OFFICIAL ANNUAL HEALTH BENEFITS ENROLLMENT INFORMATION

SPOTLIGHT ON YOUR BENEFITS

SPRING 2026

dhrm

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GET READY FOR OPEN ENROLLMENT

MAY 15-29, 2026

EFFECTIVE FOR PLAN YEAR JULY 1, 2026 - JUNE 30, 2027

DHRM OE WEBSITE
https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027

It's Time for Open Enrollment!

Annual Open Enrollment is the time each spring that you can make changes related to your health plan and flexible spending accounts (FSAs). Be sure to consider your options carefully.

STARTING JULY 1, 2026

ALL PLANS

- **Breast Exam Cost Share $0 Before Diagnosis:** Virginia law now requires insurance companies to cover in-network diagnostic or supplemental breast exams (pre-diagnosis) at no member cost.
- **New Prior Authorization Criteria for Weight Loss GLP-1 Medication:** A Body Mass Index (BMI) of 35 or higher is required to obtain a weight loss GLP-1 medication.

COVA CARE

- **$150/$300 Pharmacy Deductible:** New Pharmacy deductible required for Tier 2, Tier 3 and Tier 4 drugs.

COVA HDHP

- **Virtual Care is $0:** Virtual care accessed through the Sydney Health app now $0.

COVA CARE AND COVA HEALTHAWARE

- **Additional Premium Rewards Requirement:** An annual preventive visit, well-adult or well-woman exam is also required.

COVA CARE, COVA HDHP AND COVA HEALTHAWARE

- **New Drug Formulary:** Your plan will cover a new list of prescription drugs.

FLEXIBLE SPENDING ACCOUNTS (FSA)

- **Contribution maximum increases:** You can put aside up to $3,400 Health FSA and $7,500 in the Dependent Care FSA in the 2026-2027 plan year.

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

What to Consider During Open Enrollment

Each year you have choices to make regarding your health benefits and flexible spending accounts (FSAs). If you take no action, your current health plan and membership will continue in the new plan year. **Your FSA must be renewed annually.**

NO ACTION IS REQUIRED IF YOU:

- Have no health plan-related changes,
- Are not enrolling in an FSA, or
- Do not plan to participate in Premium Rewards.

YOU MAY TAKE ACTION TO:

- Enroll in or change your health plan.
- Elect or remove optional buy-ups for COVA Care, COVA HDHP and COVA HealthAware.
- Waive coverage.
- Add or remove family members.

FLEXIBLE SPENDING ACCOUNTS (FSAS)

- Enroll in a Health or Dependent Care FSA or both.
- You must submit an enrollment request every year to have an FSA.

PREMIUM REWARDS

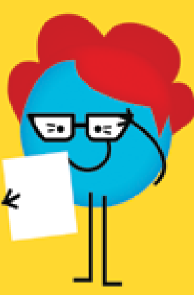
- Eligible members must complete a health assessment and have an annual preventive visit, well-adult or well-woman exam to receive the Premium Rewards incentive.

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 (DHRM) website at https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027. Paper copies of the SBCs are available, free of charge, by emailing ohb@dhrm.virginia.gov.

YOUR HEALTH PLAN CHOICES AND WHERE AVAILABLE

Health Plan Choices	Where Available	
COVA Care	Eligible for Premium Rewards	Statewide and elsewhere
COVA HealthAware	Eligible for Premium Rewards	Statewide and elsewhere
COVA HDHP	Statewide and elsewhere	
Kaiser Permanente HMO	Regional, mostly in Northern Virginia	
Sentara Health Plans HMO	Regional, Greater Hampton Roads and Eastern Shore	
TRICARE Supplement	Statewide and elsewhere for participants or spouses who are military retirees	



Not sure which health plan is the best for you? Talk to ALEX, your online benefits counselor. ALEX evaluates your input and recommends a plan tailored just for you! Visit ALEX at https://start.myalex.com/cova.

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

SUBMITTING YOUR OPEN ENROLLMENT ELECTIONS IN CARDINAL

Make changes related to your health plan coverage and flexible spending accounts (FSA) during the upcoming Open Enrollment (OE) period from Friday, May 15, 2026, to Friday, May 29, 2026. You will use Cardinal HCM to make your online OE elections. First time in Cardinal? Forgot your Cardinal password? Visit www.cardinalproject.virginia.gov/login-help for log-in tips and assistance.

1. Visit https://my.cardinal.virginia.gov to log in.
2. Once in Cardinal, click on the **Human Capital Management (HCM)** link.
3. Click on the **Benefit Details** tile.
4. Click the **Benefits Enrollment** list item (left-hand side of the screen).
5. Click the **Start** (or **Re-Elect**) button to begin the OE process.
6. Click the Medical tile to select or update your health plan.
7. Review your existing dependents covered under your health plan to determine if changes are needed. **If you do not need to add a dependent, skip to Step 29.**

ADD A DEPENDENT

8. Click the **Add Dependent** button.
9. Click the **Add Individual** button.
10. Click the **Add Name** button.
11. Enter your dependent's name information.
12. Click the **Done** button.
13. Input your dependent's **Date of Birth** and **Gender**.
14. Select "Child" or "Spouse" in the **Relationship to Employee**.
15. Select your dependent's marital status using the **Marital Status** dropdown button.
16. The **Student** field defaults to "No". This field is not tracked in Cardinal nor transmitted to the Health Benefits Vendor.
17. The **Disabled** field defaults to "No" and cannot be changed.
18. The **Smoker** field defaults to "Non-smoker". This field is not tracked in Cardinal nor transmitted to the Health Benefits Vendor.
19. If your dependent has the same address as you do, verify that the **Address** section is set to "Same as mine". **Note:** If your dependent has a different address than you, edit accordingly.

Scan the QR Code to watch the Cardinal Open Enrollment tutorial video!

Need additional information? Visit www.cardinalproject.virginia.gov/OE.

20. Click the **Add National ID** button.
21. Complete the **Country, National ID Type, and National ID (SSN)** fields for the dependent.
22. Click the **Done** button.
23. Skip the **Add Phone/Add Email** buttons, this information is not required for dependents.
24. Click the **Save** button in the top right-hand corner. **Note:** If you don't have an SSN for your dependent, you can still save. Your agency Benefits Administrator will contact you later to obtain the SSN.
25. A **Saved Successfully** message displays in a pop-up window.
26. Click the **OK** button.
27. Repeat Steps 8 – 26 as required until all dependents are added.
28. After all dependents are added, click the **Close (X)** icon in the upper right-hand corner.

ENROLL IN HEALTH PLAN

29. Under the Enroll Your Dependents section, choose the blue Enroll checkbox option for the appropriate dependent(s) who should receive coverage. **Note: If you uncheck the dependent, you are removing that dependent from coverage.**
30. Under the **Enroll in Your Plan** section, click the **Select** button to select the applicable Benefits Plan.
31. Click the **Done** button in the upper right-hand corner.
32. The **Medical** tile now displays the coverage selected, the number of dependents enrolled, the Pay Period Cost (or Annual Cost, depending on your agency), and the Status field is updated to "Changed".

ELECT FLEXIBLE SPENDING ACCOUNTS

33. If you are not enrolling in a Flexible Spending Account (FSA), skip to Step 36.

34. Two Flexible Spending Accounts are available: Flex Spending Medical and Flex Spending Dependent Care. **Note:** If you use these plans, **you must re-elect each year!** Repeat this step to elect both FSAs.

- Click the **Flex Spending Medical** tile (or the Flex Spending Dependent Care tile).
- Click the **Select** button to elect Flex Spending Medical (or Flex Spending Dependent Care).
- Enter the amount in the **Annual Pledge** field. The amount entered must be the amount you want to come out of your pay for the entire plan year.
- Click the **Done** button in the upper right-hand corner.

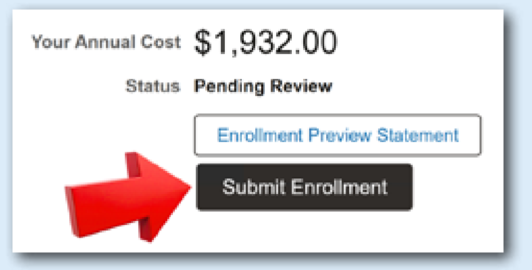
35. Skip the **Flex Spending Admin Fee** tile, this is automatically elected and will show the admin fee associated with your FSA.

FINAL STEPS

36. Confirm your elections by checking the following items:

- **Enrollment Summary**: Total Pay Period Cost
- **Medical tile**: Plan and total dependents enrolled match your coverage elections
- **FSA tiles**: Plan and Pay period cost match your elections

37. Click the Submit Enrollment button to complete Open Enrollment!



DO NOT MISS YOUR OPEN ENROLLMENT DEADLINE!

Submit your online elections in Cardinal beginning May 15 and no later than 11:59 pm EDT on May 29, 2026.

REVIEW YOUR HEALTH BENEFITS CONFIRMATION STATEMENT

After your elections are submitted, an automated email will be sent overnight from Cardinal with the subject line of "Your Health Benefits Confirmation Statement – Now Available Online". You will receive this email whether you or your Benefits Administrator entered your elections. **Log in to** Cardinal and review your confirmation statement to ensure your elections are correct!

At the close of Open Enrollment, **all eligible participants** will receive a confirmation statement, even if you did not make any elections during the open enrollment period. This ensures that all participants have a record of their current benefit status.

Questions?
Contact your agency Benefits Administrator.

DON'T WAIT TO GET INTO CARDINAL!

If it's near the end of the Open Enrollment period (and you haven't tried to access Cardinal) submit a paper enrollment form to your agency Benefits Administrator before the deadline. OHB cannot accept Open Enrollment health plan coverage changes or FSA election requests after the May 29 deadline. See instructions below for submitting a paper enrollment form.

SUBMITTING YOUR OPEN ENROLLMENT ELECTION USING PAPER ENROLLMENT FORM

Complete the fillable form on the DHRM website at https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027. Print, sign and submit it to your Benefits Administrator by the close of business on May 29, 2026! Remember to complete all applicable sections of the enrollment form.

COMPARE PLANS

COMMONWEALTH OF VIRGINIA STATE HEALTH BENEFITS PROGRAM

Proposed 2026 - 2027 Employee Monthly Premiums

Salaried employees **working 30 hours or more a week** pay the "**Employee Pays**" amount.
Salaried employees **working less than 30 hours a week** pay the "**Total Premium**" amount.

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

HEALTH CARE PLANS			2025-2026 MONTHLY PREMIUMS			PROPOSED 2026-2027 MONTHLY PREMIUMS		
			You Only	You Plus One	You Plus Two or More	You Only	You Plus One	You Plus Two or More
COVA Care		Employee Pays	$108	$248	$340	$123	$285	$394
		State Pays	$830	$1,488	$2,179	$973	$1,745	$2,553
		Total Premium	$938	$1,736	$2,519	$1,096	$2,030	$2,947
COVA Care	+ Out-of-Network	Employee Pays	$131	$291	$402	$151	$338	$469
		State Pays	$830	$1,488	$2,179	$973	$1,745	$2,553
		Total Premium	$961	$1,779	$2,581	$1,124	$2,083	$3,022
COVA Care	+ Expanded Dental	Employee Pays	$141	$308	$428	$156	$345	$482
		State Pays	$830	$1,488	$2,179	$973	$1,745	$2,553
		Total Premium	$971	$1,796	$2,607	$1,129	$2,090	$3,035
COVA Care	+ Out-of-Network + Expanded Dental	Employee Pays	$164	$351	$490	$184	$398	$557
		State Pays	$830	$1,488	$2,179	$973	$1,745	$2,553
		Total Premium	$994	$1,839	$2,669	$1,157	$2,143	$3,110
COVA Care	+ Expanded Dental + Vision & Hearing	Employee Pays	$161	$345	$482	$176	$382	$536
		State Pays	$830	$1,488	$2,179	$973	$1,745	$2,553
		Total Premium	$991	$1,833	$2,661	$1,149	$2,127	$3,089
COVA Care	+ Out-of-Network + Expanded Dental + Vision & Hearing	Employee Pays	$184	$388	$544	$204	$435	$611
		State Pays	$830	$1,488	$2,179	$973	$1,745	$2,553
		Total Premium	$1,014	$1,876	$2,723	$1,177	$2,180	$3,164
COVA HealthAware		Employee Pays	$19	$64	$70	$29	$110	$141
		State Pays	$830	$1,511	$2,215	$981	$1,762	$2,579
		Total Premium	$849	$1,575	$2,285	$1,010	$1,872	$2,720
COVA HealthAware	+ Expanded Dental	Employee Pays	$52	$124	$158	$62	$170	$229
		State Pays	$830	$1,511	$2,215	$981	$1,762	$2,579
		Total Premium	$882	$1,635	$2,373	$1,043	$1,932	$2,808
COVA HealthAware	+ Expanded Dental & Vision	Employee Pays	$62	$144	$186	$72	$190	$257
		State Pays	$830	$1,511	$2,215	$981	$1,762	$2,579
		Total Premium	$892	$1,655	$2,401	$1,053	$1,952	$2,836
COVA HDHP		Employee Pays	$0	$0	$0	$0	$0	$0
		State Pays	$739	$1,366	$1,998	$922	$1,708	$2,492
		Total Premium	$739	$1,366	$1,998	$922	$1,708	$2,492
COVA HDHP	+ Expanded Dental	Employee Pays	$33	$60	$88	$33	$60	$88
		State Pays	$739	$1,366	$1,998	$922	$1,708	$2,492
		Total Premium	$772	$1,426	$2,086	$955	$1,768	$2,580
Kaiser Permanente HMO *(available primarily in Northern Virginia)*	+ Expanded Dental & Vision	Employee Pays	$91	$214	$306	$106	$251	$360
		State Pays	$830	$1,479	$2,161	$894	$1,586	$2,317
		Total Premium	$921	$1,693	$2,467	$1,000	$1,837	$2,677
Sentara Health Plans (HMO) *(Hampton Roads/Eastern Shore)*	+ Expanded Dental & Vision	Employee Pays	$91	$214	$306	$106	$251	$360
		State Pays	$816	$1,464	$2,125	$904	$1,617	$2,345
		Total Premium	$907	$1,678	$2,431	$1,010	$1,868	$2,705
TRICARE Voluntary Supplement*		Total Premium	$61	$120	$161**	$61	$120	$161**

** 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*

WHY ARE HEALTHCARE PREMIUMS INCREASING?

Healthcare premiums are determined based on the expenses incurred by the plan, including claim payments and administration. The plan must adjust premiums to ensure adequate funding to cover increasing costs to fund the State Health Benefits Program.

Each year, the State Health Benefits Program reviews the total cost of providing medical, behavioral health, and pharmacy benefits to members. After completing this year's review, we must adjust premiums to ensure the plan remains financially stable and able to meet members' needs.

Several factors are driving this year's premium increase:

- **Higher medical and pharmacy claims**
  Members used more health care services over the past year, including hospital care, outpatient procedures, and specialty medications. These services continue to rise in costs nationwide, and the plan is experiencing the same trend.

- **Rising prescription drug costs**
  Specialty drugs—used to treat conditions such as autoimmune disorders, cancer, and rare diseases and GLP-1 medications – used to treat weight loss. These medications have been the fastest growing cost drivers. Even when used by a small number of members, these medications significantly increase overall plan expenses.

- **Increased use of mental health and preventive services**
  More members are accessing behavioral health care and preventive screenings. While this supports long term improved health, it also increases short term plan costs.

- **Inflation in health care labor and supplies**
  Hospitals, clinics, and pharmacies are facing higher labor, equipment, and supply costs. These increases are reflected in the claims submitted to the plan.

- **Maintaining required financial reserves**
  State law and sound financial practice require the plan to maintain adequate reserves to pay future claims. Premium adjustments help ensure the plan remains stable and compliant with these requirements.

The State Health Benefits Program understands that any increase in premiums affects your household budget. The goal is to continue providing comprehensive, high quality coverage while managing rising healthcare costs responsibly, and being committed to offering a range of plan options that best fits you and your family's needs.

5 WAYS TO SAVE ON HEALTHCARE COSTS

Getting the most from your health plan starts with a few smart choices. Here are five ways to help lower healthcare costs for you and your family this year:

1. Choose doctors and facilities in your plan's network

When you use doctors and hospitals in your plan's network, you'll usually pay less. Before you schedule, confirm they're in your plan's network by checking your health plan app or website.

2. Choose the right place for care

The ER is best for life-threatening emergencies. For most non-emergency needs, you can save money by using your primary care doctor, urgent care, or virtual care. Health plans have virtual care options available on their website or through their app. If it's an emergency, call 911 or go to the ER.

3. Compare costs before you receive care

Prices for labs, procedures, and visits can vary. Anthem and Aetna members can use SmartShopper (a free benefit) to find lower-cost, high-quality options in your area. Learn more at cova.smartshopper.com.

4. Stay up to date on preventive care

Annual checkups and recommended vaccines can help catch issues early before they become more serious and more expensive. Preventive care is covered by insurance, so it's a great way to protect your health and your budget.

5. Stay on track with ongoing conditions

Managing chronic conditions and taking medications as prescribed can help you feel your best and avoid ER visits. Drugs can also cost more or less depending on the tier. Work with your doctor to find the drugs that work best for you while also considering the formulary preferred medications.

2026 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, 2026*	$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	$0	$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					
Deductible - per plan year		$150 one person/ $300 two or more persons on Tiers 2, 3 & 4			
Retail Pharmacy	20% after deductible	Tier 1: $15 Tier 2: $30 Tier 3: $45 Tier 4: $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	Tier 1: $30 Tier 2: $60 Tier 3: $90 Tier 4: $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.

2026 BENEFITS AT A GLANCE

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

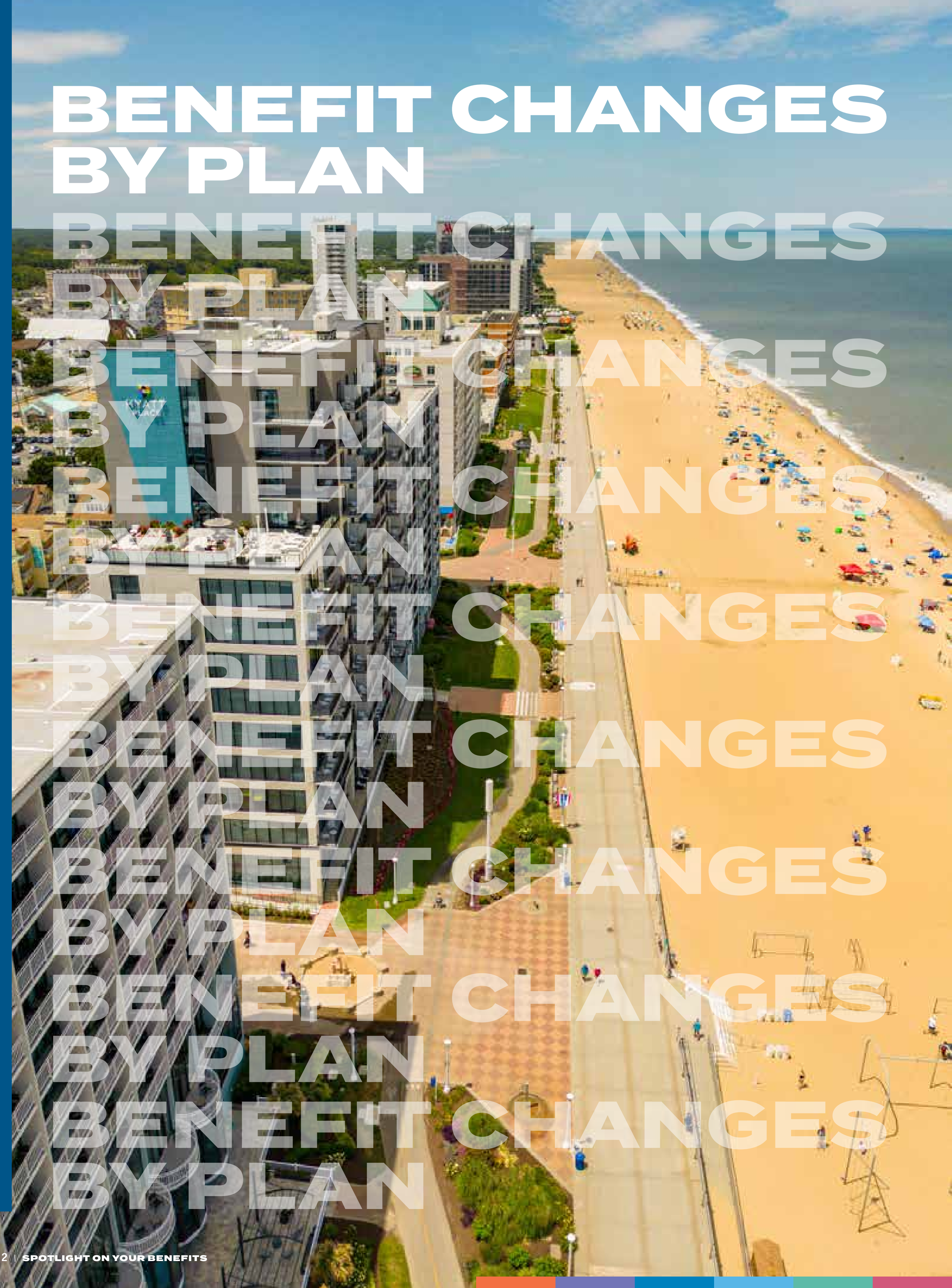
Health Plans	COVA HealthAware	COVA Care	COVA HDHP	Kaiser Permanente HMO	Sentara Health Plans HMO
In-Network Benefits	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Wellness & Preventive Services					
Office visits at specified intervals, immunizations, lab and x-rays	$0	$0	$0	$0	$0
Annual 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.

BENEFIT CHANGES BY PLAN



BENEFIT CHANGES BY PLAN: EFFECTIVE JULY 1, 2026

ALL PLANS

BREAST EXAM COST SHARE $0 BEFORE DIAGNOSIS

Virginia law requires coverage with no cost sharing ($0 member cost) for certain diagnostic or supplemental breast exams performed to help determine whether breast cancer is present (pre-diagnosis). This $0 member cost share applies for in-network providers for the situations below and includes exams performed using diagnostic mammography, breast MRI, or breast ultrasound:

- Diagnostic breast exams to evaluate:
  - An abnormality seen or suspected on a screening exam, or
  - An abnormality found through another type of exam.
- Supplemental breast exams when:
  - No abnormality is seen or suspected, and
  - The exam is based on personal/family history or other risk factors that increase breast cancer risk.

After a diagnosis is made, normal plan benefits apply. Subsequent breast exams may require a copayment, coinsurance and/or apply toward deductible requirements depending on the plan.

COVA HDHP

VIRTUAL CARE VIA SYDNEY HEALTH APP NOW $0

Virtual Care accessed through the Sydney Health app including LiveHealth Online, is now $0 for COVA HDHP members. Previously there was a 20% coinsurance. Secure video visits with board-certified care providers are available for:

- 24/7 Urgent care for coughs, colds, rashes, pink eye, minor cuts, and more.
- Primary care for yearly check-ups and managing chronic health conditions.
- Specialists such as mental health professionals, dermatologists and allergists.

Log into anthem.com or your Sydney Health app, select Care, then Virtual Care.

PHARMACY BENEFIT CHANGES BY PLAN

COVA CARE

PHARMACY DEDUCTIBLE ADDED TO TIERS 2 - 4

A **pharmacy deductible of $150/$300** now applies before your plan will pay anything toward **Tier 2, Tier 3, or Tier 4** prescriptions.

- **The deductible is**
  - **$150 for one person**
  - **$300 for two or more persons**
- You must first pay **the pharmacy deductible out of pocket** before the plan starts sharing the cost for Tier 2–4 drugs. The deductible does not apply to Tier 1 prescriptions.
- **Once you've met the full deductible,** you start paying the normal **tier copay right away** for those drugs.
- Drugs are grouped into four tiers, and each tier has a set copay for a **34-day supply**:

Drug tiers (34-day supply copays)

- **Tier 1:** $15 copay (generic drugs)
- **Tier 2:** $30 copay (lower-cost preferred brand name drugs)
- **Tier 3:** $45 copay (higher-cost non-preferred brand name drugs)
- **Tier 4:** $55 copay (high cost specialty drugs)

Example: One Person with $150 deductible (Tier 3 drug; costs $100 per fill)

First fill (deductible not met yet):

- You pay **$100** (this applies toward the deductible)
- Plan pays **$0**

Second fill (deductible partially met)

- You pay **$50** (fulfills the deductible) + **$45** (Tier 3 copay)
- Plan pays **$5**

Third and future fills (deductible fully met):

- You pay **$45** (Tier 3 copay)
- Plan pays **$55**

IMPORTANT NOTES

- Purchases at a participating retail pharmacy, home delivery pharmacy, or specialty pharmacy all count toward the deductible.
- Amounts you pay toward this deductible also count toward your plan's out-of-pocket maximum.

COVA CARE, COVA HDHP, COVA HEALTHAWARE

UPDATE TO WEIGHT LOSS GLP-1 PRIOR AUTHORIZATION CRITERIA

A Body Mass Index (BMI) of 35 or higher is required to obtain a weight loss GLP-1 medication. Additional Prior Authorization guidelines and criteria will continue to be required. Current utilizers will be subject to the updated BMI criteria once their existing prior authorization (PA) expires.

NEW DRUG FORMULARY

Your drug formulary is changing to the National Direct Preferred formulary, meaning your plan will cover a new list of prescription drugs. Certain brand name drugs will be plan-preferred and cost less than others. Drugs may also change tiers which means their costs may increase or decrease.

If you take a drug that is affected, you will receive a letter in advance with plan-preferred medications that you can discuss with your doctor. If a brand name drug is replaced with another brand name drug, a new prescription will be needed from your doctor. If a brand name drug is replaced with a generic drug, the change may be managed through your pharmacy. You have the option to continue taking the non-preferred medications, but you may need to take steps for additional approvals and potentially pay more. You can view the list of medications that are no longer preferred at anthem.com/cova.

PHARMACY FAQS

Q1: What if my medicine is not on the new formulary?

A1: You can still take your medicine, but you may have to:

- Pay **the full cost**, or
- Pay **more than before, if the drug changes tiers**

Q2: What if my medicine moves from one tier to another?

A2: The member cost will increase or decrease.

Q3: How do I check if my medicine is covered and the new cost?

A3: During open enrollment, the list of impacted drugs is available on anthem.com/cova.

Once the new formulary begins on July 1, 2026, go to anthem.com and follow these steps to see the cost of specific medications and alternatives:

1. Sign in to anthem.com
2. Choose **My Plans**
3. Choose **Pharmacy Benefits**
4. Under **Prescriptions**, choose **Price a Medication**
5. You can see:
   - If your medicine is covered
   - What it may cost
   - Other options if it is not covered

Q4: Is a new prescription needed from my doctor?

A4: It depends. If you take a brand name medication and are switching to another brand name medication, a new prescription is needed from your doctor. If you are switching from a brand name drug to a generic, then the pharmacy may be able to make this change without a new prescription.

Q5: What if no other medicine works for me?

A5: You or your doctor can ask the plan for **preapproval** (also called **prior authorization**). If the plan approves it, you may be able to keep taking your current medicine. Visit anthem.com/pharmacy-information.com for additional information.

Q6: What if I have additional questions about the formulary changes?

A6: If you have additional questions regarding your drugs and the formulary, you can call **Pharmacy Member Services** (the phone number is on the back of your member ID card) or go to anthem.com/pharmacy-information.com.

ADDITIONAL HEALTH PROGRAMS *(Effective April 1, 2026)*

COVA CARE, COVA HDHP, COVA HEALTHAWARE

HELLO HEART

Your health plan has partnered with Hello Heart to support your heart health. Hello Heart is a digital heart health program that helps eligible members track blood pressure and better understand how daily habits impact heart health using an easy-to-use app. Members who qualify receive a Hello Heart blood pressure monitor at no cost. Click here to claim your benefit.

Your kit includes:

- No cost blood pressure and heart rate monitor
- Heart health tracking app
- Personalized feedback & digital coaching
- Secure, detailed reports
- Activity, medication, & cholesterol tracking

It takes minutes to sign up. Your kit ships to your door at no cost. Claim your no cost welcome kit today.

HINGE HEALTH

With Hinge Health, you can get virtual physical therapy and more at no cost to you. Use your benefit to:

- Recover from an injury
- Relieve pelvic pain and discomfort
- Reduce everyday joint and muscle aches
- Improve your balance, strength, and mobility

Work with real people, including a Hinge Health physical therapist, who are dedicated to helping you feel your best.

- A care plan designed for your everyday activities and long-term goals — and to treat multiple areas of your body at once
- Access exercise therapy sessions you can do in as little as 15 minutes — anytime, anywhere with the Hinge Health app
- Get 1-on-1 support from a physical therapist or health coach to tailor your sessions as needed and help you reach your goals

Hinge Health replaces the Sword Virtual Physical Therapy program previously offered through Anthem only. Visit hinge.health/cova to learn more.

VIRTA

Virta is an online health program that helps you improve your metabolic health through simple, sustainable changes to what you eat. Through COVA, eligible members have access to three programs tailored to their needs at no cost:

- **Diabetes Reversal:** A clinically supported program where members work closely with a care team including medical providers and health coaches to reduce or eliminate the need for certain diabetes medications while improving blood sugar through nutrition-first care.
- **Sustainable Weight Loss:** A personalized program where members are supported by health coaches and a clinical team to lose weight and keep it off by addressing the root causes of weight gain without relying on restrictive dieting or medications.
- **Diabetes Management:** Support for members with type 2 diabetes who may not be ready to make significant lifestyle changes but still want to improve blood sugar and A1c, with ongoing guidance from a dedicated care team of clinicians and health coaches.

All programs are delivered virtually and include a dedicated care team of medical providers and health coaches who support you and track your progress from home. Many members see meaningful health improvements, including weight loss, better blood sugar control, and reduced reliance on medications over time.

Virta replaces the Lark Diabetes Prevention Program. previously offered through Anthem only. Learn more at go.virta.com/cova.

EARN PREMIUM REWARDS EVERY MONTH!

Premium Rewards are health plan incentives for COVA Care and COVA HealthAware plan participants who complete a health assessment and the **New Requirement:** an annual preventive visit, well-adult or well-woman exam. An employee or their enrolled spouse **can receive an incentive of $204 annually or $408 annually for both employee and spouse**, beginning July 1, if they fulfill both requirements to earn a Premium Reward.

HOW DO I EARN A REWARD?

To be eligible for the Premium Reward starting July 1, 2026, you must complete the following:

1. **Enrollment:** Be active and enrolled in a COVA Care or COVA HealthAware plan.
2. **New Requirement - Wellness Exam:** Have an annual preventative visit, well-adult or well-woman exam **completed**, **processed and paid**, between January 1, 2025 through May 31, 2026. The annual preventive visit, well-adult or well-woman exam must have been completed under the COVA Care and COVA HealthAware plans. The health plan administrators will send notification of this information. There is no information that you need to provide; however, keep a copy of your Explanation of Benefits (EOB) which shows that your claim has been processed and paid.
3. **Health Assessment:** Complete the health assessment using your health plan's app or website. Complete or update your health assessment between May 1, 2026 through May 31, 2026. Be sure to keep a copy of your confirmation.
   - Enrolled employees and spouses must each register with a separate account with their health plan administrator to submit a health assessment.
   - Current COVA Care or COVA HealthAware members who may be changing their plans for July 1, 2026, will need to complete their health assessment with their current health plan administrator.
   - Employees and/or spouses enrolling for the first time in COVA Care or COVA HealthAware during Open Enrollment may have to wait until July 1, 2026 to complete a health assessment.

   USE YOUR OWN DEVICE: *We strongly encourage participants to use their own personal devices to complete a health assessment since the user can manage limitations such as firewalls and cookies.*

   Participants may receive an error when using a state issued computer to access the health assessment due to the system administrator's limitations.

WHAT IF YOU MISS EARNING A REWARD FOR JULY 1, 2026?

If you do not meet the requirements by May 31, 2026 you can still participate in the Premium Rewards program for July 1, 2026 through June 30, 2027, plan year. The Premium Rewards would be effective after July 1, 2026.

The incentive will only be applied once both requirements have been completed.

ACCESSING THE HEALTH ASSESSMENT

COVA CARE MEMBERS

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

Online

- Log in to www.anthem.com.
- Select **My Health Dashboard** from the top navigation menu and select **Dashboard** from the dropdown 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 will 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 download 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 in to the Sydney Health app.
- From the Sydney Welcome screen, you can click on the "**Menu**" 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 will 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 download 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.

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

COVA HEALTHAWARE MEMBERS

Here are links to access your COVA HealthAware Health Assessment Navigation Guide for the MyActiveHealth Mobile App and the Aetna Member Website. Please refer to these guides for step-by-step instructions for how to access and complete your health assessment, and how to take a screenshot of your health assessment's completion date for your records.

ACCESSING FROM YOUR AETNA MEMBER WEBSITE

Please note: The Aetna Health Your Way platform will experience a system outage from Saturday, May 16, 2026 at 4:00 PM until Sunday, May 17, 2026 at 12:00 PM and Tuesday, May 19, 2026 at 11:00 PM until Wednesday, May 20, 2026 at 6:00 AM. Please plan accordingly.

- Log in to 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 "**Aetna Health Your Way**" in this section
- First time logging in:
  - Enter your information when prompted and accept the Terms and Conditions.
  - You will be automatically prompted to begin your health assessment. Click on "**Update my Health Assessment**" to begin your assessment.
- After the first time logging in:
  - Click "**My Profile**".
  - Click on your "**MyHealth100 Score**" next to your profile picture.
  - Scroll down and click on the "**Health Assessment**" button.

ACCESSING FROM YOUR MYACTIVEHEALTH MOBILE APP

(refer to the MyActiveHealth Mobile App guide for a link/QR code to download the app):

- Log in to the MyActiveHealth mobile app.
- First time logging in:
  - Enter your information when prompted and accept the Terms and Conditions.
  - You will be automatically prompted to begin your health assessment. Click on "**Update my Health Assessment**" to begin your assessment.
- After the first time logging in:
  - Tap on the "**Profile**" tab.
  - Tap on your "**MyHealth100 Score**" next to your profile picture.
  - Scroll down and click on the "**Health Assessment**" button.

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

TO SAVE ON TAXES ENROLL IN A FLEXIBLE SPENDING ACCOUNT (FSA)

Save money on out-of-pocket expenses for health or dependent care by enrolling in an FSA! You can contribute to one or both FSAs if you are eligible for health benefits, even if you are not enrolled in a state health plan.

- Enroll in a Health or Dependent Care FSA or both.
- You must submit an enrollment request each year you wish to have a Health and/or Dependent Care FSA.

WHAT EXPENSES ARE ELIGIBLE?

- **Health FSA:** Use your pre-tax dollars to pay for eligible health care expenses, such as:
  - Copays, coinsurance and deductibles.
  - Other out-of-pocket eligible medical expenses.
- **Dependent Care FSA:** Use your pre-tax dollars for eligible work related dependent care expenses, including:
  - Care for your child under the age of 13.
  - Care for your qualifying child, spouse or relative who is physically or mentally incapable of self-care and lives in your home more than half of the year.

COVA HEALTHAWARE MEMBERS

ENROLLING IN AN FSA

Remember when planning for a Health FSA: The health reimbursement arrangement (HRA) pays first for certain eligible medical and pharmacy expenses.

CONSULT YOUR FSA SOURCEBOOK FOR ASSISTANCE

Review the 2026 Inspira FSA Sourcebook and visit the Inspira website for details about what expenses are eligible, how the accounts work, and more. Visit https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027 or call 855-516-8595.

MAKE IT SIMPLE. PAY WITH YOUR INSPIRA HEALTH FSA MASTERCARD.

Your Health FSA includes an Inspira MasterCard. Once the card is activated, you receive immediate access to your Health FSA funds. Only new participants will receive a new Inspira MasterCard. If you re-enroll in a Health FSA, you can continue to utilize your current Inspira MasterCard until it expires. All others will receive a new Inspira MasterCard.

You simply pay for eligible health care expenses at most merchants where MasterCard is accepted. (Note: MasterCard cannot be used for dependent care expenses.)

- Be sure to pay special attention to Health FSA card transactions that require verification. See the FSA Sourcebook or go to the Inspira website for more information.
- Resolve all card transactions by the end of your runout period.

DON'T LOSE MONEY!

When your current account ends on June 30, 2026, you have until September 30, 2026, to file for reimbursement and resolve outstanding card transactions. (**Note:** If your account ends before June 30, you have three months after your coverage ends to take action.) Submit your reimbursement request and documentation to Inspira. For more information, contact Inspira at 855-516-8595 or inspirafinancial.com.

THINGS TO KNOW ABOUT FSAS

MAXIMUM FSA CONTRIBUTIONS

- **Health FSA:** Increase for 2026! Up to $3,400 per plan year.
- **Dependent Care FSA:** Increase for 2026! Up to $7,500 per plan year depending on your tax filing status.

CALCULATING YOUR FSA CONTRIBUTION

- Decide how much to set aside for the plan year. Use the FSA worksheet at https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027 to determine your annual contribution amount.

ADMINISTRATIVE FEE

- $2.10 deducted monthly on a pre-tax basis for one or both FSAs.

USE IT OR LOSE IT!

- Submit claims for reimbursement by your filing deadline (runout period) or you will forfeit any remaining FSA funds. Your contributions will not roll over to the new plan year.
- If your account is for part of the plan year, you may file eligible FSA claims up to three months after your coverage period ends.
- If your account ends on June 30, 2027, you have until September 30, 2027 to file your claims for reimbursement for dates of service during the plan year ending on June 30, 2027.

IF YOU HAVE DEPENDENT CARE EXPENSES

You are not required to enroll in a Dependent Care FSA for Open Enrollment. If you have a change in dependent care costs, you are allowed to make a corresponding change within 60 days. For example, if your child enrolls in dependent care in the fall, you may enroll in the Dependent Care FSA at that time. Please plan accordingly.

GET TO KNOW YOUR DEPENDENT CARE FSA

You can save money on eligible dependent care expenses that you're paying for out of pocket. With a Dependent Care FSA, you can set aside up to $7,500 of your income per plan year on a pre-tax basis. Use your pre-tax dollars for eligible dependent care expenses provided to your qualifying individual so you (and your spouse if you're married) can work or look for work. A qualifying individual must meet the IRS requirements and include:

- Your dependent child under the age of 13 who lives with you for more than half the year.
- Your spouse or other qualifying dependent who is physically or mentally incapable of self-care and lives with you for more than half the year.

What expenses are eligible for reimbursement under a Dependent Care FSA?

- Preschool or nursery school
- Before and after-school care
- Babysitter (certain rules apply)
- Elder day care for a qualifying individual

What expenses are not eligible for reimbursement under a Dependent Care FSA?

- Out-of-pocket expenses for medical care received by your spouse or dependent.
- Tuition and/or educational expenses (such as summer school and tutoring programs)
- Money paid to your spouse or your child under the age of 19
- Food expenses (unless it can't be separated from care)

Be sure to plan your expenses carefully, as any funds that you do not use will be forfeited to the plan. If you experience a change in the cost of the coverage provided to your dependent during the plan year, you may be eligible to make a corresponding election change.

See the Flexible Benefits Sourcebook for more detailed information on the requirements for a qualifying individual and eligible expenses under the Dependent Care FSA.

ELIGIBILITY AND ENROLLMENT

DEPENDENTS ELIGIBLE FOR COVERAGE AND REQUIRED DOCUMENTATION

LEGAL SPOUSE

Eligibility Definitions

Marriage must be recognized as legal in the Commonwealth of Virginia

NOTE: Ex-Spouses are not eligible, even with a court order

Documentation Required

- Photocopy of certified or registered marriage certificate, and
- Photocopy of the top portion of the first page of the employee's most recent Federal Tax return that shows the dependent listed as "Spouse".

NOTE: All financial information and the Social Security Numbers can be redacted

NATURAL OR ADOPTED SON/DAUGHTER

Eligibility Definitions

A son or daughter may be covered to the end of the year in which they turn age 26

Documentation Required

- Photocopy of birth certificate or legal adoptive agreement showing employee's name

NOTE: If this is a legal pre-adoptive agreement, it must be reviewed and approved by the Office of Health Benefits

STEPSON OR STEPDAUGHTER

Eligibility Definitions

A stepson or stepdaughter may be covered to the end of the year in which they turn age 26

Note: Stepchildren are only eligible, while their natural parent remains eligible

Documentation Required

- Photocopy of birth certificate (or adoption agreement) showing the name of the employee's spouse; and
- Photocopy of marriage certificate showing the employee and the dependent parent's name and
- Photocopy of the most recent Federal Tax Return that shows the dependent's parent listed as "Spouse"

NOTE: All financial information and the Social Security Numbers can be redacted

OTHER FEMALE OR MALE CHILD

Eligibility Definitions

An unmarried child in which a court has ordered the employee (and/or the employee's legal spouse) to assume **sole permanent custody** may be covered until the end of the year in which they turn age 26 if:

- the principal place of residence is with the employee;
- They are a member of the employee's household;
- They receive over one-half of their support from the employee and
- The custody was awarded prior to the child's 18th birthday

Documentation Required

- Photocopy of the Final Court Order granting sole permanent custody with presiding judge's signature

CLARIFICATION ON SUBMITTING REQUIRED ELIGIBLITY DOCUMENTATION

When adding dependents to coverage, supporting documentation is required that provides proof of eligibility. **If you do not have the documentation, do not miss the enrollment deadline, you can still submit your election request. The supporting documentation can be submitted later, even if you obtain the documentation after 30 days. See your agency Benefits Administrator for assistance.**

Health care coverage will not be effective until required documentation is received. See your agency Benefits Administrator for more information.

NOTE: No person can be enrolled in more than one state health benefits plan under any circumstances. If a person is enrolled in error, the plan has the right to take corrective action.

QUALIFIED MID-YEAR LIFE EVENTS OUTSIDE OF OPEN ENROLLMENT

You may make certain election changes during the plan year that are based on certain qualified mid-year life events. These include events such as a birth, marriage, or divorce. For a complete list of qualified mid-year life events, visit the DHRM website. You must submit your election change request and supporting documentation within 60 calendar days of the event. **The countdown begins on the day of the event. If you do not have the documentation, do not miss your deadline. The supporting documentation can be submitted later, even if you obtain the documentation after 30 days. See your agency Benefits Administrator for assistance.**

Health care coverage **will not** be effective until approved documentation is received. See your agency Benefits Administrator for more information.

REMOVE INELIGIBLE DEPENDENTS

Only family members who meet the eligibility definition can be covered. You are required to remove dependents that do not meet the plan's eligibility requirements. Outside of Open Enrollment, you have 60 calendar days to submit the enrollment action to remove an ineligible dependent. **The countdown begins on the day of the event.**

Employees who enroll or fail to remove ineligible persons within the 60-day window may be subject to penalties including exclusion from the health benefits program for up to three years.

Contact your agency Benefits Administrator or visit the DHRM website for more information.

MOVING IN/OUT THE SERVICE AREA?

Sentara Health Plans and Kaiser Permanente are regional health plans that require you to **live or work in the service area to enroll and maintain coverage**. If you no longer live or work in the service area the **health plan coverage will terminate on the first day of the month following the change. You have 60-days from the address or work location change to enroll in a new health plan. If a new election is not submitted, you will have no health plan coverage.** Your next opportunity to make an election will be with a consistent qualifying mid-year life event or at the next Open Enrollment. Check the zip codes for the plan's service area at the Sentara Health Plans or Kaiser Permanente website, or contact your agency Benefits Administrator.

HEALTH BENEFITS AND FSAS QUESTIONS AND ANSWERS

Q1: Do I need to do anything during the Open Enrollment period?

A1: No election is required if you have no health plan coverage changes, are not participating in Premium Rewards, and are not enrolling in a Flexible Spending Account (FSA).

- You must submit an enrollment request every year to have an FSA. Please see page 19 for more information.
- You will need to take action to access or continue the Premium Reward for the 2026-2027 plan year. Please see page 17 for more information.

Even if you do not plan to make changes, we recommend logging into Cardinal (https://my.cardinal.virginia.gov) to review your current health benefit elections.

Q2: How do I determine my current health plan?

A2: You can log into Cardinal HCM at my.cardinal.virginia.gov and from the Cardinal Homepage select the 'Benefit Details' tile to review your current health benefits summary or contact your Benefits Administrator.

Q3: This is my first time logging in to Cardinal. What do I do?

A3: Depending on your agency and the email address on your employee profile (personal or agency-provided), you may need to register your account before you can log in for the first time.

To get started:

- **Confirm your email address:** Contact your HR Administrator to verify the email on your Cardinal record and whether registration is required.
- **Register your account (if needed):** Follow the Cardinal Active Employees Registration Guide, available on the Cardinal Login Help webpage.

Q4: I'm having trouble logging in to Cardinal. What should I do?

A4: If you are experiencing issues such as a forgotten password or other login problems, visit the Cardinal Login Help page for assistance.

Q5: Open Enrollment (OE) is almost over and I cannot access Cardinal. What should I do?

A5: If you cannot access Cardinal, you may still complete your enrollment by submitting a paper enrollment form to your agency Benefits Administrator before the May 29 deadline.

Important: Health plan changes and FSA elections cannot be accepted after Open Enrollment ends on Friday, May 29.

Q6: What if I want to add an eligible dependent to my health plan but I do not currently have the required documentation?

A6: You need to make your election request from May 15, 2026 to May 29, 2026. Do not miss the Open Enrollment deadline. The documentation can be submitted later, even if you obtain the documentation after 30 days. See your agency Benefits Administrator for assistance. See page 21 for additional details.

Note: Health care coverage **will not** be effective until approved documentation is received. See your agency Benefits Administrator if you have questions.

Q7: Can I add my dependent that is age 26?

A7: Dependents that reach age 26 during the 2026 calendar year may be enrolled during Open Enrollment. However, the dependent will be automatically removed from coverage on December 31, 2026. If you receive an error, you will need to submit a paper enrollment form to your agency. Please contact your agency Benefits Administrator.

Q8: Do I need to remove my dependent child that is age 26 this calendar year?

A8: No. There is no requirement for you to remove your dependent during Open Enrollment or the month that the dependent turns age 26. Eligible dependents remain eligible under the State Health Benefits Program until the end of the calendar year in which they turn age 26. These dependents will automatically be removed from coverage on December 31, 2026.

Q9: Can I enroll a dependent that is already enrolled in another Commonwealth of Virginia State Health plan?

A9: No person can be enrolled in more than one state health plan under any circumstances. A corresponding election to remove the dependent from the other state health plan must be made if you wish to enroll the dependent.

Q10: Can my spouse and I both enroll in a Flexible Spending Account (FSA)?

A10: **Health account** - Yes, both you and your spouse can have a health FSA and contribute up to the employer's health FSA plan year maximum.

Dependent care account - Yes, depending on your tax filing status and in accordance with the IRS limits.

Note: You and your spouse cannot submit the same expenses for reimbursement.

Q11: Once the new plan year starts, can I use my FSA MasterCard to pay for expenses from the last plan year?

A11: No. You may not use your FSA debit card after June 30, 2026 to pay for expenses from the 2025-2026 plan year. You may only use your FSA MasterCard for expenses incurred on or after July 1 of each plan year. After June 30, you must file paper claims for reimbursement of the previous plan year's expenses.

Q12: How will I know if my Open Enrollment elections were submitted successfully?

A12: You will receive an automated email from Cardinal HCM overnight directing you to log into Cardinal HCM to review your Open Enrollment confirmation statement. You can log into **Cardinal HCM** at https://my.cardinal.virginia.gov and from the Cardinal Homepage select the 'Benefit Details' tile followed by 'Benefit Statements' to review your confirmation statement.

At the close of Open Enrollment, all eligible participants will receive a confirmation statement, even if you did not make any elections during the Open Enrollment period. This ensures that all **eligible participants** have a record of their current benefit status.

If you do not receive notification after submitting your election, please contact your Benefits Administrator.

Q13: What should I do if I missed the Open Enrollment deadline?

A13: The last day to make an Open Enrollment election, including FSA elections, is May 29, 2026. We are unable to accept health plan coverage changes or FSA election requests after the deadline. Your next opportunity will be at Open Enrollment 2027 or with a consistent qualifying mid-year life event. Your health plan elections will remain as designated now if you did not make any changes. Since members **must re-enroll** every year for FSAs, you will not be enrolled in an FSA for the new plan year.

BENEFITS FOR EVERYONE

SIGN-UP TO RECEIVE TEXT MESSAGES TO YOUR SMARTPHONE!

You can 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.

HELP WITH LIFE'S CHALLENGES BIG AND SMALL!

GET TO KNOW YOUR EMPLOYEE ASSISTANCE PROGRAM/EAP

It's important to take the time to care for your mental and emotional well-being. EAP is designed to help you with life's challenges, big and small. EAP is **entirely confidential**, and available to employees and their household members. Take advantage of **up to 4 no-cost counseling visits*** per issue per plan year whether face-to-face, telephonic, or virtual visits. Speak with a trained counselor or therapist about anxiety, grief, depression, family conflict, or work-life balance. In addition to providing support during life's tough moments, EAP provides quick and easy access to no-cost, short-term, solution-focused resources to help meet the challenges of everyday life.

Contact EAP to access services like:

- Financial counseling and free online resources
- Legal services and free forms including wills, advance directives, bills of sale, etc.
- Child and elder care referral resources
- Pet care resources

Contact your health plan for additional information regarding coverage and additional EAP offerings.

* Sentera Health Plan HMO members have up to 5 no-cost counseling visits.

EAP SERVICES ARE FOR EVERYONE.

Anthem's Employee Assistance Program (EAP) is available to all wage employees—including those who are not eligible for benefits, those with a TriCare supplement, and those who waived medical coverage. You and your household members can use EAP services even if you do not have medical insurance.

What's included:

- Up to 4 free counseling sessions (online or in person) per issue, per year for employees and household members
- Additional well-being tools and resources on the EAP website

Visit anthemeap.com/cova or call 855-223-9277.

THE COMMMONWEALTH OF VIRGINIA'S EMPLOYEE WELLNESS PROGRAM

wellness@dhrm.virginia.gov

commonhealth.virginia.gov

HEALTH EDUCATION CAMPAIGNS

Get wellness topics delivered to your agency or team by your regional CommonHealth Wellness Consultant. To schedule, contact your CommonHealth Agency Coordinator (or HR Benefits Administrator). Not sure who that person is Email wellness@dhrm.virginia.gov to find out.

WEEKLY WELLNOTES

Employees receive a weekly newsletter with information on a variety of wellness topics and upcoming events right in their email inbox. Not receiving them? Email wellness@dhrm.virginia.gov to get on the list.

WELLNESS CHAMPION AWARD

Nominate a Commonwealth of Virginia employee who has made significant changes in their health behavior, motivated others to make healthier choices, or helped create a culture of wellness in the workplace or beyond. See eligibility details and submit a nomination at commonhealth.virginia.gov/wellnesschampions.html.

MINUTE WITH A MANAGER EMAILS

Managers and supervisors get monthly messages with quick tips to help create a workplace culture of wellness. Sign up at forms.office.com/g/661fGes4LM .

WELLNESS WEDNESDAYS EMAILS

Get weekly messages with tips, tricks, information, and puzzles to help you make healthy choices. Register at forms.office.com/g/tnhiia6U1C.

WEIGHT WATCHERS DISCOUNT

Benefits-eligible Commonwealth of Virginia employees, spouses,and adult dependents (18+) get 50% off the retail price and can join Weight Watchers for as low as $9.75 per month. Sign up at www.weightwatchers.com/us/commonhealth.

FACEBOOK

Get wellness tips and info on events and programs by following CommonHealth at https://www.facebook.com/CommonHealthVA.

YOUTUBE

Access a variety of short, informative videos to support you in your wellness journey and add more movement, relaxation, & knowledge to your day. Visit youtube.com/@commonhealthva9169/videos.

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. Your SPDs can be obtained on the Department of Human Resource Management's website at www.dhrm.virginia.gov; You may also request a paper copy free of charge by emailing obh@dhrm.virginia.gov. 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 website 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 provide important protection for you and your family in 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 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.

If you would like more information on WHCRA benefits, contact your Benefits Administrator or DHRM.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

Effective January 1, 2010, GINA prohibits health coverage and employment discrimination against a Plan participant based on his or her genetic information. Genetic information generally includes family medical history and information about an individual's and his or her family members' genetic tests and genetic services. Under GINA, group health plans and health insurers providing group health plan coverage cannot use genetic information with respect to eligibility, premiums or contribution amounts. They also cannot request, require or purchase genetic information prior to a person's enrollment in a health care plan or request or require genetic testing of an individual for underwriting purposes. The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential, as required by GINA and the Health Insurance Portability and Accountability Act of 1996.

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 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.

NOTICES REGARDING WELLNESS PROGRAM

PLAN YEAR JULY 1, 2026 THROUGH JUNE 30, 2027

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 and annual physical/wellness exam by employees/retirees and their enrolled spouses in the COVA Care or COVA HealthAware Plans are the two requirements that will result in earning a premium reward. You are not required to complete the HRA or to participate in other medical examinations. Although you are not required, employees/retirees and enrolled spouses who choose to participate in the wellness program by completing the HRA and an annual physical/wellness exam will earn an incentive of $17 per month. The premium reward will be effective based on the date both requirements are satisfied and the claim processed.

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." 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, based on participation and compliance
Completion of Designated Health Activities (Do-Rights)	Contribution to the Health Reimbursement Arrangement, depending on plan design, based on completion

The following are the medical plan claims administrators that administer wellness programs:

Plan	Claims Administrator
COVA Care	Anthem Blue Cross and Blue Shield
COVA High Deductible Health Plan (HDHP)	Anthem Blue Cross and Blue Shield
COVA Health Aware	Aetna

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 January 31, 2026. 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
Louisiana Medicaid Website:
https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line:
1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

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)

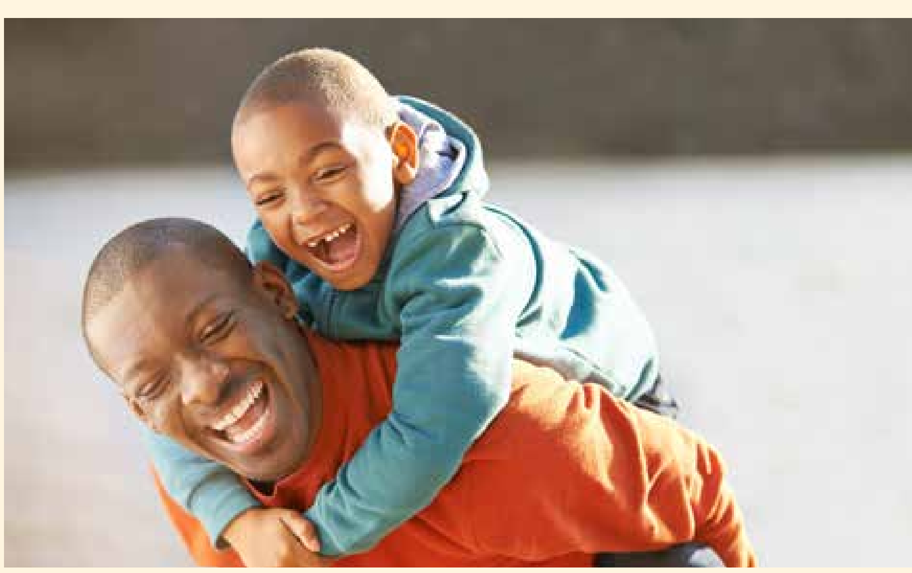
WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

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 January 31, 2026, 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.

dhrm
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 and Well-being Coach: **844-507-8472** • Building Healthy Families: www.anthem.com (or the Sydney mobile app) > My Health Dashboard > Programs - **833-812-1776**
	Shared Savings Incentive Program – SmartShopper: https://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) – Resources for Living: 888-238-6232 or www.resourcesforliving.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 or MyActiveHealth mobile app) > Health & Wellness > Aetna Health Your Way
	Health and Wellness Programs - **855-414-1901** or log in at www.aetna.com > Member Resources > Well-being Resources
	Shared Savings Incentive Program – SmartShopper: https://cova.smartshopper.com/ or Aetna: **833-849-0567**
Available to COVA Care, COVA HDHP and COVA HealthAware	Virta Member Support Email: support@virtahealth.com
	Hello Heart Member Support Email: support@helloheart.com Phone: **800-767-3471**
	Hinge Health Member Support Email: help@hingehealth.com Phone: **855-902-2777**
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 https://myhealth.kaiserpermanente.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)
Flexible Spending Accounts (FSA)	Inspira Financial FSA: **855-516-8595** (TTY:711) or inspirafinancial.com
Open Enrollment Information	Cardinal HCM: https://my.cardinal.virginia.gov/
	https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027 Office of Health Benefits: openenrollment@dhrm.virginia.gov Having problems with Cardinal? Contact your **Benefits Administrator**

OFFICIAL ANNUAL HEALTH BENEFITS ENROLLMENT INFORMATION

EFFECTIVE FOR PLAN YEAR JULY 1, 2026 – JUNE 30, 2027

OPEN ENROLLMENT

MAY 15–29, 2026

DHRM OE WEBSITE

https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027

(formerly known as Twitter):

https://twitter.com/VirginiaDHRM

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