



Commonwealth of Virginia Retiree Health Benefits Program

Enclosed are Annual Premium Rate Notification materials for Medicare-Eligible Participants. These include:

1. Your Rate Notification Booklet

• Your 2010 Premium Cost	Page 1
• Your 2010 Benefits	Page 3
• Your Options for 2010	Page 5
• Other Important Retiree Program Information <ul style="list-style-type: none"> • Enrolling in Medicare Advantage Plans • ID Cards • Member Handbooks • Medicare-Eligible Participants Under Age 65 • Prompt Payment of Premiums • Resources for Retiree Group Participants • Address Changes • Your Benefits Administrator 	Page 6

2. Your *Open Forum* Newsletter

• More Information About Your 2010 Premium
• Medicare Part D Coverage

3. Member Handbook Prescription Drug Insert Amendment

• If you have Medicare Part D prescription drug coverage through the state program, a Member Handbook Notification of Changes is enclosed.
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DISTRIBUTION: Only Enrollees (Retirees, Survivors and Long-Term Disability Participants) will receive this package. Medicare-eligible covered dependents will not 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 12, 2009**

Important Information Regarding Your Health Benefits

This notification booklet includes information about coverage for Medicare-eligible participants in 2010. 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 2010 Premium Cost

How much is my health plan premium for 2010?

Your 2010 Medicare-coordinating plan monthly premium cost is listed below. Your *Open Forum* newsletter also includes information about your premium.

Plan – Single Membership	Premium Effective January 1, 2010
Advantage 65	\$258
Advantage 65 + Dental/Vision	\$285
Medicare Complementary (Option I)	\$247
Medicare Supplemental (Option II)	\$321
Option II + Dental/Vision	\$348
Advantage 65—Medical Only*	\$130
Advantage 65—Medical Only + Dental/Vision*	\$157

*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.

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 2010 monthly premium will be reduced by*:
100%	\$32
75%	\$24
50%	\$16
25%	\$8

*If the reduction amount provided by Medicare is not a whole dollar, the state program rounds the reduction up to the next whole dollar.

Your Medco Annual Notice of Changes and Evidence of Coverage will include information about specific benefits provided to those who qualify for this assistance.

Those participants who have qualified for extra help are encouraged to explore other Medicare Part D plan options outside of the state program. While your state program premium is reduced due to your subsidy as indicated above, you are still paying the premium balance for an enhanced Medicare Part D benefit that may not be providing additional coverage. The Medicare web site (www.medicare.gov) or 1-800- MEDICARE offers a summary of other plans and benefits that are available to you, including some plans that have a \$0 premium.

If you would like more information about the low income subsidy, contact the Social Security Administration at 1-800-772-1213.

When will I begin paying my new 2010 premium?

For participants whose premiums are deducted from a VRS retirement benefit, the new January 2010 premium amount will be deducted in the February retirement benefit payment. If a premium increase means that your retirement benefit will no longer support your premium deduction (if your benefit is not enough to pay your premium), you will be moved to direct billing from Anthem Blue Cross and Blue Shield. Direct billing is mailed 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 premium will be billed in December. If you have requested a change in coverage, the premium change may be later depending on the date of your request. 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 2010 Benefits

Will medical, dental and vision benefits change for 2010?

There will be no change in the supplemental medical benefits under any of the state's Medicare-coordinating plans for 2010. 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 2010* publication regarding your Medicare coverage.

Will prescription drug benefits change for 2010?

Note: Advantage 65 Medical-Only Plan participants may skip this section and go to “Your Options for 2010 —What You Need To Do” on page five.

If you choose to maintain prescription drug coverage under the state program's enhanced Medicare Part D plan, be sure to review the following updates for 2010:

Formulary/Drug List – This is your list of covered drugs, referred to as your “Drug List” in your *Annual Notice of Changes* (ANOC) from Medco. Medco will provide all participants with a new partial Drug List for 2010 as a part of the ANOC. It is important to check your Drug List to see if any of the drugs you are currently taking will change tiers, change restrictions, or be removed. If you are unable to find your drugs in your new Drug List, contact Medco at 1-800-572-4098 for assistance. You may also check the status of your drugs by going to the Commonwealth of Virginia-specific web site 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 “2010 Rate Notification Information” and then on the “Medco—Medicare Part D Plan” quick link. Starting January 1, 2010, you may also go to **www.medco.com** for complete formulary information. Registration is required if you have not done so previously.

Certain changes can be made to the formulary during the year, as approved by Medicare, 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 generic equivalents 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. Chapter three 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 \$295 to **\$310** in 2010. However, there will still be no deductible for covered generics.

Co-payments/Coinsurance – There will be no change to co-payments or coinsurance for covered drugs in 2010. These will remain as follows:

Covered Tier 1 (generic) Drugs	2010 Co-payment
Per one-month (up to 34-day) supply at a retail network pharmacy*	\$7
A 90-day supply through the mail-order service	\$7

Covered Tier 2 (preferred brand) Drugs	2010 Co-payment
Per one-month (up to 34-day) supply at a retail network pharmacy*	\$25
A 90-day supply through the mail-order service	\$50

Covered Tier 3 (non-preferred brand) Drugs	2010 Coinsurance
Per one-month (up to 34-day) supply at a retail network pharmacy	You pay 75%
A 90-day supply through the mail-order service	You pay 75%

Covered Tier 5 (specialty) Drugs	2010 Co-payment
A one-month (up to 34-day) supply at a retail network pharmacy	You pay 25%
A 90-day supply through the mail-order service	You pay 25%

*Chapter three, Section 2.4, of your Medco Evidence of Coverage includes information about retail pharmacies that may accept a lower co-payment for long-term supplies of maintenance drugs.

Catastrophic Coverage – In 2010, if your annual true out-of-pocket drug expense (not including the cost of non-covered or excluded drugs) reaches \$4,550, you will pay either a \$2.50 co-payment (generics or drugs treated as generics) or \$6.30 co-payment (brand-name drugs) or 5% coinsurance, whichever is greater, for the rest of the year. 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, a Notice of Creditable Coverage is not required. However, beneficiaries will not have to pay a higher premium for any period during which 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 other election, 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 program'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 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 program's 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 are no medical-only plan options 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?

Check other Medicare Part D options that are available to you for 2010. Compare premium cost and benefits to ensure that you are selecting the best plan for your individual needs. Your *Open Forum* newsletter has additional information.

Your Options for 2010 – What You Need To Do

If you wish to maintain your current benefit plan, no action on your part is necessary. 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, 2010, you must request the change by taking one of the following actions:

- Obtain an enrollment form from your Benefits Administrator (see page eight), or from the web at www.dhrm.virginia.gov and submit your request to your Benefits Administrator no later than December 15, 2009. An enrollment form specifically designed for January 1, 2010, plan changes is available. (Requests received after December 15, 2009, but before January 1, 2010, 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, 2009, by using EmployeeDirect at 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 access to EmployeeDirect 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.

Allowable changes requested after December 31, 2009, 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 as long as you remain eligible (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 through 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.

- 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 group 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?

The state's Medicare-coordinating plans specifically exclude services or supplies that are received through Medicare Advantage plans, so enrolling in a Medicare Advantage Plan may result in loss of benefits under the state program's Medicare-coordinating plans. State program participants may terminate their state program Medicare-coordinating coverage prospectively at any time (no return to the program). If you wish to enroll in a Medicare Advantage plan, please consider cancelling your coverage in the state program. (This would also result in termination of coverage for any covered dependents.) If you enroll in a Medicare Advantage Plan and do not cancel your state coverage, consider carefully whether you wish to continue paying for coverage that may

provide minimal, if any, medical benefits. 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 re-enrollment allowed). Please note that the Advantage 65 Plans are not Medicare Advantage plans.

Will I get a new ID card for 2010?

If you do not make a plan change for 2010, you may continue to use your current identification (ID) card or cards (Anthem and Medco as appropriate to your election) after December 31, 2009. If you change your medical plan, 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 2010, your 2009 Medco card will not be functional for prescription drug claims after December 31, 2009.

Will I get a new Member Handbook for 2010?

Please continue to use your existing Medicare-Coordinating Plan 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 an amendment to their Prescription Drug Benefits Insert included with this booklet. Please keep this with your current Prescription Drug Insert as updated information for 2010. If you decide to terminate your drug coverage for 2010, your insert will no longer apply.

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 should 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 Medicare-coordinating coverage 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 (Original Medicare) in order to get the full benefit of any state program Medicare-coordinating plan since Medicare becomes the primary payer of claims for those who are no longer covered based on current employment. This also provides an opportunity for enrollment in Medicare Part D based on enrollment in the Advantage 65 or Advantage 65 with Dental/Vision Plan (pending approval by Medicare)

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 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 retirement benefit 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 at the discretion of the Department of Human Resource Management and only under extreme circumstances.

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 five 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:

<i>If You Are A:</i>	<i>Contact This Benefits Administrator</i>
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Enrollee	The Virginia Retirement System 1-888-827-3847 www.varetire.org
Local or Optional Retirement Plan Retiree/ Survivor or a non-VSDP LTD participant	Your Pre-Retirement Agency Benefits Administrator
Non-Annuitant Survivor (surviving spouse or child of an employee or retiree—not receiving a VRS benefit)	The Department of Human Resource Management 1-888-642-4414 www.dhrm.virginia.gov