OFFICIAL ANNUAL HEALTH BENEFITS ENROLLMENT INFORMATION

dhrm

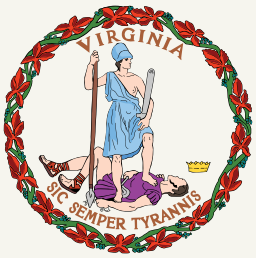
ANNUAL OPEN ENROLLMENT

for Non-Medicare Retirees, Survivors and
Long Term Disability Participants &
Non-Medicare Eligible Covered Family Members

MAY 16-30, 2025

EFFECTIVE FOR PLAN YEAR JULY 1, 2025 - JUNE 30, 2026

JANET L. LAWSON
DIRECTOR



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COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

YOUR ANNUAL OPEN ENROLLMENT

Your Open Enrollment will take place from **May 16 through May 30** 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 for plan year July 1, 2025 – June 30, 2026. This booklet includes information about coverage options in the new plan year. Other resources to help you make your Open Enrollment decision include:

• A **2025 *BENEFITS AT A GLANCE*** comparison of available plan benefits.

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). Medicare-eligible Retirees, Survivors and Long Term Disability enrollees who cover non-Medicare-eligible family members may use this information to make changes on behalf of their non-Medicare covered family members.

If you wish to maintain your current plan and do not plan to participate in Premium Rewards, NO ACTION on your part is necessary.

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

Monthly Premium Costs Effective July 1, 2025

The following chart includes your plan choices and monthly premiums starting July 1, 2025. 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 5.

PREMIUM AND PLAN BENEFITS MAY CHANGE SUBJECT TO FINAL STATE BUDGET APPROVAL.

PLANS		Single	Two-Person	Family
COVA Care (with preventive dental)		$938	$1,736	$2,519
COVA Care	+ Out-of-Network	$961	$1,779	$2,581
COVA Care	+ Expanded Dental	$971	$1,796	$2,607
COVA Care	+ Out-of-Network + Expanded Dental	$994	$1,839	$2,669
COVA Care	+ Expanded Dental + Vision & Hearing	$991	$1,833	$2,661
COVA Care	+ Out-of-Network + Expanded Dental + Vision	$1,014	$1,876	$2,723
COVA HealthAware (with preventive dental)		$849	$1,575	$2,285
COVA HealthAware	+ Expanded Dental	$882	$1,635	$2,373
COVA HealthAware	+ Expanded Dental & Vision	$892	$1,655	$2,401
COVA HDHP (with preventive dental)		$739	$1,366	$1,998
COVA HDHP	+ Expanded Dental	$772	$1,426	$2,086
Kaiser Permanente HMO*	+ Expanded Dental & Vision	$921	$1,693	$2,467
Sentara Health Plans (HMO)*	+ Expanded Dental & Vision	$907	$1,678	$2,431
TRICARE Voluntary Supplement**		$61	$120	$161***

** Kaiser Permanente HMO and Sentara Health Plans 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 Sentara directly for specific information.*

*** New York residents contact the Office of Health Benefits for TRICARE premium amount*

****If an employee covers multiple children without a spouse the rate is $120*

REMINDERS:

- 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 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.

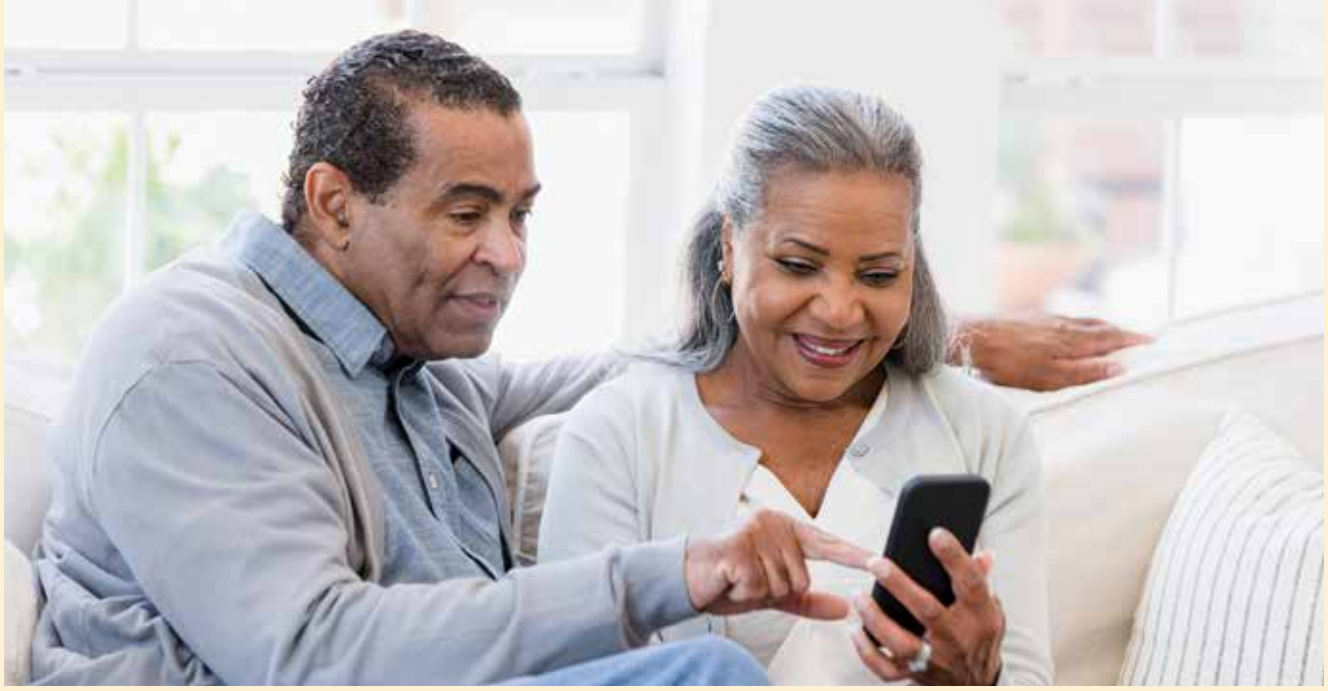
If your premium is direct billed, you will receive your monthly invoice or payment coupons from your billing administrator.

EARN PREMIUM REWARDS

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 retiree or their enrolled spouse, or $34 per month if the requirement is met by both the retiree and spouse.

Eligible participants must complete/update and submit their online health assessment between **May 16-30** to earn a reward starting July 1. Be sure to keep a copy of your confirmation. If this requirement is not completed, any existing Premium Reward will end on June 30, 2025. Visit your plan's website or mobile app to access your health assessment.

Remember, you must be active and enrolled in COVA Care or COVA HealthAware to be eligible for a reward. Enrolled non-Medicare retiree group participants and spouses must register with a separate account to submit a health assessment. Enrollees and/or spouses enrolling for the first time in COVA Care or COVA HealthAware during Open Enrollment may have to wait until July 1, 2025, to complete a health assessment. Current COVA Care or COVA HealthAware members who may be changing their plans for July 1, 2025, will need to complete their assessment with their current health plan administrator.



TO EARN A REWARD BEGINNING JULY 1, 2025:

HOW TO ACCESS THE HEALTH ASSESSMENT

COVA CARE MEMBERS

Online

Here are links to access your COVA Care Health Assessment Navigation Guide for the Sydney Health Mobile App and the Sydney Navigation Guide.

- Log in to www.anthem.com.
- Select **My Health Dashboard** from the top navigation menu and select Dashboard from the drop-down menu.
- The My Health Check-in tile will display at the top. Click **Get started**.
- My Health Check-in can also be accessed from the Programs page and click **View assessment**.
- Click on the **submit** button when you have completed your assessment.
- After completing your assessment, you be shown some custom recommendations based on your answers.
- Within the purple tile for My Health Check-in is a link for **View Completed Assessments**. This will allow you to print or email the date of your last completion of My Health Check-in assessment.
- If you have previously completed the assessment in the current calendar year, you will see the **Retake assessment** link.

Sydney Health Mobile App

- Log into the Sydney Health app.
- From the Sydney Welcome screen, you can click on the **More** button, in the bottom right corner.
- From the Access Care menu, select **Access to care** dropdown arrow.
- From the Access Care menu, select **My Health Dashboard**.
- My Health Check-in will be at the top; **Click Get Started**.
- At the Welcome Page Click **View Assessment**.
- Once you have answered all the questions click **Submit**.
- After completing your assessment, you be shown some custom recommendations based on your answers.
- Within the purple tile for My Health Check-in is a link for **View Completed Assessments**. This will allow you to print or email the date of your last completion of My Health Check-in assessment.

- If you have previously completed the assessment in the current calendar year, you will see the **Retake assessment** link.

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 the registration, follow the above instructions for accessing the Health Assessment.

For COVA Care members with literacy, language, or technological challenges, you may contact Anthem at 1-800-552-2682 for help.

COVA HEALTHAWARE MEMBERS

Online

- Log into your Aetna Member Website on 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 into 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**.

For COVA HealthAware members with literacy, language, or technological challenges, you may contact the Aetna Concierge team at 1-855-414-1901 for help.

The Member Engagement Platform will experience system outages from Saturday, May 17, 2025 at 4:00pm EDT until Sunday, May 18, 2025 at 12:00pm EDT. Tuesday, May 20, 2025 at 11:00pm EDT until Wednesday, May 21, 2025 at 6:00am EDT. Please plan accordingly.

PLAN AHEAD: GET YOUR WELLNESS EXAM

Premium Rewards Requirements changing for the 2026-27 Plan Year

There will be a wellness exam component added to the requirements to qualify for the Premium Reward incentive. In addition, to completing the Health Assessment, a wellness exam will be required to receive your Premium Rewards incentive starting July 1, 2026. We encourage you to have a wellness exam this year to meet the new Premium Rewards requirements. Remember, an annual/preventive wellness exam is $0 cost to the member. Failure to get your wellness exam could result in the loss of the Premium Rewards incentive effective July 1, 2026. More details to come prior to July 1, 2026.

2025 BENEFITS AT A GLANCE

PREMIUM AND PLAN BENEFITS MAY CHANGE SUBJECT TO FINAL STATE BUDGET APPROVAL.

Health Plans	COVA HealthAware	COVA Care	COVA HDHP	Kaiser Permanente HMO	Sentara Health Plans HMO
Benefits	**You Receive**	**You Receive**	**You Receive**	**You Receive**	**You Receive**
Health Reimbursement Arrangement (HRA) *Employer deposit to your HRA on July 1, 2025*	$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	$200
Two or more persons	$3,000	$600	$3,500	None	$400
Out-of-pocket expense limit – per plan year					
• One person / Two or more persons	$3,000 / $6,000	$1,500 / $3,000	$5,000 / $10,000	$1,500 / $3,000	$2,000 / $4,000
Doctor's visits (in person and telemedicine)					
• Primary care physician	20% after deductible	$25	20% after deductible	$25	Tier 1: $10 / Tier 2: $30
• Telehealth physician visit	$0	$0	20% after deductible	$0	$0
• Specialist	20% after deductible	$40	20% after deductible	$40	Tier 1: $20 / Tier 2: $50
• Urgent Care	20% after deductible	$25 PCP/$40 specialist	20% after deductible	$40	$60
Hospital services					
• Inpatient / Outpatient	20% after deductible	$300 per stay / $125 per visit	20% after deductible	$300 per admission / $75 per visit	$500 per admission / $200 per visit
Emergency room visits	20% after deductible	$300 per visit (waived if admitted)	20% after deductible	$75 per visit (waived if admitted)	$200 per visit (waived if admitted)
Ambulance travel	20% after deductible	20% after deductible	20% after deductible	$50 per service	Non-Emergency - 20% after deductible Emergency - $200
Outpatient diagnostic laboratory and x-rays	20% after deductible	20% after deductible	20% after deductible	$0 lab, pathology, shots, radiology, diagnostic tests	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)	$30*
• Physical therapy only	20% after deductible	$15	20% after deductible	$40 (30 visits/episode)	$30*
• 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)	$30*
• 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 service/ $40 specialist	PCP: Tier 1: $10, Tier 2: $30 Specialist: Tier 1: $20, Tier 2: $50
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	$500 per admission
• Intensive outpatient treatment (IOP)	20% after deductible	$125 per episode of care	20% after deductible	$12 group/$25 individual	$200
Employee Assistance Program (EAP)	Up to 4 visits per incident	Up to 4 visits per incident	Up to 4 visits per incident	Up to 4 visits per incident	Up to 5 visits per incident
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/NA **

*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.
**90-day supply for Specialty Tier 4 is not available.

2025 BENEFITS AT A GLANCE

PREMIUM AND PLAN BENEFITS MAY CHANGE SUBJECT TO FINAL STATE BUDGET APPROVAL.

Health Plans	COVA HealthAware	COVA Care	COVA HDHP	Kaiser Permanente HMO	Sentara Health Plans HMO
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	Optional benefit*	Not available	$25 PCP/$40 specialist	$40
Hearing aids and other hearing-aid related services children age 18 and younger (per hearing impaired ear)	Balance after plan pays $1,500 (once every 24 months)	Balance after plan pays $1,500 (once every 24 months)	Subject to the deductible, then 0% coinsurance. Allowance is $1,500 (once every 24 months)	Balance after plan pays $1,500 (once every 24 months)	Balance after plan pays $1,500 (once every 24 months)
Dental Services					
Diagnostic and preventive	$0	$0	$0	$0	$0
Expanded Dental	*Optional Benefit*:*	*Optional Benefit*:*	*Optional Benefit*:*	Included with Medical:	Included with Medical:
• 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	*Included with Medical:*	*Included with Medical:*	*Included with Medical:*	*Included with Medical:*	*Included with Medical:*
• 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 $20 $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	*Optional Benefit*:*	*Optional Benefit*:*			
• 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 balance after plan pays $100 Balance after plan pays $100 Covered in full	Not available	Not available	Not available
Routine Hearing	*Included in Basic Plan:*	*Optional Benefit*:*		*Included in Basic Plan:*	*Included in Basic Plan:*
• 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 Adults
Out-of-Network	*Included in Basic Plan:*	*Optional Benefit*:*	*Included in Basic Plan:*		
	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.	Additional deductible and out-of-pocket limits apply. 30% coinsurance after deductible of $1,750/$3,500. Balance billing may apply.	Not available	Not available. Out-of-area Dependent Children Program available. See plan's website for form.

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.


NEW IN 2025

STARTING JULY 1, 2025

SMS/TEXT MESSAGING TO YOUR SMARTPHONE

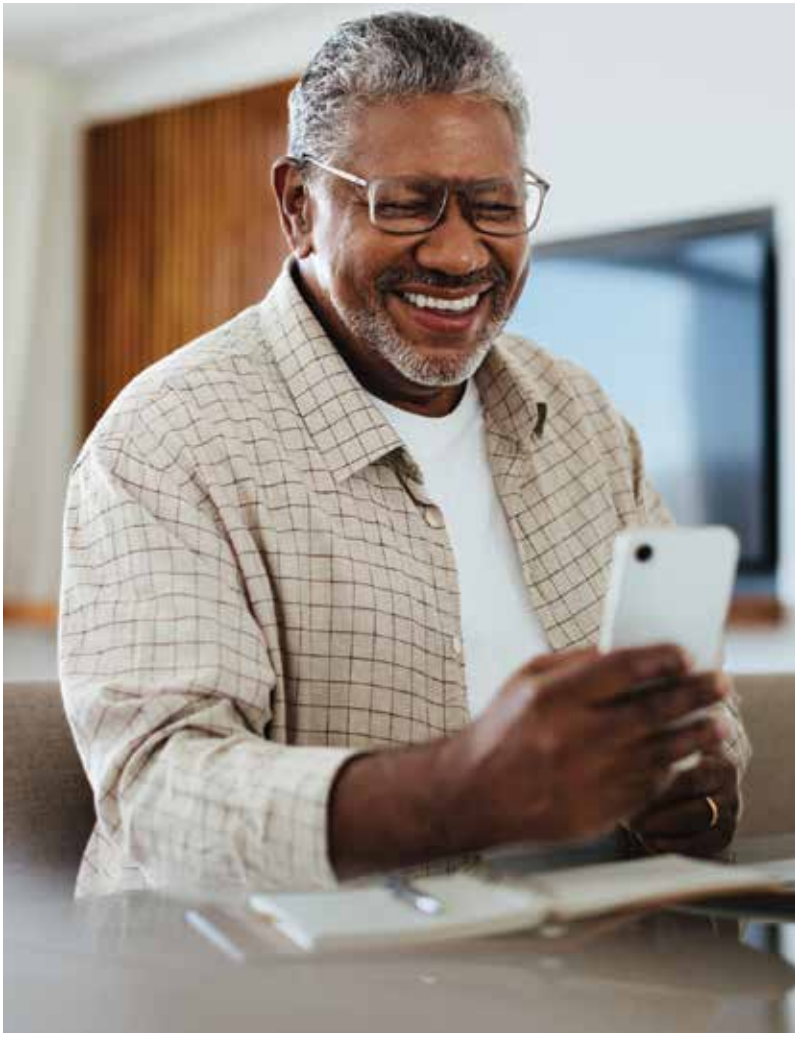
Get ready to receive important health benefits program information from the OHB directly to your mobile device. Your agreement to receive text messages, will allow quick real-time notifications to be sent to you.

Signing up is easy! If you would like to receive text messages, go to the DHRM website https://public.govdelivery.com/accounts/VADHRM/signup/40873 and provide your mobile number and consent.

Signing up for this text messaging feature is separate from any other information that may be captured by your agency and/or DHRM and does not replace any other information. This information is solely for OHB to provide benefits updates and will not be shared with any other entity. This new communication feature will begin once enough participants have signed up.

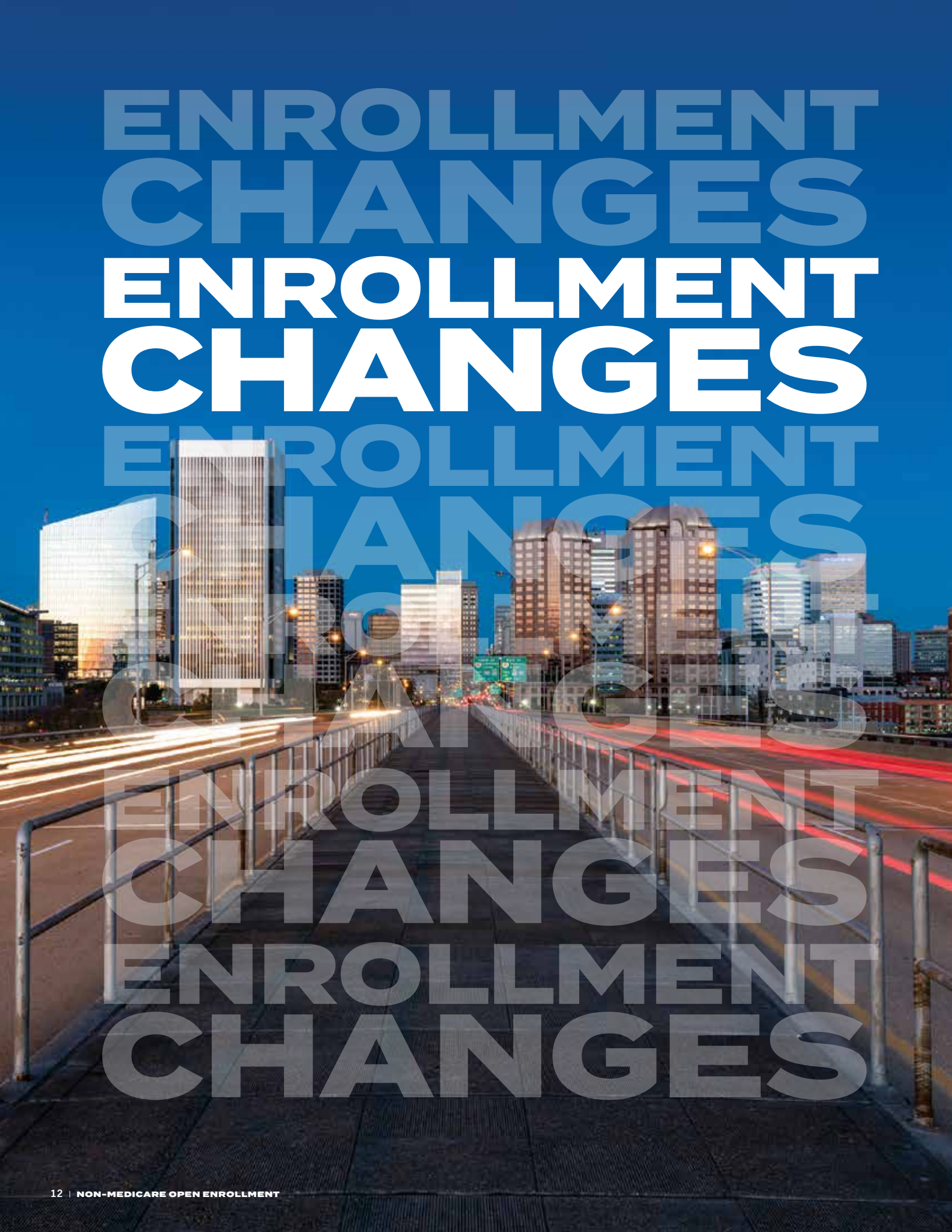
To Opt-out or discontinue receiving messages, reply STOP from your mobile device. Your Opt-out will be confirmed by text message and you will not receive any additional messages, unless you Opt-in again.

Message and Data rates may apply. For help or to view the Terms and & Conditions visit: https://granicus.com/wireless/ (DHRM has partnered with Granicus to provide this service). For the DHRM website policy visit https://www.dhrm.virginia.gov/web-policy



SENTARA HEALTH PLANS (HMO)

- Intensive Outpatient Treatment (IOP): Copay reduces to $200.
- Employee Assistance Program (EAP): Increases to 5 visits per incident. *(See changes on Benefits At A Glance)*


ENROLLMENT CHANGES
ENROLLMENT CHANGES

MAKE 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 https://www.dhrm.virginia.gov/employeebenefits/health-benefits/health-benefits-forms

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 30, 2025, 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 certified 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 natural 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 life event/qualifying mid-year 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 life event/qualifying mid-year event.** Retiree group Enrollees may **decrease** membership prospectively (going forward) at any time.


NEWS AND REMINDERS

RETIREE GROUP NEWS AND REMINDERS

MEMBER HANDBOOKS

YOUR MEMBER HANDBOOK IS ONLINE!

Health Plan Member handbooks are posted on the DHRM website at https://www.dhrm.virginia.gov/employeebenefits/health-benefits/non-medicare-retirees. 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).

HOW TO GET A COPY OF THE SUMMARY OF BENEFITS AND COVERAGE (SBC)

The Summary of Benefits and Coverage (SBC) for each plan, which summarizes important information about health coverage options in the standard format, is available on the

Department of Human Resource Management's website at https://www.dhrm.virginia.gov/employeebenefits/health-benefits/summary-of-benefits. Paper copies of the SBCs are available, free of charge, by emailing ohb@dhrm.virginia.gov.

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.

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.

REMINDER TO NON-ANNUITANT SURVIVORS

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

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

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 state 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 life event/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 – Please let your Benefits Administrator know when you move and contact them 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.

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.

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

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

The Department of Human Resource Management website has more information about the State Retiree Health Benefits Program. Go to www.dhrm.virginia.gov.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IMPORTANT NOTICES

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual member handbook, which serves as the summary plan description (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. The Commonwealth of Virginia reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

REMINDER OF AVAILABILITY OF PRIVACY NOTICE

This is to remind plan participants and beneficiaries of the Commonwealth of Virginia State Health Benefits Program (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You should receive from your agency Benefits Administrator a copy of the Office of Health Benefits Notice of Privacy Practice. If you do not receive your notice, please contact your benefits office or visit the DHRM Web site at www.dhrm.virginia.gov to obtain a copy. If you have any questions, please contact the Department of Human Resource Management Office of Health Benefits at ohb@dhrm.virginia.gov.

AFFORDABLE CARE ACT (ACA)

SUMMARIES OF BENEFITS AND COVERAGE (SBCS)

The health benefits available to you through the Commonwealth of Virginia represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC) for each plan, which summarizes important information about any health coverage option in a standard format, to help you and your family compare across options.

The SBCs are available on the Department of Human Resource Management's website at www.dhrm.virginia.gov. Paper copies of the SBCs are available, free of charge, by emailing ohb@dhrm.virginia.gov.

For a complete description of plan benefits, limits and exclusions, always refer to your plan Member Handbook.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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, including coverage for nipple and areola reconstruction (including re-pigmentation) to restore physical appearance of the breast, and chest wall reconstruction with aesthetic flat closure;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, under a HIPAA Special Enrollment you may be able to enroll yourself and your dependents in this plan if:

- You or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days of the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- You have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and all eligible dependents. However, you must request enrollment within 60 days of the marriage, birth, adoption or placement for adoption
- You or your dependent become eligible for a Medicaid or SCHIP premium assistance subsidy and you request coverage under the plan within 60 days of the date of your eligibility is determined.

To request a HIPAA Special Enrollment or obtain more information, contact your agency Benefits Administrator.

EXTENDED COVERAGE/COBRA NOTICES

Upon enrollment in COVA Care, COVA HealthAware, COVA HDHP, Sentara Health, Kaiser Permanente, or the Medical Flexible Spending Accounts, you should receive an Extended Coverage (COBRA) General Notice. The notices are distributed by Inspira Financial. If you do not receive your notice, please contact your COBRA Administrator Inspira Financial Health to obtain a copy.

Continued coverage is available for you and covered family members who lose eligibility under the State Health Benefits Program unless you enroll in the TRICARE supplement. More information about Extended Coverage (COBRA) is available on the DHRM website or from your Benefits Administrator. Portability information for the TRICARE supplement is available from the plan administrator.

NOTICE REGARDING WELLNESS PROGRAM

PLAN YEAR JULY 1, 2025 THROUGH JUNE 30, 2026

REASONABLE ALTERNATIVE STANDARD NOTICE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees.

If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means.

Contact us at 888-642-4414 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

EEOC NOTICE REGARDING WELLNESS PROGRAMS

Voluntary wellness programs are available to all employees, retiree group participants and spouses enrolled in the COVA Care, COVA HealthAware, and COVA High Deductible Health Plans under the Commonwealth of Virginia Employee/Retiree Health Benefits Program. The programs are administered by the medical plan claims administrators, as noted below, according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you decide to participate in the wellness program that is available to you, you can choose to complete a voluntary online health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). Completion of the HRA by employees/retirees and their enrolled spouses in the COVA Care or COVA HealthAware Plans will result in earning a premium reward. You are not required to complete the HRA or to participate in other medical examinations. However, employees/retirees and enrolled spouses who choose to participate in the wellness program by completing the HRA will earn an incentive of $17 per month for each completed HRA. The premium reward will be effective based on the date the HRA is completed. Although you are not required to complete the HRA, only employees/retirees and spouses who do so will earn a premium reward.

Additional incentives are available for employees and spouses enrolled in the COVA Care and COVA HealthAware Plans who participate in certain health-related activities as listed at the end of this Notice. These programs are described in detail in your Member Handbook. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Department of Human Resource Management's Office of Heath Benefits by email at ohb@dhrm.virginia.gov or by telephone at 888-642-4414. Employees/retirees and enrolled spouses in the COVA High Deductible Health Plan may participate in these wellness programs, but no incentive is available. The information from your HRA or health plan claims will be used to provide you with information to help you understand your current health and potential risks. It may also be used to offer services through the wellness program, such as those listed at the end of this Notice, or other information that provides personalized health guidance. You are also encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the Commonwealth of Virginia Employee and Retiree Health Benefits Program may use aggregate information it collects to design a program based on identified health risks in the workplace, claims administrators will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that is provided in connection with the wellness program and that personally identifies you will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. Only your medical plan's claims administrator, which administers available wellness programs, will receive your personally identifiable health information in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separately from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Department of Human Resource Management's Office of Health Benefits by email at ohb@dhrm.virginia.gov or by phone at 1-888-642-4414.

The following wellness program incentives are also available as a part of the COVA Care and COVA HealthAware Plans:

PROGRAM	AVAILABLE INCENTIVE
Maternity Support	Copayment waiver or contribution to Health Reimbursement Arrangement, depending on plan design
Completion of Designated Health Activities (Do-Rights)	Contribution to the Health Reimbursement Arrangement, depending on plan design, based on completion

LANGUAGE ACCESS SERVICES - (TTY/TDD:711)

(Spanish) - Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.

(Chinese) - 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website:
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.


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WHO TO CONTACT
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Plan or Benefit	Contact Information
COVA Care and COVA HDHP	Medical, Vision & Hearing - Anthem: **800-552-2682** or www.anthem.com/cova
	Prescription Drug - Anthem Pharmacy (CarelonRx): **833-267-3108** or www.anthem.com
	Behavioral Health & Employee Assistance Program (EAP) - Anthem: **855-223-9277** or www.anthemeap.com/cova
	Dental - Delta Dental of Virginia: **888-335-8296** or www.deltadentalva.com
	Virtual Care Options Including LiveHealth Online: Sydney Health app or www.anthem.com/cova
	My Health Check-In Health Assessment - Login at www.anthem.com (or the Sydney mobile app) > My Health Dashboard > Programs Contact Anthem at **800-552-2682** to complete a telephonic My Health Check-In health assessment.
	Health and Wellness Programs - www.anthem.com (or the Sydney mobile app) > My Health Dashboard > Programs • Condition Care (formerly Disease Management) and Well-being Coach: **844-507-8472** • Building Healthy Families (formerly Future Moms): www.anthem.com (or the Sydney mobile app) > My Health Dashboard > Programs - **833-414-4200**
	Shared Savings Incentive Program – SmartShopper: www.cova.smartshopper.com or Anthem: **844-277-8991**
COVA HealthAware	Medical, Vision, Hearing & Behavioral Health - Aetna: **855-414-1901** or www.covahealthaware.com Behavioral Health: **866-885-5596**
	Prescription Drug - Anthem Pharmacy (CarelonRx): **833-267-3108** or www.anthem.com
	Employee Assistance Program (EAP) - Aetna: **888-238-6232** or www.mylifevalues.com (Username & Password: COVA)
	Dental - Delta Dental of Virginia: **888-335-8296** or www.deltadentalva.com
	Teladoc: www.teladoc.com/aetna or **855-835-2362**
	Health Assessment - Log in at www.aetna.com (or the Aetna mobile app) > Member Resources > Well-being Resources
	Health and Wellness Programs - **855-414-1901** or log in at www.aetna.com > Member Resources > Well-being Resources
	Shared Savings Incentive Program – SmartShopper: www.cova.smartshopper.com or Aetna: **833-849-0567**
Kaiser Permanente HMO *(Primarily Northern Virginia - see website for specific zip codes)*	Medical, Prescription Drug and Vision – Kaiser Permanente: **800-777-7902**, **301-468-6000** in Washington, D.C. or www.my.kp.org/commonwealthofvirginia
	Online doctor visit: www.kp.org or **800-777-7904**
	Dental – Liberty Dental: **800-764-5393** or www.libertydentalplan.com/kp-cova
	Behavioral Health - Kaiser: **866-530-8778**
	Employee Assistance Program (EAP) - Carelon Behavioral Health: **866-517-7042** or www.carelonwellbeing.com/kaiser
Sentara Health Plans Vantage HMO *(Greater Hampton Roads and Eastern Shore See website for specific zip codes)*	Medical, Prescription Drug, Dental, Vision and Behavioral Health - Sentara Health: **866-846-2682**, www.sentarahealthplans.com/cova or members@sentara.com
	Online doctor visit: **MDLIVE** or **866-648-3638**
	Employee Assistance Program (EAP): www.sentaraeap.com (User name: COVA) or **800-899-8174**
TRICARE Supplement	Selman & Company (SelmanCo): **800-638-2610** (press Option 1)
Open Enrollment Information	https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2025-26 Office of Health Benefits: openenrollment@dhrm.virginia.gov

OFFICIAL ANNUAL HEALTH BENEFITS ENROLLMENT INFORMATION

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ANNUAL OPEN ENROLLMENT

MAY 16–30, 2025

Commonwealth of Virginia
Office of Health Benefits
Department of Human Resource Management
James Monroe Building
101 North 14th Street
Richmond, VA 23219