

Commonwealth of Virginia Retiree Health Benefits Program

Medicare-Coordinating Plan Options

Effective January 1, 2025

COMPARISON OF MEDICARE AND STATE SUPPLEMENTAL PLANS

Use the chart on pages one and two to review Medicare's benefits and the supplemental/Medicare-coordinating plan benefits available to State Retiree Health Benefits Program participants who are eligible for Medicare.

More information about optional prescription drug, dental and vision benefits are summarized on pages 3-5.

Part A Services	Medicare	Advantage 65	Advantage 65 – Medical Only
Hospital Inpatient (medical)	<ul style="list-style-type: none"> • Pays up to 60 days of medically necessary services, except Part A hospital deductible • Pays up to an additional 30 days, except daily coinsurance • If more than a 90-day hospital stay, can pay up to 60 Medicare lifetime reserve days, except daily coinsurance • No payment for more than a 90-day hospital stay per benefit period if no lifetime reserve days remain or if you choose not to use them 	<ul style="list-style-type: none"> • Pays Medicare Part A deductible except for first \$100 • Pays Medicare Part A coinsurance • Pays 100% of allowable charge for eligible expenses for an additional 365 days 	<ul style="list-style-type: none"> • Pays Medicare Part A deductible except for first \$100 • Pays Medicare Part A coinsurance • Pays 100% of allowable charge for eligible expenses for an additional 365 days
Skilled Nursing Facility	<ul style="list-style-type: none"> • Pays 100% for 20 days at a Medicare-certified skilled nursing facility • Pays up to an additional 80 days at a skilled nursing facility, except daily coinsurance • Medicare does not pay for more than 100 days at a skilled nursing facility in a benefit period 	<ul style="list-style-type: none"> • Pays Medicare Part A coinsurance (days 21-100) • Pays above coinsurance amount for an additional 80 days per Medicare benefit period 	<ul style="list-style-type: none"> • Pays Medicare Part A coinsurance (days 21-100) • Pays above coinsurance amount for an additional 80 days per Medicare benefit period
Part B Services	Medicare	Advantage 65	Advantage 65 – Medical Only
Physician And Other Services	<ul style="list-style-type: none"> • Generally pays 80% of Medicare-approved charges for services such as a doctor's care and outpatient physical or occupational therapy (within limits). Certain screenings and wellness/preventive services are covered at no cost – see your "Medicare and You" publication for more information • An annual deductible may apply 	<ul style="list-style-type: none"> • Does not pay Medicare Part B deductible, but does pay Part B coinsurance 	<ul style="list-style-type: none"> • Does not pay Medicare Part B deductible, but does pay Part B coinsurance

Note: This chart is meant to provide a basic overview of Original Medicare coverage and the supplemental plans available under the state program. The Medicare-Coordinating Plans Member Handbook and applicable inserts, available at www.dhrm.virginia.gov, include detailed information about benefits, exclusions, limitations and your responsibilities under these plans.

Part D Services	Medicare	Advantage 65	Advantage 65 – Medical Only
Prescription Drug Coverage	<ul style="list-style-type: none"> • Pays a benefit based on the specific Part D plan in which the beneficiary is enrolled 	<ul style="list-style-type: none"> • <i>Enhanced Medicare Part D plan – see pages 4-5</i> 	<ul style="list-style-type: none"> • <i>Does not include outpatient prescription drug coverage – once this plan is elected, participants may not elect a state program Medicare-coordinating plan with prescription drug coverage at a later date</i> • <i>Participants may elect drug coverage through another (non-state program) Medicare Part D plan or other creditable coverage</i>
Other Services	Medicare	Advantage 65	Advantage 65 – Medical Only
Routine Vision Benefits	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • <i>Optional – see page 3</i> 	<ul style="list-style-type: none"> • <i>Optional – see page 3</i>
Routine Dental Benefits	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • <i>Optional – see page 3</i> 	<ul style="list-style-type: none"> • <i>Optional – see page 3</i>
Routine Hearing Benefits	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • Pays for one routine hearing test every 48 months, except for \$40 copayment • Pays up to \$1,200 toward the cost of hearing aids and supplies every 48 months 	<ul style="list-style-type: none"> • Pays for one routine hearing test every 48 months, except for \$40 copayment • Pays up to \$1,200 toward the cost of hearing aids and supplies every 48 months
Out-Of-Country And Major Medical Services	<ul style="list-style-type: none"> • Not covered 	For Out-Of-Country services only: <ul style="list-style-type: none"> • <i>Pays 80% of allowable charge after you pay \$250 calendar year deductible</i> 	For Out-of-Country services only: <ul style="list-style-type: none"> • <i>Pays 80% of allowable charge after you pay \$250 calendar year deductible</i>
At Home Recovery Care And Visits	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • <i>Pays up to \$40 per visit, not to exceed \$1,600 each calendar year and 7 visits each week</i> 	<ul style="list-style-type: none"> • <i>Pays up to \$40 per visit, not to exceed \$1,600 each calendar year and 7 visits each week</i>

Note: This chart is meant to provide a basic overview of Original Medicare coverage and the supplemental plans available under the state program. The Medicare-Coordinating Plans Member Handbook and applicable inserts, available at www.dhrm.virginia.gov, include detailed information about benefits, exclusions, limitations and your responsibilities under these plans.

DENTAL/VISION OPTION

Dental/Vision coverage may be added to Advantage 65 or Advantage 65—Medical Only at any time, and it may be cancelled at any time. However, once the Dental/Vision option has been elected and cancelled one time under any Medicare-coordinating plan, it may not be elected again. When adding Dental/Vision, your election will be effective the first of the month following receipt of your request.

Dental Benefits		The Plan Pays:	
<i>The maximum benefit per calendar year is \$2,000 per enrollee. There is no annual deductible. Some limitations may apply. See your Dental/Vision Member Handbook Insert for additional information.</i>			
Diagnostic and Preventive Care, including: <ul style="list-style-type: none">• Two routine oral evaluations, cleanings and one bitewing x-rays per calendar year• One full mouth x-ray every five years		100% of the allowable charge	
Basic Dental Care, including: <ul style="list-style-type: none">• Fillings (<i>amalgam or composite resin</i>)• Simple extractions of natural teeth and surgical extractions of fully-erupted teeth• Root canal therapy (endodontic)• Repair of broken removable dentures• Re-cementing existing crowns, inlays and bridges (<i>once every 12 months – some limitations may apply</i>)		80% of the allowable charge	
Major Dental Care, including: <ul style="list-style-type: none">• Crowns (single crowns, inlays and onlays)• Prosthodontics (<i>partials or complete dentures and fixed bridges - once every seven years</i>)• Dental Implants (<i>once every seven years</i>)		50% of the allowable charge	
Vision Benefits		The Member Pays or Plan Allows:	
<i>The following benefits apply to network providers. Your Dental/Vision Member Handbook Insert provides out-of-network benefit levels.</i>			
Routine Vision Examination (<i>once each calendar year</i>)		\$20 copayment (<i>network provider</i>)	
Eyeglass frames (<i>once per plan year</i>)		\$100 allowance then 20% off remaining balance (<i>network provider</i>)	
Eyeglass lenses (<i>one of the following per plan year</i>) <ul style="list-style-type: none">• Standard plastic single vision lenses (<i>one pair</i>)• Standard plastic bifocal lenses (<i>one pair</i>)• Standard plastic trifocal lenses (<i>one pair</i>)• Standard progressive lenses (<i>one pair</i>) OR Contact Lenses (<i>one of the following per plan year</i>) <ul style="list-style-type: none">• Elective conventional contact lenses• Elective disposable contact lenses• Non-Elective contact lenses Eyeglass lens upgrades <ul style="list-style-type: none">• UV Coating• Tint (<i>solid and gradient</i>)• Standard scratch-resistance• Standard polycarbonate• Standard anti-reflective coating• Other add-ons and services		\$20 copayment (<i>network provider</i>) \$20 copayment (<i>network provider</i>) \$20 copayment (<i>network provider</i>) \$85 copayment (<i>network provider</i>) \$100 allowance and 15% discount off remaining balance (<i>network provider</i>) \$100 allowance (<i>network provider - no additional discount</i>) Covered in full (<i>network provider</i>) \$15 (<i>network provider</i>) \$15 (<i>network provider</i>) \$15 (<i>network provider</i>) \$40 (<i>network provider</i>) \$45 (<i>network provider</i>) 20% off retail price (<i>network provider</i>)	

Use of a non-participating provider will generally result in a reduced benefit and higher out-of-pocket costs. Your Member Handbook Dental/Vision Insert includes additional information.

ENHANCED MEDICARE PART D PLAN OPTION

Effective January 1 – December 31, 2025

Participants covered under the Advantage 65 Plan or Advantage 65 + Dental/Vision Plan will have the outpatient prescription drug coverage described below (pending Medicare approval). The level of coverage is based on:

- Whether the drug is included on the plan's formulary — the list of covered drugs for the current plan year which is available at www.express-scripts.com/documents or by calling Customer Service at 1-800-572-4098 (TTY users call 1-800-716-3231)
- Generally, drugs that are not on the plan's formulary will not be covered; however additional information regarding exceptions is provided in the Evidence of Coverage.
- The coverage tier of the drug — tiers are described in the chart below and are designated for all covered drugs in your formulary
- The coverage stage — each coverage stage is described below

Deductible Stage – A \$590 annual deductible will apply to covered brand-name drugs. There is no deductible for covered generics.

Initial Coverage Stage – Once the annual deductible has been met for covered brand-name drugs (and immediately for covered generics), the Initial Coverage Stage will provide the following benefit until total drug cost reaches \$2,000:

Drug Tier	Supply of Medication/ Method of Purchase	Your Copayment/Coinsurance Amount
Tier 1 Generics	Up to a 34-day supply of a covered generic drug at a participating retail pharmacy	\$7.00
Tier 1 Generics	Up to a 90-day supply of a covered generic drug purchased through the mail service program	\$7.00
Tier 2 Preferred Brands	Up to a 34-day supply of a covered preferred brand drug at a participating retail pharmacy	\$25.00 (after deductible)
Tier 2 Preferred Brands	Up to a 90-day supply of a covered preferred brand drug purchased through the mail service program	\$50.00 (after deductible)
Tier 3 Non-Preferred Brands	Up to a 34-day supply of a covered non-preferred brand drug at a participating retail pharmacy	75% of the cost of the drug (after deductible)
Tier 3 Non-Preferred Brands	Up to a 90-day supply of a covered non-preferred brand drug purchased through the mail service program	75% of the cost of the drug (after deductible)
Tier 4 Specialty Drugs	Up to a 34-day supply of a covered specialty drug at a participating retail pharmacy	25% of the cost of the drug (after deductible)
Tier 4 Specialty Drugs	Up to a 90-day supply of a covered specialty drug purchased through the mail service program	25% of the cost of the drug (after deductible)

Coverage Stages continued on page 5

Coverage Gap Stage – This plan does not have a coverage gap. For 2025, the Coverage Gap stage is eliminated.

Catastrophic Coverage Stage – In 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs. If your annual true out-of-pocket drug expense (including deductible, copayments, coinsurance, but not including the cost of non-covered or excluded drugs) reaches \$2,000, the plan will pay the full cost for your covered Part D drugs. If the plan covers additional drugs not normally covered by Medicare, you may have a cost share for such drugs under an enhanced benefit.

Medicare Explanation of Benefits (EOB) – To help participants track their coverage stages, an EOB is provided by the claims administrator for any months during which their benefit is used. You may also obtain a copy electronically by accessing the website at www.express-scripts.com or by contacting Express Scripts Medicare Customer Service at 1-800-572-4098, TTY callers 1-800-716-3231.

Your **Evidence of Coverage** provides more detailed information about this prescription drug coverage. You may request a copy of this document from Express Scripts Medicare by contacting Customer Service at 1-800-572-4098 (TTY users call 1-800-716-3231) or by visiting their website at www.express-scripts.com/documents.