Prescription Drug Benefits

This insert will accompany the Medicare-Coordinating Plans Member Handbook for enrollees who are eligible for and have elected these benefits.

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January 2018
Commonwealth of Virginia
Department of Human Resource Management

IMPORTANT NOTICE

This insert describes the outpatient prescription drug benefits that You have under the Commonwealth of Virginia Retiree Health Benefits Program if You are enrolled in a plan that includes this coverage. Plans including these outpatient prescription drug benefits are Advantage 65, Advantage 65 with Dental/Vision, Medicare Supplemental/Option II, and Medicare Supplemental/Option II with Dental/Vision. This program is an enhanced Medicare Part D Plan, approved by Medicare and administered by Express Scripts. The plan is called Express Scripts Medicare for the Commonwealth of Virginia Retiree Health Benefits Program. Materials from Express Scripts will reflect this plan name.

Throughout this insert, there are words that begin with capital letters. In most cases, these are defined terms. See the "Definitions" sections of Your Medicare-Coordinating Plans Member Handbook and/or this insert for the meaning of these words.

Your outpatient prescription drug coverage is generally limited to the drugs that are listed on the plan's Formulary. However, drugs that are not on the plan's Formulary but have been approved through the Exception or appeal process are also covered. Usually, drugs that are excluded by Medicare will not be granted an Exception. Drugs covered by Medicare Part B, as prescribed and dispensed, are not covered. Generally, only drugs that are covered under the Medicare Prescription Drug Benefit (Part D) and that are included on this plan's Formulary are covered. To obtain Formulary information, You may to go **www.Express-Scripts.com** or call 800-572-4098.

Some of the drugs covered under this plan have coverage limits as indicated in the Formulary. This could include, but is not limited to, restricting the amount of medication covered within a period of time (Quantity Limits), requiring Prior Authorization and/or requiring Step Therapy. If You have questions about complying with any coverage limits, contact Express Scripts Medicare Customer Service at 800-572-4098.

There are some rules and information that apply to all benefits (medical, dental, vision and/or prescription drugs as applicable to Your own coverage), including "General Rules Governing Benefits", "Exclusions", "Basic Plan Provisions", "Definitions" and "Eligibility", which are included in Your Commonwealth of Virginia Retiree Health Benefits Program Medicare-Coordinating Plans Member Handbook. Any rules or information that applies specifically to these outpatient prescription drug benefits will be included in this insert. In addition, Your Evidence of Coverage, provided by Express Scripts Medicare as part of Your welcome kit or annual notice of changes, together with any riders and amendments that may be sent to You by Express Scripts Medicare, describe rules governing Medicare Part D plans.

USING YOUR PRESCRIPTION DRUG BENEFITS

You must use a Network Pharmacy to receive benefits under this plan. Except in certain limited circumstances, failure to use a Network Pharmacy will result in denial of benefits. See Your Evidence of Coverage, provided by Express Scripts Medicare, for more information. To identify a Network Pharmacy, contact Express Scripts Medicare Customer Service at 800-572-4098, go to **www.Express-Scripts.com** or consult Your pharmacy directory, which is based on Your zip code of record. The pharmacy network can change at any time. Be sure to confirm participation before filling any prescription.

This plan also offers a home delivery pharmacy service. This service is generally used to fill prescriptions for maintenance drugs (drugs that You take on a regular basis for chronic or long-term medical conditions). The drugs available through the home delivery service are indicated on your Formulary. Usually, home delivery service will get your order to you in no more than 10 days. However, sometimes your home delivery may be delayed. Make sure you have at least a 14-day supply of Your medication on hand. For more information, contact Express Scripts Medicare Customer Service.

WHO TO CONTACT FOR ASSISTANCE

Outpatient Prescription Drug Plan/Claims Administration/Customer Service

Customer Service — Express Scripts Medicare
P. O. Box 14570
Lexington, KY 40512
800-572-4098 / TTY/TDD 800-716-3231
24 hours a day, 7 days a week

Web Address — **www.Express-Scripts.com**

Coverage Determinations and Prior Authorizations — Express Scripts
Attn: Medicare Reviews
P. O. Box 66571
St. Louis, MO 63166-6571
1-844-374-7377 / TTY/TDD 800-716-3231

Refer to your Evidence of Coverage for complete contact information for appeals and complaints.

State Program Eligibility and Enrollment

If You Are A:	Contact This Benefits Administrator
Virginia Retirement System Retiree/Survivor or VSDP Long Term Disability Program Participant	The Virginia Retirement System 888-827-3847 **www.varetire.org**
Local or Optional Retirement Plan Retiree or Survivor or non-VSDP LTD Participant	Your Pre-Retirement Agency Benefits Administrator
Non-Annuitant Survivor (No VRS Survivor benefit)	The Department of Human Resource Management (see page 4)

Program Administration

Department of Human Resource Management

Web Address	**www.dhrm.virginia.gov**
E-Mail	**ohb@dhrm.virginia.gov**

Medicare

Web Address	**www.medicare.gov**
By Phone	800-MEDICARE

GENERAL RULES GOVERNING BENEFITS

All applicable "General Rules Governing Benefits" listed in the Medicare-Coordinating Plans Member Handbook also apply to the outpatient prescription drug benefits described in this insert.

When Benefits End

You may terminate the benefits described in this insert prospectively by submitting an enrollment form to Your Benefits Administrator indicating Your request to terminate coverage. There are some situations that would require Your disenrollment from this coverage. Generally, Your enrollment in another Medicare Part D plan or any disenrollment sent by Medicare would result in disenrollment from the Commonwealth of Virginia Retiree Health Benefits Program's Medicare Part D coverage described in this insert. Please refer to Your Evidence of Coverage, provided by Express Scripts Medicare, for more information about disenrollment from this or other Medicare Prescription Drug Plans.

Appeals

Except as described below, the Appeals section of "General Rules Governing Benefits" in Your Medicare-Coordinating Plans Member Handbook does not apply to this Medicare Prescription Drug Plan. Refer to Your Evidence of Coverage, provided by Express Scripts Medicare, for a complete description of the appeals and grievance process available to You. Since this is a Medicare-approved plan, there is no claim appeals process available through the Department of Human Resource Management, the Program Administrator. However, You may appeal administrative decisions that are based strictly on the policies and procedures of the Department by writing to the Director of the Department of Human Resource Management and including Your name, identification number and a full description of the administrative matter. (See Your Medicare- Coordinating Plans Member Handbook for more information about Your appeal rights to the Department of Human Resource Management). The Department will not adjudicate appeals unrelated to its own policies and procedures.

Coordination of Benefits

See Your Evidence of Coverage, provided by Express Scripts Medicare, for more information about having other prescription drug coverage in addition to this Medicare Part D plan. Participants may not be enrolled in more than one Medicare Prescription Drug Plan at any time.

Your Rights and Responsibilities under a Medicare Prescription Drug Plan

Your Evidence of Coverage, provided by Express Scripts Medicare, describes Your rights, protections, and responsibilities as a participant in a Medicare Prescription Drug Plan.

PRESCRIPTION DRUG BENEFITS

Following are the provisions of this Medicare prescription drug plan. Consult Your Evidence of Coverage (provided by Express Scripts Medicare) for additional information.

Formulary - Generally, only drugs included on the plan's Formulary will be covered. (However, participants may apply for a Formulary Exception by requesting a Coverage Determination/Decision-see Your Evidence of Coverage for complete information).

To determine whether a drug is included on the plan's Formulary and its coverage tier, contact Express Scripts Medicare Customer Service or go to the Express Scripts Medicare Web site at **www.Express-Scripts.com**. Some of the drugs covered under this plan have coverage limits. This could include restricting the amount of medication covered within a period of time, requiring Prior Authorization, or requiring Step Therapy.

If a drug is removed from the Formulary or moved to a higher cost-sharing tier, or if Prior Authorizations, Quantity Limits and/or Step Therapy restrictions are added after January 1, the start of the plan year, and You are taking the drug affected by the change, You will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year. However, if a Brand Name Drug is replaced with a new Generic drug, or the Formulary is changed as a result of new information on a drug's safety or effectiveness, You may be affected by this change during the plan year. You will be notified of the change at least 60 days before the date that the change becomes effective, or You will be provided with a 60-day supply at the pharmacy (unless the drug is removed from the Formulary because it has been recalled from the pharmacies, in which case the drug will be removed immediately and affected participants will be notified as soon as possible). Please refer to Your Welcome Kit or Annual Notice of Changes, provided by Express Scripts Medicare, for additional information.

Drugs that are excluded for Medicare Part D coverage as determined by Medicare will not be included on the Formulary.

Tier - Drugs included on the Formulary are placed in tiers. The co-payment or coinsurance amount that You pay for any covered drug depends on its tier. Charts describing the type of drug in each tier and your co-payment or coinsurance are included in this insert.

Coverage Stages

Deductible Stage - A $405 plan year (January 1-December 31) deductible will apply to all covered drugs except Generics. There will be no deductible for covered Generics. This means that participants must pay the first $405 of actual drug cost for covered Brand Name Drugs. Once the deductible has been met, the applicable co-payment or coinsurance will apply.

Initial Coverage Stage – Once your deductible has been met for covered Brand Name Drugs (and immediately for covered Generics), your co-payments/coinsurance will remain as follows until your total covered drug cost reaches $3,750.

Initial Coverage Stage - Covered Tier 1 (Generic) Drugs	Co-payment
Per one-month (up to 34-day) supply at a retail Network Pharmacy	$7
Per up to a 90-day supply through the home delivery service	$7

Initial Coverage Stage - Covered Tier 2 (preferred Brand) Drugs	Co-payment
Per one-month (up to 34-day) supply at a retail Network Pharmacy	$25
Per up to a 90-day supply through the home delivery service	$50

Initial Coverage Stage - Covered Tier 3 (non-preferred Brand) Drugs	Coinsurance
Per one-month (up to 34-day) supply at a retail Network Pharmacy	You pay 75%
Per up to a 90-day supply through the home delivery service	You pay 75%

Initial Coverage Stage - Covered Tier 4 (specialty) Drugs	Coinsurance
Per one-month (up to 34-day) supply at a retail Network Pharmacy	You pay 25%
Per up to a 90-day supply through the home delivery service	You pay 25%

If your doctor prescribes less than a full month's supply, you may not have to pay the cost of an entire month's supply - Typically, you pay a copayment or coinsurance to cover a full month's supply (up to a 34-day supply) of a covered drug. However, your doctor can prescribe less than a full month's supply. There may be times when you want to ask your doctor about prescribing less than a full month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees to prescribe less than a full month's supply, you will not have to pay for the full month's supply for certain drugs. If the drug is in a tier that has a copayment (instead of coinsurance), your copayment will be based on the number of days of the drug that you receive. The amount of copayment you pay each day for a month's supply will be calculated, and you will pay the "daily cost-sharing rate," (If the drug is in a tier that has coinsurance, you will pay a percentage of the total cost of the drug, so you are already paying based on the actual number of days prescribed.)

Coverage Gap Stage – Once your total drug cost exceeds $3,750, you move into the Coverage Gap Stage. In most cases, the amount you pay in the Coverage Gap Stage will not be different from the amount you paid in the Initial Coverage Stage (after any deductible was met). The way that your claim is paid changes. You receive the benefit of the Medicare Coverage Gap Discount Program, which pays 50% of the cost of any covered brand drug manufactured by a program participant. The discount is applied to the cost of the drug, and your co-payment or coinsurance, based on the tier of the drug, is applied. The plan pays the remaining cost. You will not have to pay more than 35% of the cost of covered brand name drugs in this coverage stage. Also, while Generic drugs are not a part of the Medicare Coverage Gap Discount Program, your cost for covered Generics will not exceed 44% in this stage. Both the manufacturer's discount and your out-of-pocket cost will count toward reaching the Catastrophic Coverage Stage.

Catastrophic Coverage Stage– If your annual out-of-pocket drug expense (including Your deductible, co-payments, coinsurance, the contribution from the Medicare Coverage Gap Discount Program, but not including the cost of non-covered or excluded drugs) reaches $5,000, you will pay the greater of either 5% coinsurance or a co-payment of $3.35 (covered Generics or drugs treated as Generics) or $8.35 (covered Brand Name Drugs). You will remain in this stage for the remainder of the year.

Explanation of Benefits – To help You track your coverage stage, You will receive an Explanation of Benefits (or EOB), which is a statement of what You have spent on Your prescription drugs and the total amount that the plan has paid for any month during which You use Your coverage.

Medication Therapy Management Programs - These programs are offered at no additional cost for participants who have multiple medical conditions, are taking many prescription drugs, or who have high drug costs. These programs were developed by a team of pharmacists and doctors and help in providing better coverage for participants. They help the plan to ensure that participants are using appropriate drugs to treat their medical conditions and help identify possible medication errors. If You are identified as meeting specific criteria for these programs, You may be contacted. While You are not required to participate, You are encouraged to do so. There is no cost for these programs.

EXCLUSIONS

All applicable “Exclusions” listed in the Medicare-Coordinating Plans Member Handbook apply to the outpatient prescription drug benefits described in this insert. Also, any exclusions or limitations listed in Your Evidence of Coverage, provided by Express Scripts Medicare, will apply.

BASIC PLAN PROVISIONS

All applicable “Basic Plan Provisions” listed in the Member Handbook also apply to the outpatient prescription drug benefits described in this insert.

PAYMENT OF MONTHLY PREMIUMS

For the coverage described in this insert, Your premium is due on the first of the coverage month. See Your Evidence of Coverage, provided by Express Scripts Medicare, for more information about paying premiums under a Medicare Prescription Drug Plan. Your prescription drug premium is a part of your total Medicare-Coordinating Plan premium. Coverage limited to only prescription drugs is not available under the State Retiree Health Benefits Program. Failure to pay your total monthly premium can result in termination of coverage, including this prescription drug coverage. Your Medicare-Coordinating Plans Member Handbook discusses premium payments under the state program.

If you qualify for the Low-Income Subsidy or “Extra Help”, your premium will be reduced based on the subsidy level determined by Social Security. Your Evidence of Coverage provides additional information.

Eligibility

Applicable eligibility information listed in the Medicare-Coordinating Plans Member Handbook, as well as eligibility information in the Evidence of Coverage, provided by Express Scripts Medicare, also applies to the outpatient prescription drug benefits described in this insert. However, new retiree group participants who are eligible for Medicare or existing retiree group participants who become eligible for Medicare and then elect a plan that does not include this prescription drug coverage, may not elect prescription drug coverage in the future under the state program. If this prescription drug coverage is terminated at any time under the state program by electing a state program plan that does not include outpatient prescription drug coverage, by enrolling in Medicare Part D coverage outside of the state program, or if Medicare terminates this coverage at any time, it may not be elected/added again in the future under the State Retiree Health Benefits Program.

Participants must be eligible for Medicare Part D to be eligible for the coverage described in this insert. All requirements of Medicare, as described in Your Evidence of Coverage, provided by Express Scripts Medicare, apply to this coverage. If You lose eligibility for Medicare Part D coverage, as determined by Medicare, including moving out of the plan's Service Area, You are no longer eligible for the benefits described in this insert. The Service Area for this plan includes all 50 states, the District of Columbia, and Puerto Rico. Participants living abroad are not eligible for these benefits since they are not considered to reside in the Service Area of this plan.

DEFINITIONS

All applicable "Definitions" listed in the Medicare-Coordinating Plans Member Handbook also apply to the outpatient prescription drug benefits described in this insert.

Brand Drug(s)/Brand Name Drug(s) – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand Name Drugs have the same active-ingredient formula as the Generic version of the drug. However, Generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the Brand Drug has expired.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs Medicare.

Coverage Determination/Decision – The decision made about the prescription drug benefits You are entitled to get under this coverage, and the amount that You are required to pay for the drug. See Your Evidence of Coverage, provided by Express Scripts Medicare, for more information.

Evidence of Coverage – The document provided by Express Scripts Medicare that explains Medicare Prescription Drug Coverage.

Exception – A type of Coverage Determination that, if approved, allows You to get a drug that is not on Your Formulary (a Formulary Exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering Exception). You may also request an Exception if Your plan requires You to try another drug before receiving the drug You are requesting, or the Plan limits the quantity or dosage of the drug You are requesting (a Formulary Exception).

Formulary – The list of drugs covered by this plan.

Generics/Generic Drug(s) – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the Brand Drug. Generally, Generic drugs cost less than Brand Name Drugs.

Low-Income Subsidy/Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance. Your Evidence of Coverage provides additional information.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Medicare Part D provides outpatient prescription drug coverage.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D Brand Name Drugs to Part D enrollees who have reached the Coverage Gap stage and who are not already receiving Extra Help. Discounts are based on agreements between the federal government and certain drug manufacturers. For this reason, most, but not all, Brand Name Drugs are discounted.

Network Pharmacy – A pharmacy where participants in this Plan can get their prescription drug benefits. We call them "Network Pharmacies" because they contract with this Plan.

Prior Authorization – Approval in advance to get certain drugs on our Formulary. Some drugs are covered only if Your doctor or other provider gets Prior Authorization. Covered drugs that need Prior Authorization are designated on the Formulary.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that is covered per prescription or for a defined period of time.

Service Area – The geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services. The service area for this plan includes all 50 states, the District of Columbia and Puerto Rico.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before the drug your physician may have initially prescribed is covered.

Get Help in Your Language

Curious to know what all this says? We would be too. Here's the English version:

This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish

Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Amharic

ይህ ማስታወቂያ ስለማመልከቻዎ ወይም ጥቅማ ጥቅሞችዎ ጠቃሚ መረጃ አለው። አስፈላጊ ቀኖችን ይፈልጉ። ጥቅማ ጥቅሞችዎን ለማቆየት ወይም ክፍያዎችን ለመቆጣጠር በሆነ ቀን አንድ እርምጃ መውሰድ ያስፈልግዎ ይሆናል። ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ። (TTY/TDD: 711)

Arabic

يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعد

(TTY/TDD:711)

Bassa

Bɔ̌i-po-po nìà kɛ ɓéɖé bɔ̌ kpaɖɛ ɓá nì ɖɛ-mó-ɖìfèɖè mɔɔ kpáná-ɖè ɓě m̀ ké dyéɛ dyí. M̀ mɛ mó wé kpaɖɛ ɓě dyi. Ɓé nì kpáná-ɖè ɓě ké m̀ xwa se mɔɔ ɓé m̀ ké pío xwa ɓéìn nyɛɛ, ɔ mu wɛ̂ìn ɓé m̀ kéó ɖɛ ɓě ti kɔ̃ nyùìn. M̀ ɓéɖé dyí-ɓèɖèìn-ɖèɔ ɓɛ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá dyé ɖé m̀ ɓíɖí-wùɖùŭn ɓó pídyi. Ɖá Mɛ́ɓà jè gbo-gmɔ Kpòè nɔ̀bà nìà nì Dyí-dyoìn-bɛ̃ɔ̃ kɔ̃ɛ, ɓó gbo-kpá-kpá dyé jè. (TTY/TDD: 711)

Bengali

আপনার আবেদন বা সুবিধার বিষয়ে এই বিজ্ঞপ্তিটিতে গুরুত্বপূর্ণ তথ্য রয়েছে। গুরুত্বপূর্ণ তারিখগুলির জন্য দেখুন। আপনার সুবিধাগুলি বজায় রাখার জন্য বা খরচ নিয়ন্ত্রণ করার জন্য নির্দিষ্ট তারিখে আপনাকে কাজ করতে হতে পারে। বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।

(TTY/TDD: 711)

Chinese

本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

این اطلاعیه حاوی اطلاعات مهم در مورد درخواست یا مزایای شما است. به تاریخهای مهم دقت کنید. ممکن است لازم باشد در برخی تاریخهای خاص اقدامی انجام دهید تا مزایای خود را حفظ کنید یا هزینه‌ها را مدیریت کنید. شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید

(TTY/TDD:711)

French

Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German

Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag oder Ihren Beihilfeleistungen. Prüfen Sie die Mitteilung auf wichtige Termine. Möglicherweise müssen Sie bis zu einem bestimmten Datum Maßnahmen ergreifen, um Ihre Beihilfeleistungen oder Kostenzuschüsse aufrechtzuerhalten. Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Hindi

इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तिथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चित तिथियों तक कार्रवाई करने की ज़रूरत हो सकती है। आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Igbo

Ọkwa a nwere ozi dị mkpa gbasara akwụkwọ anamachọihe ma ọ bụ elele gị. Chọgharịa ụbọchị ndi dị mkpa. Ị nwere ike ịme ihe n'ụfọdụ ụbọchị iji dowe elele gị ma ọ bụ jikwaa ọnụego. Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Korean

이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Russian

Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.

(TTY/TDD: 711)

Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu

یہ نوٹس آپ کی درخواست یا فائدوں کے بارے میں اہم معلومات پر مشتمل ہے۔ اہم تاریخیں دیکھیے۔ اپنے فائدوں یا لاگتوں کو منظم کرنےکے لیے آپ کو بعض تاریخوں پر اقدام کرنے کی ضرورت ہوسکتی ہے۔ آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔

(TTY/TDD:711)

Vietnamese

Thông báo này có thông tin quan trọng về đơn đang ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yoruba

Àkíyèsí yìí ní ìwífún pàtàkì nípa ìbéèrè tàbí àwọn ànfàní rẹ. Wá déètì pàtàkì. O le ní láti gbé ìgbésẹ̀ ní déètì kan pàtó láti tọ́jú àwọn ànfàní tàbí ṣàkóso iye owó rẹ. O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)