

OFFICIAL ANNUAL HEALTH BENEFITS ENROLLMENT INFORMATION



ANNUAL OPEN ENROLLMENT

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

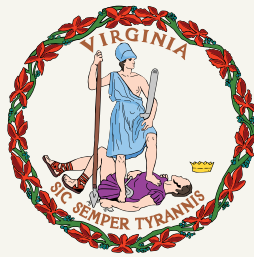
MAY 15 - 29, 2026



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



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COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

YOUR ANNUAL OPEN ENROLLMENT

Your Open Enrollment will take place from **May 15 through May 29** and provides your annual opportunity to make changes to your non-Medicare-coordinating health plan and membership level (as allowed by eligibility policy). Changes will be effective for plan year July 1, 2026 – June 30, 2027. This booklet includes information about coverage options in the new plan year. Other resources to help you make your Open Enrollment decision include:

- A **2026 BENEFITS AT A GLANCE** comparison of available plan benefits.

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

This Open Enrollment period does not apply to participants in Medicare-coordinating plans (Advantage 65 and Medicare Supplemental/Option II Plans). Medicare-eligible Retirees, Survivors and Long Term Disability enrollees who cover non-Medicare-eligible family members may use this information to make changes on behalf of their non-Medicare covered family members.

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

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

An Equal Opportunity Employer

Proposed Monthly Premium Costs

Effective July 1, 2026



The following chart includes your plan choices and monthly premiums starting July 1, 2026. If you enroll in either a COVA Care or COVA HealthAware Plan, the premiums (see shaded premiums) can be reduced by completing the requirement to earn a Premium Reward. More detailed information about starting or continuing Premium Rewards can be found on page 5.

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

PLANS		Single	Two-Person	Family
COVA Care (with preventive dental)		\$1,096	\$2,030	\$2,947
COVA Care	+ Out-of-Network	\$1,124	\$2,083	\$3,022
COVA Care	+ Expanded Dental	\$1,129	\$2,090	\$3,035
COVA Care	+ Out-of-Network + Expanded Dental	\$1,157	\$2,143	\$3,110
COVA Care	+ Expanded Dental + Vision & Hearing	\$1,149	\$2,127	\$3,089
COVA Care	+ Out-of-Network + Expanded Dental + Vision	\$1,177	\$2,180	\$3,164
COVA HealthAware (with preventive dental)		\$1,010	\$1,872	\$2,720
COVA HealthAware	+ Expanded Dental	\$1,043	\$1,932	\$2,808
COVA HealthAware	+ Expanded Dental & Vision	\$1,053	\$1,952	\$2,836
COVA HDHP (with preventive dental)		\$922	\$1,708	\$2,492
COVA HDHP	+ Expanded Dental	\$955	\$1,768	\$2,580
Kaiser Permanente HMO*	+ Expanded Dental & Vision	\$1,000	\$1,837	\$2,677
Sentara Health Plans (HMO)*	+ Expanded Dental & Vision	\$1,010	\$1,868	\$2,705
TRICARE Voluntary Supplement**		\$61	\$120	\$161***

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

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

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

REMINDERS

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

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.



EARN PREMIUM REWARDS EVERY MONTH!

Non-Medicare retiree group enrollees and non-Medicare-eligible covered spouses in the COVA Care or COVA HealthAware Plans are eligible to earn Premium Rewards by completing an online health assessment and the **New Requirement**: an annual preventive visit, well-adult exam or well-woman exam. Monthly premium cost in either a COVA Care Plan or a COVA HealthAware Plan will be reduced by \$17 per month when the requirement is met by the retiree or their enrolled spouse, or \$34 per month if the requirement is met by both the retiree and spouse.

Remember, you must be active and enrolled in COVA Care or COVA HealthAware to be eligible for a reward. Enrolled non-Medicare retiree group participants and spouses must register with a separate account to submit a health assessment. Enrollees and/or spouses enrolling for the first time in COVA Care or COVA HealthAware during Open Enrollment may have to wait until July 1, 2026, to complete 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 assessment with their current health plan administrator.

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 January 1, 2025 through May 31, 2026. Be sure to keep a copy of your confirmation.
 - Enrolled retirees 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.
- Retirees 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.*

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 Premium Reward 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.



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) <i>Employer deposit to your HRA on July 1, 2026</i>	\$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	<i>Optional Benefit**:</i>	<i>Optional Benefit**:</i>	<i>Optional Benefit**:</i>	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	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>	<i>Included with Medical:</i>
• Annual Routine Vision Exam	\$0	\$15	\$15	\$25 PCP/\$40 specialist	\$15
• Eyeglass frames	65% of the retail price	80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses	80% of the retail price, OR 65% of the retail price when purchased as a complete pair of eyeglasses	Balance after plan pays \$75 (age 19+) <19 \$0 (1 pair/plan year)	80% after plan pays \$100
• Eyeglass lenses - standard plastic - Single - Bifocal - Trifocal	\$40 \$60 \$80	\$50 \$70 \$105	\$50 \$70 \$105	Balance after plan pays \$75 (age 19+) <19 \$0 (1 pair/plan year)	\$20 \$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	<i>Optional Benefit**:</i>	<i>Optional Benefit**:</i>			
• Eyeglass frames	80% after plan pays \$100	80% after plan pays \$100	Not available	Not available	Not available
• Lenses - Eyeglass lenses (standard plastic, single, bifocal or trifocal) or	\$20	\$20	Not available	Not available	Not available
• Contact lenses** - Conventional** - Disposable** - Non-elective**	85% of the retail price Balance after plan pays \$100 Balance after plan pays \$250	85% of balance after plan pays \$100 Balance after plan pays \$100 Covered in full	Not available	Not available	Not available
Routine Hearing	<i>Included in Basic Plan:</i>	<i>Optional Benefit**:</i>		<i>Included in Basic Plan:</i>	<i>Included in Basic Plan:</i>
• Routine hearing exam (once every plan year)	\$0	\$40	Not available	\$25 PCP / \$40 Specialist	\$40
• Hearing aids and other hearing-aid related services*	Not available	Balance after plan pays \$1,200 (once every 48 months)	Not available	Not available	Balance after plan pays \$1,200 (once every 48 months)
• Benefit maximum	Not available	\$1,200	Not available	Not available	\$1,200 Adults
Out-of-Network	<i>Included in Basic Plan:</i>	<i>Optional Benefit**:</i>	<i>Included in Basic Plan:</i>		
	Additional deductible and out-of-pocket limits apply. 40% coinsurance after deductible of \$3,000/\$6,000. Balance billing may apply.	Plan payment reduced by 25%. Balance billing may apply.	Additional deductible and out-of-pocket limits apply. 30% coinsurance after deductible of \$1,750/\$3,500. Balance billing may apply.	Not available	Not available. Out-of-area Dependent Children Program available. See plan's website for form.

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

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

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



NEW IN 2026
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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](https://www.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](https://www.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](https://www.anthem.com/cova).



Once the new formulary begins on July 1, 2026, go to [anthem.com](https://www.anthem.com) and follow these steps to see the cost of specific medications and alternatives:

1. Sign in to [anthem.com](https://www.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](https://www.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](https://www.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.



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 retirees 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.

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



ENROLLMENT
CHANGES

**ENROLLMENT
CHANGES**

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MAKE OPEN ENROLLMENT CHANGES

If you wish to make a plan or membership change during Open Enrollment, you must complete a State Health Benefits Program Enrollment Form for Retirees, Survivors and LTD Participants. The forms are available online in a fillable format on the DHRM website at <https://www.dhrm.virginia.gov/employment/benefits/open-enrollment-2026-2027-for-non-medicare-retirees>.

Completing the form:

- Indicate “*Open Enrollment*” as the reason for your change.
- Sign the completed form. **The Enrollment form must be signed by the eligible Enrollee.**

This is either the Retiree, Survivor, or Long Term Disability participant through whom eligibility for coverage is obtained - **not a covered family member**. Even those covered family members who have separate/individual ID numbers must have their enrollment forms signed by the Enrollee. Enrollment Forms will not be accepted if not signed by the Enrollee.

- Follow the mailing instructions on the form to submit your changes to your Benefits Administrator.
- **Forms must be postmarked no later than May 29, 2026, to be accepted.**

If you make a plan change, be sure that you understand the provisions of the plan that you choose. **After the Open Enrollment period ends, you may not revise your Open Enrollment election because you changed your mind, or you completed the form incorrectly.**

If you are requesting a membership increase, you must include documentation to support eligibility for the new family member. For example:

- To add an existing spouse, you must provide photocopies of the certified marriage certificate and the top portion of the first page of the retiree group Enrollee’s most recent Federal Tax Return that confirms the spouse (all financial information and Social Security Numbers should be removed).
- To add a natural or adopted child, you must include a photocopy of the birth certificate showing the retiree group Enrollee’s or spouse’s name as the parent or a photocopy of a legal pre-adoptive or adoptive agreement.

For other eligible membership additions, contact your Benefits Administrator to confirm the necessary documentation. Supporting documentation must be received by the end of the Open Enrollment period. If it is not received, your membership increase will not be processed.

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



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RETIREE GROUP NEWS AND REMINDERS

MEMBER HANDBOOKS

YOUR MEMBER HANDBOOK IS ONLINE!

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

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

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

Department of Human Resource Management's website at <https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027-for-non-medicare-retirees>. Paper copies of the SBCs are available, free of charge, by emailing ohb@dhrm.virginia.gov.

IMPORTANT!

WHEN YOU BECOME ELIGIBLE FOR MEDICARE

When Retiree Group Enrollees (Retirees, Survivors, Long Term Disability Participants) or their covered family members become eligible for Medicare, Medicare becomes the primary health plan, and they must make a decision as to whether they wish to maintain secondary coverage under the State Retiree Health Benefits Program or terminate that coverage. In most cases, Medicare-eligible participants will be contacted through the Enrollee and provided with their options approximately three months in advance of their Medicare eligibility date due to age. If no positive election is made, they will be automatically moved to the Advantage 65 with Dental/Vision Plan, a Medicare supplemental plan that includes Medicare Part D prescription drug coverage (contingent upon approval by Medicare), dental and vision.

Even though the state program makes every effort to identify participants who become eligible for Medicare, it is the responsibility of the Enrollee to ensure that any participants who become eligible for Medicare are moved to Medicare-coordinating coverage immediately upon Medicare eligibility. Failure to move to Medicare-coordinating coverage immediately upon eligibility for Medicare can result in retraction of primary payments made in error and a gap in coverage. The state program will not make primary claim payments when Medicare should be the primary coverage. Contact your Benefits Administrator if you need additional information.

Some important things to consider when making this coverage decision:

- If you wish to select your Medicare-coordinating plan through the state program, you must enroll in Medicare Parts A and B (Original Medicare) in order to get the full benefit of the Advantage 65 Plans, the state program's Medicare supplemental coverage. Failure to enroll in Medicare Parts A and B can result in a significant deficit in your coverage since Advantage 65 will not pay claims that Medicare would have paid had you been enrolled.
- As a Medicare-eligible participant, you may select from available Advantage 65 Plans.
- If an Enrollee requests termination of coverage in the State Retiree Health Benefits Program, he or she may not re-enroll. Termination of the Enrollee will result in termination of all covered family members. For more information about Medicare and the State Retiree Health Benefits Program, go to www.dhrm.virginia.gov and look for Retiree Fact Sheets.

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

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

Prompt Payment of Premiums – Enrollees are responsible for timely payment of their monthly premiums (either through VRS retirement benefit deduction or by direct payment to the billing administrator). Participants who pay directly receive monthly bills or coupons which indicate when premium payments are due. Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Claims paid during

any period for which premium payment is not received will be recovered. Once an Enrollee and/or his/her covered family members have been terminated for non-payment of premiums, re-enrollment in the state program is not allowed except at the sole discretion of the Department of Human Resource Management.

Enrollees are responsible for understanding the amount of their premium and for notifying their Benefits Administrator within 60 days of any life event/qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the Enrollee to advise the program of membership reductions may result in loss of the overpaid premium amount.

Address Changes – Please let your Benefits Administrator know when you move and contact them immediately to make an address correction, including an updated telephone number. If you have an email address, you may ask to have it included in your eligibility record. Failure to update your mailing address can result in missing important information about your health benefits program. The Department of Human Resource Management will not be responsible for information that participants miss, including billing statements, because their address of record is incorrect. The Department's only means of reaching many retiree group participants is through the US Postal Service.

If You Need Help – Retiree group participants should contact their Benefits Administrator with enrollment and eligibility questions. Benefits Administrators are generally unable to assist with claim or coverage problems, and those questions should be directed to your claims administrator.

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

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

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



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 ohb@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 Health 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](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.flmedicaidprecovery.com/flmedicaidprecovery.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: KIHIPPPROGRAM@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: masspreassistance@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: HSHIPPProgram@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://dhcnp.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.ncdhs.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 \(CHIP\) \(pa.gov\)](https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html)

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 Rlte 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](https://www.healthinsurancetexas.gov/health-insurance-premium-payment-hipp-program)

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](https://www.healthinsurancetexas.gov/health-insurance-premium-payment-hipp-program)

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.



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 <ul style="list-style-type: none"> • 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 <i>(Primarily Northern Virginia - see website for specific zip codes)</i>	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 <i>(Greater Hampton Roads and Eastern Shore See website for specific zip codes)</i>	Medical, Prescription Drug, Dental, Vision and Behavioral Health - Sentara Health: 866-846-2682 , www.sentarahealthplans.com/cova or members@sentara.com
	Online doctor visit: MDLIVE or 866-648-3638
	Employee Assistance Program (EAP): www.sentaraeap.com (User name: COVA) or 800-899-8174
TRICARE Supplement	Selman & Company (SelmanCo): 800-638-2610 (press Option 1)
Open Enrollment Information	https://www.dhrm.virginia.gov/employeebenefits/open-enrollment-2026-2027-for-non-medicare-retirees

OFFICIAL ANNUAL HEALTH BENEFITS ENROLLMENT INFORMATION



ANNUAL OPEN ENROLLMENT

MAY 15 - 29, 2026



Commonwealth of Virginia
Office of Health Benefits
Department of Human Resource Management
Main Street Centre
600 East Main Street, 17th Floor
Richmond, VA 23219