family members who have separate coverage (under their own ID numbers) will not receive Open Enrollment materials directly. Medicare-eligible Retirees, Survivors and Long Term Disability participants who cover family members who are not eligible for Medicare receive this package in order to make a change on behalf of the family member for whom they provide coverage. Only Retirees, Survivors and Long Term Disability participants can request Open Enrollment changes for covered family members. (Medicare-eligible Retirees, Survivors and Long Term Disability participants do not have an Open Enrollment period.)***



COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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To: State Retiree Health Benefits Program Retirees, Survivors and Long Term Disability Participants who are not eligible for Medicare or who cover a family member who is not eligible for Medicare

From: Office of State and Local Health Benefits Programs

Date: April 26, 2012

Open Enrollment

Your annual Open Enrollment will take place from **May 1 through May 25** and provides your annual opportunity to make changes to your non-Medicare-coordinating health plan and membership level, which will be effective July 1, 2012. This booklet includes information regarding coverage in the new plan year starting July 1 so that you can decide if you wish to select another available plan option. If you need information regarding another option, you can use the enclosed updates along with current member handbooks, which are available at www.dhrm.virginia.gov. If you do not have a computer, your Benefits Administrator can provide these materials. Your Benefits Administrator is identified on page eight.

If you continue to be eligible and wish to maintain your current plan and membership level, you do not need to take any action.

This Open Enrollment period does not apply to participants in Medicare-coordinating plans (Advantage 65, Medicare Complementary/Option I and Medicare Supplemental/Option II Plans), but Retirees, Survivors and Long Term Disability Enrollees who cover non-Medicare-eligible family members may make a plan change on their behalf at this time.

NOTE: The premium rates and information included in this booklet are subject to change pending final approval of the state budget.

ATTENTION – MORE PLAN OPTIONS AVAILABLE JULY 1!

DURING THIS OPEN ENROLLMENT AND EFFECTIVE JULY 1, 2012, ALL NON-MEDICARE-ELIGIBLE ENROLLEES (OR MEDICARE-ELIGIBLE ENROLLEES ELECTING COVERAGE FOR THEIR NON-MEDICARE-ELIGIBLE COVERED FAMILY MEMBERS) MAY ELECT EITHER A COVA CARE PLAN, A COVA CONNECT PLAN, OR THE COVA HDHP (HIGH DEDUCTIBLE HEALTH PLAN), REGARDLESS OF WHERE THEY LIVE.

This opens up coverage in the COVA Care Plans (administered by Anthem Blue Cross and Blue Shield, Express Scripts/Medco, Delta Dental, and ValueOptions) to Enrollees in the formerly designated COVA Connect zip code area in Hampton Roads. This also opens up coverage in the COVA Connect Plans (administered by Optima Health and Delta Dental) to Enrollees outside of the Hampton Roads area.

While the benefits under COVA Care and COVA Connect are the same, there are differences in the medical provider networks and in the tier levels of some prescription drugs. Your medical providers should be able to confirm their participation in either network, or you may contact the medical plan administrators for additional information. If you have questions regarding the tier of the drugs that you are currently taking, you may contact the plans' pharmacy benefits managers. Contact information is provided on page eight.

In addition to the COVA Care, COVA Connect, and COVA HDHP Plans, the Kaiser Permanente HMO is available to Enrollees living in its designated service area, and a TRICARE supplement is available to non-Medicare-eligible retiree program family groups when all family members are also entitled to TRICARE. The Department of Human Resource Management web site (www.dhrm.virginia.gov), plan administrators, or your Benefits Administrator can direct you to additional information about these plans.

Changing plan administrators will be allowed if moving outside of the plan's service area. While COVA Care, COVA Connect, and the COVA HDHP have provider networks around the country, the service area for the state program will be designated as the Commonwealth of Virginia. Moving into or out of Virginia will allow a plan administrator change (e.g., from COVA Connect to COVA Care or vice versa). Enrollees living outside of Virginia will also be allowed to make a plan administrator change if moving to another location outside of Virginia to assure the best provider network for their individual needs.

COVA Care and COVA Connect Benefit Changes Effective July 1, 2012

- **Diabetes Management Pilot Program** – Any participant enrolled in their plan's Disease Management Program who meets certain requirements will receive Tier 1 and Tier 2 diabetes prescription drugs and supplies at no cost. If you are identified as being eligible for this program, you will receive additional information.
- **Coinsurance for IV or Injected Drugs** – Participants using IV or infused drugs, including chemotherapy, will pay 20% coinsurance after meeting their annual deductible.
- **Coverage for Applied Behavior Analysis (ABA)** – Children, ages two through six, diagnosed with autism spectrum disorder will be covered for these services up to a \$35,000 annual limit. There will be a \$25 copayment per service.
- **Enhanced Routine Vision Benefit** – Enrollees who have elected the optional Vision and Hearing benefit will have access to a vision benefit once every 12 months (increased from once every 24 months). There is no change to the routine hearing benefit.

Medco Health Solutions is now Express Scripts/Medco

Medco Health Solutions, pharmacy benefits manager for the COVA Care plans, has been acquired by Express Scripts. While you may begin to see the “Medco” name being replaced with “Express Scripts”, we do not anticipate any other changes affecting your coverage at this time.

COVA HDHP Benefit Changes Effective July 1, 2012

The COVA HDHP will also cover Applied Behavior Analysis (see previous description). Coverage for eligible children will require payment of a 20% coinsurance after the annual deductible.

Kaiser Permanente HMO Benefit Changes Effective July 1, 2012

Ambulance Travel – There will be a \$50 copayment per service

Prescription Drug Copayment Changes:

Up to a 30-day supply: Medical Center = \$15/\$25/\$40
 Community Participating Pharmacy = \$20/\$45/\$60
 Home Delivery Pharmacy = \$13/\$23/\$38

90-day supply: 3 x above copayment for Medical Center and Community Pharmacy
 2 x above copayment for Home Delivery Pharmacy

Monthly Premium Rates Effective July 1, 2012

On the following page, you will find monthly premium costs for the new plan year beginning July 1, 2012. The subsidy is the result of the program’s participation in the Early Retiree Reinsurance Program (ERRP), a federal program established under the Affordable Care Act. This reduced premium costs for fiscal year 2013 (July 2012—June 2013) to less than the current premium level.

If you make an allowable coverage change that increases your monthly premium cost and your Virginia Retirement System (VRS) benefit is no longer sufficient to accommodate your premium deduction, direct billing will automatically begin in June for your July premium. Otherwise, your new premium will be deducted or billed in the usual manner. Keep in mind that, due to administrative differences, direct billing occurs in advance of the coverage month, while VRS benefit-deducted premiums are collected in arrears. This means that you will generally be billed initially for a two-month premium should you need to transition from a retirement benefit deduction to direct billing. If you are set up for an automatic deduction of your monthly premium billing through your financial institution or you use automatic bill pay to generate your monthly premium payment, be sure to update your account to reflect your new premium amount.

NOTE: The premiums provided on the next page are subject to change pending final approval of the state budget.

Monthly Premium Cost for July 2012—June 2013*

<i>Plan</i>	<i>Single Premium</i>	<i>Two-Person Premium</i>	<i>Family Premium</i>
COVA Care/COVA Connect Basic <ul style="list-style-type: none"> • Total Premium • Subsidy • YOU PAY: 	\$501 -\$10 \$491	\$927 -\$18 \$909	\$1,355 -\$27 \$1,328
COVA Care/COVA Connect + Out-of-Network <ul style="list-style-type: none"> • Total Premium • Subsidy • YOU PAY: 	\$513 -\$10 \$503	\$943 -\$18 \$925	\$1,378 -\$27 \$1,351
COVA Care/COVA Connect + Expanded Dental <ul style="list-style-type: none"> • Total Premium • Subsidy • YOU PAY: 	\$516 -\$10 \$506	\$957 -\$18 \$939	\$1,400 -\$27 \$1,373
COVA Care/COVA Connect + Out-of-Network and Expanded Dental <ul style="list-style-type: none"> • Total Premium • Subsidy • YOU PAY: 	\$528 -\$10 \$518	\$973 -\$18 \$955	\$1,422 -\$27 \$1,395
COVA Care/COVA Connect + Expanded Dental and Vision/Hearing <ul style="list-style-type: none"> • Total Premium • Subsidy • YOU PAY: 	\$529 -\$10 \$519	\$979 -\$18 \$961	\$1,429 -\$27 \$1,402
COVA Care/COVA Connect + Out-of-Network, Vision, Hearing and Expanded Dental <ul style="list-style-type: none"> • Total Premium • Subsidy • YOU PAY: 	\$541 -\$10 \$531	\$995 -\$18 \$977	\$1,451 -\$27 \$1,424
COVA HDHP (High Deductible Health Plan) <ul style="list-style-type: none"> • Total Premium • Subsidy • YOU PAY: 	\$402 -\$10 \$392	\$745 -\$18 \$727	\$1,089 -\$27 \$1,062
Kaiser Permanente HMO** <ul style="list-style-type: none"> • Total Premium • Subsidy • YOU PAY: 	\$526 -\$10 \$516	\$969 -\$18 \$951	\$1,413 -\$27 \$1,386
TRICARE Supplement – YOU PAY:	\$60	\$119	\$160

*Retirees who have qualified as Assistance Eligible Individuals due to involuntary termination of employment under the **American Recovery and Reinvestment Act, as amended (ARRA)**, will have their premium reduced by 65% for the duration of their eligibility period. At the end of their premium reduction period, the full premium indicated in this chart will apply.

**Kaiser Permanente HMO is only available to participants who live in the Kaiser service area. If you are a current Kaiser member and do not live in its service area, you must make another plan selection. You may confirm the Kaiser service area by contacting Kaiser directly—see *Resources* on page 8 of this correspondence for contact information.

Making Changes

Open Enrollment Changes - If you wish to make a plan or membership change during Open Enrollment, your completed Enrollment Form must be mailed to your Benefits Administrator and postmarked no later than May 25, 2012. If you need assistance identifying your Benefits Administrator, refer to *Resources* on page eight. Indicate “*Open Enrollment*” as the reason you are making the change.

The *State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants* is available from your Benefits Administrator or at www.dhrm.virginia.gov. Use of an incorrect form can result in a delay in your requested changes. You may also make allowable changes on line by using *EmployeeDirect*, which is available at www.dhrm.virginia.gov, no later than May 25, 2012. If you make a plan change, be sure that you understand the provisions of the plan that you choose. Once an election is made, it will not be changed except as allowed by the policies of the Department of Human Resource Management. After the Open Enrollment period ends, you may not revise your Open Enrollment election because you changed your mind or you completed the form incorrectly.

If you are requesting a membership increase, you must include documentation to support the eligibility of the new dependent. For example, to add an existing spouse, you must provide photocopies of the marriage certificate and the top portion of the first page of the retiree group enrollee’s most recent Federal Tax Return that shows the dependent listed as “Spouse” (all financial information and Social Security Numbers should be removed/obscured). To add a biological or adopted child, you must include a photocopy of the birth certificate showing the retiree group Enrollee’s name as the parent or a photocopy of a legal pre-adoptive or adoptive agreement. For other eligible membership additions, contact your Benefits Administrator to confirm the necessary documentation. If you are enrolling using *EmployeeDirect*, you will be contacted by your Benefits Administrator if documentation to support your addition is not received. If documentation is not received by the end of the Open Enrollment period, your membership increase will not be processed.

If you are submitting an Enrollment Form to make an Open Enrollment change to be effective July 1, 2012, be sure to check the *Open Enrollment* box as the reason for making the change.

If you submit an Enrollment Form, ***it must be signed by the eligible Enrollee***. This is either the Retiree, Survivor or Long Term Disability participant through whom eligibility for coverage is obtained—***not a covered family member***. Even those covered family members who have separate/individual ID numbers must have their Enrollment Forms signed by the Enrollee. Enrollment Forms will not be accepted if not signed by the Enrollee.

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.

Making Changes After Open Enrollment - After the Open Enrollment period, membership ***increases*** will only be allowed based on the occurrence of a consistent qualifying mid-year event (such as marriage or birth of a child). Membership increases must be accompanied by appropriate documentation to support the addition. Your Benefits Administrator can provide additional information regarding documentation. **Enrollees have 60 days to make a change based on a qualifying mid-year event.** Of course, retiree group participants may ***decrease*** membership prospectively (going forward) at any time. Any membership change due to a qualifying mid-year event will also allow a plan change.

HIPAA Privacy

The Office of Health Benefits Notice of Privacy Practice describes how the health plan can use and disclose your health information and how you can get access to this information. Participants enrolled in COVA Care, COVA Connect or COVA HDHP can contact their Benefits Administrator (see page eight) or visit the DHRM web site at www.dhrm.virginia.gov to obtain a copy of the privacy notice.

Other Retiree Group News and Information

ID Cards – New ID cards will be issued **only** to participants who change plans or plan administrators (not including just changing optional benefits).

Member Handbooks – If you do not make a plan change, this notice should be kept along with your current Member Handbook or Evidence of Coverage as your reference for plan coverage. If you change plan administrators, you will receive a new Member Handbook.

IMPORTANT!! When You Become Eligible for Medicare - When retiree group Enrollees (Retirees, Survivors, Long Term Disability Participants) or their covered family members become eligible for Medicare, Medicare becomes the primary health plan, and they must make a decision as to whether they wish to maintain secondary coverage under the State Retiree Health Benefits Program or terminate coverage. In most cases, Medicare-eligible participants will be contacted through the Enrollee and provided with their options approximately three months in advance of their Medicare eligibility date. If no positive election is made, they will automatically be moved to the Advantage 65 with Dental/Vision Plan, a Medicare supplemental plan that includes Medicare Part D prescription drug coverage (contingent upon approval by Medicare).

Even though the state program makes every effort to identify participants who become eligible for Medicare, it is ultimately the responsibility of the Enrollee to ensure that participants (Enrollees and their covered family members) who become eligible for Medicare are moved to Medicare-coordinating coverage immediately upon Medicare eligibility. Failure to move to Medicare-coordinating coverage immediately upon eligibility for Medicare can result in retraction of primary payments made in error and a gap in coverage. The state program will not make primary claim payments when Medicare should be the primary coverage. If you or a covered family member becomes eligible for Medicare and is not contacted by your Benefits Administrator, it is the responsibility of the Enrollee to notify the appropriate Benefits Administrator of Medicare eligibility.

Some important things to consider when making this coverage decision:

- If you wish to select your Medicare-coordinating plan through the state program, you must enroll in Medicare Parts A and B (the Original Medicare Plan) in order to get the full benefit of the Advantage 65 Plans, the state program's Medicare supplemental coverage. Failure to enroll in Medicare Parts A and B can result in a significant deficit in your coverage since Advantage 65 will not pay claims that Medicare would have paid had you been enrolled.
- As a Medicare-eligible participant, you may select from available Advantage 65 Plans.
- If an Enrollee requests termination of coverage in the State Retiree Health Benefits Program, he or she may not re-enroll. Termination of the Enrollee will result in termination of all covered dependents.

For more information about *Medicare and the State Retiree Health Benefits Program*, go to www.dhrm.virginia.gov and look for *Retiree Fact Sheets*.

Becoming Eligible for Medicare During the Open Enrollment Period - If you become eligible for Medicare during the Open Enrollment period, you may receive both an Open Enrollment package and a package notifying you of your Medicare eligibility. If you become eligible for Medicare prior to or on July 1, your Medicare plan election will supersede any Open Enrollment election. If you become eligible for Medicare after July, you may make an Open Enrollment election for July 1, and your Medicare plan election will take place on the first of the appropriate month after July.

Prompt Payment of Premiums - Enrollees are responsible for timely payment of their monthly premiums (either through VRS retirement benefit deduction or by direct payment to the billing administrator). Participants who pay directly receive monthly bills or coupons which indicate when premium payments are due. Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Claims paid during any period for which premium payment is not received will be recovered. Once an Enrollee and/or his/her covered family members have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except at the sole discretion of the Department of Human Resource Management.

Enrollees are responsible for understanding their premium obligation and for notifying their Benefits Administrator within 60 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee to advise the program of membership reductions may result in loss of the overpaid premium amount.

If your billing administrator is Anthem Blue Cross and Blue Shield, you may request automatic draft of your premium from your bank account. Contact Anthem for more information.

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, including an updated telephone number. If you have an e-mail address, you may ask to have it included in your eligibility record. Failure to update your mailing address can result in missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss, including billing statements, because their address of record is incorrect. The Department's only means of communicating important information to retiree group participants is through the mail. Please let your Benefits Administrator know when you move! You may also change your address by using *EmployeeDirect* on the Web at www.dhrm.virginia.gov—click on the *EmployeeDirect* link.

If You Need Help... - Retiree group participants should contact their Benefits Administrator with questions regarding Open Enrollment or about eligibility and administrative issues. For most retiree group participants, the Virginia Retirement System (VRS) acts as Benefits Administrator. However, local and optional retirement plan retirees continue to use their pre-retirement agency's Benefits Administrator. Benefits Administrators are generally unable to assist with claims concerns, and those questions should be directed to your claims administrator. Please see *Resources* on page eight for contact information.

Attachment:

Notice – Women's Health and Cancer Rights (page 8)

Enclosure:

CHIP Notice

Notice
Women's Health and Cancer Rights

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

RESOURCES FOR PLANS AND OPTIONAL BENEFITS

Plan	Administrator	Contact Information
COVA Care <ul style="list-style-type: none"> • Medical • Outpatient Prescription Drugs • Dental • Behavioral Health/EAP 	Anthem Blue Cross and Blue Shield Express Scripts/Medco Delta Dental ValueOptions	800-552-2682 800-355-8279 888-335-8296 866-725-0602
COVA Connect <ul style="list-style-type: none"> • Dental • All other benefits 	Delta Dental Optima Health	888-335-8296 866-846-2682
COVA HDHP <ul style="list-style-type: none"> • Medical, Dental, Prescriptions • Behavioral Health • Employee Assistance Program 	Anthem Blue Cross and Blue Shield Anthem Blue Cross and Blue Shield Anthem Blue Cross and Blue Shield	800-552-2682 800-991-6045 800-346-5484
Kaiser Permanente HMO <ul style="list-style-type: none"> • Medical, Prescriptions • Behavioral Health/EAP • Dental 	Kaiser ValueOptions Dominion Dental	800-777-7902 866-517-7042 888-518-5338
TRICARE Supplement	Association & Society Ins. Corp. (ASI)	866-637-9911

If you have questions about eligibility and enrollment, contact:

<i>If You Are A:</i>	<i>Contact This Benefits Administrator</i>
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Participant	The Virginia Retirement System 888-827-3847 www.varetire.org
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

The Department of Human Resource Management Web site also has information about the State Retiree Health Benefits Program. Go to www.dhrm.virginia.gov.