



**COMMONWEALTH OF VIRGINIA**  
**DEPARTMENT OF HUMAN RESOURCE MANAGEMENT**

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To: State Retiree Health Benefits Program Participants Eligible for Medicare

From: Mary P. Habel, Director  
 State and Local Health Benefits Programs

Date: November 6, 2006

Re: • Medicare-Coordinating Plan Monthly Premium Rates Effective January 1, 2007  
 • Retiree Group Information and Updates

**IMPORTANT INFORMATION:** Please be sure to read these materials carefully to ensure that you understand premium and benefit changes for 2007, as well as your coverage options.

**Recipients of this Package:** Retiree group participants receiving this package include Medicare-eligible Retirees, Survivors, Long Term Disability Participants and some eligible dependents who have separate, individual plans based on their Medicare eligibility. Receipt of any benefit-specific information in this package does not guarantee those benefits (e.g., outpatient prescription drug benefits) under the State Retiree Health Benefits Program.

**2007 Plans and Premium Rates**

The chart below provides premium rates for Medicare-coordinating plan participants to be effective January 1, 2007. Please note that there is no increase to the premium for the medical (and, if applicable, dental/vision) portion of your coverage. The \$11 increase is in the prescription drug portion of your premium.

<b>Plan – Single Membership</b>	<b>Current (2006) Monthly Premium</b>	<b>Your Monthly Premium for 2007</b>
Advantage 65	\$220	<b>\$231</b>
Advantage 65 + Dental/Vision	\$249	<b>\$260</b>
Medicare Complementary (Option I)	\$183	<b>\$194</b>
Medicare Supplemental (Option II)	\$259	<b>\$270</b>
Option II + Dental/Vision	\$288	<b>\$299</b>
Advantage 65—Medical Only*	\$117	<b>\$117</b>
Advantage 65—Medical Only + Dental/Vision*	\$146	<b>\$146</b>

\*Does not include outpatient prescription drug 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 you have qualified through the Social Security Administration for extra help with paying the cost of your Medicare Part D coverage, your premium will be reduced as follows:

If your subsidy is:	Your monthly premium will be reduced by*:
100%	\$29
75%	\$22
50%	\$15
25%	\$8

\*The state program rounded the reductions defined by Medicare up to the next whole dollar.

If you have qualified for extra help, you may wish to investigate other Medicare Part D plan coverage outside of the state program. While your state program premium is reduced due to your subsidy, you are still paying the balance for an enhanced Medicare Part D benefit that may not be providing you with additional benefits. The Medicare Web site ([www.medicare.gov](http://www.medicare.gov)) or 1-800- MEDICARE can provide you with a summary of additional plans and benefits that are available to you.

For participants whose premiums are deducted from their VRS retirement benefit, the new January premium will be reflected in your February retirement payment. For those who pay through direct billing, your new January premium will be reflected in your December bill (or later based 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. If the premium increase means that your retirement benefit will no longer support your premium deduction, you will be converted to direct billing by Anthem Blue Cross and Blue Shield. However, please be aware that, while benefit deductions are taken in arrears of the coverage month, direct billing is in advance of the coverage month.

### **Medical, Dental and Vision Benefits for 2007**

There will be no change in your medical benefits under any of the state's Medicare-coordinating plans for 2007. However, while your plan benefit will not change, the Medicare Part B annual deductible will increase from \$124 to \$131. For those participants who are enrolled in plans that include routine dental and vision coverage, those benefits will remain unchanged for 2007.

There will be an enhancement to the service that you are receiving through your plan. Effective January 1, 2007, your Medicare supplemental claims (claims that have been paid first by Medicare and then will be supplemented by your Anthem Blue Cross and Blue Shield secondary plan) will automatically be filed for you. (This does not apply to dental and vision benefits that are not covered by Medicare since they are still paid as primary coverage by your state plan if you are enrolled in that coverage.) If you have more than one Medicare supplemental plan, you may need to file claims to the other (tertiary) plan. Contact the insurer of your other plan for more information.

### **Prescription Drug Benefit Changes for January 1, 2007**

If you choose to maintain prescription drug coverage under the state-sponsored enhanced Medicare Part D plan, the following changes will take place for 2007. Generally, these changes are consistent with Medicare requirements for Part D plans. **(Medical-Only Plan participants may skip this section and go to "What Do You Need To Do?" on page four.)**

**Formulary** – This is your list of covered drugs. Medco will provide all participants with a new partial formulary for 2007. For additional information, contact Medco Customer Service at 1-800-572-4098 or go to the Web site that will be available until December 31, 2006, 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 the *Medco—Medicare Part D Plan* quick link. Your Annual Notice of Change, sent to you by Medco, includes adverse formulary changes that will become effective on January 1, 2007. Please review these materials carefully to ensure that you are prepared for any changes that affect you. After December 31, you may get additional formulary information from Medco Customer Service or the Medco Web site at [www.medco.com](http://www.medco.com).

Generally, if you are taking a drug that is included in the 2007 formulary at the beginning of the year, Medco will not discontinue or reduce coverage of the drug in 2007 except when a new, less-expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other formulary changes, such as adding a utilization management rule, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing amount for the remainder of the year for those members. If any drugs are removed from the formulary or if prior authorization requirements, quantity limits and/or step therapy restrictions are added, or if a drug is moved to a higher cost-sharing tier, affected participants will be notified at least 60 days before the change takes effect, and this will include information regarding any extension of unreduced benefits. The Centers for Medicare and Medicaid Services must approve all coverage rule additions and tier changes not due to generic drug introductions, and members taking the drug are exempt from the change for the rest of the plan year. Please refer to your Formulary, Summary of Benefits and Evidence of Coverage, provided by Medco, for additional information.

The 2007 formulary will continue to exclude drugs that are excluded for Medicare Part D coverage as determined by Medicare. Consequently, effective January 1, 2007, drugs for treatment of erectile dysfunction will no longer be covered. This includes drugs such as Viagra, Cialis, Levitra and Caverject.

**Deductible** – Your annual outpatient prescription drug deductible will increase to \$265 in 2007. However, there will still be no deductible associated with covered generics.

**Copayments** – Your copayments will increase effective January 1, 2007, as follows:

Drug Tier	Type of Drug/Method of Purchase	Your Copayment Amount
Tier 1	Per up to a 34-day supply of a covered <b><u>generic drug</u></b> at a participating retail pharmacy (up to a 90-day supply)	\$5.00
Tier 1	Up to a 90-day supply of a covered <b><u>generic drug</u></b> purchased through the mail service program	\$5.00
Tier 2	Per up to a 34-day supply of a covered <b><u>preferred brand</u></b> at a participating retail pharmacy (up to a 90-day supply)	\$20.00 (after deductible)
Tier 2	Up to a 90-day supply of a covered <b><u>preferred brand</u></b> purchased through the mail service program	\$40.00 (after deductible)

**Coinsurance** – There will be no change in coinsurance levels for Tiers 3 and 5 drugs for 2007.

Drug Tier	Type of Drug/Method of Purchase	Your Coinsurance Amount
Tier 3	Per up to a 34-day supply of a covered <b><u>non-preferred brand</u></b> at a participating retail pharmacy (up to a 90-day supply)	75% of the cost of the drug (after deductible)
Tier 3	Up to a 90-day supply of a covered <b><u>non-preferred brand</u></b> purchased through the mail service program	75% of the cost of the drug (after deductible)

Drug Tier	Type of Drug/Method of Purchase	Your Coinsurance Amount
Tier 4	Non-Covered Drugs	No Coverage – you pay 100% of the cost of the drug
Tier 5	Per up to a 34-day supply of a covered <b>specialty drug</b> at a participating retail pharmacy	25% of the cost of the drug (after deductible)
Tier 5	Up to a 90-day supply of a covered <b>specialty drug</b> purchased through the mail service program	25% of the cost of the drug (after deductible)

**Catastrophic Coverage** – After your annual true out-of-pocket drug expense (not including the cost of non-covered or excluded drugs) reaches \$3,850, you will pay either a \$2.15 (generic or preferred brand) or \$5.35 (other drugs) copayment or 5% coinsurance, whichever is greater. You will receive a monthly Explanation of Benefits directly from Medco which will track your covered drug costs.

**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 qualified Medicare Part D plan. As such, no Notice of Creditable Coverage is required to be provided to participants. However, beneficiaries will not have to pay extra premium for any period that 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 (including this plan) coverage of 63 or more days.

### **Additional Prescription Drug Coverage Information**

For those enrolled in the state's enhanced Medicare Part D plan, the enclosed *Open Forum* Newsletter contains additional information regarding Medicare prescription drug coverage. Please take a few moments to review this information.

### **What Do You Need To Do?**

**If you wish to maintain your current benefit plan, no action on your part is required.** Your new monthly premium will automatically be deducted or billed in the usual manner.

**If you wish to make an allowable plan change for January 1, 2007, you must submit the enclosed Enrollment Form so that it is received by your Benefits Administrator no later than December 15, 2006.** Timely submission will ensure that your change is in place on January 1, 2007. Enrollment Forms received after December 31, 2006, will be effective the first of the month after they are received. However, if you wish to make an allowable change later than January 1, 2007, it is preferable to use a standard enrollment form instead of the abbreviated enrollment form enclosed with this material. This is available from your Benefits Administrator or by going to [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov). 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.
- You may make a plan change as follows:
  - You may elect Medical-Only coverage, but you will not be able to elect Medicare-coordinating prescription drug coverage under the state program at any time in the future.
  - If you are in Advantage 65, Medicare Supplemental—Option II or Advantage 65—Medical Only, 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 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 either 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 plans to enroll in any Advantage 65 plan, you may not re-enroll in Option I or Option II.

- Retirees, Survivors and LTD Participants may terminate dependent coverage at any time on a prospective basis. However, once dependents of a Medicare-eligible participant have been terminated, they may only be added with the occurrence of a consistent qualifying mid-year event.
- All Medicare-eligible family members (e.g., retiree and spouse) may make separate plan elections.
- You may terminate your state coverage as a participant 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 termination of coverage for any covered dependents.
- Medical-Only Plan participants **may not** enroll in any state-sponsored Medicare-coordinating plan that includes outpatient prescription drug coverage.

Please note that 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 (Medicare). The State Retiree Health Benefits Program must remove prescription drug coverage from the enrollment of any participant whom Medicare has advised is not eligible for this 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-sponsored Medicare Part D plan.

**Your Benefits Administrator** – The enclosed Enrollment Form identifies the Benefits Administrator to whom your enrollment form should be sent should you choose to make a coverage change.

### **Other Important Retiree Program Information**

**New ID Cards** – If you do not make a plan change for 2007, you may continue to use your current identification (ID) card or cards (Anthem and Medco). 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, your 2006 Medco card will not be functional for prescription drug claims after December 31, 2006.

**Member Handbooks** – Please continue to use your 2006 Member Handbook and applicable insert(s), which were just mailed to you in October. However, if your plan includes outpatient prescription drug coverage, an amendment to your prescription drug insert is enclosed. Please keep this amendment with your current member handbook and insert(s).

**Medicare-Eligible Participants Under Age 65** – When an Enrollee (retiree, survivor, LTD participant) or a covered dependent becomes eligible for Medicare prior to age 65, an enrollment form must be submitted immediately to elect a Medicare-coordinating plan. While this letter is being directed to participants already enrolled in Medicare-coordinating plans, we provide this information to ensure that other covered family members in non-Medicare plans are also moved to a plan that coordinates with Medicare 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 in order to get the full benefit of any state-plan-sponsored Medicare supplemental coverage since Medicare becomes the primary payer of claims. If you wish to obtain prescription drug coverage through the state program, enrollment for Medicare Part D will be automatic (pending approval by Medicare) if

you enroll in the Advantage 65 Plan immediately upon eligibility for Medicare. If you wish to stay in the state program but obtain your prescription drug benefit directly from another Medicare Part D plan, you should enroll in Medicare Part D when you enroll in Parts A and B. 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 Plan immediately. (The addition of Dental/Vision coverage to Advantage 65, if elected, will generally be effective the first of the month after an enrollment form is received.) If participants have declined Medicare coverage, it could result in a delay in enrollment and a critical gap in coverage until coverage goes into effect. The state plan will not pay any claims that should have been paid by Medicare had the participant been properly enrolled in Medicare coverage.

**Prompt Payment of Premiums** – Plan participants are responsible for timely payment of their monthly premiums (either through annuity 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 not allowed except in extreme circumstances and 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.

**Resources for Retiree Group Participants** – 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. Retiree Fact Sheets, which are available at the following link, contain subject-specific information directed to retiree group participants. Just go to <http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html>.

**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. Please let us know when you move!

**HIPAA Privacy Notice** – An updated "Disclosure of Protected Health Information to the Employer as Defined and Outlined in the Health Insurance Portability and Accountability Act Privacy Regulation" is included in your 2006 Member Handbook for Medicare-Coordinating Plans, which was distributed in October to all Medicare-eligible retiree group participants.

Enclosures: Enrollment Form

*Open Forum* Newsletter (only for those enrolled in plans that include outpatient prescription drug coverage)

Prescription Drug Benefits Notification of Changes (only for those enrolled in plans that include outpatient prescription drug coverage)