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To: State Retiree Health Benefits Program Enrollees Eligible for Medicare or Enrollees who cover Medicare-Eligible Family Members

From: Office of State and Local Health Benefits Programs

Date: November 13, 2020

Annual Benefit and Premium Rate Notification for 2021:

This notification booklet includes information about coverage for Medicare-eligible participants in 2021. Be sure to read these materials carefully to ensure that you understand your options.

If you wish to maintain your current plan, NO ACTION on your part is necessary. If you continue to be eligible, your new monthly premium will be automatically deducted or directly billed.

GREAT NEWS!
No Change to Your 2021 Premium Rate

How much is my health plan premium for 2021?

All State Medicare-coordinating plan medical (including hearing), dental and routine 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 Express Scripts and is an enhanced Medicare Part D plan.

Following is a summary of 2021 premium:

Since retiree, group participants pay the full cost of their health plan coverage in the State Retiree Health Benefits Program, premiums are based on the amount required to fund the costs of the Program. This includes all claims and administrative cost. For all State Medicare Plan Option plan participants the State experienced a cost savings that was passed on to you!

Final total premiums are rounded to the nearest whole dollar.

Plan – Single Membership	2020 Premium	2021 Premium	% Increase
Advantage 65	**$273**	**$273**	**0%**
Advantage 65 + Dental/Vision	**$307**	**$307**	**0%**
Medicare Supplemental/Option II	**$357**	**$357**	**0%**
Option II + Dental/Vision	**$391**	**$391**	**0%**
Advantage 65—Medical Only	**$170**	**$170**	**0%**
Advantage 65—Medical Only + Dental/Vision	**$204**	**$204**	**0%**

All State Medicare-coordinating plan medical (including hearing), dental and routine 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 Express Scripts and is an enhanced Medicare Part D plan.

Note to Medicare Supplemental/Option II Enrollees…

Option II enrollees can significantly reduce their monthly premium if they move to an Advantage 65 Plan. All premiums are provided above for comparison, but, as an example, the cost of Advantage 65 with Dental and Vision is $84 dollars a month less than Option II with Dental and Vision. That's a $996 savings for 2021!

Your Medicare-Coordinating Plans Member Handbook describes the benefits under both the Advantage 65 and Option II Plans. The differences are:

- Option II has a major medical benefit that can be used for claims both in and out of the country. Historically, there has been minimal utilization of this benefit within the US. There is more use outside of the US, but the Advantage 65 plans have their own out-of-country major medical benefit. Contact Anthem to see if you have ever used this benefit.
- Option II pays the annual Medicare Part B deductible, which is not covered under Advantage 65. For 2020, the Part B deductible is $198 and may change for 2021 but that would not exceed the offset by the premium savings under Advantage 65.
- Advantage 65 provides an At-Home Recovery Services benefit, which is not covered under Option II.

Consider the higher premium cost of Option II as compared to the value of its additional benefits. Many participants will find that a plan change to Advantage 65 will be a good choice.

If I qualify for "Extra Help" with my prescription drug costs, how will my premium be affected?

If you have qualified through the Social Security Administration for "Extra Help" paying the cost of your Medicare Part D coverage and you are approved for enrollment in the state program, your premium will be reduced for each month you are approved for the subsidy. You will receive

confirmation of your premium reduction from Express Scripts Medicare at the time of your subsidy approval or as a part of your Annual Notice of Changes. More information about "Extra Help" (also known as the low-income subsidy or LIS) is available in the Express Scripts Medicare Evidence of Coverage, which is available online or by requesting a printed copy. Following are the "Extra Help" reductions for 2021:

Subsidy Level	Monthly Premium Reduction
1-6	$33.00
7	$25.00
8	$17.00
9	$9.00

Participants who have qualified for "Extra Help" are encouraged to explore other Medicare Part D plan options outside of the state program. While your state program premium is reduced by the amount indicated above based on your subsidy level, beneficiaries are still paying the remaining premium for an enhanced Medicare Part D benefit that may not be providing additional coverage. The Medicare web site (**www.medicare.gov**) or 1-800-MEDICARE can provide a summary of other plans and benefits that are available to you, including plans with lower premium cost.

If you would like more information about "Extra Help" (the low income subsidy), contact the Social Security Administration at 800-772-1213.

Can my income affect the cost of Medicare Part D?

Beneficiaries with incomes above a level set by Medicare may have to pay a higher cost for Part D prescription drug coverage. You will be notified by Social Security if this applies to you. Any income-related adjustment will be collected through your Social Security or equivalent benefit and **not** as a part of your Commonwealth of Virginia Retiree Health Benefits Program premium.

Your income can also affect the cost of your Part B medical coverage. Consult your *"Medicare and You 2021"* publication which has more information about the cost of Medicare Part B and Part D.

When will I begin paying the premium for 2021?

For participants whose premiums are deducted from a VRS retirement benefit, the new January 2021 premium will be deducted from the retirement benefit payment you receive in February. For those who already pay through direct billing, the new premium will be billed in December for January's premium. If you have requested a change in coverage, the premium change may take place later depending on the date of your request. For those who are paying through Anthem automatic bank draft, your first deduction of the new premium amount will take place in your January draft. If you are paying through your financial institution, please ensure that you authorize the appropriate premium payment amount for January 1.

If a premium change results in your VRS benefit no longer supporting your premium deduction, Anthem Blue Cross and Blue Shield will directly bill you. Direct billing notification is mailed the month prior to the coverage month.

Important Note to Direct Bill Participants

(If your monthly premium is deducted from your retirement benefit, disregard this section)

If you receive a bill for your monthly health plan premium, a flier is enclosed that includes important information about your payment address as well as other payment options. ***Be sure to read this information carefully to ensure that your payment reaches the correct destination!***

Your Benefit Options for 2021

Will my medical benefits change for 2021?

Your Medicare supplemental benefits and any other medical benefits under an Advantage 65 or Medicare Supplemental/Option II Plan will not change for 2021.

Consult your "*Medicare and You 2021"* publication to determine if there are any changes to your primary Medicare coverage for 2021.

Will my dental and vision benefits change for 2021?

For those enrolled in the dental/vision option, those benefits will not change for 2021.

Will my prescription drug benefits change for 2021?

There will be no changes in your prescription drug copayment or coinsurance levels based on the tier of covered drugs. Coverage stage updates are provided later in this section.

Evidence of Coverage (EOC): You may access your Express Scripts Medicare Evidence of Coverage at **www.express-scripts.com/documents** or you can request a copy by contacting Customer Service at 1-800-572-4098. TTY users can contact 1-800-716-3231. This document is a resource for your rights and rules you will need to follow for covered services and drugs under the plan.

Formulary (Drug List): You will not receive a printed formulary booklet in your Annual Notice of Changes package from Express Scripts Medicare. However, you may obtain formulary information by logging in at **www.express-scripts.com/documents** or by calling Customer Service at 1-800-572-4098. TTY users can call 1-800-716-3231.

You are encouraged to use this resource to check the status of maintenance drugs that you are currently taking to be sure that there are no changes. However, anyone who is taking a drug that will experience a formulary change effective January 1, 2021 (e.g., higher out-of-pocket cost, no longer included on the formulary, new coverage restrictions, changes approved by Medicare), will receive individual notification from Express Scripts Medicare in December. Your Annual Notice of Changes has additional information about your options should you experience a formulary change.

Four Coverage Stages

Following is a summary of the 2021 coverage stages. Be sure to review the limits and benefits of each stage so that you understand your coverage.

Deductible Stage – Your annual outpatient prescription drug deductible will increase to $445 in 2021. This means that you will pay the full cost of any covered brand-name drug until you have paid $445 out-of-pocket. Covered generics continue to be excluded from any deductible.

Initial Coverage Stage –There are no changes in copayments and coinsurance for each cost-sharing tier for 2021. Once your deductible has been met for covered brand drugs (and immediately for covered generics), your copayments/coinsurance will remain as follows until your total covered drug cost reaches $4,130.

Initial Coverage Stage - Covered Tier 1 (generic) Drugs	**2021 Copayment**
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	**2021 Copayment**
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	**2021 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	**2021 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%

Coverage Gap Stage – ***This plan does not have a coverage gap.*** After your total drug costs reach $4,130 in the 2021 plan year (the point at which standard plans reach their Coverage Gap), this plan will generally cover generic and formulary brand-name drugs at the same copayment or coinsurance as in the Initial Coverage Stage. However, due to the Medicare Coverage Gap Discount Program, the amount you pay for non-preferred drugs may be lower. You will stay in this stage until your out-of-pocket drug cost plus the amount paid by the Coverage Gap Discount Program for this plan year reaches $6,550. The plan's Evidence of Coverage has complete information.

Catastrophic Coverage State – In 2021, if your annual true out-of-pocket drug expense (including deductible, copayments, coinsurance, and the contribution from the Medicare Coverage Gap Discount Program, but not including the cost of non-covered or excluded drugs) reaches $6,550, you will pay the greater of either 5% coinsurance or a copayment of $3.70 (generics or drugs treated as generics) or $9.20 (brand-name drugs). You will remain in this stage for the remainder of the year.

Express Scripts Mobile App – You can manage your prescriptions using your mobile device by registering for the Express Scripts Mobile App. Go to **www.express-scripts.com** or your mobile device's app store to register.

Your Medicare Explanation of Benefits (EOB) – To help you track your coverage stages, you will receive an EOB directly from Express Scripts for any months during which you use your benefit. 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 contact 1-800-716-3231.

Notice of 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 Medicare Part D plan and, therefore, creditable coverage. As such, a Notice of Creditable Coverage is not required. However, beneficiaries will not have to pay a higher premium for any period during which 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 coverage of 63 or more days.

Enrolling in Part D Plans Outside of the State Program – Your enrollment in Medicare prescription drug coverage outside of the state program will result in your disenrollment from the state program's Medicare Part D plan. If you do not notify the state program of your other election, Medicare will do so. **Once you have enrolled in Medicare Part D coverage outside of the state program, you may not re-enroll in the state program's Part D plan.**

Enrollment in the state's enhanced Medicare Part D plan for outpatient prescription drug coverage must be approved by the Centers for Medicare and Medicaid Services. The State Retiree Health Benefits Program must remove prescription drug coverage from the plan of any participant whom Medicare has advised is not eligible for coverage. This could be due to conflicting coverage in another Medicare Part D plan, loss of eligibility for Medicare, or any reason that is determined by Medicare. If Medicare disenrolls you from the state program's Medicare Part D plan, you will be moved to the corresponding Advantage 65—Medical Only Plan. There are not any medical-only plan options under the Medicare Supplemental/Option II Plans.

Is the state program's prescription drug coverage the best plan for me?

That's a question that only you can answer, but be a good consumer and investigate other Medicare prescription drug plan options for 2021. Compare premium cost and benefits to ensure that you are selecting the best plan to meet your individual needs. The Medicare Annual Coordinated Election Period that runs from October 15 through December 7 is a good time to review your current coverage and compare it to other available options.

Resources available to help you review your options include:

- Call 1-800-MEDICARE or go to **www.medicare.gov** for information about other Medicare prescription drug coverage or Medicare health plan options.
- Contact the Virginia Department for the Aging Insurance Counseling and Assistance Program (VICAP) at 1-800-552-3402 for assistance with selecting an available plan outside of the state program. If you live outside of Virginia, resources in your state are listed in the Express Scripts Medicare Evidence of Coverage, which is available online or by request.

If you find a prescription drug plan that better meets your needs, you can drop your state program coverage prospectively at any time by selecting a medical-only plan. However, once you leave the state program's Medicare Part D plan, you may not return.

Your Options for 2021 – What You Need To Do?

<u>If you wish to maintain your current plan, NO ACTION on your part is necessary. If you continue to be eligible, your new monthly premium will be automatically deducted or directly billed.</u>

<u>Making allowable plan changes for January 1, 2021</u>: **Online enrollment is not currently available.** If you wish to make an allowable plan change, you must complete a State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants. You may obtain an enrollment form as follows:

- Contact your Benefits Administrator:
- Online fillable forms are available on the DHRM website at **<u>www.dhrm.virginia.gov</u>**.

Once completed, be sure to sign the form and follow the mailing instructions to submit your request so that it is received by **December 16, 2020**. Forms received after **December 16, 2020, but before January 1, 2021**, will be effective on January 1, but there may be a delay in implementing the change and updating your premium.

Allowable changes requested after **December 31, 2020**, will be effective the first of the month after the request is received per program policy. **All Enrollment Forms must be signed by the Enrollee (Retiree, Survivor or LTD Participant); forms signed by a covered family member will not be accepted.**

The following options are available to you for January 1:

- **If you are in an Advantage 65 or Medicare Supplemental/Option II Plan, you may keep your current benefits as long as you remain eligible (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 through the state program again in the future.
    - If you are in Advantage 65, Medicare Supplemental/Option II or Advantage 65-Medical Only (and have not previously elected the Dental/Vision option), 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.
    - Medicare Supplemental/Option II participants may elect a corresponding (with or without dental/vision) Advantage 65 Plan prospectively at any time—see page two for more information.

- Retirees, Survivors and LTD Participants may cancel a family member's coverage at any time on a prospective basis (going forward). However, once family members of a Medicare-eligible participant have been cancelled, they may only be added within 60 days of the occurrence of an allowable qualifying mid-year event (e.g., loss of eligibility for other group coverage) that is

consistent with the addition. Medicare-eligible Enrollees do not have an annual Open Enrollment opportunity. ***Non-Medicare eligible covered family members may not make an Open Enrollment election to increase membership.***

- All Medicare-eligible covered family members (e.g., retiree and spouse) may have separate plan elections, but only the Enrollee can request a change.

- State coverage as an Enrollee may be cancelled completely, but you will not have an opportunity to return to the program at any time in the future. This will also result in the cancellation of any covered family members.

NOTE: Medical-Only Plan participants may not enroll in any state-program-sponsored Medicare-coordinating plan that includes outpatient prescription drug coverage.

For Your Information…

Are there fitness benefits available under the Advantage 65 Plans?

None of the state program's Medicare-coordinating plans currently provide any fitness benefits such as fitness programs, memberships or general exercise equipment. In response to some participants who have asked about adding this type of benefit to the program, the Department of Human Resource Management's Office of Health Benefits (the Department) investigated programs that are offered under other plans and found the following:

- Even though the utilization of fitness programs is generally low, there would be an additional premium cost to ALL participants to add this type of benefit. If this benefit were offered as a stand-alone option, enrollment would generally be limited to those who would actually use the benefit. Since retiree group participants pay the full cost of their coverage, it would result in a premium cost that would be the full cost of the benefit.
- The provider network for the program is not fully developed in all areas where participants reside, so not all participants in the state program would have convenient access to a participating provider even though all participants would be sharing the cost.

The Department considers very carefully any benefit change that increases the premium cost to retirees who pay the full cost of coverage. At this time, the additional premium cost, along with the network deficiencies in some areas, suggested that this was not a good enhancement for all participants.

Anthem does offer some fitness program discounts that is available to ALL members, regardless of plan or product. Because Special Offers is an online only program, members can only redeem the discounts by logging in to the member portal first, then clicking on the link for the discount they want to use. This is especially important because if a member does not click the link on the discounts page, they will not be recognized as eligible for the discount. Special Offers is not a reimbursement program so members cannot purchase a service or goods on their own, outside of the links on the discounts page, and then submit to Anthem for reimbursement. A summary of discount programs is included with this booklet.

Reminder to Non-Annuitant Survivors

Non-Annuitant Survivors are family members of employees or retirees who were covered under the State Health Benefits Program at the time of the employee's or retiree's death but are not beneficiaries of a VRS survivor annuity. There are specific eligibility guidelines for these participants, as follows:

- Non-annuitant surviving spouses may be covered until remarriage or obtaining alternate health insurance coverage. Coverage will be terminated at the end of the month in which the loss-of-eligibility event occurs. There is no Extended Coverage/COBRA available to Non-Annuitant Surviving Spouses who lose eligibility for the program.
- Non-annuitant surviving children may be covered until the end of the year in which they turn age 26, and if they meet the eligibility criteria for an adult incapacitated dependent, they may be covered after age 26 until they are no longer incapacitated (see eligibility criteria for adult incapacitated children in Member Handbooks). They will lose coverage at the end of the month in which their loss-of-eligibility event occurs, but they may be offered Extended Coverage/COBRA due to losing dependent child status.
- Non-Annuitant Survivors may not increase membership.

Can I enroll in a Medicare Advantage Plan?

The state program's Medicare-coordinating plans specifically exclude services or supplies that are received through Medicare Advantage Plans, so enrolling in a Medicare Advantage Plan will generally result in loss of benefits under the state program's Medicare-coordinating plans. State program participants may terminate their state program Medicare-coordinating coverage prospectively at any time (no return to the program). If you wish to enroll in a Medicare Advantage Plan, consider cancelling your coverage in the state program. (This would also result in termination of any covered family members.) If you enroll in a Medicare Advantage Plan and do not cancel your state coverage, consider carefully whether you wish to continue paying for coverage that may provide minimal, if any, medical benefits. In some cases, enrollment in a Medicare Advantage plan or other Medicare supplemental coverage could conflict with your state program enrollment. Also, if your other plan includes prescription drug coverage, it will likely result in your disenrollment from the state program's Medicare Part D plan (no re-enrollment allowed). ***Please note that the Advantage 65 Plans are not Medicare Advantage plans.***

A new plan year and Medicare enrollment period are good times to review all plan options available to you as a Medicare beneficiary. There could be a plan outside of the state program that better meets your needs, either in types of benefits, cost levels or both. However, be sure that you understand the impact of enrolling in other plans if you still want to keep your state plan coverage. Some things to think about and compare include:

- Premium cost
- Benefits
- Out-of-pocket expenses such as deductible, copayments, or coinsurance
- Drugs covered on the plan's formulary (are your drugs covered)

Use the resources listed on page seven to help you make a choice that meets your individual needs. If you have questions about Medicare's rules for conflicting coverage, please contact Medicare.

Will I get a new Member Handbook for 2021?

A new Medicare-Coordinating Plans Member Handbook is being finalized for printing. Until you receive your new handbook, continue to use your existing handbook, applicable inserts, amendments, and this notice as your description of coverage. Following is a link to all of the existing materials on line:

https://www.dhrm.virginia.gov/employeebenefits/health-benefits/medicare-retirees (click on Member Handbooks)

What resources are available for information about the State Retiree Health Benefits Program?

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:

https://www.dhrm.virginia.gov/employeebenefits/health-benefits/medicare-retirees (click on Frequently Asked Questions)

How does Medicare eligibility prior to age 65 affect program participation?

When an Enrollee (Retiree, Survivor, LTD participant) or a covered family member becomes eligible for Medicare prior to age 65, an enrollment form should be submitted immediately to elect a Medicare-coordinating plan. While this letter is being directed to Enrollees already in Medicare-coordinating plans, this information is provided to ensure that other covered family members who may be in non-Medicare plans are also moved to Medicare-coordinating coverage immediately upon eligibility. It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so may 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 (Original Medicare) in order to get the full benefit of any state program Medicare-coordinating plan since Medicare becomes the primary payer of claims for those who are no longer covered based on current employment. This also provides an opportunity for enrollment in the state program's Medicare Part D plan as a part of the Advantage 65 or Advantage 65 with Dental/Vision Plan (pending approval by Medicare).

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 with Dental/Vision plan immediately. If participants have declined Medicare coverage, it could result in a delay in enrollment and a critical gap in coverage until Medicare goes into effect. The state program will not pay any claims that should have been paid by Medicare had the participant been properly enrolled in Medicare coverage. The state program tracks Medicare eligibility due to age and can generally identify eligibility prior to age 65, but it is in the best interest of the Enrollee to report eligibility as soon as it is determined.

What happens if I fail to pay my premium?

Plan participants are responsible for timely payment of their monthly premiums (either through retirement benefit deduction or by direct payment to the billing administrator). Monthly premiums that remain unpaid for 31 days after the due date will be processed for termination of coverage. Once an Enrollee and his/her family members have been terminated for non-payment of premiums, re-enrollment in the program is at the discretion of the Department of Human Resource Management.

Direct-bill participants may enroll to have an automatic deduction of their monthly premium from their bank accounts and may make payments on line or by phone. Contact Anthem for more information. Participants are responsible for understanding their premium obligation and for notifying the program within 60 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.

What should I do if my 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 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 enrollees is through the mail. Please let your Benefits Administrator know when you move!

How can I get information about HIPAA Privacy Protections?

The Office of Health Benefits Notice of Privacy Practice describes how the health plan can use and disclose your health information and how you can get access to this information. Participants can obtain a copy of the privacy notice at **www.dhrm.virginia.gov.**

Who is my Benefits Administrator?

If you have questions about eligibility and enrollment, contact:

If You Are A:	*Contact This Benefits Administrator*
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Enrollee	The Virginia Retirement System (888) 827-3847 **www.varetire.org**
Local or Optional Retirement Plan Retiree/ Survivor or a non-VSDP LTD participant	Your Pre-Retirement Agency Benefits Administrator
Non-Annuitant Survivor (surviving spouse or child of an employee or retiree—not receiving a VRS benefit)	The Department of Human Resource Management (888) 642-4414 **www.dhrm.virginia.gov**

NOTE: Receipt of benefit-specific information in this package does not guarantee those benefits. In family groups with multiple Medicare-eligible family members, Enrollees will receive information about all plans within their family group. (For example, if you are in a plan without dental and vision coverage, but you are covering a family member in a plan that includes dental and vision, you will receive dental and vision information.)

DISTRIBUTION: Only Enrollees (Retirees, Survivors and Long-Term Disability Participants) will receive this package. Medicare-eligible covered family members will not receive annual premium rate notification materials directly, even if they have individual ID numbers. This means that Enrollees must share this information with their Medicare-eligible covered family members. Only Enrollees can request coverage changes for covered family members. If you are an Enrollee who is not eligible for Medicare but you are covering a Medicare-eligible family member, you are receiving this package due to the Medicare-eligible family member covered through your eligibility.