



Virginia Department of  
**HUMAN RESOURCE  
MANAGEMENT**

## Commonwealth of Virginia Retiree Health Benefits Program

Annual Open Enrollment April 15 through May 16, 2011

### *Information included in this booklet:*

Open Enrollment.....	Page 1
Dependent Eligibility Change Effective July 1, 2011.....	Page 1-2
Benefit Changes Effective July 1, 2011.....	Page 2
Appeals and Claims.....	Page 2-3
Early Retiree Reinsurance Program.....	Page 3
Monthly Premium Rates Effective July 1, 2011.....	Page 3-4
Making Changes.....	Page 4-5
Reconciliation/Update of COVA Care and COVA Connect.....	Page 5-6
Informational Meetings.....	Page 6
Other Retiree Group News and Information.....	Page 6-8
ID Cards	
Member Handbooks	
When You Become Eligible for Medicare	
Becoming Eligible for Medicare During the Open Enrollment Period	
Retiree Medicare Entitlement Advocacy Program – Update	
Prompt Payment of Premiums	
Address Changes	
If you Need Help	
NOTE Regarding Booklet	
Notice – Women’s Health and Cancer Rights.....	Page 9
Notice About the Early Retiree Reinsurance Program.....	Page 9
Resources.....	Page 10

**IMPORTANT INFORMATION:** Be sure to read these materials carefully to ensure that you understand your coverage options and any changes for July 1, 2011.

**Recipients of this Package:** Retiree group enrollees receiving this package include Retirees, Survivors and Long Term Disability Participants (not dependents\*).

*\*Dependents who have separate coverage (under their own ID numbers) will not receive Open Enrollment materials directly. Medicare-eligible Retirees, Survivors and Long Term Disability participants who cover dependents who are not eligible for Medicare receive this package in order to make a change on behalf of the dependent for whom they provide coverage. Only Retirees, Survivors and Long Term Disability participants can request Open Enrollment changes for covered dependents. (Medicare-eligible Retirees, Survivors and Long Term Disability participants do not have an Open Enrollment period.)*





**COMMONWEALTH OF VIRGINIA**  
**DEPARTMENT OF HUMAN RESOURCE MANAGEMENT**

SARA REDDING WILSON  
DIRECTOR

James Monroe Building  
101 N. 14<sup>th</sup> Street  
Richmond, Virginia 23219

To: State Retiree Health Benefits Program Retirees, Survivors and Long Term Disability Participants who are not eligible for Medicare or who cover a dependent who is not eligible for Medicare

From: Office of State and Local Health Benefits Programs

Date: March 30, 2011

***Open Enrollment***

Your annual Open Enrollment will take place from **April 15 through May 16** and provides your annual opportunity to make changes to your non-Medicare-coordinating health plan and membership level to be effective July 1, 2011. This booklet includes information regarding coverage in the new plan year starting July 1 so that you can decide if you wish to select another available plan option. If you need information regarding another option, you can use the enclosed updates along with current member handbooks, which are available at [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov). If you do not have a computer, your Benefits Administrator can provide these materials. Your Benefits Administrator is identified on page 10.

***If you wish to maintain your current plan and membership level, you do not need to take any action.***

This Open Enrollment period does not apply to participants in Medicare-coordinating plans (Advantage 65, Medicare Complementary/Option I and Medicare Supplemental/Option II Plans), but Retirees, Survivors and Long Term Disability enrollees who cover non-Medicare-eligible dependents may make a plan change for their non-Medicare-eligible dependent/s at this time.

***Dependent Eligibility Change Effective July 1, 2011***

***Dependents May Be Covered up to Age 26***

As a result of the Patient Protection and Affordable Care Act, better known as national health care reform, eligible children may now be covered until the end of the year in which they turn age 26.

This includes biological children, stepchildren, adopted children, and children placed for adoption. The current eligibility criteria have also been expanded to include children who are married or unmarried, who may or may not reside full-time with the retiree group enrollee or other natural or adoptive parents, who may or may not be away at school, and who may or may not receive financial support from the retiree group enrollee. Retiree group enrollees with sole, permanent custody may cover a child until the end of the year in which he/she turns 26 as long as custody was awarded prior to the child's 18<sup>th</sup> birthday and the child is unmarried, resides full-time with the retiree group enrollee, and receives more than half of his/her support from the retiree group enrollee.

Incapacitated children may continue to be covered after age 26 if they fulfill the eligibility criteria of the plan. See your Member Handbook for complete information.

To add your dependent based on the new eligibility criteria, submit your *State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants* to your Benefits Administrator (see page 10) by May 16, 2011, and check "Open Enrollment" and "Enrollee/Enrollee and Dependents" under the "Reason Form Is Being Submitted" section of the form.

If you have a child who is newly eligible based on these criteria and is currently being covered through Extended Coverage/COBRA due to former age limitations, you may add him/her at this time. If you do not take this opportunity to add the child, he/she will continue to be covered through Extended Coverage for the duration of the previous eligibility period (up to 36 months). You may add a child who is already age 26 for the remainder of 2011, at which time he/she will be provided an Extended Coverage/COBRA Election Notice. As documentation for biological children, you will need to provide a copy of the dependent's birth certificate showing the retiree group enrollee or the spouse of the retiree group enrollee as a biological parent. If the dependent is a stepchild of the retiree group enrollee, you must also provide a copy of the marriage certificate documenting the spouse's marriage to the retiree group enrollee. For adopted children, include the legal adoptive agreement.

You may also exercise an Open Enrollment election on-line using EmployeeDirect. Your Benefits Administrator will still need to receive the above documentation. See pages 4--5 for more information about making changes.

### ***Benefit Changes Effective July 1, 2011***

All non-Medicare-coordinating plans offered by the State Retiree Health Benefits Program currently cover the full cost for an annual wellness visit and certain preventive care services. However, national health care reform has resulted in additional preventive care coverage starting July 1. This includes aortic aneurysm screenings, obesity counseling and screenings, and depression screenings for children up to age 18. Also, your chiropractic benefit will cover up to 30 visits per plan year, and there will be no annual dollar limit. A complete list of covered services will be available in your new Member Handbook or Evidence of Coverage.

### ***Appeals and Claims***

Starting July 1, health care reform is expected to bring changes to the medical appeals process. Final regulations are pending. The program anticipates:

- External review by an independent review organization for adverse decisions related to determinations that a requested service is experimental or investigational; requirements for

medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

- Removing the restriction on appeals where the member's cost is less than \$300.
- Under some circumstances, a member will not be required to complete the plan administrator's (e.g., Anthem, Optima, Medco, ValueOptions or Delta Dental) appeal process before appealing directly to DHRM.
- Decisions on expedited appeals will be required within 72 hours.

For more information, review your new Member Handbook or Evidence of Coverage.

### ***Early Retiree Reinsurance Program (ERRP)***

The Commonwealth of Virginia Health Benefits Program is certified as a participant in the ERRP, which was established under health care reform. It reimburses employer health plans for some of the health care costs paid by or on behalf of non-Medicare eligible retirees and certain family members who participate in these plans.

The Commonwealth may use the reimbursement to reduce or offset increases in certain out-of-pocket costs that all plan participants pay, such as premiums, deductibles, co-payments or coinsurance, or the costs it incurs to maintain health coverage.

To continue providing affordable health care coverage to all plan members, the Commonwealth has opted to use the ERRP reimbursement to reduce its health care cost trend each year. This trend, or the rate of growth in expenses, is used to set premiums for state health plans. An ERRP Notice is provided on page 9 of this booklet.

### ***Monthly Premium Rates Effective July 1, 2011***

Listed below are monthly premium costs for the new plan year beginning July 1, 2011. You will note that there is no change in premium for the COVA Care, COVA Connect and COVA HDHP Plans. Only the Kaiser Permanente HMO premium will increase for this plan year based on increased costs experienced by that plan.

If your premium increases due to a plan or membership change, or if you are a Kaiser Permanente HMO participant, and your Virginia Retirement System (VRS) benefit is no longer sufficient to accommodate your premium deduction, direct billing will automatically begin in June for your July premium. Otherwise, your new premium will be deducted or billed in the usual manner. Keep in mind that, due to administrative differences, direct billing occurs in advance of the coverage month, while VRS benefit-deducted premiums are collected in arrears. This means that you will generally be billed for a two-month premium should you need to transition from a retirement benefit deduction to direct billing.

If you are set up for an automatic deduction of your monthly premium billing through your financial institution or you use automatic bill pay to designate your monthly premium payment and your premium changes due to your request or the Kaiser premium increase, be sure to update your records to reflect your new premium amount.

## Monthly Premium Cost for July 2011—June 2012\*

<i>Plan</i>	<i>Single Premium</i>	<i>Two-Person Premium</i>	<i>Family Premium</i>
COVA Care/COVA Connect Basic	<b>\$500</b>	<b>\$925</b>	<b>\$1,352</b>
COVA Care/COVA Connect + Out-of-Network	<b>\$512</b>	<b>\$941</b>	<b>\$1,374</b>
COVA Care/COVA Connect + Expanded Dental	<b>\$515</b>	<b>\$955</b>	<b>\$1,396</b>
COVA Care/COVA Connect + Out-of-Network and Expanded Dental	<b>\$527</b>	<b>\$970</b>	<b>\$1,417</b>
COVA Care/COVA Connect + Expanded Dental and Vision/Hearing	<b>\$526</b>	<b>\$974</b>	<b>\$1,422</b>
COVA Care/COVA Connect + Out-of-Network, Vision, Hearing and Expanded Dental	<b>\$537</b>	<b>\$989</b>	<b>\$1,442</b>
COVA HDHP (High Deductible Health Plan)	<b>\$401</b>	<b>\$743</b>	<b>\$1,086</b>
Kaiser Permanente HMO**	<b>\$539</b>	<b>\$993</b>	<b>\$1,448</b>

\*Retirees who have qualified as Assistance Eligible Individuals due to involuntary termination of employment under the **American Recovery and Reinvestment Act, as amended, (ARRA)** will have their premium reduced by 65% for the duration of their eligibility period. At the end of their premium reduction period, the full premium indicated in this chart will apply.

\*\*Kaiser Permanente HMO is only available to participants who live in the Kaiser service area. If you are a current Kaiser member and do not live in its service area, you must make another plan selection. You may confirm the Kaiser service area by contacting Kaiser directly—see *Resources* on page 10 of this correspondence for contact information.

### ***Making Changes***

***Open Enrollment Changes*** - If you wish to make a plan or membership change during Open Enrollment, your completed Enrollment Form must be mailed to your Benefits Administrator and postmarked no later than May 16, 2011. If you need assistance identifying your Benefits Administrator, refer to *Resources* on page 10. Indicate “*Open Enrollment*” as the reason you are making the change. See pages 1-2 for more information regarding dependent eligibility.

The *State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants* is available from your Benefits Administrator or at [www.dhrm.virginia.gov/form.html](http://www.dhrm.virginia.gov/form.html) (click on *Health Benefits* and then on *Retiree and VSDP/LTD Enrollment Form*). Use of an incorrect form can result in a delay in your requested changes. You may also make allowable changes on line by using *EmployeeDirect*, which is available at [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov), no later than May 16, 2011. If you make a plan change, be sure that you understand the provisions of the plan that you choose. Once an election is made, it will not be changed except as allowed by the policies of the Department of Human Resource Management. After the Open Enrollment period ends, you may not revise your Open Enrollment election because you changed your mind or you completed the form incorrectly.

If you are requesting a membership increase, you must include documentation to support the eligibility of the new dependent. For example, to add an existing spouse, you must provide photocopies of the marriage certificate and the top portion of the first page of the retiree group enrollee’s most recent Federal Tax Return that shows the dependent listed as “Spouse” (all financial information and Social Security Numbers should be removed/obscured). To add a biological or adopted child, you must include a photocopy of the birth certificate showing the retiree group enrollee’s name as the parent or a photocopy of a legal pre-adoptive or adoptive agreement.

For other eligible membership additions, contact your Benefits Administrator to confirm the necessary documentation (see pages 1-2 for more information regarding expanded dependent eligibility). If you are enrolling using *EmployeeDirect*, you will be contacted by your Benefits Administrator if documentation to support your addition is not received. If documentation is not received by the end of the Open Enrollment period, your membership increase will not be processed.

If you are submitting an Enrollment Form to make an Open Enrollment change to be effective July 1, 2011, be sure to check the *Open Enrollment* box as the reason for making the change.

If you submit an Enrollment Form, ***it must be signed by the eligible enrollee***. The eligible enrollee is the Retiree, Survivor or Long Term Disability participant through whom eligibility for coverage is obtained—***not a covered dependent***. Even those covered dependents who have separate/individual ID numbers must have their Enrollment Forms signed by the enrollee. Enrollment Forms will not be accepted if not signed by the enrollee.

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 *EmployeeDirect* access 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.

**Making Changes After Open Enrollment** - After the Open Enrollment period, membership ***increases*** will only be allowed based on the occurrence of a consistent qualifying mid-year event (such as marriage or birth of a child). Membership increases must be accompanied by appropriate documentation to support the addition. Your Benefits Administrator can provide additional information regarding documentation. **Enrollees now have 60 days (formerly 31 days) to make a change based on a qualifying mid-year event.** Of course, retiree group participants may ***decrease*** membership prospectively (going forward) at any time. Any membership change due to a qualifying mid-year event will also allow for a plan change.

**Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Notice** –CHIPRA created two new Special Enrollment rights for certain eligible employees and dependents who lose coverage or become eligible for premium assistance under a Medicaid or state children's health insurance program. Coverage changes must be requested within 60 days of the eligibility determination. Please note that you must be eligible for employer/retiree coverage in order to exercise these special enrollment opportunities. For additional information, refer to your Notice entitled "Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage To Children And Families", which will be provided along with your new Member Handbook by the end of June.

### ***Reconciliation/Update of COVA Care and COVA Connect Elections by Service Area***

Eligibility for a COVA Care or COVA Connect Plan is based on whether the enrollee lives in or out of the COVA Connect zip code area. After the start of the plan year, moves in or out of this area may result in enrollment in a plan that does not coincide with your zip code of record. For example, an enrollee living in the COVA Connect zip code area who moves outside of that area during the plan year would be allowed to keep the COVA Connect coverage or make a plan change based on his/her new address. However, each year, this is reconciled for the start of the plan year on July 1. If you are in the COVA Care or COVA Connect Plan but do not live in the coinciding zip code area for that plan, you will be moved to the appropriate plan based on your zip code of record on April 1, and the plan change will be effective July 1. If you move to a zip code that does not coincide with your plan for July 1 after April 1 (the date designated to generate your plan for July 1), you may either remain in the assigned plan or elect another plan within 60 days of

the move. However, if you do change plans, you must live in the zip code area of the new plan. If you need additional information, please contact your Benefits Administrator.

***You're Invited—Informational Meeting Schedule***

The Department of Human Resource Management's Office of Health Benefits will be conducting informational meetings for participants to discuss national health care reform and answer questions regarding the state program as follows:

<b><i>Date</i></b>	<b><i>Location</i></b>	<b><i>Address</i></b>	<b><i>Time</i></b>
April 11	Hampton	Thomas Nelson Community College Moore Hall, Espada Room 99 Thomas Nelson Drive	11:00 am
April 12	Va. Beach	Tidewater Community College, Va. Beach Campus Advanced Technology Center, Technology Theater 1700 College Crescent	2:30 pm
April 19	Richmond	Department of Motor Vehicles, Cafeteria 2300 West Broad Street	4:00 pm
April 19	Fredericksburg	University of Mary Washington, Stafford Campus North Building, 125 University Boulevard	1:00 pm
April 21	Abingdon	Virginia Highlands Community College Keyser-Aday Theatre, Room 605 Learning Resource Center 110 Opportunity Lane	11:00 am
April 22	Roanoke	Virginia Western Community College Whitman Auditorium, Business Science Bldg. 3095 Colonial Avenue, SW	10:00 am
April 22	Annandale	Northern Virginia Community College The Theatre, Ernst Community Cultural Center 4001 Wakefield Chapel Road	1:00 pm
April 25	Harrisonburg	James Madison University, Highlands Room Festival Conference and Student Center 1301 Carrier Drive	1:00 pm

***Other Retiree Group News and Information***

***ID Cards*** – New ID cards will be issued **only** to participants who change plans (not including just changing optional benefits).

***Member Handbooks*** – Enrollees in the COVA Care and COVA Connect Plans will receive a new Member Handbook by the end of June to be effective July 1. COVA HDHP participants may continue to use their existing Member Handbook. Kaiser Permanente HMO Enrollees will receive a new Evidence of Coverage.

***IMPORTANT!! When You Become Eligible for Medicare*** - When retiree group enrollees (Retirees, Survivors, Long Term Disability Participants) or their covered dependents become eligible for Medicare, Medicare becomes the primary health plan, and they must make a decision as to whether they wish to maintain secondary coverage under the State Retiree Health Benefits Program or terminate coverage. In most cases, Medicare-eligible participants will be contacted

through the enrollee approximately three months in advance of their Medicare eligibility date and provided with their options. If no positive election is made, they will automatically be moved to the Advantage 65 with Dental/Vision Plan, a Medicare supplemental plan that includes Medicare Part D prescription drug coverage (contingent upon approval by Medicare).

Even though the state program makes every effort to identify participants who become eligible for Medicare, it is ultimately the responsibility of the enrollee to ensure that participants (enrollees and their covered dependents) who become eligible for Medicare are moved to Medicare-coordinating coverage immediately upon Medicare eligibility. Failure to move to Medicare-coordinating coverage immediately upon eligibility for Medicare can result in retraction of primary payments made in error and a gap in coverage. The state program will not make primary claim payments when Medicare should be the primary coverage. If you or a covered dependent becomes eligible for Medicare and is not contacted by your Benefits Administrator, it is the responsibility of the enrollee to notify the appropriate Benefits Administrator of Medicare eligibility.

Some important things to consider when making this coverage decision:

- If you wish to select your Medicare-coordinating plan through the state program, you must enroll in Medicare Parts A and B (the Original Medicare Plan) in order to get the full benefit of the Advantage 65 Plans, the state program's Medicare supplemental coverage. Failure to enroll in Medicare Parts A and B can result in a significant deficit in your coverage since Advantage 65 will not pay any benefit for which Medicare would have paid had you been enrolled.
- As a Medicare-eligible participant, you may select from available Advantage 65 Plans.
- If an enrollee requests termination of coverage in the State Retiree Health Benefits Program, he or she may not re-enroll. Termination of the enrollee will result in termination of all covered dependents.

For more information about Medicare and the State Retiree Health Benefits Program, go to [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov) and look for *Retiree Fact Sheets*.

**Becoming Eligible for Medicare During the Open Enrollment Period** - If you become eligible for Medicare during the Open Enrollment period, you may receive both an Open Enrollment package and a package notifying you of your Medicare eligibility. If you become eligible for Medicare prior to or on July 1, your Medicare plan election will supersede any Open Enrollment election. If you become eligible for Medicare after July, you may make an Open Enrollment election for July 1, and your Medicare plan election will take place on the first of the appropriate month after July.

**Retiree Medicare Entitlement Advocacy Program- Update** – The State Retiree Health Benefits Program is still considering the introduction of this program to identify service retirees and dependents of other retiree group participants who may be eligible for Social Security Disability benefits, which ultimately results in eligibility for Medicare. This would help to maximize the efficiency of the program while providing a useful service to its participants since there are advantages to be gained by individuals and the program through identifying eligibility for these benefits. While the program is still in the planning stages, you should be aware that this program is being investigated to avoid any concerns created if information is disseminated at a later date. At this time, there is no firm time frame for implementation.

**Prompt Payment of Premiums** - Enrollees are responsible for timely payment of their monthly premiums (either through VRS retirement benefit deduction or by direct payment to the billing administrator). Participants who pay directly receive monthly bills or coupons which indicate when premium payments are due. Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Claims paid during any period for which premium payment is not received will be recovered. Once an Enrollee and/or his/her dependents have been terminated

for non-payment of premiums, re-enrollment in the program is not allowed except at the sole discretion of the Department of Human Resource Management.

Participants are responsible for understanding their premium obligation and for notifying their Benefits Administrator within 31 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the enrollee to advise the program of membership reductions may result in loss of the overpaid premium amount.

Contact your billing administrator to discuss automatic draft of your monthly premium from your bank account or electronic payment.

**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, including an updated telephone number. If you have an e-mail address, you may ask to have it included in your eligibility record. 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, including billing statements, because their address of record is incorrect. The Department's only means of communicating important information to retiree group participants is through the mail. Please let your Benefits Administrator know when you move! You may also change your address by using *EmployeeDirect* on the Web at [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov)—click on the *EmployeeDirect* link.

**If You Need Help...** - Retiree group participants should contact their Benefits Administrator with questions regarding Open Enrollment or about eligibility and administrative issues. For most retiree group participants, the Virginia Retirement System (VRS) acts as Benefits Administrator. However, local and optional retirement plan retirees continue to use their pre-retirement agency's Benefits Administrator. Benefits Administrators are generally unable to assist with claims concerns, and those questions should be directed to your claims administrator. Please see *Resources* on page 10 for contact information.

**NOTE** - All information included in this booklet was accurate at the time of printing. However, all published information is subject to change pending final approval of the state budget after the General Assembly veto session. Enrollees will be notified immediately if this information changes.

**Attachments:**

- Notice – Women's Health and Cancer Rights (page 9)
- Notice About The Early Retiree Reinsurance Program (page 9)
- Resources (page 10)

***Notice***  
***Women's Health and Cancer Rights***

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

***NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM***

You are a plan participant in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, coinsurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

## RESOURCES

***If you have questions regarding claims, benefits or participating providers, contact:***

<b><i>Benefit</i></b>	<b><i>Contact This Administrator</i></b>
<ul style="list-style-type: none"> <li>• COVA Care Medical</li> <li>• COVA Care Optional Vision and Hearing</li> <li>• COVA HDHP Medical, Prescription Drug and Dental</li> </ul>	Anthem Blue Cross and Blue Shield Member Svcs. 800-552-2682 TDD: 804-354-4327 (Richmond) or 800-554-7752
<ul style="list-style-type: none"> <li>• COVA Connect Medical, Vision, Hearing, Behavioral Health or Employee Assistance Program and Prescription Drugs</li> </ul>	Optima Health 866-846-COVA (2682) or 757-687-6350
<ul style="list-style-type: none"> <li>• COVA Care Behavioral Health or Employee Assistance Program</li> </ul>	Value Options, Inc. 866-725-0602
<ul style="list-style-type: none"> <li>• COVA HDHP Behavioral Health</li> </ul>	Anthem Blue Cross and BlueShield 800-991-6045
<ul style="list-style-type: none"> <li>• COVA HDHP Employee Assistance Program</li> </ul>	Anthem Blue Cross and BlueShield 800-346-5484
<ul style="list-style-type: none"> <li>• COVA Care or COVA Connect Dental</li> </ul>	Delta Dental 888-335-8296
<ul style="list-style-type: none"> <li>• COVA Care Prescription Drugs</li> </ul>	Medco Health Solutions, Inc. 800-355-8279
<ul style="list-style-type: none"> <li>• Kaiser Permanente HMO (all benefits)</li> </ul>	Medical: 800-777-7902 or 301-468-6000 (in Washington, DC) Behavioral Health and EAP: 866-517-7042 Dental: 888-518-5338

***If you have questions about eligibility and enrollment, contact:***

<b><i>If You Are A:</i></b>	<b><i>Contact This Benefits Administrator</i></b>
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Participant	The Virginia Retirement System 888-827-3847 <a href="http://www.varetire.org">www.varetire.org</a>
Local or Optional Retirement Plan Retiree	Your Pre-Retirement Agency Benefits Administrator
Non-Annuitant Survivor (a survivor of an employee or retiree, not receiving a VRS benefit)	Department of Human Resource Management 888-642-4414 <a href="http://www.dhrm.virginia.gov">www.dhrm.virginia.gov</a>

The Department of Human Resource Management Web site also has information about the State Retiree Health Benefits Program. Go to [www.dhrm.virginia.gov](http://www.dhrm.virginia.gov).