Virginia Department of
HUMAN RESOURCE
MANAGEMENT

Commonwealth of Virginia Retiree Health Benefits Program

Annual Premium Rate Notification Materials for Medicare-Eligible Participants

This Rate Notification Booklet includes:

<u>DISTRIBUTION</u>: ***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.***

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COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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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 29, 2018**

Important Information Regarding Your Health Benefits

This notification booklet includes information about coverage for Medicare-eligible participants in 2019. Be sure to read these materials carefully to ensure that you understand your options.

Your 2019 Premium Cost

- ***How much is my health plan premium for 2019?***

Plan – Single Membership	2018 Premium	2019 Premium Effective 1/1/19	% Change
Advantage 65	**$277**	**$262**	**-5.4%**
Advantage 65 + Dental/Vision	**$310**	**$294**	**-5.2%**
Medicare Supplemental/Option II	**$356**	**$355**	**-0.3%**
Option II + Dental/Vision	**$389**	**$387**	**-0.5%**
Advantage 65—Medical Only	**$156**	**$159**	**1.9%**
Advantage 65—Medical Only + Dental/Vision	**$189**	**$191**	**1.1%**

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.

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 cost. For all Advantage 65 plans, there was a small increase in the cost for the Medicare supplement, resulting in a $3 per month premium increase. For those who have the dental and vision option, there was a small decrease, and the premium was reduced by slightly over $1 per month. The biggest change was in the prescription drug program for which funding was adjusted to reflect positive claims trend, and a reduction of $18 per month for the prescription drug portion of the total premium.

Enrollees in the Medicare Supplemental/Option II Plan shared in the savings for the drug portion of their benefit and the dental/vision option, if applicable. However, the Medicare supplement costs continue to increase for this small population. Enrollees in the Option II Plan are encouraged to consider moving to an Advantage 65 Plan so that their supplement expenses can be mitigated by the larger Advantage 65 participant pool—see below for more details.

▪ ***Note to Medicare Supplemental/Option II Enrollees…***

Option II enrollees can reduce their premium if they move to an Advantage 65 Plan ($93 lower monthly premium for Advantage 65 + Dental/Vision as compared to Option II + Dental/Vision—that's $1,116 per year!). (The $2 total premium difference is due to offsetting the supplement increase with the prescription drug decrease.)

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.
- Option II pays the annual Medicare Part B deductible, which is not covered under Advantage 65. For 2019, the Part B deductible will increase to $185.
- Advantage 65 covers At-Home Recovery Services, which are not covered by Option II.

Consider the higher premium cost of Option II as compared to the value of its additional benefits. You will likely find that a plan change to Advantage 65 will be a good choice for you. Pages 7-8 have more information about how to make a plan change.

▪ ***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 2019:

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 your Part B medical coverage. Consult your *"Medicare and You 2019"* publication which has more information about the cost of Medicare Part B and Part D.

▪ *When will I begin paying my new 2019 premium?*

For participants whose premiums are deducted from a VRS retirement benefit, the new January 2019 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.

While just the Medical-Only plans have an increase for 2019, any premium increase that results in a VRS deduction no longer supporting your premium will mean that you will be moved to direct billing by Anthem Blue Cross and Blue Shield. Direct billing is mailed before the coverage month.

Your 2019 Benefits

▪ *Will my medical benefits change for 2019?*

The Medicare supplement and any other medical benefits under an Advantage 65 or Medicare Supplemental/Option II Plan will not change for 2019.

Consult your "*Medicare and You 2019"* publication to determine if there are any changes to your primary Medicare coverage for 2019.

▪ ***Will my dental and vision benefits change for 2019?***

The Dental and Vision Benefits under the Advantage 65 or Medicare Supplemental/Option II Plan will not change for 2019 for those who are enrolled in the dental/vision option.

▪ ***Will my prescription drug benefits change for 2019?***

There will be no changes in 2019 to your prescription drug copayment or coinsurance levels based on the tier of a drug. Coverage stage updates are provided later in this section.

Following are administrative changes that will be effective January 2019, as approved requirements by Medicare.

Evidence of Coverage (EOC): You will no longer receive an Evidence of Coverage booklet in your Annual Notice of Changes package from Express Scripts Medicare. 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 **express-scripts.com.** This document is a resource for your rights under the plan and for rules you will need to follow to get covered prescription 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. You may obtain formulary information by visiting Express Scripts Medicare website at **express-scripts.com/drugs,** or you may request a printed copy of this booklet by contacting Customer Service at 1-800-572-4098, TTY users 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, 2019 (e.g., higher out-of-pocket cost, no longer included on the formulary, new coverage restrictions), will receive individual notification from Express Scripts Medicare in December. If you experience a change, Express Scripts can assist you with identifying your options.

Additionally, certain changes can be made to the formulary during the year, as approved by Medicare, such as adding drugs to or removing drugs from the formulary; adding prior authorizations, quantity limits and/or step therapy restrictions to a drug; or, moving a drug to a higher or lower cost-sharing tier.

Starting in 2019, Express Scripts Medicare, may immediately remove a brand-name drug on the drug list if, at the same time, the brand-name drug is replaced with a new generic drug with the same or fewer restrictions.

Also, when adding the new generic drug, the brand-name drug may remain on the drug list, but immediately move to a different cost-sharing tier or add new restrictions. This means if you are taking the brand-name drug that is being replaced by the new generic (or the tier or restriction on the brand-name drug changes) you will no longer receive advance notice 60 days prior to the effective change nor will you be able to get a 60-day refill of your brand-name drug at a network pharmacy. You will still receive information on the specific change(s) made, but the notice may arrive after the change has become effective.

Also, effective 2019, prior to Express Scripts making any other formulary changes during the year that will require advance notice to you if you're taking an affected drug, Express Scripts will provide you with notice 30 days, rather than 60 days, before the change is made or they will give you a one-month supply, rather than a 60-day, refill of your brand-name drug at a network pharmacy.

Members in long-term care (LTC) facilities who may be affected by a formulary change will be allowed to receive up to a 31-day temporary supply of medication rather than a 90 to 98 day supply. This is a change from the range provided in 2018. During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide your next course of action when your temporary supply is complete. You can either switch to another drug covered by the plan or request a formulary exception. To learn more about when you can get a temporary supply and how to ask for one, contact Customer Service at 1-800-572-4098, TTY users call 1-800-716-3231.

Four Coverage Stages

There are some changes to this plan's coverage stages for 2019 as described below by tier. 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 $415 in 2019. This means that you will pay the full cost of any covered brand-name drug until you have paid $415 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 2019. 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 $3,820.

Initial Coverage Stage - Covered Tier 1 (generic) Drugs	2019 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	2019 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	2019 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	2019 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 – Once your total drug cost (the amount paid by you and the plan) exceeds $3,820**,** you move from the Initial Coverage Stage into the Coverage Gap Stage, and the way that your claim is paid changes. You get 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. This means that:

- Plan costs are further reduced by the discount.
- The amount that participants pay in copayment/coinsurance PLUS the amount paid by the discount program will count toward reaching the Catastrophic Coverage Stage.
- If the balance of the drug cost after the discount is less than your coinsurance, you will pay less than you paid in the Initial Coverage Stage.

Health Care Reform requires that in 2019, beneficiaries pay no more than 30% of the cost of brand drugs in the Coverage Gap Stage. While generic drugs are not a part of the Medicare Coverage Gap Discount program, your cost for generic drugs will be no more than 37% in this stage. In most cases, this plan provides a greater benefit.

Catastrophic Coverage Stage – In 2019, 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 $5,100, you will pay the greater of either 5% coinsurance or a copayment of $3.40 (generics or drugs treated as generics) or $8.50 (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 **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 **express-scripts.com** or by contacting Express Scripts Medicare Customer Service at 1-800-572-4098, TTY callers 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 2019. 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.

As the percentage of drug cost that beneficiaries pay during the Medicare coverage gap stage gets smaller, you may find that the enhancements of the state program are not as beneficial.

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 (see page 4).

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 2019 – What You Need To Do

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 automatically be deducted or billed.

Making allowable plan changes for January 1, 2019: **Online enrollment through Employee Direct 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 through one of the following ways:

- From your Benefits Administrator (see page 11). Send your completed form to your Benefits Administrator.
- Online fillable forms are available on the DHRM website at **www.dhrm.virginia.gov**. Once completed, print and sign the form. Follow the mailings instructions on the form to submit your request to your Benefits Administrator.

Submit your form so that it is received by December 14, 2018. Forms received after December 14, 2018, but before January 1, 2019 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, 2018, 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 a consistent qualifying mid-year event (e.g., loss of eligibility for other group coverage) that would allow the addition. Medicare-eligible Enrollees do not have an annual Open Enrollment opportunity. ***Non-Medicare eligible dependent(s) 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.

Other Important Retiree Program 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 there would be an additional premium cost to ALL participants to add a fitness program benefit. Further, the fitness benefit would not be a stand-alone benefit. Therefore, members would not be able to opt out of just that portion of the benefit program.

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 suggests that this type of benefit program would not be a good enhancement for the majority of participants.

▪ ***As a Non-Annuitant Surviving Spouse will my eligibility for coverage change if I remarry?***

Non-annuitant surviving spouses may be covered until remarriage, obtaining alternate health insurance coverage, or death. 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).

Non-annuitant survivors may not add new dependents. Non-annuitant surviving spouses who lose eligibility will lose coverage at the end of the month in which the loss-of-eligibility event occurs. Non-annuitant surviving children will also lose coverage at the end of the month in which they lose eligibility, but they may elect Extended Coverage. There is no Extended Coverage qualifying event for Non-Annuitant Surviving Spouses who lose eligibility for the program.

▪ ***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, if allowed by Medicare, 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 <u>not</u> 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?)
- Coverage in the gap or "donut hole" (have you ever had enough total drug cost to reach the donut hole?)—keep in mind that the cost of drugs in the coverage gap is decreasing each year until 2020 when it reaches 25%

Use the resources listed on page 7 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 ID card for 2019?***

If you make no changes that would affect the accuracy of your current ID card(s), you may continue to use your existing card.

▪ ***Will I get a new Member Handbook for 2019?***

A new 2019 Medicare-Coordinating Plans Member Handbook and associated inserts based on your enrollment will be mailed in 2019. Until then, keep this notice with your current Handbook and Inserts as your description of coverage.

▪ ***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 **http://www.dhrm.virginia.gov/hbenefits/retirees/medicareretiree.html**.

▪ ***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 online check payments. 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 1-888-827-3847 **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 1-888-642-4414 **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.)

LANGUAGE ASSISTANCE SERVICES:

ATTENTION: If you need help in the language you speak, language assistance services are available to you free of charge. Send your request for language assistance to appeals@dhrm.virginia.gov or fax to 804-786-0356.
The Commonwealth of Virginia's State and Local Health Benefits Programs (the "Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our Nondiscrimination Notice lists the services available and how to file a complaint if you feel that the Health Plan has failed to provide these services or discriminated in another way.

Spanish:
ATENCIÓN: Si necesita ayuda en el idioma que habla, servicios de asistencia lingüística están a su disposición de forma gratuita. Envíe su solicitud de asistencia lenguaje para appeals@dhrm.virginia.gov~~V o por fax al 804-786-0356.
La Comunidad de salud estatales y locales de Virginia Programas de Beneficios (el "Plan de Salud") cumple con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, o sexo. Nuestro Aviso de No Discriminación enumera los servicios disponibles y cómo presentar una queja si considera que el Plan de Salud no ha podido proporcionar estos servicios o discriminado de otra manera.

Korean:
주의 : 당신이 말하는 언어로 도움이 필요한 경우, 언어 지원 서비스를 무료로 당신에게 사용할 수 있습니다. 804-786-0356에 언어 appeals@dhrm.virginia.gov~~V하는 지원이나 팩스에 대한 요청을 보냅니다.
버지니아 주 및 지방 보건의 커먼 웰스는 프로그램 (이하 "건강 보험")는 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 근거하여 차별하지 않습니다 혜택. 우리의 무차별주의를 사용할 수 방법은 건강 보험이 이러한 서비스를 제공하는 데 실패하거나 다른 방법으로 차별했다고 생각되면 불만을 제기하는 서비스를 나열합니다.

Vietnamese:
Chú ý: Nếu bạn cần giúp đỡ trong ngôn ngữ bạn nói, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn miễn phí. Gửi yêu cầu để được hỗ trợ ngôn ngữ để appeals@dhrm.virginia.gov~~V hoặc fax 804-786-0356.
Khối thịnh vượng chung của Nhà nước và địa phương sức khỏe của Virginia lợi Programs (các "Health Plan") phù hợp với luật dân quyền liên bang áp dụng và không phân biệt đối xử trên cơ sở chủng tộc, màu da, nguồn gốc quốc gia, tuổi tác, khuyết tật, hoặc quan hệ tình dục. Thông báo Không Kỳ của chúng tôi liệt kê các dịch vụ sẵn có và làm thế nào để nộp đơn khiếu nại nếu bạn cảm thấy rằng Kế hoạch Y tế đã thất bại trong việc cung cấp các dịch vụ hoặc phân biệt đối xử theo một cách

Chinese:
注意：如果你需要在你講的語言幫助，語言協助服務提供給您免費。發送您的語言協助appeals@dhrm.virginia.gov~~V或傳真至804-786-0356請求。
弗吉尼亞州和地方衛生聯邦福利項目（下稱"健康計劃"），適用的聯邦民權法的規定和種族，膚色，國籍，年齡，殘疾，或性的基礎上不歧視。我們的非歧視通知列出了可如何，如果你覺得健康計劃未能提供這些服務或以其他方式歧視提出申訴的服務。

Arabic:
تنبيه: إذا كنت بحاجة إلى مساعدة في اللغة التي يتتكلم، تتوفر لك خدمات المساعدة اللغوية مجانا. إرسال
طلب للحصول على
المساعدة لغة إلى appeals@dhrm.virginia.gov~~V أو الفاكس إلى 804 - 786 - 0356 .
ولاية فيرجينيا كومنولث في الدولة والمحلية الفوائد الصحية برامج ("خطة الصحة")يتوافق مع
القوانين الاتحادية السارية الحقوق
المدنية ولا تميز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة، أو الجنس. يسري انل عدم
التمييز لاحظ الخدمات
المتاحة وكيفية تقديم شكوى إذا كنت تشعر بأن خطة الصحة فشلت في توفير هذه الخدمات أو التمييز
في طريقة أخرى.

Persian:
توجه: اگر شما زاين به كمک در زبان شما صحبت مى كنند، خدمات كمک زبان در دسترس شما هستند
ل اسرا .دشاب مى ناگيار
درخواست خود را براى كمک به زبان appeals@dhrm.virginia.gov~~V اي فكس به 804 - 786 - 0356 .
اب قباطم)"نامرد و تشادهب حرط" (همانرب ىاياژم اينيجريو تشادهب ىلحم و ىتلاايا عفانملا كرتشم
ىندم قوقح لاردف نيناوق
دوش ىمن لئاق ىسنج هطبار اي و تيلولعم ،نس ،تيلم ،تسوپ گنر ،داژن ساسا رب و دنک ى مى ارجا لباق.
ام ضيعبت مدع هجوت
هئارا هب قفوم ىتشادهب همانرب هک ديکنى مى ساسحا امش رگا تياکش هب هنوگچ و سرتسد رد تامدخ تسيل
ضيعبت اي و تامدخ نيا
ىرگيد هار رد.

Amharic:
ኣዳምጥ: አንተ የሚናገሩት ቋንቋ እርዳታ የሚፈልጉ ከሆነ, የቋንቋ እርዳታ አገልግሎቶች ከክፍያ ነፃ ለእርስዎ የሚገኙ ናቸው. 804-786-0356 ቋንቋ appeals@dhrm.virginia.gov~~V እርዳታ ወይም በፋክስ ጥያቄዎን ይላኩ.
የቨርጂኒያ ግዛት እና የአካባቢ ጤና ኮመንዌልዝ ፕሮግራሞች (የ "የጤና ዕቅድ") A ግባብነት ያላቸውን የፌዴራል ሲቪል መብቶች ሕጎች ጋር መጣጣማቸውን እና በዘር, በቀለም, በብሄር, በእድሜ, በአካል ጉዳት, ወይም የወሲብ መሠረት ላይ ዝቅ አድርጎ አይመለከትም Benefits. የእኛ ድልዎ ማስታወቂያ የሚገኝ እና እንዴት የጤና እቅድ እነዚህን አገልግሎቶች ለመስጠት አልተሳካም ወይም በሌላ መንገድ ውስጥ አድልዎ እንደሆነ የሚሰማህ ከሆነ ቅሬታ ለማቅረብ አገልግሎቶች ይዘረዝራል.

Urdu:
جراچ نا ے ک تف م تامدخ ی ک ددم ی ک نا بز ،و ت ےہ را کرد ددم ںی م نا بز پآ ر گا : پآ رگا :ہجوتہجو ت
و ک پآ
ل ے ک سا ا ی ددم و ک appeals@dhrm.virginia.gov~~V سک ی ف 804-786-0356 نا بز . ںی ہ بای ت س د
پآ ےئ
ک ی درخوا ست ب ھ جی ںی .
ن م ی ک تحص") مار گور پ د ئاو ف ہ کرت ش م ت لود ی ک تحص ىماق م روا تس ا ىر ی ک ای ن ی جرو
ہ بوص
،رمع ،تی مو ق ،گنر ،لس ن روا ےہ ق باطم ے ک نی ناو ق ے ک قوق ح ىرہش ی قا فو قالطا ل با ق (" ىدن ب
ی ک روا بای ت س د س ٹو ن زای ت ما مدع ارامہ . ا ترک ںی ہ ن ق ىرف ت ر پ دای ن ب ی ک سن ج ا ی ،ىروذعم
ےس
ی ک نا ىدن ب ہ بوص ن م ی ک تحص ہ ک ںی ہ ے ترک سوس حم پآ ےئ ل ے ک ے نر ک جرد ت ىاک ش
م ہار ف تامدخ
ف ی ک تامدخ و ت ےہ ای گ ای ک کول س ىزای ت ما ےس حرط روا ىس ک ا ی ںی ہ ےہر ما کا ن ںی م ے نر ک
تس رہ
ہے ..

French:
ATTENTION: Si vous avez besoin d'aide dans la langue que vous parlez, les services d'assistance linguistique sont à votre disposition gratuitement. Envoyez votre demande d'assistance linguistique pour appeals@dhrm.virginia.gov~~V ou par télécopieur au 804-786-0356.
La Communauté d'État et des collectivités locales de la santé de la Virginie Avantages Programmes (le «régime de santé») est conforme aux lois fédérales relatives aux droits civils applicables et ne fait pas de discrimination sur la base de la race, la couleur, l'origine nationale, l'âge, le handicap ou le sexe. Notre Nondiscrimination Avis répertorie les services disponibles et la façon de déposer une plainte si vous estimez que le plan de santé a omis de fournir ces services ou victimes d'une autre manière.

Russian:
ВНИМАНИЕ: Если вам нужна помощь на языке вы говорите, переводческие услуги доступны бесплатно. Отправьте запрос о помощи языка к appeals@dhrm.virginia.gov~~HEAD=pobj~~V или по факсу 804-786-0356.
Содружество государственного управления и местного здравоохранения Вирджинии Преимущества программы ("План здоровья") соответствует действующим федеральным законам о гражданских правах и не допускать дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, инвалидности или пола. Наш Недискриминации Примечание перечислены доступные услуги и как подать жалобу, если вы чувствуете, что план здравоохранения не в состоянии обеспечить эти услуги или дискриминации по-другому.

Hindi:
ध्यान दें: आप भाषा बोलते हैं आप में मदद की जरूरत है, भाषा सहायता सेवाओं के प्रभार से मुक्त आप के ललए उपलब्ध हैं। appeals@dhrm.virginia.gov~~V करने के ललए या फैक्स भाषा सहायता 804-786-0356 करने के ललए आपके अनुरोध भेजें।
वजीननया के राज्य और स्थानीय स्वास्◌्य के राष्ट्रमंडल लाभ काययक्रम ("स्वास्◌्य योजना") लागू संघीय नागररक अधधकारों के कानून के अनुरूप है और जानत, रंग, राष्ट्रीय मूल, आयु, ववकलांगता, या ललंग के आधार पर भेदभाव नहीं करता। हमारे nondiscrimination सूचना उपलब्ध है और कैसे एक लिकायत दजय करने के ललए अगर आपको लगता है कक स्वास्◌्य योजना इन सेवाओं को प्रदान करने में ववफल रहा है या ककसी अन्य तरह से भेदभाव ककया गया है सेवाओं की सूची है।

German:
ACHTUNG: Wenn Sie in der Sprache sprechen Sie Hilfe benötigen, die Sprache Hilfeleistungen zur Verfügung stehen Ihnen kostenlos zur Verfügung. Senden Sie Ihre Anfrage für sprachliche Unterstützung zu appeals@dhrm.virginia.gov~~V oder Fax an 804-786-0356.
Die Commonwealth of Virginia staatlichen und lokalen Nutzen für die Gesundheit Programme (das "Health Plan") mit den geltenden Bundesbürgerrechte Gesetze erfüllt und keine Diskriminierung auf der Grundlage von Rasse, Hautfarbe, nationaler Herkunft, des Alters, einer Behinderung oder Geschlecht. Unsere Nondiscrimination Hinweis listet die verfügbaren Dienstleistungen und wie eine Klage einreichen, wenn Sie das Gefühl, daß der Gesundheitsplan hat es versäumt, diese Dienste zur Verfügung zu stellen oder in einer anderen Art und Weise diskriminiert.

Bengali:
দৃষ্টি আকর্ষণ: আপষ্টি ভার্া আপষ্টি কথা বলতে সাহায্য প্রত াজি হ , োহতল ভার্া সহা োা সসবা ষ্টিখরচা আপিার জিয উপলব্ধ. appeals@dhrm.virginia.gov~~V অথবা ফ্যাক্ষ ভার্া সহা োা 804-786-0356 করার জিয আপিার অিুতরাধ পাঠাি.
ভাষ্টজষষ্টি া রাজয এবং স্থাি ী স্বাস্থয কমিওত লথ সুষ্টবধাষ্টদ সপ্রাগ্রাম ("স্বাস্থয পষ্টরকল্পিা") প্রতয্াজয সম্ডাতরল িাগষ্টরক অষ্টধকার আহি সমতি চতল এবং জাষ্টে, রঙ, জাী উৎপষ্টি, ব স, অমো, বা ষ্টলতের ষ্টভষ্টিতে ববমর্ময িা. আমাতদর আতবদি গ্রহণ সিাটিশ পাও া য্া এবং ষ্টকভাতব একটি অষ্টভতয্াগ দাত র করতে যষ্টদ মতি কতরি সয্ স্বাস্থয পষ্টরকল্পিা এই সসবা প্রদাি করতে বযথয হত তে অথবা অিয সকাতিা উপাত ববমর্ময কতরতে সসবা প্রদশষি করা হ .

Bassa:
Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jŭ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀bɛ́ìn m̀ gbo kpáa. Ɖá 804-786-0353.
The Commonwealth of Virginia’s State and Local Health Benefits Programs (the "Health Plan") Nyɔ ɓɛ̀ɛ̀kpɔ̃nyɔŏn-dyù gbo-gmɔ̀-gmà ɓɛ̀ɔ̀dyi ké wa ní ge nyɔŏn-dyù mú dyììn ɖé ɓóɖó-dù nyɔɔ̀sɔ̀ kɔ̃ɛ mú, mɔɔ kà nyɔɔ̀dyɔɔ̀-kù nyu nìɛ̀kɛ mú, mɔɔ ɓóɖó bɛ́nyɔɔ̀sɔ̀kɔ̃ɛ mú, mɔɔ zɔ̃jĩ ̀kà nyɔɔ̀ ɖă nyuɛ mú, mɔɔ nyɔɔ̀mɛ kɔ́dyíɛ mú, mɔɔ nyɔɔ̀mɛ mɔ̀gàa, mɔɔ nyɔɔ̀mɛ mɔ̀màa kɛɛ mú.

Igo (Igbo):
Ntị: Ọ bụrụ na ị chọrọ enyemaka na asụsụ ị na-asụ, asụsụ aka ọrụ dị ka ị n'efu. Send gị arịrịọ maka asụsụ aka appeals@dhrm.virginia.gov~~V ma ọ bụ faksị ka 804-786-0356.
The Commonwealth of Virginia si State na Obodo ike uru Programs (the "Health Plan") complies na ọdabara Federal ruuru iwu na adighị akpa ókè na ndabere nke agbụrụ; ụcha akpụkpọ, mba o, afọ, nkwarụ, ma ọ bụ mmekọahụ. Anyị Nondiscrimination Rịba ama Nsuso na ọrụ dị na otú igba akwụkwọ ma ọ bụrụ na ị na-eche na Health Plan nke na-emezughị na-enye ọrụ ndị a ma

Yoruba:
Akiyesi: Ti o ba nilo iranlọwọ ninu ede ti o sọrọ, ede iranlowo iṣẹ ni o wa wa si o free ti idiyele. Fi ìbéèrè rẹ fun ede iranlowo to appeals@dhrm.virginia.gov tabi Faksi to 804-786-0356.
The Commonwealth of Virginia ká State ati Agbegbe Health Anfani Eto (awọn "Health Eto") complies pẹlu wulo Federal ilu awọn ẹtọ ofin ati ki o ko soto lori ilana ti ije, awọ, orilẹ-Oti, ojo ori, ailera, tabi ibalopo. Wa Nondiscrimination Akiyesi awọn akojọ ti awọn iṣẹ wa ati bi lati faili kan ẹdun ti o ba ti o ba lero wipe Health Eto ti kuna lati pèsè àwọn ìpèsè wọnyí tabi obo ni ona miiran.

Filipino:
Pansin: Kung kailangan mo ng tulong sa wikang nagsasalita ka, serbisyo ng tulong sa wika ay magagamit sa iyo nang walang bayad. Ipadala ang iyong kahilingan para sa tulong sa wika upang appeals@dhrm.virginia.gov~~V o fax sa 804-786-0356.
Ang Komonwelt ng Virginia Estado at Lokal na Health Benefits Programs (ang "Health Plan") ay sumusunod sa mga naaangkop na mga Pederal na batas sa mga karapatang sibil at hindi maaaring makita ang kaibhan sa batayan ng lahi, kulay, bansang pinagmulan, edad, kapansanan, o sex. Ang aming Walang Diskriminasyon Notice ay naglilista ng mga serbisyo na makukuha at kung paano maghain ng reklamo kung sa palagay mo na ang Health Plan ay nabigo upang magbigay ng mga serbisyo o discriminated sa ibang paraan.

A10369