



COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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

From: Office of State and Local Health Benefits Programs

Date: April 1, 2022

Subject: ANNUAL OPEN ENROLLMENT – MAY 2—16, 2022

Your Annual Open Enrollment

Your Open Enrollment will take place from **May 2 through May 16** and provides your annual opportunity to make changes to your non-Medicare-coordinating health plan and membership level (as allowed by eligibility policy). Changes will be effective July 1, 2022. This booklet includes information about coverage options in the new plan year. Other resources to help you make your Open Enrollment decision include:

- A 2022 *BENEFITS AT A GLANCE* comparison of available plan benefits (see page 10)
- A link to *ALEX*, your online benefits counselor (see page 4)

Use these resources to help you choose the plan that best meets you and your covered family members' individual needs.

This Open Enrollment period does not apply to participants in Medicare-coordinating plans (Advantage 65 and Medicare Supplemental/Option II Plans), but Medicare-eligible Retirees, Survivors and Long-Term Disability Enrollees who cover non-Medicare-eligible family members receive this package so that they can make changes on behalf of their Non-Medicare covered family members.

NOTE: PREMIUMS AND PLAN BENEFITS INCLUDED IN THIS BOOKLET MAY CHANGE SUBJECT TO FINAL STATE BUDGET APPROVAL

Monthly Premium Costs Effective July 1, 2022

The following chart includes your plan choices and monthly premiums starting July 1, 2022. If you enroll in either a COVA Care or COVA HealthAware Plan, the premiums (see shaded premiums) can be reduced by completing the requirement to earn a premium reward. More detailed information about starting or continuing premium rewards can be found on page 3.

Plans	Single	Two-Person	Family
COVA Care (with preventive dental)	\$819	\$1,514	\$2,197
COVA Care + Out-of-Network	\$838	\$1,549	\$2,249
COVA Care + Expanded Dental	\$854	\$1,579	\$2,291
COVA Care + Out-of-Network + Expanded Dental	\$873	\$1,613	\$2,343
COVA Care + Expanded Dental + Vision and Hearing	\$874	\$1,615	\$2,345
COVA Care + Out-of-Network + Expanded Dental + Vision & Hearing	\$893	\$1,650	\$2,396
COVA HealthAware (with preventive dental)	\$726	\$1,346	\$1,947
COVA HealthAware + Expanded Dental	\$759	\$1,406	\$2,034
COVA HealthAware + Expanded Dental & Vision	\$770	\$1,428	\$2,065
COVA HDHP (with preventive dental)	\$614	\$1,143	\$1,670
COVA HDHP + Expanded Dental	\$648	\$1,205	\$1,761
Kaiser Permanente HMO*	\$752	\$1,382	\$2,014
Optima Health Vantage HMO*	\$782	\$1,447	\$2,095
TRICARE Supplement	\$61	\$120	\$161

*Kaiser Permanente HMO and Optima Health Vantage HMO are only available to participants living in the plans' defined services areas. If you enroll in one of these plans but do not live in the service area, you will be required to change plans. Contact Kaiser or Optima directly for specific information—see *Resources* on page 12.

Some reminders if your premium is changing:

- If your premium is deducted from your VRS retirement benefit and an increase result in your VRS benefit no longer being sufficient to allow your premium deduction, direct billing will automatically begin in June for your July premium. Otherwise, your premium payments will be deducted or billed in the usual manner.
- Keep in mind that, due to administrative differences, direct billing is mailed before the coverage month, while VRS benefit deductions are taken after the coverage month. This means that you may initially be billed for a two-month premium if transition to direct billing is required.
- If you have an automatic deduction of your monthly premium billing through your financial institution or you use automatic bill pay to generate your monthly premium payment, be sure to update your account to pay your new premium amount.
- If you are receiving a health insurance credit and your premiums are not being deducted by VRS, you may need to submit a VRS-45 to report a premium change. Contact VRS for more information.

If your premium is direct billed, you will receive your monthly invoice or payment coupons from the following billing administrator:

<i>If your plan is:</i>	<i>You will be billed by:</i>
COVA Care	Anthem Blue Cross and Blue Shield
COVA HealthAware	PayFlex
COVA HDHP	Anthem Blue Cross and Blue Shield
Kaiser Permanente HMO	Kaiser
Optima Health Vantage HMO	Optima
TRICARE Supplement	Selman and Company

Earn Premium Rewards Again This Year!

Non-Medicare retiree group enrollees and non-Medicare-eligible covered spouses in the COVA Care or COVA HealthAware Plans are eligible to earn Premium Rewards by completing an online health assessment. Monthly premium cost in either a COVA Care Plan or a COVA HealthAware Plan will be reduced by \$17 per month when the requirement is met by the enrollee, and \$34 per month if the requirement is also met by the spouse.

Eligible participants must complete/update and submit their online health assessment between May 2 – 16 to earn a reward starting July 1. **If this requirement is not completed, any existing premium reward will end on June 30, 2022.** Visit your plan’s website or mobile app to access your health assessment.

To earn a reward BEGINNING July 1, 2022:

How to Access theHealth Assessment

COVA Care Members

Online

- Log in to www.anthem.com
- Select “My Health Dashboard” from the top navigation menu
- Select “Programs”
- Under “Programs”, select “Learn more” on the WebMD Health Risk Assessment tile.
- Click “Start your assessment” or “take it again” if you have previously completed an assessment.
- Click on the “Save and finalize” button, then answer three questions.
- Answer the feedback question, then click “Finish” for your confirmation. Print or save a screenshot.

Sydney Health mobile app

- Log in to the app, from the bottom of home screen select “More”
- Select “My Health Dashboard” from the menu list
- Scroll down and click on “Featured Programs,” then click “View All”
- Scroll down the program list to the WebMD Health Assessment option
- Click “Start your assessment” or “take it again” if you have previously completed an assessment.
- Click on the “Save and finalize” button, then answer three questions.
- Answer the feedback question, then click “Finish” for your confirmation. Print or save a screenshot.

COVA HealthAware Members

Online

- Log in to www.aetna.com
- Scroll down until you see “Member Resources” on the right side of the page and click on “Well-being Resources” in this section to open your Member Engagement Platform.
- Once the Member Engagement Platform opens, hover over “My Health” in the menu at the top and then click on “Health Assessment.”

Aetna Health mobile app

- Log in to the Aetna Health mobile app
- Select the Improve tab
 - When accessing this tab for the first time, select “Get Started”
 - When accessing this tab after the first time, select “Health Survey”

If you do not have a computer or a Smart Device, you also may contact Anthem Blue Cross and Blue Shield at **1-800-552-2682** to complete a telephonic health assessment.

Note: As a first time user, you will need to download the *Sydney Health* mobile app from either Google Play or Apple app store. Once you have completed registration, follow the above instructions for accessing the Health Assessment.

To earn a reward to start AFTER July 1, 2022:

- Eligible participants can complete and submit the health assessment by the 15th of any month to start receiving the premium reward in six to eight weeks.

Follow the instructions listed above for your respective plan to submit your health assessment.

ALEX, Your Online Benefits Counselor

ALEX will again be available during Open Enrollment to assist you in comparing your health plan options. ALEX can help you decide which plan may be the most cost-effective for you. ALEX will gather information from you and, in turn, provide information to you about available plans, including an estimate of different plan costs based on your input. The final decision is yours, but ALEX is a resource to help you decide—just go to www.myalex.com/cova/2022.

BENEFIT CHANGES FOR JULY 1

COVA Care, COVA HDHP

Starting on July 1, coverage for continuous glucose monitors (CGMs) will be available **ONLY under the IngenioRx pharmacy benefit**. COVA Care and COVA HDHP members will be able to fill a CGM prescription at any participating pharmacy in the plan's network or have CGM supplies delivered to their home through IngenioRx Home Delivery. After July 1, **members will need to request a new prescription for CGM supplies from their doctor** and send it to their pharmacy.

For all other health plans, CGMs will continue to be covered under both the pharmacy and durable medical equipment (DME) medical benefit.

COVA Care, COVA HDHP and COVA HealthAware

The *Healthy Smile Healthy You* program will offer an additional cleaning and exam beyond the annual limit for patients with cancer, a weakened immune system, kidney disease or undergoing kidney dialysis.

Health and Wellness Programs

Preventive Screenings Could Save Your Life

Early detection of health issues can help keep treatment costs down and can increase the likelihood of positive health outcomes. Regular preventive care is included in your health benefits. Making time for it is one of the best ways you can make sure you and your family are at your healthy best.

The Commonwealth's plans offer annual adult and well-child exams, gynecological exams, vaccinations, and cancer screenings at no cost to you. To find out what screenings and vaccines are recommended, consult your plan Member Hand-book or Evidence of Coverage, call your health plan or visit the plan website. Contact information is on page 12. Your doctor may suggest additional screenings or vaccinations based on various factors such as your age and health history.

- **COVA Care, COVA HDHP and COVA HealthAware Health and Wellness Programs**
Disease Management programs provide support to help manage chronic conditions such as asthma, heart disease, diabetes, chronic obstructive pulmonary disease (COPD) coronary artery disease and hypertension. These programs are administered by the medical plan claims administrator. Contact your health plan (see *Resources* on page 12).
- **COVA Care and COVA HealthAware Incentive Programs**
Participants in these plans can receive certain medications or supplies at no cost to treat the following conditions: asthma, chronic obstructive pulmonary disease (COPD), diabetes and high blood pressure. Medication compliance and quarterly health coaching are required. Contact your health plan (see *Resources* on page 12).

- Enrolled members have access to a nurse coach and other maternity support specially designed to help make good choices throughout the pregnancy and to help you have a safe delivery and a healthy child. Enrollment within the first 16 weeks of pregnancy and participation with a nurse coach can result in waiver of the hospital copayment or a \$300 contribution to your Health Reimbursement Arrangement (HRA), depending on your plan.
- Plan participants have access to a weight management coach who will provide one-on-one goal oriented support for weight management and nutrition counseling as well as personalized coaching and disease management. You are required to participate in your plan's 12-month weight management coaching and education program. Contact your health plan (see *Resources* on page 12).

You may also find information on similar programs for Kaiser Permanente and Optima Health Vantage HMO on their respective websites.

Making Open Enrollment Changes

If you wish to make a plan or membership change during Open Enrollment, you must complete a *State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants*. The forms are available online in a fillable format on the DHRM website at www.dhrm.virginia.gov, or complete the enrollment form enclosed in your open enrollment packet.

Completing the form:

- Indicate “*Open Enrollment*” as the reason for your change.
- Sign the completed form. **The Enrollment form must be signed by the eligible Enrollee.** This is either the Retiree, Survivor, or Long Term Disability participant through whom eligibility for coverage is obtained—***not a covered family member***. Even those covered family members 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.
- Follow the mailing instructions on the form to submit your changes to your Benefits Administrator.
- Forms must be postmarked no later than May 16, 2022, to be accepted.

If you make a plan change, be sure that you understand the provisions of the plan that you choose. **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 eligibility for the new family member. 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 confirms the spouse (all financial information and Social Security Numbers should be removed).
- To add a biological or adopted child, you must include a photocopy of the birth certificate showing the retiree group Enrollee’s or spouse’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. Supporting documentation must be received by the end of the Open Enrollment period. If it is not received, your membership increase will not be processed.

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/life event (such as marriage or birth of a child). Membership increases must be accompanied by appropriate documentation to support the addition (see above). **Enrollees have 60 days from the event to make a change based on a qualifying mid-year event/life event.** Retiree group Enrollees may **decrease** membership prospectively (going forward) at any time

Retiree Group News and Reminders...

Member Handbooks –Plan Member handbooks are posted on the DHRM website at www.dhrm.virginia.gov/employeebenefits/health-benefits. Be sure to review your plan's member handbook and associated amendments for more details on your plan. If you are enrolled in a regional plan, please visit your plan's website for the Evidence of Coverage (EOC).

IMPORTANT!! When You Become Eligible for Medicare – When Retiree Group Enrollees (Retirees, Survivors, Long Term Disability Participants) or their covered family members 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 that coverage. In most cases, Medicare-eligible participants will be contacted through the Enrollee and provided with their options approximately three months in advance of their Medicare eligibility date due to age. If no positive election is made, they will be automatically 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), dental and vision. Even though the state program makes every effort to identify participants who become eligible for Medicare, it is the responsibility of the Enrollee to ensure that any participants 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. Contact your Benefits Administrator if you need additional information (see page 9).

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 (Original Medicare) 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 claims that 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 family members. For more information about *Medicare and the State Retiree Health Benefits Program*, go to www.dhrm.virginia.gov and look for *Retiree Fact Sheets*.

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 covered family members 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.

Enrollees are responsible for understanding the amount of their premium and for notifying their Benefits Administrator within 60 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.

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 email address, you may ask to have it included in your eligibility record. Failure to update your mailing 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 reaching many retiree group participants is through the US Postal Service. Please let your Benefits Administrator know when you move!

If You Need Help... Retiree group participants should contact their Benefits Administrator with enrollment and eligibility questions. Benefits Administrators are generally unable to assist with claim or coverage problems, and those questions should be directed to your claims administrator. Please see *Resources* on page 12 for contact information.

Enclosures:

- **Summary of Benefits and Coverage for your current plan**
- **Important Notices Summary**
- **CHIP Notice**
- **Balance Billing Notice**
- **State Health Benefits Enrollment Form for Retirees, Survivors and LTD Participants**

If you have questions about eligibility and enrollment, contact your Benefits Administrator:

<i>If You Are A:</i>	<i>Contact This Benefits Administrator</i>
Virginia Retirement System Retiree/Survivor or a VSDP Long Term Disability Program Participant	The Virginia Retirement System 888-827-3847 <u>www.varetire.org</u>
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 <u>www.dhrm.virginia.gov</u>

The Department of Human Resource Management web site has more information about the State Retiree Health Benefits Program. Go to **www.dhrm.virginia.gov**

2022 BENEFITS AT A GLANCE

Health Plans	COVA HealthAware	COVA Care	COVA HDHP	Kaiser Permanente	Optima Health
Benefits	You Receive	You Receive	You Receive	You Receive	You Receive
Health Reimbursement Arrangement (HRA) Employer deposit to your HRA on July 1, 2022	\$600 employee \$600 enrolled spouse	Not available	Not available	Not available	Not available
In-Network Benefits	You Pay	You Pay	You Pay	You Pay	You Pay
Deductible – per plan year					
• One person	\$1,500	\$300	\$1,750	None	\$150
• Two or more persons	\$3,000	\$600	\$3,500	None	\$300
Out-of-pocket expense limit – per plan year					
• One person	\$3,000	\$1,500	\$5,000	\$1,500	\$1,500
• Two or more persons	\$6,000	\$3,000	\$10,000	\$3,000	\$3,000
Doctor's visits (in person and telemedicine)					
• Primary care physician	20% after deductible	\$25	20% after deductible	\$25	Tier 1: \$5 Tier 2: \$25
• Telehealth physician visit	\$0 www.teladoc.com/aetna	\$0 www.livehealthonline.com	20% after deductible www.livehealthonline.com	\$0 www.kp.org • 1-800-777-7904	\$0 MDLIVE 866-648-3638
• Specialist	20% after deductible	\$40	20% after deductible	\$40	Tier 1: \$10 Tier 2: \$40
Hospital services					
• Inpatient	20% after deductible	\$300 per stay	20% after deductible	\$300 per admission	\$300 per admission
• Outpatient	20% after deductible	\$125 per visit	20% after deductible	\$75 per visit	\$125 per visit
Emergency room visits	20% after deductible	\$150 per visit (waived if admitted)	20% after deductible	\$75 per visit (waived if admitted)	\$150 per visit (waived if admitted)
Ambulance travel	20% after deductible	20% after deductible	20% after deductible	\$50 per service	20% after deductible
Outpatient diagnostic laboratory and x-rays	20% after deductible	20% after deductible	20% after deductible	\$0 lab, pathology, shots, radiology, diagnostic tests \$75 specialty imaging	20% after deductible
Infusion services (includes IV or injected chemotherapy)	20% after deductible	20% after deductible	20% after deductible	\$25 PCP \$40 specialist	\$40 copay per office visit \$100 copay for pre-authorized Injectable/Infused Medications
Outpatient therapy visits					
• Occupational and speech therapy	20% after deductible	\$25 PCP/\$35 specialist	20% after deductible	\$40 (30 visits/episode)	\$25*
• Physical therapy only	20% after deductible	\$15	20% after deductible	\$40 (30 visits/episode)	\$25*
• Physical therapy and other related services, including manual intervention & spinal manipulation	20% after deductible	\$25 PCP/\$35 specialist	20% after deductible	\$40 (30 visits/episode)	\$25*
• Chiropractic services (30-visit plan year limit per member)	20% after deductible	\$25 PCP/\$35 specialist	20% after deductible	\$40	\$35
Autism spectrum disorder treatment and related services	20% after deductible	\$25 per service/\$40 specialist	20% after deductible	\$25 per visit /\$40 specialist	PCP Tier 1: \$5 Tier 2: \$25 Specialist Tier 1: \$10 Tier 2: \$40
Behavioral health					
• Medical and non-medical professional visits	20% after deductible	\$25	20% after deductible	\$12 group/\$25 individual	\$10
• Inpatient residential treatment	20% after deductible	\$300 per stay	20% after deductible	\$300 per admission	\$300 per admission
• Intensive outpatient treatment (IOP)	20% after deductible	\$125 per episode of care	20% after deductible	\$12 group/\$25 individual	\$125
Employee Assistance Program (EAP) Up to 4 visits per incident	\$0	\$0	\$0	\$0	\$0
Prescription drugs – mandatory generic					
Retail Pharmacy	20% after deductible	Up to 34-day supply \$15/\$30/\$45/\$55	20% after deductible	Up to 30-day supply KP center: \$15/\$25/\$40 Specialty: 50%, \$75 max Community participating: \$20/\$45/\$60 (3 x copayment for 90 days)	Up to 30-day supply \$15/\$30/\$45/\$55
Home Delivery Pharmacy	20% after deductible	Up to 90-day supply \$30/\$60/\$90/\$110	20% after deductible	\$13/\$23/\$38 (2 x copayment for 90 days)	Up to 90-day supply \$30/\$60/\$90/\$55**

*Occupational and Physical therapy are limited to a maximum combined benefit of 30 visits per plan year. Speech therapy is limited to a maximum of 30 visits per plan year.

**30-day supply for Specialty Tier 4

2022 BENEFITS AT A GLANCE

Health Plans	COVA HealthAware	COVA Care	COVA HDHP	Kaiser Permanente	Optima Health
In-Network Benefits	You Pay	You Pay	You Pay	You Pay	You Pay
Wellness & Preventive Services					
• Office visits at specified intervals, immunizations, lab and x-rays	\$0	\$0	\$0	\$0	\$0
• Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays	\$0	\$0	\$0	\$0	\$0
• Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening	\$0	\$0	\$0	\$0	\$0
Annual Routine Vision Exam	\$0	\$15	\$15	\$25 PCP/\$40 specialist	\$15
Annual Routine Hearing Exam	\$0	<i>Optional benefit*</i>	Not available	\$25 PCP/\$40 specialist	\$40
Dental Services					
• Diagnostic and preventive	\$0	\$0	\$0	\$0	\$0
Expanded Dental	<i>Optional Benefit*:</i>	<i>Optional Benefit*:</i>	<i>Optional Benefit*:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>
• Maximum benefit – per member	\$2,000	\$2,000	\$2,000	\$1,000	\$2,000
• Deductible	\$50/\$100/\$150	\$50/\$100/\$150	\$50/\$100/\$150	\$25 per person/\$75 family	\$50/\$150
• Primary (basic) care	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
• Complex restorative (inlays, onlays, crowns, dentures, bridgework)	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
• Orthodontic – Lifetime maximum benefit	50% no deductible \$2,000	50% no deductible \$2,000	50% no deductible \$2,000	50% up to \$1,000 (age 19 and under)	50% no deductible \$2,000
Routine Vision – Basic Plan	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>
• Annual Routine Vision Exam	\$0	\$15	\$15	\$25 PCP/\$40 specialist	\$15
• Eyeglass frames	65% of the retail price	80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses	80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses	Balance after plan pays \$75 (age 19+) <19 \$0 (1 pair/plan year)	80% after plan pays \$100
• Eyeglass lenses - standard plastic - Single - Bifocal - Trifocal	\$40 \$60 \$80	\$50 \$70 \$105	\$50 \$70 \$105	Balance after plan pays \$75 (age 19+) <19 \$0 (1 pair/plan year)	\$20
• Contact lenses** - Conventional** - Disposable** - Non-elective**	Conventional contact lenses: 85% of the retail price	Conventional contact lenses: 85% of the retail price (discount applies to materials only)	Conventional contact lenses: 85% of the retail price (discount applies to materials only)	Balance after plan pays \$25 discount if purchased at KP Optical	85% after plan pays \$100 Balance after plan pays \$100 \$0
Expanded Routine Vision	<i>Optional Benefit*:</i>	<i>Optional Benefit*:</i>			
• Eyeglass frames	80% after plan pays \$100	80% after plan pays \$100	Not available	Not available	Not available
• Lenses - Eyeglass lenses (standard plastic, single, bifocal or trifocal) or	\$20	\$20	Not available	Not available	Not available
• Contact lenses** - Conventional** - Disposable** - Non-elective**	85% of the retail price Balance after plan pays \$100 Balance after plan pays \$250	85% of the retail price (discount applies to materials only) Balance after plan pays \$100 Balance after plan pays \$250	Not available	Not available	Not available
Routine Hearing	<i>Included in Basic Plan:</i>	<i>Optional Benefit*:</i>		<i>Included in Basic Plan:</i>	<i>Included in Basic Plan:</i>
• Routine hearing exam (once every plan year)	\$0	\$40	Not available	\$25 PCP \$40 Specialist	\$40
• Hearing aids and other hearing-aid related services	Not available	Balance after plan pays \$1,200 (once every 48 months)	Not available	Not available	Balance after plan pays \$1,200 (once every 48 months)
• Benefit maximum	Not available	\$1,200	Not available	Not available	\$1,200
Out-of-Network	<i>Included in Basic Plan:</i>	<i>Optional Benefit*:</i>			
	Additional deductible and out-of-pocket limits apply. 40% coinsurance after deductible of \$3,000/\$6,000. Balance billing may apply.	Plan payment reduced by 25%. Balance billing may apply.	Not available	Not available	Not available. Out-of-area Dependent Children Program available.

The program also offers the TRICARE voluntary supplement, which coordinates with federal TRICARE benefits.

*Optional benefits are offered for an additional premium, and may be purchased in combinations as shown in your Open Enrollment booklet (see premium summary).

**Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when eyeglasses are not an option for vision correction.

RESOURCES

Plan	Benefit	Contact Information
COVA Care and COVA HDHP	<ul style="list-style-type: none"> • Medical, Vision & Hearing (Anthem BCBS) • Behavioral Health Benefits & EAP (Anthem) • Dental (Delta Dental of Virginia) • Prescription Drug (Anthem Pharmacy) 	<ul style="list-style-type: none"> • 800-552-2682 <u>www.anthem.com/cova</u> • 855-223-9277 <u>www.anthemEAP.com</u> Company Code: Commonwealth of Virginia • 888-335-8296 <u>www.deltadentalva.com</u> • 833-267-3108 <u>www.anthem.com</u>
COVA HealthAware	<ul style="list-style-type: none"> • Medical, Vision, Hearing and Behavioral Health (Aetna) • Employee Assistance Program (EAP) (Aetna) • Prescription Drug (Anthem Pharmacy) • Dental (Delta Dental) • Teladoc Virtual Visits 	<ul style="list-style-type: none"> • 855-414-1901 <u>www.covahealthaware.com</u> • 888-238-6232 <u>www.mylifevalues.com</u> (Username & Password: COVA) • 833-267-3108 <u>www.anthem.com</u> • 888-335-8296 <u>www.deltadentalva.com</u> • <u>www.teladoc.com/aetna</u>
Kaiser Permanente HMO	<ul style="list-style-type: none"> • Medical, Prescription Drug and Vision (Kaiser) • Dental (Dominion National) • EAP (Beacon Health Options) • Behavioral Health (Kaiser) 	<ul style="list-style-type: none"> • 800-777-7902; 301-468-6000 in Washington, D.C. <u>https://my.kp.org/commonwealthofvirginia/</u> • 855-733-7524 <u>http://www.DominionNational.com/kaiser</u> • 866-517-7042 <u>www.achievesolutions.net/kaiser</u> • 866-530-8778
Optima Health Vantage HMO	<ul style="list-style-type: none"> • Medical, Prescription Drug, Dental, Vision, Behavioral Health • Employee Assistance Program (EAP) 	<ul style="list-style-type: none"> • 866-846-2682 <u>www.optimahealth.com/cova</u> or <u>members@optimahealth.com</u> • <u>https://login.optimahealth.com</u> (Username: Cova)
TRICARE Supplement	Selman and Company (SelmanCo)	<ul style="list-style-type: none"> • 800-638-2610 (press option 1)