



Virginia Department of  
**HUMAN RESOURCE**  
MANAGEMENT

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## Commonwealth of Virginia Retiree Health Benefits Program

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

#### This Rate Notification Booklet includes:

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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 individual 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 you 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: **October 3, 2011**

**Important Information Regarding Your Health Benefits**

This notification booklet includes information about coverage for Medicare-eligible participants in 2012. Be sure to read these materials carefully to ensure that you understand your options.

Receipt of benefit-specific information in this package does not guarantee those benefits.

***Your 2012 Premium Cost***

▪ **How much is my health plan premium for 2012?**

Your 2012 Medicare-coordinating plan monthly premium cost is provided on the following page. Premium changes reflect increases and decreases in plan costs, primarily the cost of claims that directly affect the amount needed to fund the program. A significant premium change is in the outpatient prescription drug portion (Medicare Part D) of the total premium for those plans that include that benefit. Page five includes additional information about the continuing impact of the Medicare Coverage Gap Discount Program. Other parts of the total premium have been adjusted to reflect cost changes under each plan, including the Medicare supplement to Parts A and B and the routine dental/vision option. For some plans, increased costs of other benefits have offset the premium savings under the drug program.

<b>Plan – Single Membership</b>	<b>Premium Effective January 1, 2012</b>
Advantage 65	<b>\$220</b>
Advantage 65 + Dental/Vision	<b>\$253</b>
Medicare Complementary/Option I	<b>\$236</b>
Medicare Supplemental/Option II	<b>\$285</b>
Option II + Dental/Vision	<b>\$318</b>
Advantage 65—Medical Only*	<b>\$137</b>
Advantage 65—Medical Only + Dental/Vision*	<b>\$170</b>

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

All State Medicare-coordinating plan medical 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. Dental benefits are administered by Delta Dental of Virginia.

▪ **Attention Option I and Option II Enrollees!**

Your annual rate notification is a great time to review you benefit choices. As a reminder, you can change your Medicare supplemental coverage in the state program to an Advantage 65 plan prospectively at any time.

- For Option II Enrollees, your premium will be reduced if you move to an Advantage 65 Plan. Use your Member Handbook to compare plan provisions. If you are not using benefits that are unique to Option II, or the benefits you are receiving do not justify the premium difference, consider moving to an Advantage 65 plan.
- For Option I Enrollees, the premium for Advantage 65 + Dental/Vision is higher, but you may find that the additional benefits more than offset the premium difference.

Once you leave Option I and Option II, you may not return to those plans later.

▪ **If I qualify for “Extra Help” with my prescription drug costs, 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:

<b>If your subsidy is:</b>	<b>Your 2012 monthly premium will be reduced by*:</b>
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 additional information about getting “Extra Help.”

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 in the amounts shown above, you are still paying the remaining premium for an enhanced Medicare Part D benefit that may not be providing additional coverage. The Medicare web site ([www.medicare.gov](http://www.medicare.gov)) or 1-800-MEDICARE can provide a summary of other plans and benefits that are available to you, including plans with minimal or no premium cost.

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

▪ **Can my income affect the cost of Medicare Part D?**

Beneficiaries with incomes above \$85,000 may have to pay a higher cost for Part D prescription drug coverage. However, any income-related adjustment will be collected through your Social Security or equivalent benefit and not as a part of your Commonwealth of Virginia Retiree Health Benefits Program premium. Your “*Medicare and You 2012*” publication has more information about the cost of Medicare.

▪ **When will I begin paying my new 2012 premium?**

For participants whose premiums are deducted from a VRS retirement benefit, the new January 2012 premium amount will be deducted from the February retirement benefit payment. If you experience a premium increase that results in your retirement benefit no longer supporting your premium deduction (your retirement benefit is not enough to pay your premium), you will be moved to direct billing from Anthem Blue Cross and Blue Shield. It is important to note that 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 take place 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 2012 Benefits***

▪ **Will my medical benefits change for 2012?**

The Medicare supplemental benefit under any Advantage 65 Plan, Medicare Complementary/Option I and Medicare Supplemental/Option II will not change for 2012.

Consult your “*Medicare and You 2012*” publication to determine if there are any changes to your Medicare coverage.

▪ **Will my dental and vision benefits change for 2012?**

For those enrolled in the routine dental and vision coverage, there will be no benefit changes for 2012.

▪ **Will my prescription drug benefits change for 2012?**

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 2012:

**Formulary/Drug List (your list of covered drugs)** – As a part of your Annual Notice of Changes (ANOC), Medco will provide all participants with a new partial formulary for 2012. It is important to check your formulary to see if any of the drugs you are currently taking are no longer included on the formulary for 2012, have changed co-payment/coinsurance tiers, or have any new coverage restrictions. However, if you are taking a drug that will experience a negative formulary change (such as moving to a higher cost-sharing tier or being removed from the formulary), you will be notified by Medco in December. If you are unable to find your drugs in your new formulary, 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/medicarenotification2012.html>

Then just click on "Medco Medicare Part D Plan link" and submit the name of your drug. Starting January 1, 2012, you may also go to [www.medco.com](http://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 to 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 were already taking the drug on January 1, 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. Your formulary includes additional information regarding changes. The Centers for Medicare and Medicaid Services has reviewed and approved your formulary.

**Coverage stages** – There are some changes to this plan's coverage stages for 2012. Be sure to review the limits and benefits of each stage so that you understand your coverage.

**Deductible Stage** – Your annual outpatient prescription drug deductible will increase to **\$320** in 2012. This means that you will pay the full cost of any covered brand-name drug until you have paid \$320 out-of-pocket. Covered generics continue to be excluded from any deductible.

**Initial Coverage Stage** – There are no changes in co-payments and coinsurance for each cost-sharing tier for 2012. Once your deductible has been met for covered brand drugs (and immediately for covered generics), your co-payments/coinsurance will remain as follows until your total covered drug cost reaches \$2,930.

<b>Initial Coverage Stage - Covered Tier 1 (generic) Drugs</b>	<b>2012 Co-payment</b>
Per one-month (up to 34-day) supply at a retail network pharmacy	\$7
Per up to a 90-day supply through the mail-order service	\$7

<b>Initial Coverage Stage - Covered Tier 2 (preferred brand) Drugs</b>	<b>2012 Co-payment</b>
Per one-month (up to 34-day) supply at a retail network pharmacy	\$25
Per up to a 90-day supply through the mail-order service	\$50

<b>Initial Coverage Stage - Covered Tier 3 (non-preferred brand) Drugs</b>	<b>2012 Coinsurance</b>
Per one-month (up to 34-day) supply at a retail network pharmacy	You pay 75%
Per up to a 90-day supply through the mail-order service	You pay 75%

<b>Initial Coverage Stage - Covered Tier 5 (specialty) Drugs</b>	<b>2012 Coinsurance</b>
Per one-month (up to 34-day) supply at a retail network pharmacy	You pay 25%
Per up to a 90-day supply through the mail-order service	You pay 25%

**Coverage Gap Stage** – Plan participants will see even greater benefit from the Medicare Coverage Gap Discount Program in 2012.

Once your total drug cost (the amount paid by you and the plan) exceeds \$2,930, you move into the Coverage Gap Stage. Your co-payment/coinsurance during the Coverage Gap Stage will be the same amount that you paid in the Initial Coverage Stage, but the Medicare Coverage Gap Discount Program will pay 50% of the cost of any covered brand drug manufactured by a program participant. This results in improved benefits to participants in this plan:

- Plan costs are further reduced by the discount, so the amount required to fund the plan is lower. Since retiree group participants pay the full cost of their health plan coverage, there is a direct effect on their premium cost. For 2012, this reduced the prescription drug portion of your premium by \$12 per month. (However, in some cases, the increased costs associated with other benefits offset the reduction in the drug portion of the total premium.)
- The amount that participants pay in co-payment/coinsurance PLUS the amount paid by the discount program will count toward your catastrophic benefit.
- If the balance of the drug cost after the discount is less than the coinsurance due based on the coverage tier of the drug, you would pay less than you paid in the Initial Coverage Stage.

**Catastrophic Coverage Stage** – In 2012, if your annual true out-of-pocket drug expense (including deductible, co-payments, coinsurance, and the contribution from the Medicare Coverage Gap Discount Program, but not including the cost of non-covered or excluded drugs) reaches \$4,700, you will pay the greater of either 5% coinsurance or a co-payment of \$2.60 (generics or drugs treated as generics) or \$6.50 (brand-name drugs). You will remain in this stage for the remainder of the year.

**Your Medicare Explanation of Benefits (EOB)** – To help you track your coverage stages, you will receive an EOB directly from Medco for any months during which you use your benefit.

**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 and, therefore, creditable coverage. 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 of 63 or more days.

**Enrolling in Part D Plans Outside of the State Program** – Your enrollment in Medicare prescription drug coverage 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. If Medicare disenrolls you from the state program's Medicare Part D plan, 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?**

That's a question that only you can answer. Be a good consumer and investigate other Medicare prescription drug plan options, as well as Medicare health plans that are available to you for 2012. Compare premium cost and benefits to ensure that you are selecting the best plan for your individual needs. The Medicare Annual Coordinated Election Period that runs from October 15 through December 7 is a good time to review your current coverage and available options.

Resources available to you to review available options include:

- Call 1-800-MEDICARE or go to [www.medicare.gov](http://www.medicare.gov) for information about other Medicare prescription drug coverage or Medicare health plan options.
- Contact the Virginia Department for the Aging Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402 for assistance with selecting an available plan outside of the state program. If you live outside of Virginia, resources in your state are listed in your Medco Evidence of Coverage.

If you find a plan that better meets your individual needs, you can drop your state program coverage prospectively at any time. Once you leave the state program, you may not return. Also, if you terminate either the state program's prescription drug coverage or its routine dental and vision coverage, you may not re-enroll in those plans later.

## ***Your Options for 2012 – 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 for your current plan will automatically be deducted or billed.**

**If you wish to make an allowable plan change for January 1, 2012, you must request the change by taking one of the following actions:**

- Obtain an enrollment form from your Benefits Administrator (see page 10), 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 1, 2011. (Requests received after December 1, 2011, but before January 1, 2012, 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, 2011, 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 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, 2011, 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 an Advantage 65 Plan 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 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 will generally 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, consider cancelling your coverage in the state program. (This would also result in termination of 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.***

A new plan year and Medicare enrollment period are good times to review all plan options available to you as a Medicare beneficiary. There could be a plan outside of the state program that better meets your needs, either in benefit or cost level or both. However, be sure that you understand the impact of enrolling in other plans if you still want to keep your state plan coverage (see above). Some things to think about and compare include:

- Premium cost
- Benefits
- Out-of-pocket expenses such as deductible, co-payments, or coinsurance
- Drugs covered on the plan's formulary (are your drugs covered?)
- Coverage in the gap or "donut hole" (have you ever had enough total drug cost to reach the donut hole?)

Use the resources listed on page six to help you make a choice that meets your individual needs.

▪ **Will I get a new ID card for 2012?**

New cards will only be issued if there is a plan change that requires a change to your existing ID card/cards. Otherwise, you may continue to use your current cards for covered services in 2012.

▪ **Will I get a new Member Handbook for 2012?**

Participants enrolled in Advantage 65, Advantage 65 with Dental and Vision, Option I, Option II and Option II with Dental and Vision will get a new prescription drug insert enclosed with this notification to reflect changes for 2012. Your 2011 Medicare-Coordinating Plan Member Handbook and the Dental/Vision Benefits Insert (if it applies to your coverage) do not require updating for 2012. However, as noted in your current Medicare-Coordinating Plans Member Handbook, the Eligibility Section has been updated on-line at [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov). Contact your Benefits Administrator if you need a handbook amendment.

▪ **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. The state program tracks Medicare eligibility due to age and now can usually identify eligibility prior to age 65, but it is in the best interest of the Enrollee to report eligibility as soon as it is determined.

▪ **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 be processed for 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.

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 vehicle for communicating important information to retiree group enrollees is through the mail. You may also update personal information by using EmployeeDirect on-line (see page seven 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
<b>Non-Annuitant Survivor (surviving spouse or child of an employee or retiree—not receiving a VRS benefit)</b>	The Department of Human Resource Management 1-888-642-4414 <a href="http://www.dhrm.virginia.gov">www.dhrm.virginia.gov</a>

Enclosure: Member Handbook Prescription Drug Insert (please discard if you enroll in Medical-Only coverage)