



State Health Benefits Program Eligibility, Elections And Enrollment Information For Employees

Overview

The following is a general description of the Commonwealth of Virginia's State Health Benefits Program eligibility and enrollment information for employees. It is not intended to replace member handbooks and other plan documents. Please read this information thoroughly before making any election and keep pages 1-4 for quick reference.

Employees are responsible for reviewing plan documents and becoming knowledgeable about their benefits. For more detailed information or clarification, visit the DHRM Web Site at www.dhrm.virginia.gov or contact your Benefits Administrator.

Participation in the State Health Benefits Program is subject to current program provisions, state and federal laws and regulations, and plan availability. The Commonwealth reserves the right to change your enrollment to ensure compliance.

Who Is Eligible?

All full-time or part-time, salaried, classified employees or regular, full-time or part-time, salaried faculty members are eligible for the health benefits program.

What Election Choices are Available?

Flexible Reimbursement Accounts allow you to set aside part of your salary each pay period before taxes. The minimum deposit is \$10 per pay period and the maximum deposit is up to \$5,000 annually. There is a monthly \$3.67 pre-tax administrative fee for one or both accounts.

- A **Medical Reimbursement Account** provides reimbursement for certain expenses incurred by you and your eligible family members. Included are eligible medical, dental and vision care expenses not covered by your health plan.
- A **Dependent Care Account** provides reimbursement for eligible expenses for the care of your child (age 12 or under), disabled spouse, elderly parent or other dependent incapable of self-care.

Important Things To Know About Flexible Reimbursement Accounts:

- Enrollment in a flexible reimbursement account authorizes the reduction of the gross salary by the elected reimbursement account contributions as indicated for the duration of the coverage period.
- A flexible reimbursement account election may not be revoked, changed, or modified during the plan year unless the revocation and new election are on account of and consistent with a qualifying mid-year event.
- Any amount remaining in a flexible reimbursement account not used for qualifying expenses incurred during your coverage period is forfeited.
- A flexible reimbursement account must only be used to pay for IRS-qualified expenses and only for IRS-eligible dependents.
- Enrollees must exhaust all other sources of reimbursement (including those provided under an employer's plans) before seeking reimbursement from a flexible reimbursement account. They may not seek reimbursement through any other source.
- Enrollees must collect and maintain sufficient documentation to validate reimbursement from a flexible reimbursement account.

Health Care Coverage provides you medical, dental, pharmacy, and behavioral health services. Certain family members who meet eligibility requirements may also be covered:

Legally married spouse

- A court order to provide coverage for a divorced spouse does not make the ex-spouse eligible for coverage under your health care plan.

Dependent child

- A dependent child is defined as: your biological child, your legally adopted child, your stepchild living with you in a parent-child relationship, a child placed in your home under a pre-adoptive agreement approved by the State Health Benefits Program, or a child placed in your home under a permanent court order granting you sole custody.
- *To be eligible*, a dependent child also must be unmarried, live at home or away at school and receive over one-half of his or her support from the employee. In the case of natural or adopted children, living at home may mean living with the other parent. *With supporting documentation, the program may determine when other children may qualify as dependent children.* Dependent children meeting eligibility requirements may be covered to the end of the year in which they turn 23.

Dependent child age 23 or older with a qualifying incapacitation

- An incapacitated dependent child may continue coverage if the incapacitation was diagnosed prior to the loss of eligibility due to age, and your request to continue coverage is approved by the health care plan. Dependent incapacitated children are subject to the above eligibility requirements and periodic recertification. An incapacitated dependent child who later recovers is no longer eligible and must be removed from coverage.

Important Things To Know About Health Care Coverage:

- Employees who enroll or fail to remove a family member who is not eligible for coverage may face disciplinary action and removal from the State Health Benefits Program for up to three years.
- In the event of an employee's death, enrolled family members may continue coverage under the employee's agency for an additional month. More information about eligibility and enrollment for a Survivor is available on the DHRM Web Site or from your Benefits Administrator.
- Continued coverage is available for you and covered family members who lose eligibility under the State Health Benefits Program. More information about Extended Coverage (COBRA) is available on the DHRM Web Site or from your Benefits Administrator.
- A Certificate of Coverage as defined by the Health Insurance Portability and Accountability Act (HIPAA) is available from your Benefits Administrator if you become covered under another group health plan that requires evidence of your prior health care coverage.

Important Things To Know About Health Plan Premiums:

- Plans and premiums are subject to change.
- Employee premium amounts apply to most full-time employees. However, full-time employees on certain leaves of absence pay the total premium.
- All part-time employees pay the total premium.
- Payroll-deducted premiums are withheld on a pre-tax basis.
- Employees are obligated to pay for any month of health care coverage already begun.
- Failure to pay the premium owed results in cancellation of coverage and forfeiture of any partial payment.

Monthly Premiums For July 1, 2009 – June 30, 2010

For the second year, health benefits program reserves will absorb increases in employee monthly premium costs. The program's expenses continue to rise and will likely be reflected in future premiums.

Health Care Plans		You Only	You + One	You + Two or More
COVA Care/COVA Connect (with basic dental)	Employee pays	\$41	\$101	\$144
	Total premium	\$485	\$898	\$1,313
COVA Care/COVA Connect + Out-Of-Network	Employee pays	\$53	\$117	\$165
	Total premium	\$497	\$914	\$1,334
COVA Care/COVA Connect + Expanded Dental	Employee pays	\$56	\$130	\$187
	Total premium	\$500	\$927	\$1,356
COVA Care/COVA Connect + Out-Of-Network + Expanded Dental	Employee pays	\$67	\$145	\$207
	Total premium	\$511	\$942	\$1,376
COVA Care/COVA Connect + Expanded Dental + Vision & Hearing	Employee pays	\$66	\$149	\$212
	Total premium	\$510	\$946	\$1,381
COVA Care/COVA Connect + Out-Of-Network + Expanded Dental + Vision & Hearing	Employee pays	\$77	\$163	\$231
	Total premium	\$521	\$960	\$1,400
COVA HDHP – High Deductible Health Plan	Employee pays	\$0	\$0	\$0
	Total premium	\$389	\$721	\$1,054
Kaiser Permanente HMO	Employee pays	\$40	\$99	\$140
	Total premium	\$478	\$882	\$1,287

Full-time Employee, Employee on Military Leave, VSDP Short-Term Disability: Pays the Employee amount

Part-time Classified Employee: Pays the total premium

Health Care Plans and Benefits At-A-Glance for 2009

In-Network Benefit	COVA Care/COVA Connect	COVA HDHP	Kaiser Permanente HMO
Deductible	\$225 per person \$450 per family	\$1,200 per person \$2,400 per family	None None
Out-Of-Pocket	\$1,500 per person \$3,000 per family	\$5,000 per person \$10,000 per family	\$3,500 \$9,400
Office Visit	\$25 PCP \$40 Specialist	20% after deductible 20% after deductible	\$10 PCP \$20 Specialist
Hospital (inpatient)	\$300 per stay	20% after deductible	\$100 per admission
Emergency Room	\$125 per visit (waived if admitted)	20% after deductible	\$75 per visit (waived if admitted)
Outpatient diagnostic labs and x-rays	20% after deductible	20% after deductible	\$0 after office visit copay
Retail Pharmacy	Up to 34-day supply \$15 Tier 1 \$25 Tier 2 \$40 Tier 3 \$50 Tier 4	20% after deductible	Up to 60-day supply \$10/20/35 Kaiser pharmacy \$20/40/55 Community pharmacy
Home Delivery Pharmacy	Up to 90-day supply \$30 Tier 1 \$50 Tier 2 \$80 Tier 3 \$100 Tier 4	20% after deductible	Up to 90-day supply \$8/18/33 Mail Service

When Can I Request Enrollment or Election Changes?

When Newly Eligible

For health care coverage and flexible reimbursement accounts, request enrollment within 31 days of the date of hire or of becoming eligible.

During Open Enrollment

The Open Enrollment period occurs each spring and is your annual opportunity to enroll or make election changes to health care coverage and to enroll in FRAs. Your enrollment in an FRA each plan year is not automatic. If you want an FRA for the upcoming plan year, you must enroll. The benefits and premiums associated with open enrollment elections are effective the following July 1.

Qualifying Mid-Year Events

Certain qualifying mid-year events permit election changes outside the Open Enrollment period, including changes to your plan and membership. Examples of qualifying mid-year events include changes in your employment, changes in your marital status, changes in the number of your eligible family members, and changes affecting the employment of a covered family member. Your change request must be received within 31 days of the event and be on account of and consistent with the event. You may be asked to provide supporting documentation. *A complete list of qualifying mid-year events may be found on the DHRM Web site and on the attached enrollment form.*

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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

There are two additional circumstances under the Health Insurance Portability and Accountability Act (HIPAA) that will permit you to enroll. You may enroll when:

- You or your dependent lose coverage in Medicaid or the State Children's Health Insurance Program (CHIP) and you request coverage under the plan within 60 days of the time your coverage ends; or
- You or your dependent become eligible for a Medicaid or CHIP premium assistance subsidy and you request coverage under the plan within 60 days after your eligibility is determined.

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

When Are Enrollment or Election Changes Effective?

Coverage always begins on the first of a month and ends at the end of a month. Most requests received within 31 days and by the end of the month are effective the first of the next month. *There are two exceptions:* coverage for a newborn or adopted child, and when a family member loses eligibility as a dependent.

How Do I Request Enrollment or Election Changes?

- **Online:** Visit the DHRM Web site at www.dhrm.virginia.gov and click on the EmployeeDirect link. It's quick, easy, and gives you immediate confirmation that your request has been received.
- **Paper:** Complete and return the attached State Health Benefits Enrollment Form for Employees to your Benefits Administrator. Be sure to allow time for it to be received within given deadlines.

State Health Benefits Program Enrollment Form For Employees

Review each section and carefully PRINT your enrollment information.

Section 1: Personal Information

Name _____ Identification Number _____
Last Name First Name M.I. Assigned ID or Social Security Number

Date of Birth _____ Gender: Male Female
Month/Day/Year

Important! If your address has changed, be sure to verify the correct format at <http://zip4.usps.com/zip4/welcome.jsp>.

Street Address _____ P.O. Box _____

City _____ State _____ Zip + 4 _____

State E-mail: _____ Personal E-mail: _____

State Phone: (_____) _____ Personal Phone: (_____) _____

Section 2: Reason For This Enrollment or Election Change Request

Check all that apply and attach the appropriate supporting documentation. Then enter the appropriate date. The numbers in parentheses are for agency use.

Initial Enrollment for Newly Eligible Employee: _____ (01)
Month/Day/Year

Open Enrollment (56) **Add to Existing Family Membership/Documentation to Support Eligibility** (19)

QUALIFYING MID-YEAR EVENT/ATTACH THIS INFORMATION FROM THE LIST OF EVENTS BELOW:

Month/Day/Year

- | | |
|---|---|
| <input type="checkbox"/> Birth or Adoption/ <i>Birth Certificate or Adoption Agreement</i> (15) | <input type="checkbox"/> HIPAA Special Enrollment/ <i>HIPAA Certificate</i> (70) |
| <input type="checkbox"/> Child Covered Under Your Plan Lost Eligibility/ <i>Documentation to Support</i> (38) | <input type="checkbox"/> Judgment, Decree or Order to Add Child/ <i>Court Order</i> (71) |
| <input type="checkbox"/> Death of Child/ <i>Documentation Validating Death</i> (17) | <input type="checkbox"/> Judgment, Decree or Order to Remove Child/ <i>Court Order</i> (67) |
| <input type="checkbox"/> Death of Spouse/ <i>Documentation Validating Death</i> (08) | <input type="checkbox"/> Lost Eligibility Under Governmental Plan/ <i>Government Documentation</i> (76) |
| <input type="checkbox"/> Dependent Care Cost or Coverage Change/ <i>Documentation from Dependent Care Provider</i> (61) | <input type="checkbox"/> Lost Eligibility Under Medicare or Medicaid/ <i>Government Documentation</i> (09) |
| <input type="checkbox"/> Divorce/ <i>Divorce Decree</i> (10) | <input type="checkbox"/> Marriage/ <i>Marriage Certificate</i> (07) |
| <input type="checkbox"/> Employment Change – Full-time to Part-time/ <i>Agency Validates Employment Change</i> (77) | <input type="checkbox"/> Move Affecting Eligibility for Health Care Plan/ <i>Agency Validates Move</i> (05) |
| <input type="checkbox"/> Employment Change – Part-time to Full-time/ <i>Agency Validates Employment Change</i> (78) | <input type="checkbox"/> Other Employer's Open Enrollment or Plan Change/ <i>Employer Documentation</i> (62) |
| <input type="checkbox"/> Employment Change – Unpaid Leave of Absence Began/ <i>Agency Validates Leave</i> (49) | <input type="checkbox"/> Spouse or Child Gained Eligibility under Their Employer's Plan/ <i>Employer Documentation</i> (28) |
| <input type="checkbox"/> Employment Change – Unpaid Leave of Absence Ended/ <i>Agency Validates Leave</i> (50) | <input type="checkbox"/> Spouse or Child Lost Eligibility under Their Employer's Plan/ <i>Employer Documentation</i> (13) |
| <input type="checkbox"/> Gained Eligibility Under Medicare or Medicaid/ <i>Government Documentation</i> (66) | |

Section 3: Flexible Reimbursement Accounts Election

To enroll in or change an FRA, enter the amount you wish deducted each pay period. For assistance in determining your pay period election, complete the FRA worksheet available on the DHRM Web site at www.dhrm.virginia.gov or from your Benefits Administrator.

I do not wish to participate in an FRA.

MEDICAL FLEXIBLE REIMBURSEMENT ACCOUNT

For eligible medical expenses incurred by you, your spouse and eligible dependents. (Minimum is \$10 per pay period; Maximum allowable contribution is up to \$5,000.)

Amount per regular paycheck
(Whole dollar amounts only) = _____

DEPENDENT CARE FLEXIBLE REIMBURSEMENT ACCOUNT

For eligible dependent care expenses incurred by you, your spouse and eligible dependents. (Minimum is \$10 per pay period; Maximum allowable contribution is up to \$5,000 depending on your tax filing status.)

Amount per regular paycheck
(Whole dollar amounts only) = _____

Section 4: Health Care Coverage Election

Check the one that applies. The letters in parentheses are for agency use.

I do not wish to participate in health care coverage (W)

No change to my current plan year election for health care coverage

Health Plans

COVA Care* (with basic dental) (ACC0)

COVA Care + Out-of-Network (ACC1)

COVA Care + Expanded Dental (ACC2)

COVA Care + Out-of-Network + Expanded Dental (ACC3)

COVA Care + Expanded Dental + Vision & Hearing (ACC4)

COVA Care + Out-of-Network + Expanded Dental + Vision & Hearing (ACC5)

COVA Connect** (with basic dental) (OCC0)

COVA Connect + Out-of-Network (OCC1)

COVA Connect + Expanded Dental (OCC2)

COVA Connect + Out-of-Network + Expanded Dental (OCC3)

COVA Connect + Expanded Dental + Vision & Hearing (OCC4)

COVA Connect + Out-of-Network + Expanded Dental + Vision & Hearing (OCC5)

COVA HDHP—High Deductible Health Plan (CHD)

Kaiser Permanente HMO – available in Northern Virginia, Central Virginia and Northern Neck designated zip codes (KP)

* COVA Care available in all areas except designated Hampton Roads zip codes

** COVA Connect available in designated Hampton Roads zip codes

Identify the eligible family members you wish to cover under your health care plan. If you need more space, list additional family members on a separate sheet and attach to this form.

I do not wish to cover any family members.

I wish to cover the following eligible family members. **Any family members not listed will not be covered.**

Relationship Codes: H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF=other female child OM=other male child

RELATIONSHIP CODE	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY NUMBER
Spouse					
Children					

Section 5: Employee Certification and Authorization

I certify that I have reviewed and understand the attached pages 1-4 of the State Health Benefits Program Eligibility, Elections and Enrollment Information For Employees and that I agree to abide by all participation requirements. I also certify that I am eligible for the benefits for which I elect to participate and that the information I have provided on this form is complete and accurate to the best of my knowledge. The health plan and its business associates have the right to use protected health information in connection with the treatment, payment and operations of a selected plan as defined by HIPAA.

Print Your Name _____ Assigned ID or Social Security Number _____

Sign Here _____ Date _____

Section 6: Agency Verification and Approval

Date Received _____ Date Keyed _____ BES Effective Date _____
Month/Day/Year Month/Day/Year Month/Day/Year

Print Contact Name _____ Phone _____ Agency/Group Number _____/_____

Important: The daily Agency Transaction Turnaround document (PM 4270) is the official record of this change. It is your responsibility to review and confirm this document to ensure that changes made are accurate.