



Virginia Department of
**HUMAN RESOURCE
MANAGEMENT**

Commonwealth of Virginia Retiree Health Benefits Program

2008 Annual Premium Rate Notification for Medicare-Eligible Participants

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Additional Enclosed Information:

- Enrollment Form to make January 1, 2008, changes
- *Open Forum* newsletter (only for those enrolled in plans that include outpatient prescription drug coverage)
- Prescription Drug Member Handbook Insert Amendment (only for those enrolled in plans that include outpatient prescription drug coverage)

IMPORTANT INFORMATION: Please be sure to read these materials carefully to ensure that you understand program changes for 2008 and 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.



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
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Date: November 5, 2007

2008 Premium Rates

The following chart provides premium rates for Medicare-coordinating plan participants to be effective January 1, 2008. A major contributor to these premium increases (\$37 per month) is the cost and utilization of prescription drugs. Even though the Advantage 65 premium is still lower than the pre-Medicare Part D premium in 2005, drug cost and its effect on premium expense are of great concern to the program. **Be sure to read your enclosed *Open Forum* for more information about your outpatient prescription drug coverage.**

Plan – Single Membership	Current (2007) Monthly Premium	Your Monthly Premium for 2008
Advantage 65	\$231	\$277
Advantage 65 + Dental/Vision	\$260	\$308
Medicare Complementary (Option I)	\$194	\$237
Medicare Supplemental (Option II)	\$270	\$319
Option II + Dental/Vision	\$299	\$350
Advantage 65—Medical Only*	\$117	\$126
Advantage 65—Medical Only + Dental/Vision*	\$146	\$157

*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%	\$28
75%	\$21
50%	\$14
25%	\$7

*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) or 1-800- MEDICARE can provide you with a summary of additional plans and benefits that are available to you. See your enclosed *Open Forum* for more information about subsidized coverage and the state program.

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 a request for change). 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 from Anthem Blue Cross and Blue Shield. However, please be aware that, while benefit deductions are taken by VRS for the previous month of coverage, direct billing occurs in advance of the coverage month.

Medical, Dental and Vision Benefits for 2008

There will be no change in your supplemental medical benefits under any of the state's Medicare-coordinating plans for 2008. 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 2008* publication regarding any changes to your Medicare coverage for 2008.

Prescription Drug Benefit Changes for January 1, 2008

Note: Medical-Only Plan participants may skip this section and go to “Options for 2008—What Do You Need To Do?” on page five.

If you choose to maintain prescription drug coverage under the state-sponsored enhanced Medicare Part D plan, the following changes will take place for 2008:

Plan Name Change – Your plan will be called “**Medco Medicare Prescription Plan for the Commonwealth of Virginia Retiree Health Benefits Program.**” It will no longer be called YOURx PLAN, but your current ID may still be used in 2008 if you continue your prescription drug coverage.

Formulary – (This is your list of covered drugs.) Medco will provide all participants with a new partial formulary for 2008. 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, 2007, 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 2008 Annual Notice of Change, sent to you by Medco, includes formulary changes that will become effective on January 1, 2008. Some formulary tier changes result in substantial increased cost to participants. Please review this information carefully to see if any drugs that you are taking will change tiers. Your *Annual Notice of Change* also provides information regarding options when your drug is removed from the formulary or moves to a more expensive cost-sharing tier.

After December 31, you may get additional formulary information from Medco Customer Service or the Medco web site at www.medco.com.

Generally, if you are taking a drug that is included in the 2008 formulary at the beginning of the year, Medco will not discontinue or reduce coverage of the drug in 2008 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, and the drug will remain available at the same cost-sharing amount for the remainder of the year. 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.

Deductible – Your annual outpatient prescription drug deductible will increase from \$265 to \$275 in 2008. However, there will still be no deductible for covered generics.

Co-payments/Coinsurance – There will be no change to your co-payments or coinsurance levels in Tiers 1, 2, 3 and 5 for 2008. (Of course, the appropriate co-payment or coinsurance will be charged if your drug changes to a different tier on January 1 or as allowed during the year.)

Catastrophic Coverage – After your annual true out-of-pocket drug expense (not including the cost of non-covered or excluded drugs) reaches \$4,050, you will pay either a \$2.25 (generics) or \$5.60 (other drugs) co-payment or 5% coinsurance, whichever is greater. 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.

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 a higher 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.

The Best Medicare Part D Plan Coverage for You

The Annual Enrollment Period for Medicare Part D begins November 15 for coverage starting January 1, 2008. This is a great time to review the many Part D plans that are available to you. For some state plan retiree group participants, the state's Medicare Part D plan might not be the best plan. Please take a few moments to read your enclosed *Open Forum* and consider whether there could be a better plan choice for you.

The Department of Human Resource Management's Office of Health Benefits will soon begin analyzing the direction of its outpatient prescription drug/Medicare Part D coverage for 2009. The Department's goal is to offer benefits that are valuable to its retiree group participants. Input from participants will be important as the direction of prescription drug coverage is reviewed. Look for information in the mail regarding retiree meetings in 2008.

Options for 2008 – 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, 2008, you must submit the enclosed Enrollment Form so that it is received by your Benefits Administrator no later than December 14, 2007. Timely submission will ensure that your change is in place on January 1, 2008. Enrollment Forms received after December 14 may result in a delay in the requested change for January 1. Generally, changes are effective the first of the month after an enrollment form is received. If you wish to make an allowable change later than January 1, 2008, 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. 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 (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 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** (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 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 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 employer coverage) that would allow the addition.
- All Medicare-eligible family members (e.g., retiree and spouse) may make separate plan elections.
- **You may cancel 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 cancellation 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 form should be sent should you choose to make an allowable change.

Enrolling in Medicare Advantage Plans

Some state program participants in the Advantage 65, Medicare Complementary/Option I and Medicare Supplemental/Option II plans have also enrolled in Medicare Advantage plans. The state's Medicare-coordinating plans specifically exclude services or supplies that are received through Medicare Advantage plans. State program participants may terminate their state program Medicare supplemental coverage prospectively at any time (no return to the program). If you wish to enroll in a Medicare Advantage plan, please consider submitting an enrollment form to your Benefits Administrator to terminate your state program coverage. (This would also result in termination of coverage for any covered dependents.) Consider carefully whether you wish to continue paying for state coverage that generally provides minimal, if any, medical benefits to those enrolled in Medicare Advantage coverage. 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 return to that coverage).

Other Important Retiree Program Information

ID Cards – If you do not make a plan change for 2008, you may continue to use your current identification (ID) card or cards (Anthem and Medco as appropriate to your election). 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 for 2008, your 2007 Medco card will not be functional for prescription drug claims after December 31, 2007.

Member Handbooks – Please continue to use your existing Member Handbook and applicable insert(s) dated January 2006. Those participants 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 in this package. Please be sure to keep this amendment with your handbook and original insert.

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 who may be 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 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 Medicare 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. 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!

Enclosures: --Enrollment Form
--*Open Forum* newsletter (only for those enrolled in plans that include outpatient prescription drug coverage)
--Prescription Drug Member Handbook Insert Amendment (only for those enrolled in plans that include outpatient prescription drug coverage)