



Commonwealth of Virginia Retiree Health Benefits Program

Annual Premium Rate Notification Materials for Medicare-Eligible Participants

1. **Your Rate Notification Booklet (attached)**
 - **Your 2011 Premium Cost** Page 1
 - **Health Care Reform** Page 3
 - Eligibility Changes
 - **Your 2011 Benefits** Page 4
 - Changes to your Medicare supplemental plan
 - Changes to your dental benefits
 - Changes to your vision benefits
 - Changes to your prescription drug benefits
 - **Your Options for 2011**..... Page 8
 - **Other Important Retiree Program Information** Page 9
 - Enrolling in Medicare Advantage Plans
 - ID Cards
 - Member Handbooks
 - Medicare-Eligible Participants Under Age 65
 - Prompt Payment of Premiums
 - Resources for Retiree Group Participants
 - Address Changes
 - Your Benefits Administrator
 2. **Delta Dental Brochure (enclosed if applicable)**
 3. **Blue View Vision Brochure (enclosed if applicable)**
-

DISTRIBUTION: Only Enrollees (Retirees, Survivors and Long-Term Disability Participants) will receive this package. Medicare-eligible covered dependents will not receive annual premium rate notification materials directly, even if they have separate coverage under their own ID numbers. This means that Enrollees must share this information with their Medicare-eligible covered dependents. Only Enrollees can request coverage changes for covered dependents since the dependents are covered based on the Enrollee's eligibility. If you are an Enrollee who is not eligible for Medicare but you are covering a Medicare-eligible dependent, you are receiving this package for the Medicare-eligible dependent whom you cover.



COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

SARA REDDING WILSON
 DIRECTOR

James Monroe Building
 101 N. 14th Street
 Richmond, Virginia 23219

To: **State Retiree Health Benefits Program Enrollees Eligible for Medicare or Enrollees who cover Medicare-Eligible Dependents**

From: **Office of State and Local Health Benefits Programs**

Date: **November 8, 2010**

Important Information Regarding Your Health Benefits

This notification booklet includes information about coverage for Medicare-eligible participants in 2011. Please note that there are some changes in claims administrators and benefits. Be sure to read these materials carefully to ensure that you understand program changes and your coverage options.

Receipt of benefit-specific information in this package does not guarantee those benefits.

Your 2011 Premium Cost

▪ **How much is my health plan premium for 2011?**

Your 2011 Medicare-coordinating plan monthly premium cost is listed below. The most significant premium change is for plans that include prescription drug coverage which will reflect a reduction in cost due to the Medicare Coverage Gap Discount Program. Additional information about this program is included for prescription drug plan participants. Other plan premiums have also been adjusted to reflect changes in group claims experience to ensure adequate funding of the program.

Plan – Single Membership	Premium Effective January 1, 2011
Advantage 65	\$227
Advantage 65 + Dental/Vision	\$258
Medicare Complementary/Option I	\$236
Medicare Supplemental/Option II	\$285
Option II + Dental/Vision	\$316
Advantage 65—Medical Only*	\$132
Advantage 65—Medical Only + Dental/Vision*	\$163

*Does not include outpatient prescription drug/Medicare Part D coverage.

All State Medicare-coordinating plan medical and vision benefits are administered by Anthem Blue Cross and Blue Shield. For plans that include prescription drug coverage (all but the Advantage 65—Medical Only Plans), the drug benefit is administered by Medco and is an enhanced Medicare Part D plan. Effective January 1, 2011, dental benefits will be administered by Delta Dental of Virginia.

▪ **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” (low income subsidy or LIS) with paying the cost of your Medicare Part D coverage, your premium will be reduced for each month you are approved for the subsidy as follows:

If your subsidy is:	Your 2011 monthly premium will be reduced by*:
100%	\$33
75% \$25	
50% \$17	
25% \$9	

*If the reduction amount provided by Medicare is not a whole dollar, the state program rounds the reduction up to the next whole dollar.

Your Medco Annual Notice of Changes and Evidence of Coverage will include additional information about specific benefits and/or eligibility.

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 due to your subsidy as indicated above, you 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 some plans that have a \$0 premium.

If you would like more information about the low income subsidy, contact the Social Security Administration at 1-800-772-1213.

▪ **Can my income affect the cost of Medicare Part D?**

In addition to “Extra Help” available to individuals with limited resources, starting January 1, 2011, beneficiaries with incomes above \$85,000 may have to pay a higher cost for Part D prescription drug coverage. However, 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 “*Medicare and You 2011*” publication has more information about the cost of Medicare.

▪ **When will I begin paying my new 2011 premium?**

For participants whose premiums are deducted from a VRS retirement benefit, the new January 2011 premium amount will be deducted from the February retirement benefit

payment. If a premium increase means that your retirement benefit will no longer support your premium deduction (if your benefit is not enough to pay your premium), you will be moved to direct billing from Anthem Blue Cross and Blue Shield. It is important to note that direct billing is mailed prior to the coverage month while deduction occurs at the end of the coverage month.

For those who already pay through direct billing, the new premium will be billed in December. 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 automatic bank draft, your first deduction in the new premium amount will take place in your January draft.

Health Care Reform – Eligibility Change for Dependent Children

Dependents whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 will be eligible to enroll in a non-Medicare-coordinating plan during the annual non-Medicare plan Open Enrollment period. Coverage will be effective July 1, 2011 (the beginning of the first plan year after September 23, 2010, the date of enactment of this provision of the Patient Protection and Affordable Care Act). Retiree group participants may request enrollment for newly-eligible children by submitting an enrollment form to their Benefits Administrator (see page 11) from June 1 through June 30, 2011. If you have a dependent who meets these qualifications but is eligible for Medicare, you may submit an enrollment form to your Benefits Administrator by December 31, 2010, to start coverage effective January 1, 2011.

Eligibility criteria for children are updated as follows:

Under the health benefits program, the following eligible children may be covered to the end of the year in which they turn age 26 (age requirement is waived for adult incapacitated children):

- (1) Natural children, adopted children, or children placed for adoption.
- (2) Stepchildren. A stepchild is the natural or legally adopted child of the participant's legal spouse. Such marriage must be recognized by the Commonwealth of Virginia.
- (3) Other children. A child for which a court has ordered the employee/retiree to assume sole permanent custody.

Additionally, if the employee/retiree or spouse shares custody with the minor child who is the parent of the "other child," then the other child may be covered.

When a child loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs.

Your Member Handbook has complete information regarding eligibility for the program.

Your 2011 Benefits

▪ **Will my medical benefits change for 2011?**

Your Medicare supplemental benefit under any Advantage 65 Plan, Medicare Complementary/Option I and Medicare Supplemental/Option II have been enhanced to include coverage for eligible expenses for an additional 365 days after Medicare Part A benefits are exhausted.

Consult your “*Medicare and You 2011*” publication regarding your Medicare coverage, including new wellness and preventive services available at no cost to Original Medicare beneficiaries in 2011.

▪ **Will my dental benefits change for 2011?**

Effective January 1, 2011, those participants enrolled in Dental/Vision coverage will have their dental benefits administered by Delta Dental of Virginia. Current enrollees will receive a Delta Dental brochure included with this booklet. Enhanced dental benefits include:

- Your annual maximum benefit will increase to \$1,500.
- You will have a new 5% benefit toward the cost of covered major restorative services such as crowns and bridges, dentures and dental implants. While you will still be responsible for 95% of the cost for covered services, if you use a Delta Dental participating provider, the total cost will be limited to Delta’s negotiated discounted rates.
- You will have access to Delta Dental’s national network of over 220,000 providers. This is especially significant for participants living outside of Virginia who can now enjoy the benefit of network discounts for covered services.
- You will have access to the “Healthy Smiles, Healthy You” program which allows an additional dental cleaning for participants with certain health conditions. Your member handbook will include more information.

Be sure to check with your dentist to confirm that he/she participates with Delta Dental. You may also contact Delta Dental at 1-888-335-8296 to check on the status of your provider or to refer your non-network dentist for possible participation in the Delta Dental network. You may also use a non-network provider but this will generally result in higher out-of-pocket cost to you.

▪ **Will my vision benefits change for 2011?**

Effective January 1, 2011, those participants enrolled in Dental/Vision coverage will have their vision benefits administered by Anthem Blue View Vision. Current participants will receive a brochure included with this booklet which provides additional information about

Anthem Blue View Vision benefits, including some new discount opportunities. Be sure to review this information to ensure that you make the best use of your benefits. Even if you have received your covered exam, frames and lenses less than 24 months ago, you will have access to other specified discounts on January 1 if you use a network provider. Because Anthem Blue View Vision has a national network of providers, participants living outside of Virginia will now have access to network discounts.

You may use a non-network provider for your routine vision services, but you may experience higher out-of-pocket costs and will not be entitled to Anthem Blue View Vision discounts.

▪ **Will my prescription drug benefits change for 2011?**

If you choose to maintain prescription drug coverage under the state program's enhanced Medicare Part D plan, be sure to review the following updates for 2011:

Formulary/Drug List (your list of covered drugs) – As a part of your Annual Notice of Changes (ANOC), Medco has provided all participants with a new partial formulary for 2011. It is important to check your formulary to see if any of the drugs you are currently taking will be removed or will change tiers or restrictions; however, you will receive additional information from Medco if your drug is being removed from the formulary or moved to a higher cost-sharing tier.

If you are unable to find your drugs in your new Drug List, contact Medco at 1-800-572-4098 for assistance. You may also check the status of your drugs by going to the Commonwealth of Virginia-specific web site at:

<http://www.dhrm.virginia.gov/hbenefits/retirees/medicarenotification2011.html>

Then just click on "Medco Medicare Part D Plan link" and submit the name of your drug. Starting January 1, 2011, you may also go to www.medco.com for complete formulary information. Registration is required if you have not done so previously.

Certain changes can be made to the formulary during the year, as approved by Medicare, such as adding or removing drugs from the formulary; adding prior authorizations, quantity limits and/or step therapy restrictions on a drug; or, moving a drug to a higher or lower cost-sharing tier. Generally, however, if drugs are removed, coverage limitations are imposed or a drug is moved to a higher cost-sharing tier during the year (after January 1) and you were already taking the drug on January 1, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year. Exceptions would include drugs replaced with generic equivalents or changes as a result of new information on a drug's safety or effectiveness. In those cases, you may be affected by the change. Your *Evidence of Coverage* provides additional information regarding formulary changes. The Centers for Medicare and Medicaid Services has reviewed and approved your formulary.

There will also be a change in the stages of your coverage for 2011.

This is the result of the Medicare Coverage Gap Discount Program, which is explained in the following pages and in your Medco Medicare Prescription Plan Evidence of Coverage.

Deductible Stage – Your annual outpatient prescription drug deductible will remain **\$310** in 2011. This means that you will pay the full cost of any covered brand-name drug until you have paid \$310 out-of-pocket. There will still be no deductible for covered generics.

Initial Coverage Stage – Once your deductible has been met for covered brand drugs (and immediately for covered generics), your co-payments/coinsurance will remain as follows until your total covered drug cost reaches \$2,840.

Initial Coverage Stage - Covered Tier 1 (generic) Drugs	2011 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 mail-order service	\$7

Initial Coverage Stage - Covered Tier 2 (preferred brand) Drugs	2011 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 mail-order service	\$50

Initial Coverage Stage - Covered Tier 3 (non-preferred brand) Drugs	2011 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 mail-order service	You pay 75%

Initial Coverage Stage - Covered Tier 5 (specialty) Drugs	2011 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 mail-order service	You pay 25%

NEW! Coverage Gap Stage – Once your total drug cost exceeds \$2,840, you move into the Coverage Gap Stage, during which your co-payment for generic drugs does not generally change, but your co-payment/coinsurance for covered brand drugs will increase as described below. *However, if your drug is manufactured by a participant in the Medicare Coverage Gap Discount Program, your increased co-payment/coinsurance will generally be offset by the program.* This means that you will usually pay no more for covered drugs during the Coverage Gap Stage than you paid during the Initial Coverage Stage.

Coverage Gap Stage - Covered Tier 2 (preferred brand) Drugs	2011 Co-payment	Your Responsibility*
Per one-month (up to 34-day) supply at a retail network pharmacy	\$50	\$25
Per up to a 90-day supply through the mail-order service	\$100	\$50

Coverage Gap Stage - Covered Tier 3 (non-preferred brand) Drugs	2011 Coinsurance	Your Responsibility*
Per one-month (up to 34-day) supply at a retail network pharmacy	100%	50%
Per up to a 90-day supply through the mail-order service	100%	50%

Coverage Gap Stage - Covered Tier 5 (specialty) Drugs	2011 Coinsurance	Your Responsibility*
Per one-month (up to 34-day) supply at a retail network pharmacy	50%	25%
Per up to a 90-day supply through the mail-order service	50%	25%

*This co-payment or coinsurance amount reflects the benefit of the Medicare Coverage Gap Discount Program. If your covered drug is manufactured by a participant in this program, the program will usually pay 50% of your co-payment/coinsurance.

Catastrophic Coverage Stage – In 2011, if your annual true out-of-pocket drug expense (including the contribution from the Medicare Coverage Gap Discount program but not including the cost of non-covered or excluded drugs) reaches \$4,550, you will pay the greater of either 5% coinsurance or a co-payment of \$2.50 (generics or drugs treated as generics) or \$6.30 (brand-name drugs). You will remain in this stage for the remainder of the year.

Your Medicare Explanation of Benefits (EOB) – To help you track your coverage stages, you will receive an EOB directly from Medco for any months during which you use your benefit.

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. 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 (including this plan) 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 is contingent upon approval 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 determined by Medicare. You will be notified if Medicare disenrolls you from the state program’s Medicare Part D plan, and you will be moved to either the Advantage 65—Medical Only Plan or the Advantage 65—Medical Only Plan with Dental/Vision (depending on your existing dental/vision enrollment status). There are no medical-only plan options under the Medicare Supplemental/Option II or Medicare Complementary/Option I Plans.

▪ **Is the state program’s prescription drug coverage the best plan for me?**

That’s a question that only you can answer. Be a good consumer and investigate other Medicare prescription drug plan options that are available to you for 2011. Compare premium cost and benefits to ensure that you are selecting the best plan for your individual needs. Resources include:

- Call 1-800-MEDICARE or go to www.medicare.gov for information about other Medicare prescription drug coverage 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 your Medco Evidence of Coverage.

Your Options for 2011 – What You Need To Do

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

If you wish to make an allowable plan change for January 1, 2011, you must request the change by taking one of the following actions:

- Obtain an enrollment form from your Benefits Administrator (see page 11), or from the web at www.dhrm.virginia.gov and submit your request to your Benefits Administrator no later than December 17, 2010. (Requests received after December 17, 2010, but before January 1, 2011, will be effective on January 1, but there may be a delay in implementing the change and updating your premium.)
- Request changes on-line no later than December 31, 2010, by using EmployeeDirect at www.dhrm.virginia.gov (click on the EmployeeDirect link). To use EmployeeDirect, you must have a personal e-mail address listed in the state's eligibility system. (A state e-mail address will not allow access to EmployeeDirect for retiree group participants.) If you do not already have an e-mail address in your eligibility file, you may contact your Benefits Administrator to update your record. NOTE: January 1 changes using EmployeeDirect must be requested during the month of December. If you request an allowable change through EmployeeDirect in November, it will generally become effective on December 1.

Allowable changes requested after December 31, 2010, 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 dependent will not be accepted.**

The following options are available to you for January 1:

- **You may keep your current benefit plan 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.
 - If you are in Medicare Complementary/Option I or Medicare Supplemental/Option II, you may move between those two plans on a prospective basis (the first of the month after

your request is received) at any time. You may also change to the Advantage 65 Plan (including Advantage 65—Medical Only) at any time on a prospective basis. The effective date of these plan changes is generally the first of the month after your enrollment form is received. Once you have left either the Option I or Option II plan to enroll in any Advantage 65 plan, you may not re-enroll in Option I or Option II.

- Retirees, Survivors and LTD Participants may cancel dependent coverage at any time on a prospective basis. However, once dependents of a Medicare-eligible participant have been cancelled, they may only be added within 31 days of the occurrence of a consistent qualifying mid-year event (e.g., loss of eligibility for other group coverage) that would allow the addition. Medicare-eligible Enrollees do not have an annual Open Enrollment opportunity.
- All Medicare-eligible covered family members (e.g., retiree and spouse) may make separate plan elections.
- State coverage as an Enrollee may be cancelled completely, but you will not have the opportunity to return to the program at any time in the future. This will also result in the cancellation of coverage for any covered dependents.
- As noted on page three, Medicare-Eligible participants may add dependents who lost eligibility due to exceeding the current limiting age (the end of the year in which the child turns age 23) but not the new limiting age (end of the year in which the child turns age 26) to be effective July 1, 2011 (non-Medicare eligible dependent) or January 1, 2011 (Medicare-eligible dependent) by submitting an enrollment form to the designated Benefits Administrator.

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

Other Important Retiree Program Information

▪ **Can I enroll in a Medicare Advantage Plan?**

The state'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, please consider cancelling your coverage in the state program. (This would also result in termination of coverage for any covered dependents.) 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. Also, if your Medicare Advantage plan includes prescription drug coverage, it will likely result in your disenrollment from the state program's Medicare Part D plan (no re-enrollment allowed). Please note that the Advantage 65 Plans are not Medicare Advantage plans.

▪ **Will I get a new ID card for 2011?**

Your Medicare Supplemental and Vision Plan – All participants in the Advantage 65 Plans, Medicare Complementary/Option I and Medicare Supplemental/Option II will get a new ID card from **Anthem Blue Cross and Blue Shield** before January 1, 2011, to use when obtaining services. It will show the full name of the plan in which you are enrolled, including whether your plan election includes dental and vision coverage (for example, "Advantage 65 with Dental/Vision"). **This card should be presented when**

obtaining services that are covered by your Medicare supplemental plan or, if applicable, your vision coverage. Those enrolled in plans that include dental coverage and/or prescription drug coverage will have separate cards to use when seeking dental or prescription drug services.

Your Dental Coverage – All participants enrolled in Dental/Vision coverage will receive a new ID card from **Delta Dental of Virginia** before January 1, 2011, to use when obtaining dental services.

Your Prescription Drug Coverage – Existing participants in the Medco Medicare Prescription Plan for the Commonwealth of Virginia Retiree Health Benefits Program may continue using their current card in 2011.

▪ ***Will I get a new Member Handbook for 2011?***

You will be mailed a new Medicare-Coordinating Plans Member Handbook in December for coverage beginning January 1, 2011. If you are enrolled in Dental/Vision or Outpatient Prescription Drug Coverage, you will also receive inserts describing those benefits for 2011. Distribution of handbooks will be based on existing coverage in December. If you terminate or change coverage, you may still get a handbook or insert for your previous election. Receipt of a member handbook or inserts does not guarantee coverage going forward.

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

When an Enrollee (Retiree, Survivor, LTD participant) or a covered dependent 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 and/or their dependents already enrolled in Medicare-coordinating plans, we provide this information to ensure that other covered family members who may be in non-Medicare plans are also moved to Medicare-coordinating coverage immediately upon eligibility. It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so could result in significant coverage deficits.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B (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 Medicare Part D based on enrollment in 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.

▪ ***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 result in termination of coverage. Once an Enrollee and his/her dependents have been terminated for non-payment of premiums, re-enrollment in the program is at the discretion of the Department of Human Resource Management and only under extreme circumstances as determined by the Department.

Direct-bill participants may enroll for automatic deduction of their monthly premium from their bank accounts and may make on-line check payments. Contact Anthem for more information. Participants are responsible for understanding their premium obligation and for notifying the program within 31 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee (Retiree, Survivor, LTD Participant) to advise the program of membership reductions may result in loss of the overpaid premium amount.

▪ **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>.

▪ **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 your missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss because their address of record has not been corrected. The Department’s only vehicle for communicating important information to retiree group participants is through the mail. You may also update personal information by using EmployeeDirect on-line (see page eight for more information about EmployeeDirect). Please let your Benefits Administrator know when you move!

▪ **Who is my Benefits Administrator?**

If you have questions about eligibility and enrollment, contact:

<i>If You Are A:</i>	<i>Contact This Benefits Administrator</i>
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

