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<City, State Zip>

**Commonwealth of Virginia  
Retiree Health Benefits Program**

**Your Medicare prescription drug coverage as a member of  
*Medco Medicare Prescription Plan*® for Commonwealth of Virginia  
Retiree Health Benefits Program**

This mailing gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2009, and explains how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

***Medco Medicare Prescription Plan* Customer Service:**

For help or information, please call Customer Service or go to our plan website at [www.medco.com](http://www.medco.com).

Calls to this number are free:

**1-800-572-4098**

TTY/TDD users call: **1-800-716-3231**

Hours of Operation:

Our business hours are 24 hours a day, 7 days a week (except Thanksgiving and Christmas).

Customer Service is available in English and other languages.

**This Plan is offered by Medco Containment Life Insurance Company and Medco Containment Insurance Company of New York, referred to throughout the Evidence of Coverage (EOC) as “we,” “us,” or “our.” *Medco Medicare Prescription Plan* is referred to as “Plan” or “our Plan.” Our organization contracts with the Federal government.**

This information may be available in a different format, including Spanish and braille. Please call Customer Service at the numbers listed above if you need plan information in another format or language.

Esta información puede estar disponible en otros idiomas u otros formatos, incluyendo una versión en español y una versión en braille. Póngase en contacto con el departamento de Atención al cliente marcando los números que se indican arriba, si necesita recibir la información del plan en otro formato u otro idioma.

# Important Information

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## How your plan will change for 2009

This is the time of year when we like to thank you for your membership and let you know of new plan changes for the upcoming year. Beginning January 1, 2009, there will be some changes to our Plan.

You are enrolled in **Medco Medicare Prescription Plan** for the Commonwealth of Virginia Retiree Health Benefits Program in 2008 and your plan coverage and costs are changing. All changes will be effective January 1, 2009.

This is just a brief summary of the changes in your Plan for 2009. **Make sure to read the next few pages for answers to important questions you may be asking.** If you have any other questions, call Customer Service. **Note:** If you are receiving help from your state Medicaid agency or State Pharmaceutical Assistance Program (SPAP), such as a reduced co-payment, these reductions are not reflected in this packet. Please call your state SPAP at the numbers listed in Section 8 of your Evidence of Coverage if you have questions.

## Changes to your monthly plan premium

Your prescription drug plan premium will continue to be billed or deducted by the Commonwealth of Virginia Retiree Health Benefits Program as part of your total health benefits premium. The Commonwealth of Virginia will be sending you a letter including your 2009 premium by November. If you have any questions about your Plan premium or different ways to pay it, please contact your Commonwealth of Virginia Benefits Administrator.

### Changes to Your Part D Prescription Drug Benefits

	2008	2009
<b>Deductible</b> Covered generic drugs Covered brand-name drugs	\$0 deductible \$275 deductible	<b>No change for 2009</b> \$295 deductible
<b>Initial Coverage Limit</b> (total medication costs paid by you before becoming eligible for catastrophic coverage – see below)	\$4,050	\$4,350

	<b>2008</b>	<b>2009</b>
<b>Tier 1 co-payments for covered generic drugs</b>	<p>\$5.00 co-payment for a one-month (up to a 34-day) supply at a retail network pharmacy</p> <p>\$15.00 co-payment for a three-month (90-day) supply at a retail network pharmacy</p> <p>\$5.00 co-payment for a three-month (90-day) supply from our mail-order pharmacy</p>	<p>\$7.00 co-payment for a one-month (up to a 34-day) supply at a retail network pharmacy</p> <p>\$21.00 co-payment for a three-month (90-day) supply at a retail network pharmacy</p> <p>\$7.00 co-payment for a three-month (90-day) supply from our mail-order pharmacy</p>
<b>Tier 2 co-payments for covered preferred brand-name drugs</b>	<p>\$20.00 co-payment for a one-month (up to a 34-day) supply at a retail network pharmacy</p> <p>\$60.00 co-payment for a three-month (90-day) supply at a retail network pharmacy</p> <p>\$40.00 co-payment for a three-month (90-day) supply from our mail-order pharmacy</p>	<p>\$25.00 co-payment for a one-month (up to a 34-day) supply at a retail network pharmacy</p> <p>\$75.00 co-payment for a three-month (90-day) supply at a retail network pharmacy</p> <p>\$50.00 co-payment for a three-month (90-day) supply from our mail-order pharmacy</p>
<b>Tier 3 coinsurance for covered non-preferred brand-name drugs</b>	<p>75% coinsurance for a one-month (up to a 34-day) supply at a retail network pharmacy</p> <p>75% coinsurance for a three-month (90-day) supply at a retail network pharmacy</p> <p>75% coinsurance for a three-month (90-day) supply from our mail-order pharmacy</p>	<b>No change for 2009</b>
<b>Tier 5 coinsurance for covered specialty drugs</b>	<p>25% coinsurance for a one-month (up to a 34-day) supply at a retail network pharmacy</p> <p>25% coinsurance for a three-month (90-day) supply at a retail network pharmacy</p> <p>25% coinsurance for a three-month (90-day) supply from our mail-order pharmacy</p>	<b>No change for 2009</b>

	2008	2009
<b>Catastrophic Coverage</b>	After your true out-of-pocket costs reach \$4,050, you are eligible for coverage as detailed below.	After your true out-of-pocket costs reach \$4,350, you are eligible for coverage as detailed below.
<b>Covered generic drugs</b>	Greater of \$2.25 for generics or drugs treated as generics or 5% coinsurance	Greater of \$2.40 for generics or drugs treated as generics or 5% coinsurance
<b>Covered brand-name drugs</b>	Greater of \$5.60 or 5% coinsurance	Greater of \$6.00 or 5% coinsurance

### Prior Authorization

Prior authorization is now required for the following drugs for the 2009 plan year:

LIDODERM
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Prior authorization will no longer be required for the following drugs for the 2009 plan year:

ARICEPT	ARICEPT ODT
EXELON	NAMENDA
NAMENDA TITRATION PAK	RAZADYNE
RAZADYNE ER	

### Prescription Drugs With Quantity Limitations

The following drugs will no longer have Quantity Limits for the 2009 plan year:

ANDROGEL	ANDROGEL PUMP
GLYCRON	NICOTROL NS
RIBAPAK 400MG	RIBAPAK 600MG
RIBASPHERE 400MG	RIBASPHERE 600MG
TAMIFLU 12MG/ML	TESTIM

### Drug Tier Changes From 2008 to 2009

Drugs	2008 Tier	2009 Tier	Drugs	2008 Tier	2009 Tier
ALKERAN	5	3	ANCOBON	2	5
BARACLUDE	2	5	CEFOXITIN SODIUM	2	1
COMBIVIR	2	5	DIBENZYLINE	2	5
EFFEXOR XR	2	3	EPIRUBICIN HCL	1	3
EPZICOM	2	5	FOSAMAX SOLUTION	2	3
HEPSERA	2	5	HEXALEN	2	5
KALETRA	5	2	LEXIVA	2	5
LITHIUM CARBONATE	1	2	MATULANE	2	5
MEPRON	2	5	METOPROLOL TARTRATE	1	2
NIMODIPINE	1	5	NORDITROPIN CARTRIDGE	5	2
NORDITROPIN NORDIFLEX PEN	5	2	OXSORALEN ULTRA	2	5
PEGASYS	2	5	PEG-INTRON	2	5
PEG-INTRON REDIPEN	2	5	PEG-INTRON REDIPEN PAK 4	2	5
PRISTIQ	3	2	REYATAZ	2	5
RIBAPAK	1	5	RIBASPHERE	1	5
RIBAVIRIN	1	5	RILUTEK	2	5
RITUXAN	3	2	TRIZIVIR	2	5
VALCYTE	2	5	VIRACEPT	5	2
XYREM	2	5			

### Drugs That Have Been Removed From Our Formulary for the 2009 Plan Year

ACCUNEB	ALIMTA	ALPHATREX
ALTACE	AMITIZA	AMITRIPTYLINE/ CHLORDIAZEPOXIDE
ANZEMET	APIDRA	BD ECLIPSE SYRINGE/ 1ML/30GX1/2"
BD NEEDLE/30G X 1/2"	CAMPTOSAR	CARNITOR

CARTROL	CEFTIN	CLARINEX
CLARINEX REDITABS	CLARINEX-D 12 HOUR	CLARINEX-D 24 HOUR
COLAZAL	COREG	CORTEF
DEPO-TESTOSTERONE	DEXASOL	DEXASPORIN
DEXTROSE 2.5%	DIFLUCAN IN NAACL	DIPROLENE
DOVONEX	DUONEB	DYNABAC D5-PAK
EFUDEX	ESTRADIOL/ NORETHINDRONE ACETATE	ETH-OXYDOSE
EVOCLIN	FAMVIR	FLOXIN OTIC
FLOXURIDINE	FLUDARA	FLUOR-OP
FOSAMAX PLUS D	FUDR	GENERLAC
JOLESSA	KETOTIFEN FUMARATE	KLARON
LAMICTAL	LIPOSYN III	LOCOID
LOPROX	LOPROX SHAMPOO	MARINOL
METHERGINE	MIOSTAT	NASAREL
NIMOTOP	NITRO-BID	NYSTATIN VAGINAL
OCUSULF-10	OLUX	OPIUM TINCTURE
ORAMORPH SR	OXYFAST	PAREGORIC
PAXIL CR	PHOSPHOLINE IODIDE	PLENAXIS
PRECOSE	PROCTO-KIT	PROSOL
PULMICORT	REQUIP	RESERPINE
RISPERDAL	ROCALTROL	SONATA
STROMECTOL	SULF-10	SULFACETAMIDE SODIUM
SURMONTIL	TESLAC	TICE BCG
TRILEPTAL	UNIPHYL	VEXOL
VOLTAREN	VUMON	ZANTAC
ZOLADEX		

With this notice, you are also receiving a 2009 Evidence of Coverage and a new formulary that will be effective January 1, 2009. Medicare has reviewed and approved the covered drugs listed in the formulary. Please see Section 10 of your Evidence of Coverage for more information about your drug coverage.

## **This is your Annual Notice of Change**

### **Why am I receiving this information?**

We are sending this Annual Notice of Change (ANOC) so you can review the 2009 coverage offered through this Plan. Each year from November 15 through December 31, all Medicare beneficiaries may make a change to their Medicare plan and Medicare prescription drug coverage, with the new plan beginning on January 1. This would include switching to a plan outside of the State Program or to a plan offered by a different organization. Certain individuals, such as those with Medicaid, those who get extra help, or those who move, can make changes at other times. The State Program allows you to cancel coverage or cancel just prescription drug coverage at any time, prospectively, but once a participant terminates coverage in the State Program, he or she may not return to the program at a later time, and if a participant cancels just the prescription drug coverage, he or she may not return to the state program's Medicare Part D coverage. Be sure you understand any limitations for enrollment in other Medicare prescription drug plans before you cancel your state coverage. If you enroll in another Medicare Part D plan to begin January 1, 2009, prescription drug coverage under the State Retiree Health Benefits Program will be terminated on December 31, 2008, you will be moved to a medical-only plan and you will not be allowed to elect the State's prescription drug coverage at a later date.

**If you want to stay in our Plan, you don't need to do anything. You will still be a member of our Plan for the coming year as long as you continue to be approved by Medicare.**

**Note:** If you are a member of a State Pharmaceutical Assistance Program (SPAP) or another employer group, you may be required to belong to a specific plan in order to continue to get the additional benefits you may be receiving. Please check with your SPAP or employer before switching to another prescription drug program. The phone numbers for your SPAP can be found in Section 8 of the Evidence of Coverage.

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### **What if my drugs are not on the formulary or are in a more expensive cost-sharing tier?**

We have changed our formulary. The new formulary is different from the one you are using. We have added drugs, removed drugs, and placed more limitations on some of the drugs we cover. Please review the changes on the previous pages and your new formulary to see if we still cover the drugs that you currently take. To get a complete listing of all the drugs we cover, you may visit our website at [www.medco.com](http://www.medco.com) or call Customer Service at 1-800-572-4098.

If a drug we currently cover for you is not on our 2009 formulary, you may wish to talk to your doctor about taking an alternative drug that is available on our new formulary. If you wish to continue coverage of your current drug, you or your doctor may also request a formulary exception on or after January 1. Beginning January 1, you may also get a temporary supply of the drug we currently cover for you that is not on our new formulary. You will need to talk to your doctor about switching to a covered drug, or request a formulary exception before your temporary supply runs out. If a drug we currently cover for you is on our new formulary but has been moved to a higher non-preferred cost-sharing tier, you may talk with your doctor about taking an alternative drug that is available in a lower cost-sharing tier. If you

wish to pay the lower preferred cost-sharing amount for your current drug, you or your doctor may request a tiering exception on or after January 1. Generally, you will not be granted a tiering exception to drugs in Tier 5. Please refer to Section 5 in the Evidence of Coverage for instructions on how to file an exception.

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### **What do I need to know if I qualify for extra help (the low-income subsidy, or LIS) from Medicare to pay for my prescription drugs?**

If you do qualify for extra help, a copy of your “**Evidence of Coverage Rider for Those Who Receive Extra Help Paying for Their Prescription Drugs**” is enclosed in this package. The “**Evidence of Coverage Rider for Those Who Receive Extra Help Paying for Their Prescription Drugs**” has more specific information on your premiums and cost-sharing in 2009. Read this important information carefully. If you don’t know what level of extra help you qualify for, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

### **Where can I get more information about *Medco Medicare Prescription Plan for the Commonwealth of Virginia Retiree Health Benefits Program*?**

The Evidence of Coverage enclosed with this notification has more information on our plan’s coverage, including information on how to make changes to your membership in Section 6.

Please call Customer Service if you have any questions. You may also get information about the Medicare program and other Medicare plans available by visiting [www.medicare.gov](http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048.







Medco Health Solutions, Inc., 100 Parsons Pond Drive, Franklin Lakes, NJ 07417

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