



Virginia Department of
HUMAN RESOURCE
MANAGEMENT

**Commonwealth of Virginia
Retiree Health Benefits Program**

Annual Open Enrollment through May 15, 2009

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IMPORTANT INFORMATION: Be sure to read these materials carefully to ensure that you understand your coverage options and premium/benefit changes for July 1, 2009.

Recipients of this Package: Retiree group participants receiving this package include Retirees, Survivors and Long Term Disability Participants (not dependents*).

**Dependents 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 dependents who are not eligible for Medicare receive this package in order to make a change on behalf of the dependent for whom they provide coverage. Only Retirees, Survivors and Long Term Disability participants can request Open Enrollment changes for covered dependents. (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 dependent who is not eligible for Medicare

From: Office of State and Local Health Benefits Programs

Date: April 23, 2009

Open Enrollment

From now until May 15, you have the opportunity to make changes to non-Medicare-coordinating health plans and membership levels to be effective July 1, 2009. This package includes information about changes that will go into effect on July 1 so that you can decide if you wish to select another available plan. Instructions explaining how to make allowable changes are provided on page five.

If you wish to maintain your current plan and membership level, you do not need to take any action. However, please note that some participants will change claims administrators effective July 1, 2009. Please see below "ATTENTION—CHANGES REGARDING AVAILABLE PLANS!" for more information about COVA Connect.

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 participants who cover non-Medicare-eligible dependents may make a plan change for their non-Medicare-eligible dependent/s at this time.

ATTENTION—CHANGES REGARDING AVAILABLE PLANS!

COVA Connect Pilot Program in Hampton Roads

Non-Medicare-eligible retiree group participants (along with active employees) in a designated area of Hampton Roads who would otherwise be enrolled in the COVA Care Plan will be part of a

pilot program called COVA Connect. While premiums and out-of-pocket costs for COVA Connect are the same as those for COVA Care, and benefits are comparable, COVA Connect represents an innovative approach to health care, including state-of-the-art technology, enhanced customer service and wellness tools, and individual health coaches—all directed toward maintaining or improving health. COVA Connect was developed under a program authorized by the General Assembly seven years ago to encourage public-private partnerships in order to increase efficiency in government. After examination of ten proposals, Optima Health was selected to administer the project in its Hampton Roads network area.

If your address of record is in the zip code areas listed below, you will find a COVA Connect-specific insert including more information with this booklet. If your address is not in this zip code area, the pilot program will not be available to you at this time.

City	Zip Codes
Chesapeake	23320—23328
Hampton	23630, 23651, 23661, 23663—23670, 23681
Norfolk	23501—23515, 23517—23521, 23523, 23529, 23541, 23551
Poquoson	23662
Portsmouth	23701—23705, 23707-23709
Suffolk	23432—23439
Virginia Beach	23450—23467, 23471, 23479

KAISER PERMANENTE HMO EXPANDS ITS SERVICE AREA

In addition to its existing service area in Northern Virginia, Kaiser has expanded its service area to include the following zip codes:

City or County	Service Area Zip Codes
Caroline	22546, 22580, 22538, 22535
Culpeper	22736
Fauquier	22720, 20119, 22728
Fredericksburg	All zip codes
Hanover	23015
King George	All zip codes
Louisa	23024, 23117
Orange	22508, 22567, 22960
Stafford	All zip codes
Spotsylvania	All zip codes
Westmoreland	22443

If you live in Kaiser’s expanded service area, you may enroll in the Kaiser plan effective July 1, 2009. If you would like more information about Kaiser’s coverage, go the www.dhrm.virginia.gov which provides a link to the Kaiser plan or call 1-800-777-7902. Also, you may attend an informational meeting to be held at Germanna Community College, Fredericksburg Campus, on April 27, 2009, at 3:00 PM, in Phase II, Workforce Building, Sealy Auditorium, Room 134, 10000 Germanna Point Drive.

Benefit Changes Starting July 1, 2009

COVA Care/COVA Connect Benefit Changes Starting July 1, 2009

Deductible – The annual deductible that applies to certain services will increase to \$225 for single coverage and \$450 for two or more covered family members.

Copayment Changes:

- Specialist Office Visit – increase to \$40
- Non-Medical Behavior Health Specialist – decrease to \$25
- Emergency Room and Outpatient Hospital Visits – increase to \$125
- Tier 2 Drugs – increase to \$25
- Tier 3 Drugs – increase to \$40
- Tier 4 Drugs – new \$50 copayment level added for specialty drugs

Coinsurance Changes:

- Outpatient Diagnostic Services Coinsurance – increase to 20%
- Infusion Services – new 20% coinsurance level

COVA Care/COVA Connect Optional Vision Benefits

If you maintain or elect the optional vision and hearing benefit, the routine vision piece of that benefit will change effective July 1, 2009. Participants in COVA Care will now have access to the Blue View Vision Network through Anthem Blue Cross and Blue Shield, and COVA Connect participants will have EyeMed Vision Care through Optima Health. Both networks offer a range of enhanced benefits including:

Routine eye exam (once every 24 months): \$40 copay

Frames: \$100 allowance and 20% discount for remaining balance

Standard plastic single vision, bifocal or trifocal lenses (1 pair): \$20 copayment

Eyeglass lens upgrades: reduced cost for certain upgrades (e.g., UV coating, tints)

Elective conventional contact lenses (your choice instead of glasses): \$100 allowance and 15% discount for remaining balance

Member discounts: Additional complete pair of eyeglasses, accessories, and more

Consult your new Member Handbook or your plan's Member Services for more information about your vision benefits.

COVA High Deductible Health Plan (HDHP)

No benefit changes for July 1, 2009

Kaiser Permanente HMO Benefit Changes Starting July 1, 2009

Copayment Changes:

- Specialist Office Visit – increase to \$20
- Outpatient Hospital Visit – increase to \$50
- Emergency Room Visit – increase to \$75

Prescription Drug Program – addition of tiers 2 and 3

Out-of-Pocket Maximum Expense Limit Added - \$3,500 for one person, \$9,400 for two or more people

Monthly Premium Rates Effective July 1, 2009

Listed below are **monthly premium costs that will become effective on July 1, 2009**. If your premium is currently deducted from your Virginia Retirement System (VRS) benefit and the premium increase (or a requested plan change) results in your retirement benefit no longer being sufficient to support the deduction of your monthly premium, 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 for a two-month premium should you need to transition from a retirement benefit deduction to direct billing.

Monthly Premium Cost for July 2009—June 2010

Plan	Single Premium	Two-Person Premium	Family Premium
COVA Care/COVA Connect Basic	\$485	\$898	\$1,313
COVA Care/COVA Connect + Out-of-Network	\$497	\$914	\$1,334
COVA Care/COVA Connect + Expanded Dental	\$500	\$927	\$1,356
COVA Care/COVA Connect + Out-of-Network and Expanded Dental	\$511	\$942	\$1,376
COVA Care/COVA Connect + Expanded Dental and Vision/Hearing	\$510	\$946	\$1,381
COVA Care/COVA Connect + Out-of-Network, Vision, Hearing and Expanded Dental	\$521	\$960	\$1,400
COVA HDHP (High Deductible Health Plan)	\$389	\$721	\$1,054
Kaiser Permanente HMO*	\$478	\$882	\$1,287

*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 (see expanded service area on page 2), you must make another plan selection. You may confirm the Kaiser service area by contacting Kaiser directly—see *Resources* on page nine 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 15, 2009. If you need assistance identifying your Benefits Administrator, refer to *Resources* on page nine.

Enrollment forms are available from your Benefits Administrator or at www.dhrm.virginia.gov. You may also make allowable changes on line by using *EmployeeDirect*, which is available at the same Web site, no later than May 15, 2009. 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 live in the service area for the COVA Connect pilot program, you may not select the COVA Care Plan, and if you do not live in the COVA Connect service area, you may not select COVA Connect. See pages 1—2 for more information about COVA Connect. Non-Medicare-eligible participants in the pilot program service area may also select the COVA HDHP.

If you are submitting an Enrollment Form to make an Open Enrollment change to be effective July 1, 2009, be sure to check the *Open Enrollment* box as the reason for making the change. Certain plan changes are only allowed at Open Enrollment. However, some changes are allowed outside of Open Enrollment. If you check another reason for your requested change, it could become effective before July 1.

If you submit an Enrollment Form, ***it must be signed by the eligible Enrollee***. The eligible Enrollee is the Retiree, Survivor or Long Term Disability participant through whom eligibility for coverage is obtained—***not a covered dependent***. Even those covered dependents 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). 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 for a plan change.

Additional Special Enrollment Rights under the Health Insurance Portability and Accountability Act (HIPAA) – Long-Term Disability participants who have waived coverage and have a right to re-enroll in the State Retiree Health Benefits Program may now enroll if they or their eligible dependent loses coverage in Medicaid or the State Children's Health Insurance Program (CHIP) and request coverage under the plan within 60 days of the time that coverage ends, or if they become eligible for a Medicaid or CHIP premium assistance subsidy and request coverage under the plan within 60 days after eligibility is determined. (Retirees or Survivors who leave the program do not have a right to return to coverage at any time.)

Other Retiree Group News and Information

Removing Ineligible Family Members – Membership in the State Retiree Health Benefits Program will be audited after July 1, 2009, to ensure that all covered dependents are eligible under the provisions of the program. This Open Enrollment provides the opportunity to remove ineligible dependents without penalty. However, if it is determined after July 1 that an Enrollee is covering a dependent who is ineligible, he or she is subject to penalties including suspension from the program for up to three years.

Eligible dependents include:

- Your spouse (once divorced, an ex-spouse is no longer eligible, regardless of any legal obligation for an Enrollee to provide coverage)
- An unmarried dependent child who lives at home or away at school and receives over one-half of his or her support from the Enrollee. Living at home for natural or adopted children may mean living with the other parent. Eligible dependent children may be covered to the end of the year in which they turn 23* and include:
 - Your biological child, legally adopted child, or stepchild living with the Enrollee in a parent-child relationship. The stepchild's principal place of residence must be with the Enrollee and the stepchild must be a member of the Enrollee's household.
 - A child placed in the Enrollee's home under a pre-adoptive agreement approved by the State Retiree Health Benefits Program or under a permanent court order granting you sole permanent custody.
 - Dependent children age 23 or older with a disability that qualifies them for coverage. Certain conditions apply, and the plan must approve a request to continue coverage.
 - Other children whom the program determines to be qualified as dependent children.

*Non-annuitant surviving children may be covered until age 21 unless the dependent is a full-time college student, in which case coverage shall not terminate until such dependent reaches age 25 or ceases to be a full-time college student.

ID Cards – Non-Medicare-eligible participants will receive new ID cards to be used for services on or after July 1.

Member Handbooks – Participants in the COVA Care, COVA Connect or COVA HDHP Plans on July 1 will receive a new Member Handbook. Kaiser Permanente HMO Members will receive a new Evidence of Coverage.

IMPORTANT!! When You Become Eligible for Medicare - When retiree group Enrollees (Retirees, Survivors, Long Term Disability Participants) or their covered dependents 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) approximately three months in advance of their Medicare eligibility date and provided with their options. 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 dependents) 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 dependent 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. Failure to enroll in Medicare Parts A and B can result in a significant deficit in your coverage since Advantage 65 will not pay any benefit for which 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 under *Retiree Facts and Information*.

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.

Retiree Medicare Entitlement Advocacy Program – In an effort to maximize the efficiency of the program and as a service to its members, the State Retiree Health Benefits Program is planning to introduce a program to identify service retirees and dependents of other retiree group participants who may be eligible for Social Security Disability benefits, which ultimately results in eligibility for Medicare. There are benefits to be gained by individuals and the program by identifying eligibility for these benefits. While the program is still in the planning stages, we wanted to let Enrollees know that this program is being investigated so that there will not be concern if information is disseminated to them in this regard. However, at this time, there is no firm time frame for implementation.

Prompt Payment of Premiums - Plan participants 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 his/her dependents have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except in extreme circumstances and at the discretion of the Department of Human Resource Management.

Participants are responsible for understanding their premium obligation and for notifying their Benefits Administrator within 31 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.

Contact your billing administrator to discuss automatic draft of your monthly premium from your bank account or electronic payment.

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 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 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 nine for contact information.

Attachments:

Notice – Women's Health and Cancer Rights (see below)
Resources (page 9)

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

If you have questions regarding claims, benefits or participating providers, contact:

<i>Benefit</i>	<i>Contact This Administrator</i>
<ul style="list-style-type: none"> • COVA Care Medical • COVA Care Optional Vision and Hearing • COVA HDHP (all benefits) 	Anthem Blue Cross and Blue Shield Member Svcs. 1-800-552-2682 TDD: 1-804-354-4327 (Richmond) or 1-800-554-7752
<ul style="list-style-type: none"> • COVA Connect Medical, Vision, Hearing, Behavioral Health or Employee Assistance Program and Prescription Drugs 	Optima Health 866-846-COVA (2682) or 757-687-6350
<ul style="list-style-type: none"> • COVA Care Behavioral Health or Employee Assistance Program 	Value Options, Inc. 1-866-725-0602
<ul style="list-style-type: none"> • COVA Care or COVA Connect Dental 	Delta Dental 888-335-8296
<ul style="list-style-type: none"> • COVA Care Prescription Drugs 	Medco Health Solutions, Inc. 1-800-355-8279
<ul style="list-style-type: none"> • Kaiser Permanente HMO 	800-777-7902 or 301-468-6000 (in Washington, DC)

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 1-888-827-3847 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)	See your insert for more information

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

