1 VAC 55-20-10. ~~Authority.~~ (Repealed.)

~~These regulations are promulgated by the Department of Human Resource Management (the "department") pursuant to §§ 2.1-20.1 and 2.1-20.1:02 of the Code of Virginia.~~

1 VAC 55-20-20. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Accident or health plan" means a plan described in the Internal Revenue Code § 105.

"Administrative services arrangement" means an arrangement whereby a third party ~~provider~~ administrator agrees to administer all or part of the health benefits program.

"Adoption agreement" means an agreement executed between a local employer and the department specifying the terms and conditions of the local employer's participation in the health benefits program.

"Alternative health benefits plans" means optional medical benefits plans, inclusive of but not limited to HMOs and PPOs, which are offered pursuant to the health benefits program in addition to the basic ~~plan~~ statewide plan(s).

"Basic ~~plan~~ statewide plan(s)" means the statewide hospitalization, medical and major medical plan offered at a uniform rate to all state employees pursuant to § ~~2.1-20.1~~ 2.2-2818 of the Code of Virginia.

"Benefits administrator" means the person or office designated in the application and adoption agreement to be responsible for the day-to-day administration of the health benefits program at the local level. The benefits administrator is an employee of the agency or local employer that employs the benefits administrator. The benefits administrator is not an agent of the health insurance plan or the Department of Human Resource Management.

"Coordinated service" means a health care service or supply covered under both the program and another health plan. The coordinated service will be provided under the program only to the extent it is not excluded or limited under the program.

"Coordination of benefits" means the establishment of a priority between two or more underwriters which provide health benefits protection covering the same claims incident.

"Department" means the Department of ~~Personnel and Training~~ Human Resource Management.

"Dependent" means any person who is determined to be an eligible family member of an employee pursuant to subsection E of 1 VAC 55-20-320.

"Director" means the Director of the Department of ~~Personnel and Training~~ Human Resource Management.

"Dual membership" means the coverage in the health benefits program of the employee and either the spouse or one dependent. This definition does not include coverage of retirees or employees or their spouses who are otherwise covered by Medicare.

"Effective date of coverage" means the date on which a participant is enrolled for benefits under a plan or plans elected under the health benefits program.

"Employee" means a person employed by an employer participating in the health benefits program or, where demanded by the context of this chapter, a retired employee of such an employer. The term "employee" shall include state employees and employees of local employers.

"Employee health insurance fund" or "~~fund~~ health insurance funds" means ~~an account~~ accounts established by the state treasury and maintained by the ~~Department of Accounts~~ department within which contributions to the plan shall be deposited.

"Employer" means the entity with whom a person maintains a common law employee-employer relationship. The term "employer" is inclusive of each state agency and of a local employer.

"Employer application" or "application" means the form, to be provided by the department, to be used by the local employer for applying to participate in the health benefits program.

"Enrollment form" means the form, to be provided by the ~~carriers~~ department, to be used by participants to enroll in a plan or to indicate a change in coverage.

“Enrollment action” means providing the information, which would otherwise be contained on an enrollment form, through an alternative means such as through the world wide web or through an interactive voice response system, for the purpose of securing or changing membership or coverage in the employee health benefits program. Submitting a properly completed enrollment form and taking an enrollment action through an employee self-service system are used interchangeably to indicate equivalent actions.

"Experience adjustment" means the adjustment determined by the department, consistent with ~~generally accepted~~ its actuarial practices, to ~~current contributions for benefits that reflects~~

~~deviations in claims experience~~ premiums for the year in which a local employer withdraws from the plan.

"Family membership" means the coverage in the health benefits program of the employee and two or more ~~persons comprising the spouse or dependents, or both~~ eligible dependents.

"Health Maintenance Organization" or "HMO" means an entity created under federal law, "The Health Maintenance Organization Act of 1973" (Title XIII of the Public Health Service Act), as amended, or one defined under state law.

"Health benefits program" or "program" means, individually or collectively, the plan or plans the department may establish pursuant to §§ 2.2-1204 and 2.2-2818 of the Code of Virginia.

"Health plan" means:

1. A plan or program offering benefits for, or as a result of, any type of health care service when it is:

a. Group or blanket insurance (including school insurance programs);

b. Blue Cross, Blue Shield, group practice (including HMOs and PPOs), individual practice (including IPAs), or any other prepayment arrangement (including this program) when;

(1) An employer contributes any portion of the premium, or

(2) An employer contracts for the group coverage on behalf of employees, or

(3) It is any labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan.

2. The term "health plan" refers to each plan or program separately. It also refers to any portion of a plan or program which reserves the right to take into account benefits of other health plans when determining its own benefits. If a health plan has a coordination of benefits provision which applies to only part of its services, the terms of this section will be applied separately to that part and to any other part.

3. A prepaid health care services contract or accident or health plan meeting all the following conditions is not a health plan:

a. One that is individually underwritten;

b. One that is individually issued;

c. One that provides only for accident and sickness benefits; and

d. One that is paid for entirely by the subscriber.

A contract or policy of the type described in this subdivision 3 is not subject to coordination of benefits.

"Impartial health entity" means an organization, which upon written request from the Department of Human Resource Management examines the adverse health benefits claim decision made by the Commonwealth's Third Party Administrator (TPA). The impartial health entity should determine whether the TPA's decision is objective, clinically valid, compatible with established principles of health care, and appropriate under the terms of the contractual obligations to the covered person.

"Insured arrangement" means an accident or health plan underwritten by an insurance company wherein the department's only obligation as it may relate to claims is the payment of insurance company premiums.

"Independent hearing officer" means an individual requested by the director of the department from a list maintained by the Executive Secretary of the Supreme Court to arbitrate disputes which may arise in conjunction with these regulations or the health benefits program.

~~"Local advisory committee" or "committee" is a committee established pursuant to §2.1-20.1:02 of the Code of Virginia which shall provide guidance to the department concerning the administration of the health benefits program.~~

"Local employees" or "employees of local governments" means all officers and employees of the governing body of any county, city, or town, and the directing or governing body of any political entity, subdivision, branch, or unit of the Commonwealth or of any commission or public authority or body corporate created by or under an act of the General Assembly specifying the power or powers, privileges or authority capable of exercise by the commission or public authority or body corporate, as distinguished from §§ ~~15.1-20, 15.1-21~~ 15.2-1300, 15.2-1303 or similar statutes, provided that the officers and employees of a social services department, welfare board, mental health and mental retardation services board, or library board of a county, city, or town shall be deemed to be the employees of local government.

"Local employer" means any county, city, or town, school board, and the directing or governing body of any political entity, subdivision, branch or unit of the Commonwealth or of any commission or public authority or body corporate created by or under an act of the General

Assembly specifying the power or powers, privileges or authority capable of exercise by the commission or public authority or body corporate, as distinguished from §§ ~~15.1-20, 15.1-21~~ 15.2-1300, 15.2-1303 of the Code of Virginia, or similar statutes.

"Local officer" means the treasurer, registrar, commissioner of revenue, attorney for the Commonwealth, clerk of a circuit court, sheriff, or constable of any county or city or deputies or employees of any of the preceding local officers.

"Local retiree" means a former local employee who has met the terms and conditions for early, normal or late retirement from a local employer.

"Open enrollment" means the period during which an employee may elect to commence, to waive or to change membership or plans offered pursuant to the health benefits program.

"Part-time employee," as defined by each local employer, means an employee working less than full time ~~who~~ whom a local employer has determined to be eligible to participate in the program. The conditions of participation for these employees shall be decided by the local employer in a nondiscriminatory manner.

"Participant" means any person actively enrolled and covered by the health benefits program.

"Plan administrator" means the department.

"Preferred provider organization" or "PPO" means an entity through which a group of health care providers, such as doctors, hospitals and others, agree to provide specific medical and hospital care and some related services at a negotiated price.

"Preexisting condition" means a condition which, in the opinion of the plan's medical advisors, displayed signs or symptoms before the participant's effective date of coverage. These signs or symptoms must be ones of which the participant was aware or should reasonably have been aware. The condition is considered preexisting whether or not the participant was seen or treated for the condition. It is also considered preexisting whether or not the signs and symptoms of the condition were correctly diagnosed.

"Primary coverage" means the health plan which will provide benefits first. It does not matter whether or not a claim has been filed for benefits with the primary health plan.

"Retiree" means any person who meets the definition of either a state retiree or a local retiree.

"Secondary coverage" means the health plan under which the benefits may be reduced to prevent duplicate or overlapping coverage.

"~~Self-insured~~ Self-funded arrangement" means a facility through which the plan sponsor agrees to assume the risk associated with the type of benefit provided without using an insurance company.

"Single membership" means coverage of the employee only under the health benefits program.

"State" means the Commonwealth of Virginia.

"State agency" means a court, department, institution, office, board, council, or other unit of state government located in the legislative, judicial or executive departments or group of independent agencies, as shown in the Appropriation Act, and which is designated in the Appropriation Act by title and a three-digit agency code.

~~"State employee" means a state employee as defined in §§51-111.10 and 51-111.10:01 [Repealed.] of the Code of Virginia, employee as defined in §51-144 [Revised, §51.1-201] of the Code of Virginia, the Governor, Lieutenant Governor and Attorney General, judge as defined in §51-161 [Revised, §51.1-30 (Amended, Act 1993, c. 895)] of the Code of Virginia and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, and interns and residents employed by the Medical College of Virginia of Virginia Commonwealth University and the School of Medicine and Hospital of the University of Virginia. The Athletic Department of Virginia Polytechnic Institute and State University is a local auxiliary whose members are considered state employees for purposes of eligibility for the program.~~

"State employee" means any person who is regularly employed full time on a salaried basis, whose tenure is not restricted as to temporary or provisional appointment, in the service of, and whose compensation is payable, no more often than biweekly, in whole or in part, by the Commonwealth or any department, institution, or agency thereof. "State employee" shall include the Governor, Lieutenant Governor, Attorney General, and members of the General Assembly. It includes "judge" as defined in § 51.1-301 of the Code of Virginia and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth.

~~"State health benefits advisory council" or "advisory council" is an advisory council established pursuant to § 2.1-20.1:01 of the Code of Virginia.~~

"State retiree" means a former state employee who has met the terms and conditions for early, normal or late retirement from the Commonwealth.

"Teacher" means any employee of a county, city, or other local public school board.

1 VAC 55-20-30. Designee and delegations of authority.

Pursuant to § ~~2.1-20.1~~ 2.2-2818 of the Code of Virginia, the Department of ~~Personnel and Training~~ Human Resource Management shall establish a health benefits program (the "program"), subject to the approval of the Governor, for providing accident or health benefit protection, including but not limited to chiropractic treatment, hospitalization, medical, surgical and major medical coverage for state employees and the employees of participating local employers.

The Director of the Department of ~~Personnel and Training~~ Human Resource Management hereby delegates to the Director of the Office of Health Benefits the authority to:

1. Propose, design, and administer one or more accident or health plans, or both. All such approved plans will, in the aggregate, constitute the health benefits program. Any plan or plans proposed by the Office of Health Benefits shall be subject to the approval of the Director of the Department of ~~Personnel and Training~~ Human Resource Management.

2. Propose regulations at any time for the purpose of the implementation, communication, funding, and administration of the health benefits program.

3. Enter into one or more contracts for the purpose of implementing, communicating, funding or administering the health benefits program. To this end, but not exclusively, such contract or

contracts may be for the underwriting, the funding, and administration, including claims processing and claims adjudication, of the program. Such contracts may be for the legal, accounting and actuarial services as well as communication, statistical analysis and any other item that may be needed to effectively review and maintain the health benefits program.

4. Evaluate the effectiveness of the health benefits program or any plan which may constitute a component part, as it might relate to the objectives of such program or such component plan and make recommendations regarding the effectiveness of such program or plan in meeting such stated objectives.

1 VAC 55-20-40. State advisory council.

In the administration of the health benefits program or any component plan or plans comprising such program, the department shall take into consideration the recommendations of the state ~~health benefits~~ human resource advisory council (the "council" or "advisory council"). The council is created pursuant to § ~~2.1-20.1:01~~ 2.2-2675 of the Code of Virginia and operated in accordance therewith. Such advisory council will serve to advise the Secretary of Administration on among other things, issues and concerns of active and retired employees of the Commonwealth who are participating in the health benefits program, such as the type and amount of benefits provided by the program, the cost to employees to participate in the program and ways to effectively control claims experience. The department shall consider the findings and recommendations of the council in its decision-making process. Further, the department may request the council's guidance on other issues of concern to the department.

1 VAC 55-20-50. ~~Local advisory committee.~~ (Repealed.)

~~In the administration of the health benefits program or any component plan or plans comprising such program, the department shall take into consideration the recommendations of the local advisory committee (the "committee" or "advisory committee"). The committee is created pursuant to § 2.1-20.1:02 of the Code of Virginia and operated in accordance therewith. Such advisory committee will serve to advise the department on issues and concerns of active and retired employees of local employers who are participating in the health benefits program, such as the type and amount of benefits provided by the program, the cost to employees to participate in the program, and ways to effectively control claims experience. The committee shall make all recommendations and findings to the department.~~

~~[The department shall consider the findings and recommendations of the committee in its decision-making process. Further, the department may request the committee's guidance on other issues of concern to the department.]~~

1 VAC 55-20-60. Types of plans.

A. The administration and underwriting of the plans shall be at the discretion of the department and may include but not be limited to ~~self-insured~~ self-funded arrangements, insured arrangements, administrative services arrangements, health maintenance organizations, and preferred provider organizations. The department is authorized to exercise judgment and discretion in the establishment, procurement and implementation of all underwriting and other services necessary for the establishment, maintenance, and administration of such plans and will be deemed to do so in good faith.

B. The department, as it deems necessary or prudent, may contract for outside services, including but not limited to actuarial, consulting, and legal counsel. The department may contract such services on an individual basis or in conjunction with other services.

1 VAC 55-20-70. Procurement.

The department shall comply with the Virginia Public Procurement Act, Chapter ~~7~~ 43 (§ ~~11-35~~ 2.2-4300 et seq.) of Title ~~11~~ 2.2 of the Code of Virginia, as it may relate to any services to which such Act shall apply.

In an effort to stabilize the administration and maintenance of the health benefits program, the department may contract for services applicable to such program for a period of time not exceeding 10 years, with the department reserving the right, in its sole discretion, to cancel such contracts annually upon 90 days written notice to the contractor.

1 VAC 55-20-80. Plan assets.

A. The assets of the health benefits program, together with all appropriations, contributions and other payments, shall be deposited in the employee health insurance ~~fund~~ fund(s) (the "~~fund~~ health insurance fund(s)") from which payments for claims, premiums or other contributions[,] cost containment and administrative expenses shall be withdrawn from time to time.

B. The health insurance fund for state employees shall be maintained separate and apart from the health insurance fund for retirees of the state eligible for Medicare and from the health insurance fund for local employees. All such funds shall be maintained for the exclusive benefit of the employees participating currently in the respective health insurance plans.

~~B.~~ C. The department may designate with the approval of the Department of the Treasury one or more insurance companies, banks or any such similar institution as a direct recipient of premiums or other contributions for part or all coverage under the health benefits program from local and state employers.

~~C.~~ D. The assets of the fund shall be held for the sole benefit of the employee health insurance fund and to that end, employees participating in the health benefits program.

Any interest on unused balances in the fund shall revert back to the credit of the fund. The State Treasurer shall charge reasonable fees to recover the actual costs of investing the assets held in the fund.

1 VAC 55-20-90. Appeals.

A. The director of the department shall be the final arbiter of any disputes arising under this chapter. The director may not redelegate this authority other than to an independent hearing officer except as provided under subsection C of this section.

All disputes arising under this chapter shall be submitted to the department, which shall have the responsibility for interpreting and administering this chapter. All disputes shall be made in writing in such manner as may be reasonably required by the department and shall set forth the facts which the applicant believes to be sufficient to entitlement to relief hereunder. The department may adopt forms for such submissions in which case all appeals shall be filed on such forms.

B. Appeals not filed within the time frames established herein shall be ~~automatically~~ denied.

Requests for review of procurements under the provisions of the VPPA shall be filed within 10 days of the department's notice of intent to award a contract.

Requests for relief from local employers or state agencies with respect to any action of the department other than a procurement shall be filed within 30 days of the action grieving the applicant. Requests for relief from state or local employees with respect to any action of the department other than a procurement shall be filed within 60 days of the action grieving the employee.

C. Upon receipt by the department for a request for review under this section, it shall determine all facts which are necessary to establish the right of an applicant for relief. The department shall approve, deny or investigate any and all disputes arising hereunder. Upon request, the department will afford the applicant the right of a hearing with respect to any finding of fact or determination related to any claim under this section. In the event of an adverse decision by the department, the applicant shall be notified of such decision as hereinafter provided. Reviews for treatment authorizations or medical claims that have been denied will be sent to an impartial health entity. The impartial health entity shall examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

D. The applicant shall be notified in writing of any adverse decision with respect to his claim within 90 days after its submission. The notice shall be written in a manner calculated to be understood by the applicant and shall include:

1. The specific reason or reasons for the denial;

2. Specific references to law, this chapter, contracts awarded pursuant to this chapter, or the Health Insurance Manual/Local Administrative Manual and related instructions on which the denial is based;

3. A description of any additional material or information necessary to the applicant to perfect the claim and an explanation why such material or information is necessary; and

4. An explanation of the review process.

If special circumstances require an extension of time for processing an initial application, the department shall furnish written notice of the extension and the reason therefore to the applicant before the end of the initial 90-day period. In no event shall such extension exceed 90 days.

E. Standards, credentials, and qualifications of the impartial health entity.

1. In order to qualify to perform either standard or expedited external reviews pursuant to this chapter or the Code of Virginia, an impartial health entity shall have and maintain written policies and procedures that govern all aspects of the standard and expedited external review processes that include, at a minimum, a quality assurance mechanism in place that ensures that:

a. External reviews are conducted within the specified time frames and required notices are provided in a timely manner;

[b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the impartial health entity and suitable matching of reviewers to specific cases; and

b. Qualified and impartial clinical peer reviewers are selected to conduct external reviews on behalf of the impartial health entity and reviewers are suitably matched to specific cases.]

c. The confidentiality of medical records is maintained in accordance with the confidentiality and disclosure laws of the Commonwealth and/or the Health Insurance Portability and Accountability Act.

2. All clinical peer reviewers assigned by an impartial health entity to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

a. Are expert in the treatment of the covered person's medical condition that is the subject of the external review;

b. Are knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical conditions as the covered person's;

c. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

d. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character.

3. An impartial health entity shall not be affiliated with or a subsidiary of nor be owned or controlled by a health plan, a trade association of health plans, or a professional association of health care providers.

4. In determining whether an independent review organization or a clinical peer reviewer of the impartial health entity has a material, professional, familial or financial conflict of interest, the director may take into consideration situations where the characteristics of that relationship or connection are such that they are not materially sufficient to disqualify the impartial health entity or the clinical peer reviewer from conducting the external review.

1 VAC 55-20-110. Authority to withhold revenues.

In the event of default by any employer participating in the health insurance program authorized by § ~~2.1-20.1:02~~ 2.2-1204 of the Code of Virginia in the remittance of premiums or other fees and costs of the program, the State Comptroller is hereby authorized to pay such premiums and costs and to recover such payments from any funds appropriated and payable by the Commonwealth to the employer for any purpose. The State Comptroller shall make such

payments, and recover an equivalent amount if possible, from an employer's appropriated funds upon receipt of notice from the director of the department that such payments are due and unpaid from the employer.

1 VAC 55-20-120. ~~Effective date. (Not set out)~~ (Repealed.)

1 VAC 55-20-130. Develop health benefits program.

A. The department shall develop a health benefits program which shall be flexible in its form and content so as to accommodate a structure which permits the creation of multiple accident and health plans. The department, however, may offer a single health insurance plan if it determines [that] that is the most effective use of plan resources. The department has full authority to make changes in plan terms including, but not limited to, benefits and contributions, or to change underwriters and administrators as it deems appropriate.

B. The department shall supplement these regulations by providing administrative guidance through the Health Insurance Manual, Local Administrative Manual, Flexible Benefits Administrative Manual, memoranda, and other communications.

1 VAC 55-20-160. Establishing contribution rates and accounting for contributions and claims.

A. The department shall establish one or more pools for establishing contribution rates and for accounting for claims and contributions for state employees and participating local employers. The plan for local employers shall be rated separately from the plan established for state employees. There are hereby authorized pools based on geographic and demographic characteristics and employment relationships. Such pools may include but shall not be limited to:

1. Active state employees, including retirees under age 65 and not eligible for Medicare;

2. Active local employees (excluding separately rated employees of public school systems);

3. Active employees of public school systems;

4. Retired state employees over age 65 and retired state employees eligible for Medicare;

5. Retired local employees (excluding separately rated employees of public school systems);

6. Retired employees of public school systems; and

7. Active employees whose employer does not sponsor a health insurance plan.

Participating employers shall make applicable contributions to the employee health insurance fund.

B. Such contributions may take into account the characteristics of the group, such as the demographics of employees, inclusive of age, sex and dependent status of the employees of an employer; the geographic location of the employer or employees; claims experience of the employer; and the pool of the employers (for example, see subdivisions 1 through 6 of 1 VAC 55-20-160 A)~~, applied according to generally accepted actuarial practices~~. Additionally, any such contributions may further be determined by spreading large losses, as determined by the department, across pools. Further, the department reserves the right to recognize, in its sole discretion, the claims experience of groups of sufficient size, regardless of their pool, where future claim levels can be predicted with an acceptable degree of credibility. The application of this rule by the department shall be exercised in a uniform and consistent manner.

C. The contribution rate in the aggregate will be composed of two factors; first, the current contribution and second, the amortization of experience adjustments. The current contributions will reflect the anticipated incurred claims and administrative expenses for the period; an experience adjustment will reflect gains and losses determined in accordance with ~~generally accepted~~ an actuarial ~~practices~~ estimate. An experience adjustment will be part of the contributions for the succeeding year; however, the department may authorize the amortization of the experience adjustment for a period not to exceed three years.

D. The department will notify a terminating local employer of any adverse experience adjustment within ~~90 days~~ [~~three~~ six ~~calendar~~] calendar months of the time the local employer terminates participation in the program. Further~~,~~ the department reserves the right to modify the amount of the experience adjustment applicable to a terminating local employer for a period not to exceed 12 months from the end of the plan year in which such termination occurred. The experience adjustment shall be payable by the local employer in 12 equal monthly installments beginning 30 days after the date of notification by the department. In the event that a terminating local employer requests in writing an extension beyond a period of 12 months, the department may approve an extension up to 36 months provided the local employer agrees to pay interest at the statutory rate on any extended payments.

1 VAC 55-20-210. Oversight.

The department has the responsibility and authority to maintain the health benefits program and take any action it deems necessary to maintain the financial and administrative integrity of the program.

A. The department shall review local administration, including state agency administration of the health benefits program to determine compliance with this chapter, law, and administrative directives. Deficiencies shall be reported to the governing body or agency administrator, who shall take prompt action to remedy the noted deficiencies. To this end, the department shall provide guidance to responsible parties regarding their duties and responsibilities in the administration of the program. Failure to correct noted deficiencies may result in the unilateral termination of participation (in the case of a local employer) in the health benefits program, or a revocation of the agency's administrative responsibility for the health benefits program (in the case of a state agency) and the imposition of a special employer contribution on the state agency to pay for the cost of direct administration of the program by the department. The cost of direct administration shall be determined by the department.

B. The department may exclude from coverage any person who is not eligible for coverage notwithstanding the participation of the state agency or local employer in the health benefits program or the payment of contributions or the previous payment of claims on behalf of such person.

If a person is determined to be ineligible for coverage, ~~contributions paid by that person shall be returned to said person for the six months prior to such determination. Contributions for periods preceding this six-month period shall not be returned. Claims~~ claims paid by the program during this ~~same six-month~~ period of ineligibility shall be recouped by the program from providers of care and from the ineligible employee to the extent practicable as determined by the department. ~~Additional claims need not be recouped unless, in the sole discretion of the department, such re-coupment, coupled with the return of additional contributions to the~~

~~employee, is required to prevent material damage to the group (see classification in 1VAC55-20-160 A and as subsequently expanded by administrative direction).~~

Employer contributions on behalf of ineligible persons shall not be returned to the participating employer in as much as the employer agrees by participating in the health benefits program that the amount of such contributions constitute liquidated damages for enrolling ineligible employees and/or their dependents. Employee contributions will not be refunded, and the membership level and contributions rate will be maintained, at the level they had been prior to the removal of the ineligible dependent, until such time as the employee makes a membership change due to a consistent qualifying midyear event, or during open enrollment.

C. The department may exclude from coverage for a period of three years any employee (and dependent) who is found by the department to have enrolled in the health benefits program through fraud, deceit, or misrepresentation of a dependent who is not eligible for the program. A signed enrollment form or equivalent enrollment action shall be deemed prima facie evidence of misrepresentation.

D. The department may refuse, notwithstanding any agreement or assignment from a participant or third party, to make a payment on behalf of a participant for covered services to a provider of care who has been determined by the department to be abusing or defrauding the program. A pattern of billing for services not rendered, misrepresenting the complexity or length of the procedures or services actually rendered, or similar abuses shall compel the department to make such a determination. For the purposes of this section, a "pattern" constitutes a number of

instances over a period of at least three months which are so similar as to suggest that the abuse is present in 5.0% or more of the services or procedures billed.

1 VAC 55-20-230. Entrance into the health benefits program.

A. Any local employer desiring to participate in the health benefits program shall complete an employer application provided by the department and execute an adoption agreement acknowledging the rights, duties and responsibilities of the department and the local employer.

As a condition of participation, the department may require the local employer to complete the application in its entirety and deliver it to the department no less than 120 days prior to the effective date of coverage under the health benefits program. The application shall include the designation of a local administrator and include a list of other individuals whose responsibilities may be such that the department may have cause to contact them.

The application of a local employer may be withdrawn without penalty any time within the first 30 days after the department's delivery of rates to the employer. A 15-day extension will be available upon written request by the employer. Thereafter, the department may levy a processing charge not to exceed $500 to cover the cost of processing the application.

B. Except in unusual circumstances to be determined by the department, ~~neither evidence of insurability nor~~ the completion of any **[**~~required~~**]** waiting periods will not be required of employees of local employers joining the program at the time of a local employer's initial participation.

C. Local employers may include in the program their active employees, or their active employees and their retirees. Local employers may not elect to cover only retirees. If the local employer wishes to provide benefits to their Medicare-eligible retirees it must also provide

coverage for non-Medicare retirees. The local employer's ~~qualified~~ beneficiaries qualified under the ~~Comprehensive~~ Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar legislation may also participate in the program. Coverage will not be available to a new employee unless the employee is on the payroll a minimum of 16 calendar days.

1 VAC 55-20-240. Payment of contributions.

A. Contributions due. It is the sole responsibility of the local employer to remit local employer and local employee contributions to the department or its designee. The local employer is responsible for remitting such contributions for ~~both~~ active ~~and~~, retired, and COBRA-participating employees. Health benefits program contributions are to be made monthly, in advance, and are due at the department on the first of each month. If the first day of the month falls on a weekend or holiday, the payment is due at the department on the first business day of the month.

B. Nonpayment of contributions. A 10-day grace period for the nonpayment of contributions is hereby provided. If the full and complete payment of contributions is not received by the 10th of the month, a notice will be sent to the local employer by the department or its designee. Additionally, there shall be imposed an interest penalty of 12% per annum of the outstanding balance unpaid as of the 10th.

In the event that payment is not received by the 20th of the month, the department shall place a notice of nonpayment of contributions in a newspaper of general circulation in the locality of the local employer notifying the employees of such local employer that claims incurred after the end of the current month will not be paid until all outstanding contributions and interest have been paid.

Furthermore, the department reserves the right to collect from a local employer the greater of the monthly contribution or any amounts incurred for claims during a period of nonpayment as well as any other costs related thereto.

C. Nonpayment as breach. The nonpayment of contributions by a local employer shall ~~be considered~~ constitute a breach of the adoption agreement and the local employer may be obligated to pay damages. In the event that the local employer terminates participation, such termination can only be prospective and the employer shall be obligated to pay the greater of past contributions or actual claims incurred during such period and any interest and damages that may be associated with such nonpayment.

D. Coverage and contribution period. ~~In the event a local employee should elect to enroll in the health benefits program in his first month of employment, such coverage shall begin on the first day of the month next following commencement of employment. Should a local employee commence employment on the first working day of the month and coverage is elected within that month, then such coverage shall commence on the local employee's date of hire or the first day of the month of hire, whichever is earlier but see 1VAC55-20-370 B.~~ Except as noted here, coverage elections including those made by new employees are made on a prospective basis, that is, effective the first of the month coinciding with or following the receipt of the election form. However, if an election form is received [from ~~by~~] a new employee on the first business day of the month, coverage for the employee will commence on the first day of that month, (see 1 VAC 55-20-370). Coverage elections made for newborns, adoption or placement for adoptions are effective the date the child is born, adopted or placed for adoption, so long as the employee makes the coverage election within 31 days of the event. Coverage terminations are

effective the end of the month following receipt of an election notice, except for terminations that are required by the plan. Coverage terminations required by the plan are effective the end of the month that the event takes place. Examples of coverage terminations required by the plan are such things as a divorce, termination of employment or a dependent child losing eligibility.

Contributions shall always be for full calendar months. Local employees who terminate employment within a calendar month shall have coverage through the end of the month in which they terminate. In the event that a terminating local employee becomes covered under an accident or health plan of another employer prior to the end of the month in which the local employee terminates, ~~the~~ this health benefits program shall be a secondary payor to the former local employee's new coverage.

1 VAC 55-20-250. Enrollment.

The local employer is responsible for providing local employees with enrollment forms for participation in the health benefits program. Such forms shall be provided to the local employer by the department or its designee. It is the responsibility of the local employer to provide information to local employees concerning the benefits offered in each of the plans comprising the health benefits program at such time and in such manner that it can be expected that the local employee can make an informed decision regarding the types of coverage that are being offered.

The local employer is responsible for ensuring that enrollment forms for participation made by local employees are fully completed on a timely basis, signed and certified. ~~Thirty~~ No later than 30 days prior to the effective date of coverage, the local employer shall forward the enrollment

forms to the department or its designee, as may be appropriate. The department shall be responsible for notifying the local employer as to the location and manner of delivery of all such local employee enrollment forms. Further, the local employer shall be responsible for reporting any changes in benefit coverage in a manner similar to the reporting of an initial application with the department having the ability to waive the 30-day notice requirement.

1 VAC 55-20-260. Minimum local employer contributions.

A. The department shall require, as a condition of local employer participation in the health benefits program, that a local employer pay a minimum portion of the plan contribution attributable to an active local employee's coverage. Contributions toward the cost of retiree coverage are permitted but not required. Unless otherwise specified in a local employer's adoption agreement, participating local employers shall contribute, at a minimum, 80% of the cost of single coverage, and 20% of the cost of dependent coverage as a condition of participation ~~the following percentages of total required plan contributions on behalf of active participating employees:~~. In the event that an employer enrolls 75% or more of all eligible employees, the employer will not be required to contribute the above amounts towards the cost of dependent coverage.

~~Contribution~~

~~Minimum Local Percentage~~
~~Employer Contributions Attributable to~~
~~In Years Single Additional Coverage~~

~~1990-1991 50% 0%~~

~~1991-1992 60% 10%~~

~~1992-1993 70% 10%~~

~~1993-1994 80% 20%~~

~~1994-1995 80% 20%~~

~~and after~~

~~For example, in the 1991-1992 plan year, a local employer would contribute, at a minimum, 60% of a single employees's membership. If an employee elects dual or family membership, a local employer would contribute, at a minimum, 60% of the single cost and 10% of any additional costs. In the event that an employer enrolls 75% or more of all eligible employees, the employer will not be required to contribute the above amounts for additional coverage.~~

B. Local employers allowing part-time employees to participate in the program must contribute a minimum of 50% of the ~~amounts listed in 1 VAC 55-20-260A~~ amount they contribute toward active employee coverage (at all membership levels) on behalf of their participating part-time employees. ~~For example, in the 1991-1992 plan year, a local employer would contribute, at a minimum, 30% of a single employee's membership and, if applicable, 5.0% of any additional cost of dual or family membership.~~

For purposes of this section, amounts contributed on behalf of an employee who has requested a reduction in salary pursuant to a plan qualified under § 125 of the Internal Revenue Code (Tax Treatment of Cafeteria Plans) will not be counted as an employer contribution.

1 VAC 55-20-280. Commencement of local employer participation.

Local employers may join initially at any time upon the timely submission of an employer application, but, thereafter, renewals must be as of July 1 of each year. Local school boards may have an October 1 renewal, if they so elect. Initial participation by a local employer at any time other than on July 1 ~~shall~~ (October 1) may be for the short plan year ending on the June 30 (September 30) following initial participation.

There shall be no specified time for local employee enrollment coincident with the local employer's initial participation in the health benefits program provided the department or its designee shall have knowledge of the local employee elections at least 30 days prior to the effective date of coverage. Thereafter the open enrollment period for local employees shall take place during the month of April or May of each year with the effective date of coverage then being July 1 of such year.

1 VAC 55-20-290. Reparticipation of local employers.

Local employers having withdrawn from the health benefits program may reenter the program only with the consent of the department, and only on the July 1 (October 1 for school boards) following the timely submission of an employer application. The July 1 (October 1) effective date may be waived for local employers who have been away from the program for more than three years. ~~Normally,~~ Employees of local employers seeking reparticipation ~~will~~ may be required ~~to furnish evidence of insurability or~~ to serve a waiting period~~, whichever the department requires~~.

Department consent shall not be granted until all pending contributions, penalties and other assessments have been paid by a local employer and there is no outstanding litigation pending

between the department and the local employer. A pending appeal will not prohibit a local employer from reparticipating in the health benefits program.

1 VAC 55-20-300. Ceasing participation in the health benefits program.

A local employer who desires to terminate participation in the health benefits program may do so at any time, as of the last day of any calendar month, with ~~90 days~~ three months notice to the department. The local employer shall be obligated to pay any and all contributions otherwise required through the date of termination of participation and interest related thereto. Additionally, a terminating local employer shall be responsible for any adverse experience adjustment which may apply with respect to the year termination occurred and any prior year within which the terminating local employer participated in the program.

Upon the local employer's cessation of participation in the program, all of the local employers' participants, including retirees, dependents of retirees and COBRA beneficiaries will cease to be covered under the program.

1 VAC 55-20-320. Eligible employees.

A. State employees.

1. ~~Only~~ Full-time salaried, classified employees and faculty as defined in 1 VAC 55-20-20 are eligible for membership in the health benefits program. A full-time salaried employee is one who is scheduled to work at least ~~40~~ 32 hours per week or carries a faculty teaching load considered to be full time at his institution.

2. ~~A state employee is one who receives a salaried paycheck from the Commonwealth.~~ Certain full-time employees in auxiliary enterprises (such as food services, bookstores, laundry services, etc.) at the University of Virginia, Virginia Military Institute and the College of William and Mary as well as other state institutions of higher learning are also considered state employees even though they do not receive a salaried state paycheck. The Athletic Department of Virginia Polytechnic Institute and State University is an example of a local auxiliary whose members are eligible for the program.

~~Medical College of Virginia house staff members are eligible for the program as long as they are on the state payroll and remain in the program. They will have payroll deductions for health benefits premiums even if they rotate to the Veterans' Administration Hospital or other acute care facility.~~

~~A salaried employee is one who receives a paycheck no more often than biweekly and who is not paid on an hourly basis.~~

3. Certain full-time employees of the Medical College of Virginia Hospital Authority are eligible for the program as long as they are on the authority's payroll and were enrolled in the program on November 1, 1996. They may have payroll deductions for health benefits premiums even if they rotate to the Veterans' Administration Hospital or other acute care facility.

4. Other employees identified in the Code of Virginia as eligible for the program.

~~3.~~ 5. Classified positions include employees who are fully covered by the Virginia Personnel Act, employees excluded from the Virginia Personnel Act by subdivision 16 of § ~~2.1-116 (16) of~~ 2.2-2905 of the ~~Virginia~~ Code of Virginia, and employees on a restricted appointment. A

restricted appointment is a classified appointment to a position that is funded at least 10% from gifts, grants, donations, or other sources that are not identifiable as continuing in nature. An employee on a restricted appointment must receive a state paycheck in order to be eligible.

B. Local employees.

1. Full-time employees of participating local employers are eligible to participate in the program. A full-time employee is one who meets the definition set forth by the local employer in the employer application.

2. Part-time employees of local employers may participate in the plan if the local employer elects and the election does not discriminate among part-time employees. In order for the local employer to cover part-time employees, the local employer must provide to the department a definition of what constitutes a part-time employee.

~~In the event of a leave of absence without pay, the local employer shall not be obligated to continue contributions toward coverage for a part-time employee.~~

The department reserves the right to establish a separate plan for part-time employees.

C. Unavailability of employer-sponsored coverage.

1. Employees, officers, and teachers without access to employer-sponsored health care coverage may participate in the plan. The employers of such employees, officers, and teachers must apply for participation and certify that other employer-sponsored health care coverage is not available. The employers shall collect contributions from such individuals and timely remit them to the department or its designee, act as a channel of communication with

the covered employee and otherwise assist the department as may be necessary. The employer shall act as fiduciary with respect to such contributions and shall be responsible for any interest or other charges imposed by the department in accordance with these regulations.

2. Local employees living outside the service area of the plan offered by their local employer shall not be considered as local employees whose local employers do not offer a health benefits plan. For example, a local employee who lives in North Carolina and works in Virginia may live outside the service area of the HMO offered by his employer; however, he may not join the program individually.

3. Employer sponsorship of a health benefits plan will be broadly construed. For example, an employer will be deemed to sponsor health care coverage for purposes of this section and 1 VAC 55-20-260 if it utilizes § 125 of the Internal Revenue Code or any similar provision to allow employees, officers, or teachers to contribute their portion of the health care contribution on a pretax basis.

4. Individual employees and dependents who are eligible to join the program under the provisions of this subsection must meet all of the eligibility requirements pertaining to state employees except the identity of the employer.

D. Retirees.

1. Retirees are not eligible to enroll in the state retiree health benefits group outside of the opportunities provided in this section.

2. Retirees are eligible for membership in the state retiree group if a completed enrollment form is received within 31 days of separation for retirement. Retirees who remain in the health

benefits group through a spouse's state employee membership may enroll in the retiree group at one of three later times: (i) future open enrollment, (ii) within 31 days of ~~an eligibility status change~~ a qualifying mid-year event, or (iii) within 31 days of being removed from the active state employee spouse's membership.

3. Membership in the retiree group may be provided to an employee's spouse or dependents who were covered in the active employee group at the time of the employee's death in service ~~in accordance with the provisions of the Health Insurance Manual~~.

4. Retirees who ~~are over~~ have attained the age of 65 or are otherwise covered or eligible for Medicare may enroll in certain plans as determined by the department provided that they apply for such coverage within 31 days of their separation from active service for retirement. Medicare will be the primary payor and the program shall serve as a supplement to Medicare's coverage.

5. Retirees who are ineligible for Medicare must apply for coverage within 31 days of their separation from active service for retirement. In order to receive coverage, the individual must meet the retirement requirements of his employer and receive an immediate annuity.

6. Local employers may offer retiree coverage at their option.

E. Dependents.

1. The following family members may be covered if the employee elects:

a. The employee's spouse;

b. The employee's unmarried natural or legally adopted children;

c. Unmarried stepchildren living with the employee in a parent-child relationship and dependent on the employee for federal tax purposes;

d. Adult ~~disabled~~ incapacitated children as long as the child was covered by the plan and the incapacitation existed prior to the termination of coverage due to the child attaining the limiting age~~.~~ ;

e. Adult incapacitated children of new employees, provided that:

(1) The enrollment form is submitted within 31 days of hire ~~and~~;

(2) The child has been covered continuously by group employer coverage since the disability first occurred; and

(3) The disability commenced prior to the child attaining the limiting age of the plan.

The enrollment form must be accompanied by a letter from a physician explaining the nature of the ~~handicap~~ incapacitation, date of onset and certifying that the dependent is not capable of self-support. This extension of coverage must be approved by the plan in which the employee is enrolled.

~~e.~~ f. Other children on an exception basis. Generally, an exception will not be granted unless:

(1) A court orders the eligible employee to assume permanent custody of the child; and

(2) Both of the child's natural parents are deceased, missing, or incarcerated or a court order has found the parents incapable of caring for the child.

Local employers and state agencies do not have the authority to grant exceptions. If the circumstances appear to meet the criteria, the facts of the case must be sent in writing to the

department for a determination. Minor children who are adopted, regardless of relationship to the employee, enjoy the same benefits as natural children. Natural or adopted children who are otherwise eligible for coverage may be covered by the employee whether or not they live with the employee.

Children of the spouse of an eligible employee may not be covered as a dependent in the health benefits program unless they live with the employee and meet the criteria for family membership, as given in previous paragraphs.

A child who is self-supporting for federal income tax purposes is ineligible to be covered under the employee's family membership. A child who is otherwise eligible to be covered by family membership may be covered until such time as ~~they become~~ he becomes self-supporting.

Coverage for a dependent child stops at the end of the month in which the child marries.

~~f.~~ g. Special rules.

(1) There are certain categories of persons who may not be covered as dependents under the program. These include: dependent siblings, grandchildren, nieces, nephews, and most other children except where the criteria for "other children" are satisfied (see 1 VAC 55-20-320 E 1 ~~e~~ f). Parents, grandparents, aunts and uncles are not eligible for coverage regardless of dependency status.

(2) Under the ~~basic plan and HMOs,~~ health benefits program, eligible children may be covered to the end of the year in which they turn age ~~19 if not a full-time student. Children who are full-time students may be covered to the end of the month in which they turn 23, or~~

~~cease to be full-time students, whichever occurs first~~ 23 regardless of student status, if the child lives at home, is not married and is not self-supporting. In the case of natural or adopted children, living at home may mean living with the other parent if the employee is divorced. Also, a child who is away at school may be covered.

Children may be covered regardless of the age if incapable of self-support because of a severe physical or mental ~~handicap which~~ incapacitation, which was diagnosed while coverage was in force. An enrollment form for continued coverage for a disabled child is required within 31 days ~~of the~~ prior to the child's age attainment (above) to maintain coverage (see 1 VAC 55-20-330).

~~(3) Under the PPO plan or plans, eligible children may be covered to the end of the year in which they turn age 23, regardless of student status, if the child lives at home and is not self-supporting. Living at home is characteristic of the child who is not self-supporting. In the case of natural or adopted children, living at home may mean living with the other parent. Also, a child who is away at school may be covered.~~

~~Children may be covered regardless of age if incapable of self-support because of a severe physical or mental handicap which was diagnosed while coverage was in force. An enrollment form for continued coverage for a disabled child is required within 31 days of the child's age attainment (above) to maintain coverage (see 1 VAC 55-20-330).~~

1 VAC 55-20-330. Enrollment form or enrollment action.

A. No coverage is available unless an employee files an enrollment form or takes an equivalent enrollment action. No changes in coverage are effective unless an employee files an enrollment

form or takes an equivalent enrollment action. Employees alone are responsible for knowing when an enrollment ~~form~~ action is required, for ~~completing the enrollment form~~ taking the action, and for certifying that the information ~~contained therein~~ conveyed is complete and true.

B. The employer is responsible for checking that the employee fills in the form completely and accurately. The employer will certify each enrollment form in the space provided on the form.

C. The effective date of coverage shall be determined from the date the enrollment form is stamped as received by a designee of the department or the date of the equivalent enrollment action. This is generally the first of the month following receipt.

Except as noted here, coverage elections including those made by new employees are made on a prospective basis, that is, effective the first of the month following the receipt of the election form or enrollment action. However, if the receipt of the form or the date of the enrollment action is the first of the month, then the effective date will be the first of the month. Additionally, if an election form or enrollment action is received from a new employee on the first business day of the month, coverage for the new employee will commence on the first day of that month (see 1 VAC 55-20-370). Coverage elections made on account of a newborn, adoption or placement for adoption are effective the date the child is born, adopted or placed for adoption, as long as the employee makes the coverage election within 31 days of the event. Coverage terminations are effective the end of the month following receipt of an election notice, except for terminations that are required by the plan. Coverage terminations required by the plan are effective the end of the month that the event takes place. Examples of coverage terminations required by the plan are such things as a divorce, termination of employment or a dependent child losing eligibility.

1 VAC 55-20-340. Payment of contributions.

A. Active employees shall pay their portion, if any, of contributions through payroll deduction.

B. State retirees ~~who retired prior to January 1, 1991,~~ will have their contributions deducted from VRS or other retirement system. If the retirement payment is not sufficient to pay the entire contribution, they may pay their contributions directly to the department's designee. ~~State retirees retiring after January 1, 1991, shall have their contributions deducted from benefits payable from the Virginia Retirement System (VRS) or other retirement system. If the payment is not made by the retirement plan, the retirees may make payment directly to the department's designee.~~ There ~~will~~ may be an administrative fee ~~of $10 per bill~~ for direct payment. Such fee may be waived by the department if payment is made monthly by bank draft.

A credit toward the cost of coverage is made by the Commonwealth on behalf of retired state employees as provided in § ~~2.1-20.1:20~~ 51.1-1400 of the Code of Virginia.

C. Retired employees of local employers shall pay contributions by either of two methods. The retired employee may authorize contributions to be deducted from the retiree's pension payment, whether it be through the VRS or otherwise. Alternatively, if the employer so provides, the retiree may pay his contribution to the employer who shall be responsible for remitting the contributions to the department or its designee. In either case the employer is responsible for collecting and submitting the premium to the plan at the time that the active premium is submitted.

1 VAC 55-20-350. Membership.

A. Type of membership. Participants have a choice of three types of membership under the program:

1. Single (employee only). If a participant chooses employee only membership, the health benefits program does not cover the employee's dependents (spouse or children). A woman with single membership under the program does have maternity coverage. However, the newborn child is covered only for routine hospital nursery care, unless the mother changes to dual or family membership within 31 days of the date of birth.

2. Dual (employee and one eligible dependent). ~~This type of membership is available to local employer plans July 1, 1990, and to state employees January 1, 1991.~~

3. Family membership (employee and two or more eligible dependents).

B. Changing type of membership.

1. Employees may change ~~from family or dual~~ membership ~~to single membership at any time~~ subject to 1 VAC 55-20-370 ~~A. Also, employees may change from family to dual membership at any time subject to 1VAC55-20-370 A~~.

a. During open enrollment.

b. Within 31 days of a qualifying mid-year event. Any such change in membership must be on account of and consistent with the event.

c. Within 31 days of a cost and coverage change, as acknowledged by the department.

~~2. The change from single to dual or family membership the change from dual to family membership may be made only at the following times:~~

~~a. Within 31 days of employment;~~

~~b. Within 31 days of return from a leave without pay, but only if all coverage or dual or family membership was dropped during the leave;~~

~~c. During the open enrollment period;~~

~~d. Within 31 days of a change in eligibility status. If a change in eligibility status occurs during a leave without pay, dual or family membership may be elected within 31 days of returning from the leave; or~~

~~e. Infrequently, an employee is hired from a foreign country and the spouse or eligible children remain for a period of time in that country. The employee may enroll in single membership initially and submit an enrollment form for dual or family membership within 31 days of the family's arrival in this country. Coverage will be effective the first of the month after the family's arrival.~~

2. All changes in membership must be made on a prospective basis except for the birth, adoption or placement for adoption of a child.

3. If the change is from single to dual or family membership or vice versa because of a ~~change in eligibility status,~~ qualifying mid-year event, the employee must certify ~~on~~ in the enrollment ~~form~~ action the type of ~~status change~~ event and the date of the ~~change~~ event.

1 VAC 55-20-360. Choice of plans.

A. During the annual open enrollment period, state employees and non-Medicare retirees eligible to participate in the health benefits program have a choice of enrolling in any plan offered by their employer, which may often include ~~the basic plan or~~ an alternative health benefits plan offered by the department. To be eligible for membership in the health benefits program, the employee or retiree must live or work within the service area of the particular plan.

B. Employees of ~~other~~ participating local employers have a choice of enrolling in the plans offered by their respective employers. Local employers have the option of requiring that employees live within the service area of the plan the employee chooses to join or of allowing employees to join a plan if they live or work in the service area.

C. An enrollment ~~form~~ action will not be accepted outside of open enrollment except for an employee ~~whose employment status or personal status changes in specified ways addressed in the Health Insurance Manual/Local Administrative manual published by the department~~ who experiences a qualifying mid-year event.

D. The employer's contribution toward coverage, if any, shall be determined by the employer except with respect to the minimum contribution rate applicable to local employers.

1 VAC 55-20-370. Effective date of coverage.

A. General. Coverage and changes in coverage or membership are generally prospective, effective on the first day of the month following the month in which the enrollment ~~form~~ action is received by the department's designee.

B. Date coverage begins. Coverage begins on the first day of the first full month of employment ~~if the employee's enrollment form for coverage is received within 31 days of employment~~ following the receipt of the employee's enrollment action. Employees who begin work on the first working day of the month are considered employed effective the first of the month. Thus, if an employee submits the completed enrollment action on or prior to the first working day of the month, coverage will be effective the first of the month in which employment commenced. ~~[Coverage will not be available to the new employee unless the employee is on the payroll for a minimum of 16 calendar days. Employees who work less than 16 days will have any premiums refunded and any claims retracted.]~~

C. Exceptions. With prior approval from the department, coverage may be allowed to commence on an earlier date in limited circumstances when prior coverage is unavailable; for example, a new employee who has moved out of the service area of an HMO.

~~D. Eligibility changes. In the event of an eligibility change as addressed under 1VAC55-20-350, coverage may be retroactive to the date of the event provided an enrollment form for the change is submitted to the department's designee within 31 days of the event.~~

1 VAC 55-20-380. Leaves of absence.

Note: This section addresses various aspects of employee leave and may or may not be applicable to a local employer.

A. Leave of absence with full pay. As long as an employee is still receiving full pay, health benefits coverage continues ~~automatically~~ with the employer making its contribution. Nothing special must be done to maintain coverage.

Local employers are not required to contribute toward coverage for any part-time employee granted any type of leave of absence.

B. Virginia Sickness and Disability Program, Long-Term Disability (VSDP-LTD)

1. Coverage with the employer contribution continues to the end of the month in which the LTD benefits begin, unless benefits begin on the first day of the month, in which case the employer contribution will end on the last day of the preceding month. Thereafter, employees may continue coverage by paying the entire cost of the coverage.

2. Employees receiving LTD benefits may enroll in the State Retiree Health Benefits Program upon service retirement regardless of whether they have maintained health coverage in the state program provided that the individuals have been continuously covered and have had no break in long-term disability benefits prior to service retirement. The LTD participant has 31 days from the date of retirement to enroll in the State Retiree Health Benefits Program. Coverage in the retiree group begins on the first day of the first full month of retirement.

~~B.~~ C. Educational leave - full or partial pay. An official educational leave is a leave for educational reasons with partial or full pay maintained for the leave, not for work rendered. It is possible to maintain health coverage on an educational leave even when less than full pay is given provided that at least half pay is given. Coverage may continue for the duration of the leave up to 24 months.

~~C.~~ D. Leave of absence without pay.

1. Coverage with the employer contribution continues to the end of the month in which the leave without pay begins provided the first day of the leave is after the first work day of the

month. If the person returns from leave the following month and works at least half of the workdays in the month, coverage will be continuous. If the leave without pay begins on or before the first work day of the month, coverage ~~with~~ and the employer contribution ceases on the ~~first~~ last calendar day of ~~that~~ the previous month.

~~If the person returns from leave the following month and works at least half of the work days in the month, coverage will be continuous.~~

~~2. If the leave without pay extends beyond the end of the month when coverage would cease, it is possible for an employee to maintain coverage (except on a military leave). Arrangements to continue coverage must be made with the employer. Employees should contact their benefits administrator for more information.~~

~~3.~~ 2. Employees who do not want to continue coverage will be asked to sign a waiver.

~~4. The conditions under which coverage may continue, the length of time coverage may extend while on leave without pay and whether the employer contribution continues are set forth in the Health Insurance Manual /Local Administrative Manual published by the department.~~

~~D.~~ E. Changing coverage while on leave. Coverage changes may be made while on leave in the same manner that changes may be made while actively employed. The same procedures and rules apply.

An employee enrolled in an alternative health benefits plan who moves out of the plan's service area while on a leave of absence may change to another plan offered by the department in his new location by ~~filing~~ taking an enrollment ~~form~~ action within 31 days of the date of the move.

~~The employee may change back to an alternative health benefits plan within 31 days of returning to the plan's service area. A new enrollment form must be completed.~~

~~E.~~ F. Returning from leave without pay.

1. Employees who have maintained coverage while on leave without pay. If the employee has maintained coverage while on leave, the employee's coverage in the health benefits program (with the employer making its contribution) will begin on the first of the month ~~in which the employee returns to work if he works at least half of the working days in the month~~ following the date the employee returns to full-time employment. However, if the return to work falls on the first day of the month then the employer contributions may begin immediately. It is not necessary for the employee to ~~file~~ take a new enrollment ~~form~~ action.

Employees may change from single to dual or family membership within 31 days of returning from leave without pay if the employee dropped dual or family membership during the leave or if there was a ~~change in eligibility status~~ qualifying mid-year event during the leave. A new enrollment ~~form~~ action must be ~~filed~~ taken. In the case of ~~an eligibility status change~~ a qualifying mid-year event, the effective date would follow the rule on initiating dual or family membership at the time of the particular ~~eligibility status change~~ qualifying mid-year event.

2. Employees who have not maintained coverage while on leave will be treated in the same manner as new employees, unless they have exercised their rights under the Family Medical Leave Act. If these rights are exercised, they will have all rights that are required by law.

a. It shall be necessary to ~~file~~ take a new enrollment ~~form~~ action to receive coverage. The enrollment ~~form~~ action shall indicate the date the employee returned to work as the date that

the employee's continuous full-time employment commenced. If the employee remained continuously eligible, waiting periods must be credited accordingly. Family members will have to serve new waiting periods as prescribed in 1VAC55-20-420.

b. The employee has a choice of type of membership and plan.

c. The usual deadlines for filing apply. Coverage begins according to the rules and procedures for new employees.

3. Employees returning from military leave for active service. Employees returning from military leave of [six months 30 days] or more have the same choice of coverage as a new employee. If the employee returning from a military leave applies for coverage within 31 days of discharge, the coverage will begin on either the first day of the month of discharge or the first of the following month, whichever is necessary to effect continuous coverage. If the employee chooses a plan with waiting periods, the employee should be given credit toward the waiting periods for the amount of time on military leave. Dependents also are credited if they were covered under the state program prior to the leave.

[4. Employees returning from leave in a country with national health coverage who reside outside of the United States will not be eligible for coverage under the state health benefits program if they are also eligible for national health care from the country in which they are residing. Upon the return to the United States these employees must apply for coverage within 31 days] of returning to the United States to have waiting periods credited and to have a choice of effective dates. The effective date for coverage will be the first of the month that the

~~person returned to the United States or the first of the following month, whichever is necessary to effect continuous coverage~~.

[~~5~~4]. Taking a second leave without pay. If an employee returns from a leave without pay and is employed full-time on every scheduled work day for at least one full calendar month before taking another leave without pay, the second leave will be treated as a new leave.

If there is less than one calendar month of full-time employment between leaves without pay, the leaves will be treated as one, regardless of the types of leave. The length of time that coverage may be continued will depend on the current type of leave.

1 VAC 55-20-390. Termination of coverage.

A. Coverage ends at the end of the month in which an employee terminates the employment relationship, otherwise loses group eligibility, or on the last day of the month for which premiums are paid.

B. Coverage ends on the date of a participant's death. Coverage for family members continues until the end of the month following the month in which the participant died.

1. A surviving beneficiary may enroll in the state retiree group if:

a. The dependent is eligible for an annuity under the VRS death-in-service provision;

b. The employee had submitted a disability retirement application naming the dependent under the survivor option before his death and the employee died prior to achieving the retirement date; or

c. The death was job related.

To continue coverage, the family member must apply within [60 ~~31~~] days of the date the coverage would otherwise end due to the death.

2. Survivors of deceased employees who are not eligible for an annuity from VRS can nonetheless be covered under the State Health Benefits Program if they had coverage at the time the employee died. To continue coverage, the family member must apply within 60 days of the employee's death.

C. In the event that an employee on leave without pay notifies the employer that he is terminating employment, coverage ends on the last day of the month in which the leave without pay ceases.

1 VAC 55-20-400. Termination of employment.

A. Coverage continues to the end of the month in which an employee terminates. Each terminating employee may elect continuation of coverage pursuant to Internal Revenue Code section 4980B and accompanying regulations.

B. Terminating employees may also have the option of converting to a non-group policy. The carrier will send the employee a letter offering non-group coverage. The employee will have 30 days after the date of the letter to reply in order for coverage to be continuous. All terminating employees will be given certificates of coverage as required by the Health Insurance Portability and Accountability Act.

1 VAC 55-20-410. Suspension and reinstatement.

A. General.

1. Coverage generally continues through the end of the month in which the suspension began. However, if the suspension was effective on or before the first work day of the month, there will be no coverage for that month unless the employee is reinstated in time to work half of the work days in the month. For example, if a suspension is effective on April 19, the employee will have coverage through the end of April. If the suspension is effective April 1, the employee will have no coverage in April. By the same token, if the suspension is effective April 2 and the employee's first workday in April is April 3, the employee will not have coverage in April. If the employee is reinstated in time to work half of the workdays in the month following the month in which the suspension began, there will be continuous coverage.

2. If the employee is suspended pending court action or pending an official investigation, the suspension may go beyond one pay period. In these cases, coverage will continue to the end of the month in which the suspension began. If the employee is reinstated in time to work half of the workdays of the month following the month in which the suspension began, there would be no break in coverage. Suspension beyond that period should be handled in the same way as a leave without pay with no employer contribution. The employee may remain in the group by paying monthly contributions to the employer in advance. Group coverage may continue until a court decision is issued or the official investigation is completed, or up to a period of 12 months, whichever is less.

3. If the employee is reinstated with back benefits, the employer should refund the employee the amount of the employer contribution during the period the employee paid the full premium. Single membership should be reinstated retroactive to the date the employee was removed from the group up to a limit of ~~three months~~ 60 days. Retroactive dual or family membership

will be available up to a maximum period of ~~three months~~ 60 days. Appropriate contributions must be made to cover the retroactive period. Alternatively, the family membership may begin the first full month of reinstatement if the employee applies within 31 days of reinstatement. ~~If there is a lapse in dual or family membership, waiting periods, where applicable, will be in force on dependent coverage unless the reinstated employee chooses the three months' retroactive family coverage.~~

B. Termination and grievance reinstatement.

1. Employees who are terminated and file a grievance shall be treated as terminated employees and may elect extended coverage or nongroup coverage. In the event such an employee is reinstated with back pay, ~~they~~ he will be given single membership retroactive up to ~~three months~~ 60 days. Retroactive dual or family membership will be available up to a maximum period of ~~three months~~ 60 days. Appropriate contributions must be made to cover the period.

2. If the employee is reinstated without full back pay, no retroactive coverage is available~~, and both the reinstated employee and the dependents must serve waiting periods, unless the reinstatement order specifically addresses health benefits~~.

1 VAC 55-20-420. ~~Waiting periods.~~ (Repealed.)

~~A. General. With the exception of coverage under HMOs, waiting periods apply for certain services and preexisting conditions.~~

~~There is a 12-month waiting period for the following services:~~

1. Pregnancy, if conception occurred prior to the effective date of coverage;

2. Hernias of any type or location;

3. Tonsil or adenoid operations;

4. Sterilizations;

5. Tuberculosis;

6. Acquired Immune Deficiency Syndrome;

7. Elective surgical services. This is nonemergency surgery. "Elective" means that the surgery can safely be postponed for 72 hours.

8. Preexisting conditions (the waiting period also applies to complications or increases in severity of the preexisting condition).

B. Twelve-month waiting period for major medical services. There is also a 12-month waiting period for services paid for under the major medical provisions of the plans or under the comprehensive plan. This waiting period begins on the participant's effective date. However, this waiting period is only for preexisting conditions and there is one exception. After 90 consecutive days during which the participant has not received any health care services or supplies for a preexisting condition, major medical services for that preexisting condition will be covered. The 90-day period may begin before the participant's effective date of coverage but must end on or after the participant's effective date.

C. Preexisting conditions.

1. These waiting periods do not apply to a participant's child who has been covered under the program since birth.

2. Participants will not be required to serve waiting periods if enrolling under the program directly from an HMO in which the participant is enrolled as a state or local employee or as a spouse or dependent of a state or local employee.

3. Dependents of reinstated employees may not have to serve waiting periods if the employee elects retroactive coverage in accordance with 1VAC55-20-410 A.

1 VAC 55-20-430. Coordination of benefits.

A. General. All covered services a participant receives are subject to this section. If a participant is eligible for coverage under two or more health plans (as defined below), benefits will be coordinated to avoid duplicate payments. The health plans involved will share the responsibility for benefits according to the priority rules listed below. Except as otherwise provided, benefits under this section will not be increased by virtue of this section.

B. Special rules. The following rules apply when participants have a claim for a coordinated service:

1. If the other health plan does contain a coordination of benefits provision of similar purpose to the one in this section, the following will apply in the order of priority listed:

a. Primary coverage will be the health plan which lists the person receiving services as the participant, not as a dependent;

~~b. Primary coverage for an enrolled child will be the health plan which lists the parent whose month and day of birth occurs earliest in the calendar year as a participant, except in the following circumstances:~~

~~(1) When the parents are separated or divorced and the parent with custody of the child has not remarried. Primary coverage will be the health plan which covers the child as a dependent of the parent with custody.~~

~~(2) When the parents are divorced and the parent with custody of the child has remarried, primary coverage will be the health plan which covers the child as a dependent of the parent with custody. In this case, the health plan of the husband or wife of the remarried parent with custody may provide primary coverage if the remarried parent with custody does not have a health plan which covers the child.~~

~~c. Notwithstanding subdivisions (1) and (2) of 1VAC55-20-430 B 1 b, if there is a court order which requires one parent to provide medical or hospital coverage for the child, primary coverage will be that parent's health plan.~~

~~2. If subdivisions a and b of 1VAC55-20-430 B 1 do not apply, primary coverage will be the health plan which has covered the participant for the longest uninterrupted period of time, except when both health plans have the same priority rules for retired or laid-off employees. In this case, primary coverage will be the health plan which covers the participant as a working employee or dependent of a working employee. Secondary coverage will be the health plan which covers the participant as a retired or laid-off employee or dependent of such an employee.~~

~~3. If a health plan does not have a coordination of benefits provision of similar purpose to the one in this Part IV (1VAC55-20-320 et seq.), that health plan will be the primary coverage.~~

~~C. Payment of coordinated benefits.~~

~~1. At the option of the health plan, payments may be made to anyone who paid for coordinated services received. These benefit payments by the health plan are ones which normally would have been made to the participant or on his behalf to a covered facility or provider. The benefit payments made by the health plan will satisfy the obligation of the health plan for covered services.~~

~~2. A participant is required to notify the health plan that he is enrolled under another health plan. The health plan is not required to investigate to determine whether or not a participant is covered by another health plan. The health plan will determine coordinated services when the health plan is made aware of enrollment under another health plan.~~

~~D. Right of recovery.~~

~~1. If the health plan provided primary coverage and discovers later that it should have provided secondary coverage, the health plan has the right to recover any excess payment from any person or organization, including the participant. If the plan requests a refund, it will send a written notice to the participant.~~

~~2. If excess benefit payments are made, the participant must cooperate with the plan in exercising its right of recovery.~~

~~E. Right to receive and release necessary information.~~

~~1. As a condition of coverage under the program, the participant is obligated to supply the health plan the information needed to administer this section. This must be done before the participant is entitled to receive benefits under this section.~~

~~2. The health plan has the right to obtain or release information about covered services or benefits received. This right will be used when working with another person or organization to settle payments for coordinated services. Prior consent of the participant is not required.~~

A. Employees are required to notify the plan administrator that they or a covered dependent are enrolled under another plan. If a plan participant is eligible for coverage under two or more plans, the plans involved will share the responsibility for the participant's benefits according to these rules.

B. If the other health benefit plan contains a coordination of benefits provision establishing the substantially same order of benefit determination rules as the ones in this section, the following will apply in the order of priority listed:

1. The plan that lists the person receiving services as the enrollee, insured or policyholder, not as a dependent, will provide primary coverage. There is one exception. If the person is also entitled to Medicare, and as a result of federal law Medicare is (i) secondary to the plan covering the person as a dependent; and (ii) primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering the person as other than a dependent.

2. Primary coverage for an enrolled child will be the plan which lists the parent whose month and day of birth occurs earliest in the calendar year as an enrollee, insured, or policyholder, except in the following circumstances:

a. When the parents are separated or divorced, primary coverage will be the plan that covers the child as a dependent of the parent with custody. The plan of the husband or wife of a remarried parent with custody may provide primary coverage if the remarried parent with custody does not have a plan that covers the child.

b. Despite subdivision 2 a of this subsection, if there is a court order that requires one parent to provide hospital or medical/surgical coverage for the child, primary coverage will be that parent's plan. If the specific terms of a court decree state that the parents will share joint custody and the court decree does not state that one of the parents is responsible for health care expenses of the child, then the rule set forth in the first sentence of subdivision 2 of this subsection, the birthday rule, will apply.

3. If subdivisions 1 and 2 of this subsection do not apply, primary coverage will be the plan that has covered the participant for the longest uninterrupted period of time. There are two exceptions to this rule:

a. The benefits of the plan that covers the person as a working employee (or the employee’s dependent) will be determined before those of the plan that covers the person as a laid-off or retired employee (or the employee’s dependent).

b. The benefits of the plan that covers the person as an employee (or the employee's dependent) will be determined before those of the plan that covers the person under a right of continuation pursuant to federal or state law.

C. If a plan does not have a coordination of benefits provision establishing substantially the same order of benefit determination rules as the ones in this section, that plan will be the primary coverage.

D. If, under the priority rules, the state plan is the primary coverage, participants will receive unreduced benefits for covered services to which they are entitled under this plan.

E. If the other plan is the primary coverage, the participant's benefits will be reduced so that the total benefit paid under this plan and the other plan will not exceed the benefits payable for covered services under this plan absent the other plan. In calculating benefits that would have been paid under this plan absent the other plan, any reduction in benefits for failure to receive a referral will not be considered. Benefits that would have been paid if the participant had filed a claim under the primary coverage will be counted and included as benefits provided. In a calendar year, benefits will be coordinated as claims are received.

F. When a health benefit plan provides benefits in the form of services, a reasonable cash value will be assigned to each covered service. This cash value will be considered a "benefit payment."

G. At the option of the plan administrator, payments may be made to anyone who paid for the coordinated services the participant received. These benefit payments by the administrator are ones that normally would have been made to the employee or on the employee's behalf to a

facility or provider. The benefit payments made by the administrator will satisfy the obligation to provide benefits for covered services.

H. If the administrator provided primary coverage and discovers later that it should have provided secondary coverage, the administrator has the right to recover the excess payment from the employee or any other person or organization. If excess benefit payments are made on behalf of the employee, the employee must cooperate with the administrator in exercising its right of recovery.

I. Employees are obligated to supply the plan administrator all information needed to administer this coordination of benefits provision. This must be done before an employee is entitled to receive benefits under this plan. Further, the employees must agree that the administrator has the right to obtain or release information about covered services or benefits received. This right will be used only when working with another person or organization to settle payments for coordinated services. The employee's prior consent is not required.

1 VAC 55-20-450. Basic plan.

The department ~~provides a medical and hospitalization plan (the "basic plan"). This plan is available to eligible participants wherever they reside. The coverage is divided into two major parts:~~ may provide self-funded plan(s) administered by a third party administrator including, but not limited to, an exclusive provider organization (EPO) and a point of service plan (POS). These plans are described in the employee handbooks, which are distributed to employees upon enrollment. The department shall denote a self-funded plan as the "basic plan," which is

required by code to be available throughout the state and shall provide the basis for all employer contributions.

~~1. Hospital and physician coverage - pays for covered hospital expenses; pays for covered doctor's care and other medical services up to the usual, customary, and reasonable allowance (UCR).~~

~~2. Major Medical - supplements the basic plan with a lifetime maximum for services such as local ambulance services, private duty nursing, and other services. Major medical payments for covered services are made subject to a deductible and coinsurance. When a participant's covered expenses exceed a specified amount in a calendar year, major medical pays 100% UCR for the balance of the calendar year. This 100% payment does not apply to outpatient mental and nervous services. Employees are also eligible for an outpatient prescription drug program.~~

1 VAC 55-20-460. Alternative health benefit plans.

The department also offers several health maintenance organization and preferred provider organization plans which are available to participants residing in the service area of the HMO or PPO. A list of these plans is available upon request to the department.

Non-Medicare-eligible retirees have the same enrollment options as active employees.

Retirees must enroll in a plan within 31 days of separation for retirement. A separating employee who defers retirement will not be eligible to enroll in a retiree medical plan when the former employee seeks retirement benefits.

1 VAC 55-20. Commonwealth of Virginia Health Benefits Program

NOTICE: The forms used in administering 1 VAC 55-20, Commonwealth of Virginia Health Benefits Program, are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Human Resource Management, 101 N. Fourteenth Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Adoption Agreement.

Health Benefits Program Application.

Enrollment Application/Waiver Form SHBP (rev. ~~4/94~~ 3/01).

~~Notification of Student Status.~~

Out of Area Exception Form.

Name/Address Change.

Claim Forms.

Extended Coverage.

~~Medical Hospitalization Payment Summary.~~

Explanation of Benefits.

Interagency Transfer Invoice.

~~Commonwealth of Virginia Application for Employment, DPT Form 10-012 (rev. 5/93).~~

~~Supplemental Experience DPT Form 10-012A (rev. 5/93).~~

HIPAA Certificate.

VA.R. Doc. No. R02-220; Filed August 4, 2003, 3:38 p.m.

I certify that this regulation is full, true, and correctly dated.

_____

Signature

Sara R. Wilson, Director

Department of Human Resource Management

Date _____