

About the Health Benefits Plans

Active State employees and non-Medicare retiree group members who are eligible for health benefits may choose to enroll in one of the following plans:

- The self-insured COVA Care plan along with several coverage options for participants that live outside the COVA Connect plan's service area,
- The self-insured COVA Connect plan along with several coverage options for participants living in the plan's service area,
- The COVA High Deductible Health Plan (HDHP) which is available statewide, or
- A Health Maintenance Organization (HMO), for participants that live or work in the plan's service area.

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COVA Care Basic, a Preferred Provider Organization (PPO) plan, is available to active participants and non-Medicare retirees unless they live in the COVA Connect plan's service area. Coverage for out-of-network services is available only in the event of an emergency. An emergency is defined as medically necessary services provided in response to a sudden and acute illness or injury which if left untreated a lay person would think that the emergency would result in death or severe physical or mental impairment.

COVA Care Basic includes the **BlueCard** feature. In addition to participating providers in Virginia, the plan provides coverage for out-of-state providers who participate in Anthem's BlueCard PPO network. Having access to the BlueCard PPO network means that employees may receive care from any physician or hospital in the U.S. that participates with any Blue Cross Blue Shield plan. Employees will generally pay the same copayment or coinsurance at the time of service as they would pay if they used a local network provider, except in a limited number of states where laws require that the rules of the local Blue Cross plan govern.

The **BlueCard Worldwide** program also helps employees obtain medical care if they need treatment when traveling or living outside the U.S. The COVA Care member handbook includes instructions on how to obtain care outside of the U.S.

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COVA Connect Basic, a Preferred Provider Organization (PPO) plan, is available to active participants and non-Medicare retirees living in the following zip codes:

Chesapeake - 23320 – 23328
Hampton - 23630, 23651, 23661, 23663 – 23670, 23681
Norfolk - 23501 – 23515, 23517 - 23521, 23523, 23529, 23541, 23551
Poquoson - 23662
Portsmouth - 23701 - 23705, 23707 – 23709
Suffolk - 23432 – 23239
Virginia Beach - 23450 - 23467, 23471, 23479

Coverage for out-of-network services is available only in the event of an emergency. An emergency is defined as medically necessary services provided in response to a sudden and acute illness or injury which if left untreated a lay person would think that the emergency would result in death or severe physical or mental impairment.

COVA Connect members should always seek care from a provider that participates with Optima Health. Outside the service area, a member may seek care from a provider who is part of the National Optima Health Network through the **Private Healthcare System (PHCS/Multiplan)**. PHCS/Multiplan is available in the 48 contiguous states, Alaska and Hawaii. A listing of PHCS/Multiplan providers may be found at www.optimahealth.com/COVA. Select “Travel Access/National PPO Network.”

The COVA Connect plan also helps employees obtain medical care if they need treatment when traveling or living outside the U.S. The COVA Connect member handbook includes instructions on how to obtain care outside of the U.S.

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Optional coverage available to COVA Care and COVA Connect participants

Additional coverage options described next are also available for an additional premium.

Expanded Dental Option – COVA Care Basic and COVA Connect Basic plans include coverage for basic diagnostic and preventive dental procedures. Active employees and non-Medicare retirees enrolled in COVA Care or COVA Connect may choose optional expanded dental care benefits for an additional premium if they want a higher level of dental coverage.

Out-of-Network Option – provides limited coverage for services performed by non-network providers.

Vision and Hearing Option – provides coverage for routine vision and hearing services.

The additional coverage options are offered to COVA Care and COVA Connect participants in the following combinations:

- Expanded Dental; or
- Out-of-Network; or
- Expanded Dental and Out-of-Network; or
- Expanded Dental and Routine Vision/Routine Hearing; or
- Expanded Dental, Out-of-Network, and Routine Vision/Routine Hearing.

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Other Plan Choices

As alternatives to COVA Care Basic and COVA Connect Basic with the optional coverages described above, employees and non-Medicare retirees may choose a high deductible health plan or an HMO (if available in their area).

COVA High Deductible Health Plan (HDHP), an Exclusive Provider Organization (EPO) plan, is available statewide to all active participants and non-Medicare retirees. There is no coverage for out-of-network services except for emergency care.

Participation in the COVA HDHP allows employees to set up a Health Savings Account (HSA) through a bank or other financial institution. An HSA is a tax-favored account that allows the participant to make tax-deductible contributions that can be used to help pay for medical expenses.

Kaiser Permanente, Health Maintenance Organization (HMO), is available in northern Virginia and the Fredericksburg area. To be eligible for membership in the Kaiser plan, the employee must live or work within Kaiser's service area. Eligible non-Medicare retirees must live in the service area. Out-of-area services may not be covered except in the case of an emergency.

For more detail on the specific benefits of each COVA Care, COVA Connect or COVA HDHP plan, please refer to the respective member handbook. Or refer to the Evidence of Coverage for the Kaiser plan.

Employees, retirees, or dependents that are eligible for Medicare have other options from which to choose. For more information, please refer to the DHRM Web site, www.dhrm.virginia.gov.

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Available Types of Membership

Once an active employee decides which health plan option is best for his or her own situation, he or she may choose from three types of membership:

Membership type...	Covers...
Single	Only the employee or retiree/survivor/LTD participant
Plus One (or dual)	Covers the employee or retiree/survivor/LTD participant and one eligible family member
Family	Covers the employee or retiree/survivor/LTD participant and all eligible family members

Plan Costs

The State plan contracts are effective July 1 through June 30 each year, and premiums are subject to change beginning July 1. Premium payments are collected from employees during the month of current coverage. For example, an employee who is paid twice a month has half of September's payment deducted from each September paycheck. An employee who is paid monthly has September's payment deducted from the September paycheck.

Coverage is available on a monthly basis only. If an employee works just a portion of a month, the full month's premium still is due.

The plan requires that all employee contributions made to the plan through payroll deduction are on a pre-tax basis. If you have a part-time classified employee whose pay does not support the employee contribution, the employee may pay the contribution to their agency on an after-tax basis with a personal check.

Each year's employee contribution rates are sent to all employees in preparation for the open enrollment period. In addition, each Agency's Benefits Office must provide enrollment materials containing rates to newly eligible employees. You can also refer employees to the DHRM Web site at www.dhrm.virginia.gov for more information about enrollment materials and rates for the various plan options.

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Retroactivity

Limited retroactivity is provided to protect an employee in the instance of agency error in the administration of the employee's health benefits. Agencies have the capability of keying transactions in BES with a retroactive effective date up to 59 days, based on the date the transaction is keyed. All requests for retroactivity beyond the agency's 59-day capability must be submitted to DHRM, in writing, by the agency Benefits Administrator using the *Agency Request for Assistance* form.

There are contractual limitations on retroactivity. The Statewide self-funded plans limit retroactive changes to 12 months. For the HMO, retroactive changes are limited to a period of 60 days. Both self-funded plans and the HMO determine the period of retroactivity based on their receipt of a copy of DHRM's authorization to the agency approving the action.

Agencies should be aware that an employee may wish to seek remedy from the agency in the case of agency error if the period of retroactivity does not afford the employee full remedy. The agency is responsible for handling these requests.

Premium Refunds

Premium refunds to agencies that result from agency error will be based upon a correction of the corresponding BES record. Agencies are limited to 59 days when making corrections to BES. If the BES record does not correspond to the refund request, DOA will not issue a refund. DHRM will not authorize retroactive refunds beyond the 59-day limited retroactivity.