THE LOCAL CHOICE ADMINISTRATIVE MANUAL

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I. INTRODUCTION

A. THE LOCAL CHOICE OVERVIEW

The Local Choice Health Benefits Program was created exclusively for local governments, authorities, school divisions and constitutional officers. Launched in July 1, 1990, the program is managed by the Commonwealth of Virginia's Department of Human Resource Management (DHRM), the same team of administrators that manages the State's employee health benefits program.

While created by an act of the General Assembly, the program is designed to be self-supporting. Premium dollars collected from member groups represent the entire funding for the program.

B. RESPONSIBILITIES OF LOCAL EMPLOYER MEMBER GROUP

Definition of "Group Benefits Administrator or BA" – Each local employer has its own organizational structure for administering The Local Choice Health Benefits Program. Responsibilities may be divided between a personnel officer and a payroll officer. Because of organizational differences among employers, we use the term "Group Benefits Administrator" to refer to the individual (or individuals) responsible for the duties associated with administering the program.

Employee Communications – A Group Benefits Administrator should counsel employees about the types of health benefits plans available to them. The BA should make certain that employees have accurate information about the health benefits plans. The most important duty of the Group Benefits Administrator is to ensure that employees receive all health benefits information and that they know when they may apply for initial health benefits coverage or for changes in plan or membership.

Orientation – The BA should assist employees and retirees with enrollment and changes in plan or membership. An employee may be disadvantaged by losing the opportunity to enroll in coverage or by paying excess premiums if he does not apply for coverage (or changes in membership) within certain time limits. You must be familiar with benefits and eligibility requirements.

New employees should receive information regarding eligibility for Extended Coverage. The Extended Coverage General Notice in this manual serves this purpose. Group Benefits Administrators are the source for employee information on eligibility and The Local Choice Program policy. Also, the Department of Human Resource Management (DHRM) provides communication and educational materials to help employees better understand their benefits and program rules. The Local Choice Web site is another important source for information such as plan handbooks, program guides, sequential memos, and other documents that may assist the group benefits administrator. The address is http://www.thelocalchoice.virginia.gov.

Each month, the Group Benefits Administrator is responsible for reporting changes in coverage or membership by completing the Group Payment Transmittal. Changes should be reported accurately and promptly so that the health benefits plan, in turn, has up-to-date information in its files. Remember, employees or their dependents could be denied admission to a hospital, or have claims denied, if there is no record of their membership.

Premium and Claims Payment – The health benefits plan must keep accurate records in order to deliver health benefits coverage to employees as quickly and efficiently as possible. One of your most important responsibilities as Group Benefits Administrator is keeping the plans informed of the membership status of employees.

Each month the health benefits plan will send you a Group Listing and a Payment Transmittal Form. Group Benefits Administrators must use this as a tool to identify discrepancies between the two records. Discrepancies must be resolved or they may create unexpected liability for the employee or employer.

Group Listing – The Group Listing outlines the information that plan records show about employees-I.D. numbers, type of membership, coverage codes, individual rate, arrears, and enrollment changes that have been made since your last bill (including additions, cancellations, or changes in type of membership or coverage).

The Group Listing, sent to you with the Payment Transmittal Form, also shows billing detail of employees for whom you are being billed. Before you begin to complete your Payment Transmittal, please check the Group Listings to ensure that all participants are listed and that the plan has made all changes that you noted on previous Payment Transmittal Forms.

Payment Transmittal Form – The Payment Transmittal Form is the statement of your employer's premiums for participants shown on the Group Listing. The information you record on the Payment Transmittal Form is essential to accurate record keeping for employees enrolled in the health benefits plan.

Claims Procedures – Under most circumstances, employees and retirees in The Local Choice Health Benefits Program do not have to file claims for health care services. Most network providers, and many non-network providers, submit claims directly.

Group Benefits Administrators should help employees understand claims issues if there are unresolved questions after contact with the plan's customer service units. You should not relate claims information if you are uncertain of its accuracy and you should always maintain confidentiality. Group Benefits Administrators should hold in confidence information on an enrollee's type of membership or plan, and information relating to an enrollee's medical services or claims. You should encourage employees to help contain health care costs whenever possible. With today's high cost for medical care, it is important that each person do his part by using benefits wisely. This helps to reduce claims experience for your Group and to keep rates as low as possible.

The Local Administrative Manual (LAM) is the administrative manual for The Local Choice Health Benefits Program, and is maintained and updated by DHRM's office of State and Local Health Benefits. This manual should help you answer most questions that arise. If you still need more information, the health benefits specialists in DHRM are always available to assist you.

II. ELIGIBILITY

A. ELIGIBLE EMPLOYEES

The Local Employer defines the categories of employees and retirees eligible to enroll when the Employer Application is completed and forwarded to the Department of Human Resource Management (DHRM) / The Local Choice (TLC).

Full-time employees of participating employers are eligible to participate in the Program and some or all classifications of part-time employees of Local Employers may participate in the Program if the employer elects. The employer determines conditions of participation for these employees. However, all part-time employees in the same classification must be treated similarly.

Retired Employees – Effective July 1, 2006:
TLC eligibility will mirror the retirement requirements of VRS whether or not a group participates with VRS. Those requirements will be:

A retiring employee must meet the employer's criteria for retirement to be eligible for health benefits coverage through the employer "Retiree Group." In addition to meeting the Local Employer criteria, the retiree must be:

At least 55 years of age, have at least five (5) years of service with the participating employer and be eligible for and receive an immediate annuity through the group's primary employer-sponsored retirement program or at least 50 years of age have at least ten (10) years of service with the participating employer and be eligible for and receive an immediate annuity through the group's primary employer-sponsored retirement program.

Employees who defer retirement are not eligible to enroll in The Local Employer's Retiree Group. A deferred retirement is one where the employee terminates service and does not elect or is ineligible for an immediate retirement annuity.

Unless a future effective date for retiree coverage is stated on the application, current retirees who are eligible for participation on the effective date of your Group will be offered a one-time opportunity to enroll in one of The Local Choice Health Benefits Program plans.

Future retirees must apply for retiree health benefits within 31 days of the separation from active service. Medicare will be the primary payer for retiree's age 65 or older (or those who are otherwise eligible for Medicare). The Program's plans will serve as a complement to Medicare's coverage.

NOTE: Elected officials that make up the governing body of a Local Employer may be eligible as either a special class of full-time employee or as part-time employees. They may not, however, participate in the retiree classification. Temporary employees, appointed board members or appointed commissions are not eligible for coverage under The Local Choice.

B. WHEN COVERAGE BEGINS AND ENDS

Coverage begins on the first day of the first full month following receipt of the employee's enrollment form. If the employee wishes to enroll or to cover family members, the enrollment form must be received within 31 days of the date of hire. Otherwise, the employee and eligible family members may be enrolled at Open Enrollment or if there is a Qualifying Mid-Year Event. Mid-year plan changes must be on account of and consistent with the event that allows the change. An employee who begins work on the first workday of the month may be covered, effective the first calendar day of the month, if the employee enrolls for health care benefits on or before the commencement of that workday. Effective dates of coverage for enrollment received within 31 days will be first of the month coinciding with or following the receipt of the election form. For example, if a new employee begins work on June 15th and submits his enrollment form on July 1 the coverage effective date will be July 1. Waiting periods are permitted as long as they do not discriminate and are uniformly applied to all employees.

Delayed enrollment in single membership is permitted only at Open Enrollment or with a Qualifying Mid-Year Event. For health benefits to begin, new employees must be on payroll on the effective date of coverage. An employee enrolled in coverage for one day is eligible for Extended Coverage if the Local Employer has 20 or more employees.

Active group coverage ends at the end of the month in which an employee terminates work or otherwise loses group eligibility. 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 coverage.

For Local Employers with 20 or more employees, Extended Coverage must be offered to all covered persons in the case of a Qualifying Event that causes the employee or dependent to lose eligibility. *Group with fewer than 20 employees are not eligible for Extended Coverage.*

When an employee or dependent loses coverage for any reason, they are entitled to receive a Certificate of Creditable Coverage from the Local Employer. A Certificate of Coverage provides evidence of prior health coverage. Employees may need to furnish this certificate if they become eligible under a group health plan that excludes coverage for certain medical conditions that existed before enrollment. This certificate, as required by the Health Insurance Portability and Accountability Act of 1986 (HIPAA), is available to all employees leaving The Local Choice Health Benefits Program.

Summary of Enrollment Deadlines – The following chart summarizes the deadlines for applying for coverage or making changes in membership.

SUMMARY OF ENROLLMENT DEADLINES

Type of Membership	If You Apply	Coverage Becomes Effective
Single Membership, Employee Plus One, or Family Membership	Within 31 days of employment	Coverage elections 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 the employee's start date is the first business day of the month and, if an election action is taken that day, coverage for the employee will commence on the first day of that month.
	During the Annual Open Enrollment	The beginning of the group's plan year, usually July 1 for most groups but may be October 1 for certain school groups.
	At any time later	Only with a consistent Qualifying Mid-Year Event, coverage begins on the first of the month following receipt of the Enrollment Form. With birth or adoption, coverage is effective on the first of the month of the event.

Active employee's dependents that are eligible for Medicare due to disability may choose to remain in the plan and the plan will be their primary insurance. Those persons who are eligible for Medicare because they are diagnosed with end stage renal disease (ESRD) may also either remain in the active health benefits group or discontinue coverage upon Medicare eligibility. However, if The Local Choice Health Plan coverage is maintained, it will pay primary to Medicare during the 30-month coordination period. After the initial 30-month period, Medicare will become the primary payer, and The Local Choice plan will coordinate with Medicare and pay secondary on claims. Contact the Social Security Administration or Medicare for more information about enrolling for Medicare Part B coverage.

It is essential that Medicare eligibility be communicated to The Local Choice. Failure to inform the plan could result in denied or retracted claims.

C. TYPES OF MEMBERSHIP

Single Membership – Single membership covers only the employee. When maternity services are covered for a member of The Local Choice Health Benefits Program, the infant's routine nursery care is covered. Coverage for the newborn beyond routine nursery services will be available only if the child is enrolled within 31 days of birth. Coverage for the newborn should be effective on the first day of the month of birth.

Employee Plus One Membership – If an employee elects Employee Plus One membership, the employee and either the spouse or one other eligible dependent may be covered. The eligibility rules for family members are described under Family membership.

Family Membership – The following dependents are also eligible for membership:

- The legally married spouse of an eligible employee.
- The eligible employee's unmarried biological or legally adopted child(ren).
- A child placed in an eligible employee's home under a pre-adoptive agreement that has been approved by the Department of Human Resource Management. Such an agreement must (1) stipulate that the biological parents have ceded all parental rights, including care, custody, and visitation, and (2) vest responsibility for the welfare of a child in a court or public agency appointed by a court.
- Unmarried stepchildren living full time with the eligible employee in a parent-child relationship and who are eligible to be claimed as a dependent on the eligible employee's federal income tax return.
- Disabled adult children who are certified as disabled by the Plan and apply within 31 days of the child's losing eligibility. A child who recovers is no longer eligible and should the child become disabled again they will not be allowed to re-enroll.
- Other children, on an exception basis approved by the Department of Human Resource Management, if the children are in the permanent custody of the eligible employee pursuant to an order of a court. Policy requires that an employee have sole custody for an "other child" in order for that child to be eligible for coverage unless custody is shared with the minor child who is the parent of the "other child" living in the home of the employee, or custody is shared with the employee's spouse who also lives in the home.
- A child living in the household of the employee, in a parent child relationship is eligible for coverage so long as either the employee or spouse has sole custody. Custody does not have to be shared with the employee.

Ineligible Persons – The following persons are never eligible for membership:

- A child who is married. (Coverage for a dependent child stops at the end of the month in which they marry.)

- A child who does not live at home and is not claimed on his/her parent's federal income tax return. Living with the other parent (if the employee is divorced), or living away at college or boarding school will be considered living at home.(Change pending fast track regulation)
- A child over the age of 23, unless eligible through disability. (Eligibility may continue through the end of the calendar year in which the child turns 23.)
- Stepchildren who do not live full time with the employee and/or stepchildren living with the employee who are not claimed as dependents on the eligible employee's federal income tax return.
- Parents.
- Grandparents.
- Brothers or sisters, unless found eligible by the Department of Human Resource Management as other children described above.
- Grandchildren, unless found eligible by the Department of Human Resource Management as other children described above.
- Ex-spouses. A court order or separation agreement that requires an employee to provide coverage for an ex-spouse does not make an ex-spouse eligible for coverage through the employee health benefits program.

NOTE: An employee's failure to remove ineligible persons from his or her health benefits membership can result in the retraction of claims and removal from the plan for up to three years according to the regulations governing The Local Choice Health Benefits Program. The employee may not be allowed to reduce health benefits membership except within 31 days of the dependent's loss of eligibility, during open enrollment or with another consistent Qualifying Mid-Year Event.

D. OPEN ENROLLMENT (OE)

Although there is variation among Employer Groups, for most, Open Enrollment occurs in the spring. During this period employees may change health benefits plans or type of membership (including enrolling in Employee Plus One or Family membership, or waiving cover). It is highly recommended that all TLC groups conduct an annual Open Enrollment. Without OE, plan and membership changes will not be permitted without a Qualifying Mid-Year Event.

For most groups, new elections become effective July 1. For some school groups, new elections become effective October 1.

Prior to the Open Enrollment period, the employer should order enrollment materials. The Group Benefits Administrator should distribute these materials to all eligible employees prior to the first day of the Open Enrollment period and make sure that all employees, retirees, and Extended Coverage participants, if applicable, are notified of the actions they may take during Open Enrollment.

The employee must sign and submit the Enrollment Form and other relevant documents to the employer during Open Enrollment if he or she wishes to make enrollment changes for July 1 (or October 1, if applicable).

Employers should not accept Enrollment Forms after the close of business on the last day of Open Enrollment. This rule must be observed very strictly. Late Open Enrollment forms will only be accepted if the employer certifies in writing that the enrollment is late due to the employer's administrative error and DHRM concurs.

An employee who has submitted Enrollment Forms to change coverage during Open Enrollment may withdraw them during the Open Enrollment period if they have not been processed. If the Group Benefits Administrator has processed them, that Enrollment Form may be nullified by submitting a new complete Enrollment Form for the coverage desired during Open Enrollment. If two Enrollment Forms bear the same date, the Form that is processed last will be the effective date used. The employee has no further control and should not be given a choice, since this acts as an extension of the Open Enrollment period for that employee. No withdrawals are permitted after the close of Open Enrollment unless the employee can prove fraud, coercion, or some other valid reason with which DHRM concurs.

All Enrollment Forms must be processed within the time frame established by DHRM and should be processed by the employer as quickly as possible. Employees will not receive identification cards and claims may be denied if Enrollment Forms are not processed promptly.

E. MEDICARE RETIREES AND EARLY RETIREES

Service Retirement – This section is for use by employers who provide a health benefits program to retired employees. A retiring employee must meet the employer's criteria for retirement to be eligible for health benefits coverage through the employer "Retiree Group." In addition to meeting the Local Employer criteria, the retiree must be:

- At least 55 years of age and have at least five (5) years of service with the participating employer; or
- At least 50 years of age and have at least ten (10) years of service with the participating employ; and
- Be eligible for and receive an immediate annuity through the group's primary employer-sponsored retirement program.

Employees who defer retirement are not eligible to enroll in The Local Employer's Retiree Group. A deferred retirement is one where the employee terminates service and does not elect or is ineligible for an immediate retirement annuity. Persons who defer retirement may be eligible for Extended Coverage or non-group coverage at termination (and conversion to non-group when Extended Coverage expires.)

To assure a smooth transition from employee coverage to retiree coverage, it is important to assist retiring employees in applying for coverage. The key to a smooth transition is to make certain that retiring employees who are eligible for coverage complete The Local Choice Health Benefits Program Enrollment Form three months before retirement but no later than 31 days after retirement.

Retiree Coverage – Normally, retirees must apply for coverage within 31 days of termination of employment for retirement.

Retirees and their dependents not eligible for Medicare – may choose from the same plans as active employees.

Retirees and their dependents over age 65 – (or who otherwise are eligible for Medicare) may be covered by one of our Medicare supplement plans. New TLC groups may select either Advantage 65 or Advantage 65 or Advantage 65 with Dental/Vision. If Medicare Complementary is offered, it may be continued and new retirees may be enrolled. If the Local Employer terminates Medicare Complementary, it may not be offered again. A Local Employer may select only one retiree plan option.

Retirees who cancel or decline coverage may not go into the plan in the future.

NOTE: *You should inform retiring employees that this is their only opportunity to enroll in the Retiree Group unless* the retiree is enrolled in a spouse's ACTIVE employee health benefits membership through the same employer. If this is the case, when the active employee terminates or retires, the spouse may elect to come into the Retiree Group within 31 days of the event. *Retiring employees who do not wish to enroll in The Local Choice Retiree Health Benefits Program should sign the waiver portion of the Enrollment Form.*

Both The Local Choice Health Benefits Program and the Social Security Administration (SSA) will consider the employee age 65 on the first of the month in

which he or she turns age 65. For health benefits purposes, if the employee plans to retire at age 65, the transition from active employee to retiree is much smoother if the retirement date is also the first of the month in which the employee turns 65. Both Part A and B of Medicare must be secured in order to get maximum benefits from the plan. If enrolling in The Local Choice Health Benefits Program as a retiree, the retiree must enroll in a TLC self-funded plan that coordinates with Medicare.

If eligible at the time of separation from service, a retiree may enroll in retiree coverage within 31 days of retirement even if they had previously waived coverage in the Active Group. A retiree may also apply to add eligible family members within 31 days of retirement even though they may not have been covered while the employee was actively employed.

Enrollees Eligible for Medicare – Medicare is a health insurance program for most people 65 and older and some people under 65 who are disabled or have end-stage renal disease. It is a Federal Government program administered by the Centers for Medicare and Medicaid Services (CMS) formerly known as Health Care Financing Administration (HCFA). Active employees or their covered dependents that are Medicare-eligible may elect Medicare as their primary coverage and leave the Local Employer Group, or they may elect to continue full coverage in the Active Group. Employees who elect to remain in the Active Group may defer enrollment in Medicare Part B and D until retirement, when, if they elect to participate in the retiree program (if offered by the Local Employer), they must enroll in a plan that supplements Medicare. The Social Security Administration (SSA) is the appropriate source for detailed information on this and other aspects of Medicare eligibility and coverage. You may contact the SSA by calling toll free 1-800-772-1213, or by visiting the Web site at www.ssa.gov. Medicare may be contacted at 1-800-633-4227 or at www.medicare.gov.

Retirees, if eligible, who wish to continue coverage through The Local Employer Group when they become Medicare-eligible should enroll in Parts A and B of Medicare because the TLC retiree plans do not pay for services covered by Medicare. Enrollment with a Medicare Part D provider may also be advisable since TLC programs that supplement Medicare do not provide coverage for Outpatient Prescription Drugs. With Medicare eligibility, they become ineligible for coverage under the plans offered to active employees.

A person who has enough quarters or employment under Social Security will be eligible for Medicare on the first day of the month that he or she turns age 65. If the birth date is on the first day of the month, the employee is eligible for the first day of the previous month.

How to Enroll in Medicare – For complete information about enrolling in Medicare, employees must contact their local Social Security office at 1-800-772-1213. Employees and retirees who are turning age 65 should apply three months before their 65th birthday.

TLC Plans When Medicare is Primary

The Advantage 65 Plan (if offered by a Local Employer) – is the self-insured plan available to Medicare-eligible retirees and their covered Medicare-eligible family members. Advantage 65 does not provide full-coverage for most medical care; it simply pays some of the Medicare deductibles and co-insurance. Advantage 65

does not provide outpatient prescription drug benefits. An Employer may elect to add the Dental/Vision Plan to Advantage 65.

The Regional HMO – plan in the TLC program is generally not available to Medicare-eligible retirees or their Medicare-eligible family members.

The Medicare Complementary Plan (Option I) – is no longer available except for those grandfathered under the plan. For groups currently covered by Medicare Complementary, please note that there is no coverage for outpatient prescription drugs.

NOTE: A Local Employer may elect only one retiree plan. Employees will not be allowed to pick the coverage they desire.

Medicare retirees may prospectively terminate coverage at any time. Once coverage is declined or canceled, the Medicare retiree may not enter the plan.

Advantage 65 is not offered to active employees and their dependents even if eligible for Medicare. Benefit plans and rates are the same as for other active employees. Local Employer contributions continue.

Employees eligible for Medicare may waive TLC coverage.

Retired Employees

The Local Choice Group may elect to offer coverage to retirees and their eligible dependents.

- Non-Medicare eligible retirees may remain in the selected plan until reaching age 65 or eligibility for Medicare, which ever comes first.
- A Medicare supplement plan may be available to retirees upon enrollment in Medicare Parts A and B. Enrollment with a Medicare Part D provider may also be advisable since TLC plans that supplement Medicare do not offer coverage for Outpatient Prescription Drugs.
- Eligible dependents may be covered under either plan based on their Medicare status.
- Eligible dependent children of a retiree may be covered through the end of the year in which the child turns age 23 as long as the child is not self-supporting or married. Adult disabled children may be eligible for coverage based on TLC dependent eligibility guidelines.
- The Local Employer must offer coverage for non-Medicare eligible retirees if a Medicare supplement plan is offered.

Retiree Coverage Funding Options Available to Local Employers – A Local Employer is not required to offer retiree coverage. If Retiree coverage is chosen, the employer may elect to cover only Retirees Not eligible for Medicare (early retirees), early retirees and Medicare Eligible retirees or both categories. An employer may not choose to cover only Medicare Eligible retirees since there can be no gap in coverage for employees going into a TLC retiree program.

The employer must also decide how to fund the early retiree benefit. Stand-Alone or Blended rate plans are available.

- Stand-Alone – The actuarial cost to provide coverage for early retirees is 2 to 3 times higher than for active employees. The first and simplest option is to apply stand-alone rates that are currently 2.0 times higher than active rates. Stand-alone rates do not impact the cost of coverage for active employees and may be initiated at the first of any month with 60 days notice.

- Blended – While blended rates still take into consideration the higher actuarial cost to provide the early retiree benefit, the additional cost is spread among all active participants in the plan. All active employees and early retirees pay the same premium, making the benefit more affordable for the typical early retiree. Groups with fewer than 50 participating employees that elect early retiree coverage are automatically blended. Larger groups must choose a funding option as well as whether or not to offer the coverage. Blended coverage may only be initiated on the plan anniversary date of July 1 (or October 1 for certain school groups).

Medicare Eligible retiree coverage is pooled for all TLC groups, meaning that rates are the same for all groups. Renewal rates are based on the experience of all TLC Medicare Eligible retirees rather than each individual group's experience.

F. SURVIVING DEPENDENTS OF RETIRED EMPLOYEES

The Local Choice Group may also elect to offer coverage to survivors of deceased retirees, if retiree coverage is offered.

- Health benefits for a covered surviving spouse and/or covered dependent children of a retired The Local Choice Group employee may be available through the Group's Retiree Health Benefits Program. If a retiree with family or dual membership dies, the covered family member may remain in the Retiree Health Benefits Group as a survivor. However, dependents who were not covered in the Employer' Retiree group before the death of the retiree may not be added. To continue coverage, the family member must apply within 60 days of the death of the retiree. If the surviving spouse remarries or dies, any dependent children covered through that spouse's eligibility would be terminated and offered Extended Coverage or conversion privileges. Surviving children covered without a parent may maintain coverage based on the above eligibility rules.

- Coverage for the surviving spouse automatically terminates at remarriage; alternate health insurance coverage being obtained; or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.

- Coverage for any surviving dependent children in this category automatically terminates at death; at the end of the year in which the child turns age twenty-three (unless eligible through disability); or if the child marries, becomes self-supporting or obtains alternate health insurance coverage. Loss of eligibility for a surviving spouse will result in the loss of eligibility for dependent children covered under the surviving spouse's membership.

- Special rules apply for dependents of employees who are disabled or killed in the line of duty. Effective July 1, 2000 health insurance premium payments through the Department of Accounts of the Commonwealth of Virginia are available to Public Safety Employees and their dependents if they are disabled or killed in the line of duty. Health care coverage will be provided at no expense to the enrollee and is to be paid in full out of the general funds of the State treasury. Spouses are eligible to continue health benefits in the retiree group; dependent children may be covered until the age 21 or up to age 25 if they are a full-time student. Both surviving spouse and children will lose coverage if they become enrolled in another health plan. This continued health coverage is an extension of coverage that the employee had prior to the death or disability. For example, if a Virginia Beach police officer became disabled, his or her health benefits would be through the coverage provided by Virginia Beach to their employees. If the coverage was through a Local Choice plan, coverage would be continued through the TLC plan if the survivors remain eligible under the terms of the TLC plan. The Line of Duty benefit is for premium payment and will not alter the eligibility set forth by TLC. In both cases the Group Benefits Administrator should contact DHRM, TLC or the Department of Accounts to arrange for payment of the coverage. The Department of Accounts monitors membership levels and any associated cost.

III. MID-YEAR CHANGES

A. QUALIFYING EVENTS

Qualifying Mid-Year Events

Once a plan and/or membership election is made, it is irrevocable until the next Open Enrollment unless a recognized Qualifying Mid-Year Event (QME) occurs. Outside Open Enrollment, membership and plan changes may be made only with a QME that is on account of and consistent with your Status Change. The following is a summary of recognized QMEs:

Change in your employment status

- begins/ends full-time employment
- begins/ends leave without pay or family medical leave
- begins retirement

Change in your marital status

- marriage, divorce or death of a spouse

Change in your number of eligible family members

- birth or adoption (DHRM must review all pre-adoptive placements to verify eligibility)
- death of a covered child
- covered child loses eligibility coverage under your plan (exceeds age limit, marries, becomes self-supporting, etc.)
- judgment, decree or order requiring coverage of a child
- permanent custody of a child

Changes affecting your family member(s) employment

- spouse or covered child gains employer health plan eligibility (including switching from part-time to full-time employment)
- spouse or eligible child loses employer eligibility (including switching from full-time to part-time employment)
- spouse begins/ends leave without pay

Other changes affecting your dependent(s)

- annual enrollment or significant change allowed under another employer's plan
- gains/loses eligibility for Medicare or Medicaid
- loses eligibility under another government-sponsored plan

Changes due to special circumstances

- employee or dependent moves in or out of plan's service area
- HIPAA special enrollment due to loss of other coverage *
- you or a family member permanently change residence, affecting eligibility for the Plan
- a court has required that another party cover your children

*Under HIPAA, if you lose your group health coverage, you may be able to enter another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. Special enrollment rights are also triggered by marriage, birth, adoption, and placement for adoption.

If you move in or out of your plan's service area

You may change plan or membership if you move in or out of your plan's service area and submit your request within 31 days of the event. The change will be effective the first of the month after the request and enrollment form is received.

Effective Dates

All changes must be made on a prospective basis except in the case of birth, adoption or placement for adoption. Changes will be effective the first of the month following submission of the Enrollment Form, if the form is submitted within 31-days of the event. Changes for the birth, adoption, or placement for adoption will continue to be made on the first day of the month in which the birth, adoption or placement for adoption occurs, so long as notification occurs within 31-days of the event.

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 coverage.

B. ENROLLING

Premium Conversion is a term often used to refer to the pre-taxing of certain payroll deducted health insurance premiums, as allowed under Section 125 of the Internal Revenue Tax Code. This manual addresses only the rules of The Local Choice Health Benefits Program. For those groups who provide the pre-tax benefit of Premium Conversion, it is advisable that when considering changes that affect an employee's health benefits payroll deduction outside of the plan's Open Enrollment Period that the group also refer to its Premium Conversion plan document.

New Employees

When a person begins employment, the following steps should be taken:

1. Inform the eligible employee that he has 31 days from the date of employment to enroll and enroll eligible dependents (except in the case where other employee benefits are providing continued coverage for a limited period of time).

2. It is the Group Benefits Administrator's responsibility to see that new employees receive complete and timely health benefits information and to obtain either a waiver or a completed Enrollment Form from each new eligible employee within 31 days of employment. If neither is obtained, document your effort and maintain a copy of the letter sent to the employee that states that he or she does not have coverage.

Enrolling Within 31 Days of Employment

A new employee must be at work in order to be eligible for the coverage and an Enrollment Form must be submitted with 31 days of employment to enroll in a health benefits plan. Thereafter coverage may be secured if the employee experiences a Qualifying Mid-Year Event or during an open enrollment period. Coverage will be effective the first of the month following enrollment.
When a new eligible employee wants to enroll, the following steps should be taken:

1. Determine if the person is eligible, according to your Group's definition of eligible employees.

2. Give the employee information about the cost of coverage. If the employee will be paying a monthly premium, explain that it will be by payroll deduction and that premiums are deducted in advance of the month of coverage.

3. Assist the employee in completing the Enrollment Form.
    - Inform the employee about eligibility criteria for dependents.
    - Ask that the employee make sure Social Security numbers are correctly listed on the Enrollment Form.
    - The Group Benefits Administrator must complete all items in the Group Approval/Verification section of the Enrollment Form.

4. Tell the employee when coverage will begin in accordance with The Local Choice Health Benefits Program.

5. Inform the employee that the health benefits plan will send four I.D. cards (one from each claims administrator) to his home address. The employee should contact you if a card is not received. Check with the plan if the membership card is delayed.

6. Make sure the employee receives a copy of the appropriate member handbook and other information describing the coverage, if that has not already been done. Current copies of the member handbooks and amendments may be downloaded from the TLC Web site at www.thelocalchoice.virginia.gov.

7. Make arrangements for premium payment if the first premium(s) due cannot be payroll deducted.

8. On the Group Payment Transmittal (that the Group Benefits Administrator receives each month), list the date coverage is to begin as the effective date, write "New Employee" in the instruction column, and give date employed.

9. Submit the Enrollment Form with the appropriate Group Payment Transmittal adding the employee to your health benefits plan. Keep a copy of the Enrollment Form for your files.

10. If the employee does not want to enroll in The Local Choice Health Benefits Program, have him complete the Waive or Cancel section of the Enrollment Form and keep the original for your files.

    New employees that do not complete the Enrollment form or waive coverage within 31 days of employment should be sent a letter stating that they do not have coverage. Give deadlines and requirements for future enrollment.

11. If your group is eligible to offer Extended Coverage you should counsel the employee concerning his right to Extended Coverage. Provide a copy of the Extended Coverage General Notice and Certificate of Creditable Coverage Notice.

Enrolling More Than 31 Days After Employment –

Enrollment procedures are the same as for enrolling within 31 days of employment, except as noted below:

1. If dependent coverage is selected other than during the Open Enrollment period, the employee must complete the Change Membership portion of the Enrollment Form. Adding dependent coverage other than at Open Enrollment requires that a Qualifying Mid-Year Event (QME) occur within 31 days of the

   application. The QME must be listed on the Enrollment Form. If in doubt, the Group Benefits Administrator should contact DHRM.

2. The effective date should be in accordance with The Local Choice Health Benefits Program rules.

3. On the Group Payment Transmittal adding the employee to the Group, write "New Coverage" in the instruction column instead of "New Employee." List the date coverage is to begin as the effective date.

4. If your group is eligible to offer Extended Coverage you should counsel the

employee concerning his right to Extended Coverage. Provide a copy of the Extended Coverage General Notice and a copy of the appropriate Member Handbook.

Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Rules

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact your Group Benefits Administrator.

C. MAKING CHANGES

Reducing Membership – It is the employee's responsibility to submit a completed Enrollment Form to the Group Benefits Administrator in order to reduce membership if a previously eligible dependent loses eligibility.

Coverage terminations, reductions in membership or waiver of coverage are effective the end of the month following receipt of a Qualifying Mid-Year Event Notification, except for terminations which are required by the plan. Requests for change must be within 31 days of a Qualifying Mid-Year Event. 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 coverage.

A (HIPAA) Certificate of Creditable Coverage must be provided for any terminating employee or dependent.

Changing Type of Membership – A new Enrollment Form must be completed in order to change to or from single, dual or family membership. The Change Membership and/or Plan section must be completed to effect a change in membership and the Qualifying Mid-Year Event must be listed, if not at open enrollment.

1. Inform the employee that new membership cards will not be issued by the plan.

2. Collect any premium necessary to adjust for an insufficient payroll deduction.

3. The change in membership must be reported on the Group Payment Transmittal. List the employee's ID Number, Subscriber Name, and the date of the change in membership in the appropriate columns.

4. In the instruction column, write, "Change to _____." (Example: "Change to Single membership")

5. In the Deduct From Bill column, put the amount that was billed for the old membership.

6. In the Add to Bill column, put the amount that should be billed for the new type of membership since the effective date.

7. A (HIPAA) Certificate of Creditable Coverage must be provided for any terminating employee or dependent.

8. If your group offers Extended Coverage, loss of eligibility is a qualifying event for COBRA. Please follow the published instructions for offering COBRA.

9. Procedures for a Regional plan may be different. If necessary, call the plan for assistance.

Death of Employee

Dropping the Employee from the Group – If an employee dies while in service, coverage extends to the end of the month in which the death occurs. To remove the employee from the Group, write "Deceased on (date)," in the Reason for Cancellation column of the Group Payment Transmittal and give the name and address of the survivor(s) if the person had Employee Plus One or Family membership. Dependent coverage also ends at the end of the month in which the employee's death occurs.

Refunds of Premium – Premiums are deducted a month in advance. If the employee was enrolled in coverage and premiums were deducted for the month following the month in which coverage ceased, a refund of the premium should be made to the administrator of the employee's estate. If there is no administrator, the refund should be held for 60 days and then paid to the surviving spouse or, if none, to the next of kin. The latter procedures are in accordance with §64.1-123 of the Code of Virginia.

Extended Coverage (COBRA) – Surviving dependents of an employee who were covered in the Employee Group may have Extended Coverage for a maximum period of 36 months, if applicable to your employer group.

Non-Group Conversion Coverage – Covered dependents of a deceased employee may convert to non-group coverage. Dependents enrolled in an Anthem administered plan will automatically receive an offer of non-group coverage after cancellation of a deceased employee's coverage. To make certain the plan offers non-group coverage to a dependent of a deceased employee, write the name and address of the survivors in the information column of the Group Payment Transmittal on which the employee is reported as deceased. Eligible dependents may convert to non-group coverage upon termination of Extended Coverage. A terminated participant may be eligible for individual coverage, offered by other insurance companies or HMOs, so long as the participant had at least 18 months of creditable coverage under one or more health plans, without a break-in-service of 63 days or more.

Terminating Employment - Coverage continues to the end of the month in which an employee terminates. The following steps will ensure that terminating employees may keep their coverage continuous.

1. Inform the employee that coverage will continue until the end of the month in which he terminates as long as full premiums for the month are paid. If the full month's premium is not paid, coverage will terminate on the last day of the month for which premiums are paid in full. Faculty members from October 1 School Groups with 10 month rates that complete the academic year will have coverage through August 31 unless they waive coverage or retire before that date. Premium refunds are not provided for 10-month rates if termination occurs after the end of the school year.

2. If your group is eligible for Extended Coverage you must provide Extended Coverage Notifications to all terminating members. If the employee covers a spouse, an Extended Coverage form should be mailed to the spouse at the last know address. If children are also covered, their forms should be sent along with the spouse's form. This form should list every affected person.

3. If eligible, terminating employees or their covered dependents should apply for Extended Coverage by submitting an Enrollment Form to their Group Benefits Administrator within the 60-day period. Please see the Extended Coverage section of this manual for details on administration.

4. Inform the employee that conversion to non-group coverage is available. You should get an address where the employee may be reached after coverage ends so that the plan may 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. Additionally, covered individuals may have certain rights under HIPAA and a certificate of creditable coverage must be issued. If an individual chooses Extended Coverage, both the conversion to an individual policy and the HIPAA rights will be available when that coverage terminates unless coverage terminates due to nonpayment of premium.

On the Group Payment Transmittal submitted for the month the person is no longer covered, the employee should be shown as dropped from the Group. In the Reason for Cancellation column, write "Left Employment (date)," and give an address where the employee may be reached.

Canceling Coverage – An employee may cancel coverage at Open Enrollment or with a Qualifying Mid-Year Event that is consistent with cancellation of coverage. The Waive or Cancel Coverage section of the Enrollment Form must be completed. The waiver takes effect the first of the month following the month the wavier is received. If the employee wants the waiver to take effect at the first of some later month, the employee should write a note on the Enrollment Form indicating the desired termination date.

After coverage is waived, the employer should send a letter stating the date coverage will end. A (HIPAA) Certificate of Creditable Coverage should be provided for any terminating employee or dependent.

Enrollment When There is a Health Care Coverage Order – In compliance with §20-79.3 of the State Code, The Local Choice Health Benefits Program groups are required to enroll eligible dependents named in the National Medical Support Notice (NMSN) from the Department of Social Services (DDS). DSS is charged with enforcing the provision of § 20-79.3 and with notifying the employing group of the requirement to provide coverage. DSS will communicate the requirement for coverage through the NMSN. There is a section on this form where a group will see an instruction to enroll a dependent in coverage. If this section is checked, proceed with the enrollment.

When a group receives a NMSN from DSS (or from an agency for another state), the group must ascertain if the dependent(s) referenced in the order is eligible for TLC health benefits, and take the following action:

If the coverage order calls for the employee to cover an eligible child, the order will apply to the group. The eligible dependent(s) must be enrolled in health benefits in accordance with the NMSN, and proper notice to the issuing agency must be given.

1. Enroll only eligible dependents in the TLC group. If you ascertain that the employee or the dependent referenced in the coverage order is not eligible

for membership in the plan, you must notify the issuing agency within 20 business days after the date of the notice. **Court orders for a former spouse will not be honored. Contact DHRM if you have eligibility questions.**

2. If dependent(s) are determined to be eligible, please observe the following procedures:

    - Assuming that the NMSN is qualified, enroll the dependent(s) in coverage prospectively. For example, if the order is received on June 21, then the child should be enrolled effective July 1.

    - If the employee currently is enrolled in a health benefits membership, add the eligible dependent(s) named in the NMSN to the membership. This may entail broadening the membership or changing plans to accommodate the newly added members. For instance, if the employee is enrolled in an HMO before receipt of the NMSN and the child lives out-of-state, the employee will need to enroll in a plan that provides access for the child.

    - If the employee currently is not enrolled in a health benefits membership, enroll the employee and the eligible dependent(s) in the employee's plan of choice, as long as the service area of the plan provides access for the child.

    - If an employee refuses to sign an Enrollment Form to comply with a NMSN, the Group Benefits Administrator should enroll the employee and sign his or her own name where the employee would normally sign, and note beside the signature that the employee has refused to sign. Attach a copy of the NMSN to the Enrollment Form, and indicate that the enrollment is being processed in compliance with the NMSN.

    - Deduct from the employee's earnings the applicable employee portion of premiums, and establish the appropriate employer contribution.

3. Coverage orders from other states are to be processed in the same manner once a determination is made that the order is qualified. An order must contain the following information to be qualified:
    - The names and last known mailing address of the participant and each dependent to be enrolled in coverage;
    - A reasonable description of the type of health coverage to be provided; and
    - The period to which the order applies.

<u>DSS Retraction of the National Medical Support Notice</u> – There may be instances where the NMSN is retracted after the coverage for dependents has been established. When this occurs, the Group Benefits Administrator should allow the employee to reduce coverage to eliminate the dependents, if he or she so desires. The effective date would be the first of the month following the DSS notice to the employer of retraction of the NMSN. This notice constitutes a Qualifying Mid-Year Event and is subject to those rules.

As always, it is essential that TLC Groups cooperate in a timely fashion with a DSS

NMSN. DHRM will serve as the liaison for questions that may arise concerning the administration of this initiative. Please contact a member of The Local Choice Health Benefits Program team if you have a question concerning the NMSN.

Personal Changes – When an employee wishes to make a change in membership based upon a Qualifying Mid-Year Event, the change must be made within 31 days of the event by submitting a new Enrollment Form. Coverage will be effective the first of the month following the date that the Enrollment Form is received. In cases of birth/adoption or placement for adoption, coverage will be retroactive to the first of the month following notification.

The Group Benefits Administrator should obtain documentation of all Qualifying Mid-Year Events.

There are times when a dependent will become ineligible for coverage under an employee's membership. When this occurs, the ineligible member must be eliminated from the employee's membership, effective the first day of the month after eligibility was lost. If the employee does not take this action timely, he risks removal from the program for up to three year.

Coverage may be continued for a child who loses eligibility due to age if the child is incapable of self-support because of a severe mental or physical disability. The condition must have been diagnosed before they ceased to be eligible due to age. Approval must be obtained from the administrator.

When a child loses coverage because he or she no longer is eligible, the child may enroll in Extended Coverage (if available) or non-group coverage with the health benefits plan in which he has been enrolled. The employee or child must contact the Group Benefits Administrator within 60 days of the loss of coverage for Extended Coverage, or must contact the health benefits plan to arrange for non-group coverage.

NOTE: An employee's failure to remove ineligible persons from his health benefits membership can result in the retraction of claims and other penalties as delineated in the Health Benefits Program Regulations.

Change of Name or Address – If there is no coverage change at the time of a name or address change, the employee should complete a Name/Address Change Form so that the employee's health benefits plan record may be updated. If, however, the employee must fill out a new Enrollment Form for change in type of coverage, a name or address change can be submitted at the same time.

Group Benefits Administrators should have copies of these forms on hand, or they can be found on the Web at www.thelocalchoice.virginia.gov. Please let your employees know that it is important to keep the plan informed of name or address changes.

Marriage – If an employee with single or employee plus one membership marries and wants to add the spouse, the employee must submit an Enrollment Form for Employee Plus One or Family membership within 31 days of the marriage. Coverage will be effective the first of the month following notification. If enrollment does not occur within 31 days of the marriage, the employee may apply for Employee Plus One or Family membership during the next Open Enrollment period.

If the employee has Family membership and marries, the spouse may be added even after 31 days. However, the spouse should be added immediately to avoid claim denials or reduction in coverage. The Enrollment Form should be completed by checking the box labeled "Change in Employee Plus One or Family membership." The name of the dependent and the date of the marriage must be provided. The addition should be made as soon as possible after the event, with coverage effective the day of the marriage.

Birth, Adoption or Placement for Adoption of A Child – If the employee enrolls a child within 31 days after the birth/adoption or placement for adoption, Employee Plus One or Family membership will be effective the first of the month in which the event takes place. In some cases this will require the collection of additional premiums.

If family membership already exists, the child can be added at any time retroactive the date of birth.

A child who is either adopted by a Local Choice employee or who resides with the employee under the authority of a formal pre-adoptive agreement will be eligible for health benefits in a manner identical to a biological child of an eligible employee. Within 31 days of the pre-adoptive placement or adoption effective date, the employee should take action to cover the adopted child if coverage is desired at the earliest date. A pre-adoptive agreement documents that an authoritative body (such as court of law, a licensed adoption agency, or DSS) is placing a child in the home of an individual under the supervision of that authority. The authority oversees the placement to ascertain if this would be a suitable permanent adoptive home for the child.

Children who are placed for adoption under a private arrangement will not be deemed eligible for coverage under a Local Choice employee's membership until a court of law transfers legal custody to the prospective adoptive parent(s). The court of law serves as the authoritative entity in the case of a private pre-adoptive placement.

DHRM must determine that a pre-adoptive agreement meets uniform eligibility standards. This determination is made at the sole discretion of DHRM that must review all related documents and authorize the enrollment of the child before coverage is effective.

A child who is adopted or is living with the employee under a formal pre-adoptive agreement (which has been approved by DHRM for the purpose of affirming eligibility) will be eligible for coverage, effective on the actual date of adoption or pre-adoptive placement. As in the case with all Qualifying Mid-Year Events, the enrollment must occur within 31 days of the event for the coverage to be effective at the earliest date.

Under the Health Insurance Portability and Accountability Act, employees may enroll themselves and other family members when there is a birth/adoption or placement for adoption of a child. Coverage is effective on the date of the event. This is the only mid-year event that allows retroactive coverage on the date of the event. All other Qualifying Mid-Year Events result in prospective changes. The practical effect of adding a child or other family members as of the date of adoption or pre-adoptive placement is that, if membership must be broadened, the change

must occur retroactive to the first of the month of the event. The Group Benefits Administrator should notify the plan that claims should not be processed for services occurring prior to the event date.

Separation and Divorce

Separation, even with a property settlement, is not a Qualifying Mid-Year Event. All eligible family member(s) should be covered by the contract of an employee with a Family membership. An employee may not selectively eliminate a spouse or other eligible family members from coverage due to separation.

When the spouse of an eligible employee is eliminated from an employee's membership due to divorce, the spouse may be covered on the employee's membership only until the end of the month in which the divorce becomes final. A new Enrollment Form is required to make such a change. (A note signed by the employee should be attached to the Enrollment Form listing the spouse's name, Social Security number, date of birth, and the date the divorce was final. The note should say that coverage on the spouse is dropped due to divorce.)

If the divorce causes a change in membership, the employee's premium will be reduced the first of the month following the event, provided that notification is made within 31 days of the event.

NOTE: Coverage terminates the first of the month following the divorce. However, if the employee does not make timely notification of the divorce, the employee will not be allowed to reduce membership until the next Open Enrollment or Qualifying Mid-Year Event. The Group Benefits Administrator should obtain signed documentation from the employee giving the date of divorce, the ex-spouses name, Social Security number, and address. If the Group Benefits Administrator is notified timely of the divorce, the group is required to send the spouse an Extended Coverage notice, if eligible. If the Group Benefits Administrator is not notified within 60 days, the group has no obligation to offer Extended Coverage.

If Family Membership is to be retained, a new Enrollment Form should be filed to remove the spouse's name from the list of dependents. For Extended Coverage eligible groups, Extended Coverage must be offered.

NOTE: It is the responsibility of the employee to assure that Employee Plus One or Family membership is obtained and that application is made within the 31-day period. Discovering that children are without coverage is not a basis for broadening a membership after 31 days from the date of divorce.

Child Turning Age 23 – Unmarried biological and adopted children may be covered by the TLC Benefits Program to the end of the year in which they turn age 23 if the child lives at home and can be claimed on the parent's federal income tax return. There are limited circumstances that would allow eligibility for the Program even if the child does not live at home. Example includes:

- The child lives with the other parent if the employee is divorced, and
- The child lives away from home while attending college or boarding school.

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

NOTE: An employee's failure to remove ineligible persons from his or her health benefits membership can result in the retraction of claims and other penalties as delineated in Section 1 VAC-55-20-210c of the Virginia Administrative Code. Additionally, the employee will be unable to reduce health benefits membership except within 31 days of the dependent's loss of eligibility, during open enrollment or with another consistent Qualifying Mid-Year Event.

If the employee wishes to reduce his or her membership from Employee Plus One or Family after a child becomes ineligible, it is up to the employee to make the enrollment change during the month before the change is needed or not later than 31 days after the change. Note that coverage terminates on December 31 regardless of notification from the employee. However, if the employee does not make timely notification of a change in membership, the employee will not be allowed to reduce membership until the next open enrollment or Qualifying Mid-Year Event, whichever occurs first. If Employee Plus One or Family membership is retained, the employee must remove the child from the list of covered dependents, as of the last day of the month of eligibility.

You will receive a report that lists employees whose records indicate that they have enrolled dependents who are losing eligibility due to age. The Group Benefits Administrator must send a notice to those employees about the impending loss of eligibility. The Local Choice supplies the model notice for Group Benefits Administrator use.

Child Over Age 23 Incapable of Self-Support – For state-wide self funded plans a request for continued coverage for a disabled child must be submitted to the Plan Administrator within 31 days of the child's loss of eligibility due to age. Insured plans usually require application and proof of incapacitation prior to the child losing coverage. Please note that approval may often be a time consuming process. Employees should be encouraged to make application well before coverage terminates.

The Group Benefits Administrator should advise the employee to contact the plan administrator to find out what actions need to be taken in order to secure coverage after the limiting age. This may include sending a letter from a physician that explains the specific nature of the handicap and the date of onset. The physician may need to certify that the dependent is not capable of self-support due to mental retardation, severe mental illness, or severe physical handicap. The doctor should include on any statement the name and ID number of the employee who wishes to continue coverage for the child. The Plan will determine the eligibility status of the adult child and follow up with the enrollee and the Group Benefits Administrator.

If an adult child, who has been determined incapable of self-support, later becomes capable of self-support, it is the employee's responsibility to terminate the child from his or her membership within 31 days of the change in the status.

When a child loses coverage due to a loss of eligibility, the child may enroll in Extended Coverage, if available, or non-group coverage with the health benefits plan in which he or she has been enrolled. The employee or the child must contact the Group Benefits Administrator within 60 days of the loss of group coverage to enroll in Extended Coverage, or must contact the health benefits plan to arrange for non-group coverage.

When a new TLC employee wishes to provide coverage for an adult disabled dependent upon enrollment in The Local Choice Health Benefits Plan, the following conditions must be met:

1. The employee must provide evidence that he or the other parent has provided coverage for the dependent from the onset of the disability.

2. The onset of the disability must have occurred before the end of the year in which the child became age 23.

3. The plan must approve the condition as disabling.

The employee must apply to enroll the child within 31 days of the hire date or within 31 days of the date the child is no longer eligible to be covered by the other parent.

Child Who Marries – Eligibility for a dependent child terminates at the end of the month in which the child marries. The child may enroll in Extended Coverage, if eligible, or non-group coverage if notice to the Group Benefits Administrator is timely.

If the employee no longer needs Employee Plus One or Family membership, an Enrollment Form for reduced membership should be filed within 31 days of the marriage.

If Family membership is retained, a new Enrollment Form should be filed to drop the child from the list of dependents. On the Enrollment Form, the employee should check “adding or dropping a dependent from Family membership” and put the first day of the month following the date of the child’s marriage as the effective date.

When a child loses coverage because he or she no longer is eligible, the child may enroll in Extended Coverage, if available, or non-group coverage with the health benefits plan in which he or she has been enrolled. The employee or the child must contact the Group Benefits Administrator within 60 days of the loss of coverage for Extended Coverage, or must contact the health benefits plan to arrange for non-group coverage.

Child Who Becomes Self-Supporting – If an otherwise eligible child becomes self-supporting, he or she becomes ineligible for coverage under the Plan at the end of the month in which the child becomes self-supporting. It is the employee’s responsibility to terminate the child from his or her membership within 31 days from the time the child becomes self-supporting.

When a child loses coverage because he or she no longer is eligible, the child may enroll in Extended Coverage, if available, or non-group coverage with the health benefits plan in which he or she has been enrolled. The employee or the child must contact the Group Benefits Administrator within 60 days of the loss of coverage for Extended Coverage, or must contact the health benefits plan to arrange for non-group coverage.

Adding Dependents to a Family Contract – A newly eligible dependent may be added to an existing Family contract. The effective date for coverage will be no earlier than the date that the dependent became eligible. On the Enrollment Form, check “adding or dropping the dependent from Family membership” and list the date the person being added became a dependent (for instance, the date of

marriage, date of adoption, etc.). The Enrollment Form should be filed early so that claim payments are not delayed. In the case of adoption, the effective date may not precede the actual date of placement in the home.

Death of Spouse or Only Dependent – If the death causes a change in membership, the employee's premium will be reduced the first of the month following the death provided that notification is made within 31 days. If the employee does not make timely notification, the employee will still be allowed to reduce membership, however, premiums can not be refunded beyond the last plan year date. Please assist your employees so that this important, but easily overlook membership change can be made.

An employee who retains Employee Plus One or Family membership should file a new Enrollment Form to update dependent information.

Change in Spouse's Coverage – An employee may broaden or reduce membership to add or remove eligible dependents if there is loss or gain of a dependent's health benefits coverage due to a Qualifying Mid-Year Event. This also applies when a covered local employee must make a change in enrollment because an ex-spouse or a dependent's other biological or adoptive parent loses employer coverage.

The Enrollment Form requesting a membership change must be submitted within 31 days of the Qualifying Mid-Year Event. Changes are effective on the first of the month following the month in which the request is received. The Change Membership section of the Enrollment form must be completed listing the reason for the change, the name and address of the dependent's employer, and the date of the Qualifying Mid-Year Event. The Group Benefits Administrator should verify a loss of coverage by letter or by documented telephone contact with the dependent's employer.

Coverage During Leave of Absence – Coverage may be continued in various leave situations. Groups must comply with their own published personnel practices. The maximum duration of coverage during leave may not exceed 12 months. An Extended Coverage Election Form should be provided to the employee upon beginning leave. If elected, Extended Coverage will run concurrently with the leave.

Employees on leave must pay their premium (with or without a Local Employer contribution) on time. Premium is due on the first workday of the month of coverage. If premium is not received on time, notify the employee in writing that there is a grace period of 30 days from the first of the month when the total premium was due. If the premium becomes over 30 days past due, terminate the coverage. Once terminated, coverage will not be reinstated for the duration of the leave.

Terminating Service While on Leave Without Pay – If an employee on LWOP notifies you that he is terminating employment, active employee group coverage must stop at the end of the month in which the termination occurs. Do not remove the employee from The Local Choice Health Benefits Program retroactive to the last month the employee worked. If applicable to your group, Extended Coverage should have been offered when the leave was initiated. If it was not, it must be offered now and will run concurrently with the leave period. The Extended Coverage beginning date will always be the end of the month in which the leave commenced.

Changing Coverage or Membership While on Leave – Rules concerning changes

in coverage and or membership while on leave, are the same as those followed by active employees. Changes may be made only at Open Enrollment or if a Qualifying Mid-Year Event occurs.

Removing Employee From Group When No Longer Eligible for Group Coverage – If an employee continues in The Local Choice Group for the maximum time allowable while on leave, you must follow these steps to terminate coverage in the Group even if the leave continues.

1. Inform the employee in writing (30 days prior to removal) that he is being removed from the active employee group and provide the date that coverage ends.

2. If Extended Coverage was available and offered prior to the initiation of leave, notify the employee of the remaining time available under Extended Coverage.

3. Inform the employee that it is possible to convert to non-group coverage once Extended Coverage is no longer available. The employee must contact the health benefits plan to enroll in non-group coverage. Application to the plan for conversion to non-group coverage should be made within 31 days of losing TLC coverage. Furthermore, if the employee has at least 18 months of creditable service as defined by HIPAA, the employee may have certain additional rights that may be exercised when securing individual coverage. Employees should be advised that insurers offering individual health plans in the Commonwealth must recognize creditable coverage so long as the employee has at least 18 months of creditable coverage and received their most recent health coverage under an employer related group health plan.

4. On the Group Payment Transmittal, notify the health benefits plan that the employee is dropped from the Group. Write, "Eligibility Ended (date) " and provide the employee's current address. Please note that there are many differences between The Local Choice Health Benefits Program plans and non-group coverage.

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. No action is required to maintain coverage.

If part-time employees are eligible, Local Employers are not required to contribute toward coverage for any part-time employee granted any type of leave of absence without pay.

Retroactivity Administration – Limited retroactivity is provided to protect an employee in the instance of employer error in the administration of employee's health benefits. A Group Benefits Administrator must submit all requests for retroactivity greater than 59-days to DHRM in writing. The maximum period permitted for statewide, self-funded plans is 12 months, however, plan years may not be crossed; the HMOs limit retroactive changes to a period of 60 days from their receipt of a copy of DHRM authorization to the Local Employer.

Local Employers should be aware that an employee may wish to seek remedy from them in the case of Local Employer error if the period of retroactivity does not afford the employee full remedy.

Premium Refunds – Premium refunds that result from agency error will be based

on the error. In most cases, DHRM/TLC will not authorize retroactive refunds beyond the 59-day limited retroactivity.

Renewal Dates

All non-school TLC groups renew on July 1 of each calendar year. Schools may choose to renew on October 1 but are not required to use that date.

Periodic Audit

TLC groups will be subject to periodic audit to measure compliance with plan rules and regulations including but not limited to COBRA (Extended Coverage) and HIPAA. Eligibility of employees, dependents and retirees may also be reviewed.

Coordination of Benefits

At a specified time during the calendar year, a COB survey will be sent to each enrollee with Employee Plus One or Family membership. The health benefits plan customer service representatives can explain how COB would work. Persons who do respond to the Plan should be informed that claims will not be paid until the information is received.

D. RETIREE PLAN CHANGES

Non-Medicare Retirees:

- May cancel coverage at any time but may not return to plan;
- May reduce membership at any time;
- May add dependents within 31 days of a consistent Qualifying Mid-Year Event, or at open enrollment, including Medicare-eligible dependents.
- May change plans at retirement, at open enrollment or if they move out of the service area.

Medicare Retirees*:*

- May cancel coverage at any time but may not return to plan;
- May reduce coverage at any time;
- May add dependents within 31 days of a consistent Qualifying Mid-Year Event.
- All retirees are required to complete an Enrollment Form to make changes.

IV. COBRA/HIPAA

A. COBRA

Extended Coverage (COBRA)

Extended Coverage is a term used by DHRM to describe coverage required of government employers under the provisions of the Public Health Service Act. These are the same provisions that apply to private employers under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Under certain circumstances, a participant who would ordinarily lose coverage because of any of the following Qualifying Events is a Qualified Beneficiary who may elect to continue coverage under the Local Employer's Health Benefits Program for a period of up to 36 months, at his or her own expense.

There is no required Local Employer contribution toward Extended Coverage. If the Local Employer desires, a fee of 2% may be added to the total monthly premium for health benefits. It is important that these charges be consistently applied and that there is no discrimination. The TLC Local Employer may keep the 2% fee, if applied, as an offset to increased administrative costs. A 50% fee will be applied for the last 11 months of Extended Coverage for a disabled individual and it must be forwarded to the plan.

Employers with fewer than 20 employees on a typical business day during the preceding calendar year are exempt from COBRA. This exclusion is based on the actual number of employees rather than plan participants. In determining the number of employees, the employer must consider all full-time and part-time employees as well as self-employed individuals as defined in Internal Revenue Code Section 401. The employer must also treat the following individuals as employees if they are eligible for coverage under a plan maintained by the employer:

- Independent contractors;
- Agents; and
- Corporate directors

All entities under the common control of the employer will be considered as a single employer in determining whether 20 or more employees are employed. Small employer status will not be granted if 20 or more employees are employed on 50% or more of the employer's annual business days.

Local employers that are not required by Federal statute to comply with COBRA will not be permitted to offer Extended Coverage to their employees or dependents.

In the case of the following Qualifying Events, coverage may be continued up to 36 months at the individual's own expense.

- Death of the employee under whose membership the affected person was enrolled as a spouse or as a dependent child.

- Divorce, when the affected person was enrolled as a spouse, or dependent child who loses eligibility as a result of the divorce. If coverage is reduced eliminating coverage for a spouse in anticipation of a divorce, the affected person still is eligible for Extended Coverage. Upon receiving timely notice

of the Qualifying Event, you should offer Extended Coverage in conjunction with the date of divorce, but not for any period before the Qualifying Event.

- Loss of dependent child status by a person enrolled in health benefits through the Program.

Under the terms of the Uniformed Services Employment and Re-employment Rights Act (USERRA), covered employees who go on active military duty, or their covered dependents, may enroll in Extended Coverage until the employee returns from active duty or 24 months, whichever occurs first.

In addition, an employee who would ordinarily lose coverage because of either of the following Qualifying Events may elect to extend coverage under the program for a period of up to 18 months at his/her own expenses.

- Voluntary or involuntary (except for gross misconduct) termination. A qualifying event occurs when the employee terminates while under coverage on LWOP.

- Reduction in work hours to less than full time. Also, reduction of hours by reason of leave without pay is a Qualifying Event. However, employees may remain in the active group for up to 12 months, depending on the reason for LWOP. Upon initiation of LWOP, employees should be given an Extended Coverage notification. Extended Coverage would not be effective until after LWOP active employee coverage is exhausted, but the 18-month clock begins the first day of the month of LWOP active coverage.

Example: An employee goes on sick LWOP June 14. The Local Employer offers Extended Coverage and the clock starts July 1, though the employee may remain in active coverage for the period allowed. At the end of the LWOP active coverage, the employee may have Extended Coverage for a period of 18 months minus the period of active coverage while on LWOP. The employee will have 60 days from the loss of coverage in which to elect the remaining six months of Extended Coverage. The first 12 months ran concurrent with the 12 months of active coverage while on LWOP.

A Qualified Beneficiary may have more than one Qualifying Event, but the period of coverage may not exceed 36 months. The 36-month period is measured from the date of the first Qualifying Event. For example, a spouse has Extended Coverage for up to 18 months because the employee terminated employment. The marriage ends in divorce nine months into the 18-month period. The spouse would be eligible for 36 months' coverage less the nine months already received, that is, for another 27 months of coverage.

Special Rule for Disabled Individuals

A Qualified Beneficiary, who is disabled, as defined by the Social Security Administration (SSA), within the first 60 days of Extended Coverage, may elect Extended Coverage for up to 29 months. The non-disabled qualified beneficiary family members are entitled to the extension if the Qualified Beneficiary has affected the extension based on disability. After the initial 18 months, the fee added to the monthly premium increases from 2% of the total premium to 50%. It is the individual's responsibility to notify the Local Employer of Social Security's determination and to provide the Local Employer with a copy of the SSA disability

certification prior to the end of the 18-month period of Extended Coverage. The Local Employer must forward the SSA certification, with a cover memo of explanation, to the health benefits plan. The plan will flag the membership record to increase the surcharge from 2% to 50% from months 18-29. If the Qualified Beneficiary is determined to be no longer disabled after the 18-month period, but before the end of the 29 months, the employee will lose eligibility for Extended Coverage, as will affected Qualified Beneficiaries who were entitled to the extension by reason of the Qualified Beneficiary's disability.

Eligibility for Extended Coverage ends at the earliest of any of the following:

- Failure to make a premium payment when due. (Partial payment is considered non-payment.)

- The Qualified Beneficiary becomes covered under any other group health plan, which does not contain any exclusion or limitation regarding a pre-existing condition of such Qualified Beneficiary. This provision does not apply if the other coverage was in place prior to the Qualifying Event.

- Entitlement to Medicare if entitlement occurs after the date of the Extended Coverage election. Dependents may be entitled to continue coverage for at least 36 months from the date of the original Qualifying Event. If a Qualified Beneficiary, already participating in Medicare Part A, elects COBRA and later begins participation in Medicare Part B, COBRA coverage will not be terminated by TLC.

- Expiration of the applicable 18, 29, or 36-month period, or other coverage period.

- Affected persons are allowed a 60-day election period in which to enroll in Extended Coverage. The election starts with the:

    - the date notice was given, or
    - the date coverage under the TLC Program would end.

- Premiums for Extended Coverage are 102% of the premiums for regular coverage, except in the case of disabled individuals, as addressed above. A Qualified Beneficiary has 45 days from the date of the election to make the initial payment.

If eligibility for Extended Coverage ends because of the expiration of the 18, 29, or 36-month term, the affected person may convert to non-group coverage, just like any other member of the Local Employer Group, by applying for coverage within 31 days of the loss of Extended Coverage. Furthermore, the employee may have certain additional rights that may be exercised when securing individual coverage. Employees should be advised that insurers that offer individual health plans in the Commonwealth must recognize creditable coverage so long as the employee has a least 18 months of creditable coverage and received their most recent health coverage under an employer related group health plan.

Qualifying Events are not the same as Qualifying Mid-Year Events, so the Qualified Beneficiary may not add new members upon enrollment. However, each Qualified Beneficiary is entitled to a separate election with respect to whether or not to enroll in Extended Coverage. A parent or legal guardian may elect on behalf of a minor

child, and a Qualified Beneficiary who is the spouse of an employee may make a binding election to provide Extended Coverage for other covered dependents. Persons enrolled in Extended Coverage may change their type of membership if they experience a Qualifying Mid-Year Event. Furthermore, individuals enrolled in Extended Coverage may utilize the annual open enrollment period.

In most instances, a group (family) of Qualified Beneficiaries is closed as of the day before the Qualifying Event. A Qualified Beneficiary who fails to elect coverage ceases to be a Qualified Beneficiary at the end of the election period, although a waiver of coverage may be withdrawn before the end of the election period. However, newborns or children born to or placed for adoption with an Extended Coverage participate during the period of Extended Coverage are considered Qualified Beneficiaries, and the Qualifying Event that gave rise to the Extended Coverage is the event applicable to that child. Thus, a subsequent event that occurs before the child is born or placed for adoption also applies to the child.

Administration of Extended Coverage

Group Benefits Administrator's must provide all new employees with information regarding Extended Coverage and the right to a Certificate of Coverage, as required under the Health Insurance Portability and Accountability Act of 1996. Also, Local Administrators should send a notice regarding eligibility for Extended Coverage to enrolled persons, at the home address of record, upon initial enrollment. A separate notice must be sent to covered dependents that reside elsewhere. A sample general notice is included at the end of this section. Local Employers are responsible for:

- Delivering proper notices,
- Counseling potential Qualified Beneficiaries,
- Determining the months of coverage available,
- Certifying eligibility, and
- Seeing that Enrollment Forms are completed correctly.

The Local Administrator must certify the enrollee's eligibility for Extended Coverage. The health benefits plans will bill the Local Employers for Extended Coverage premiums through the group transmittal. The Local Employer must collect premiums from Qualified Beneficiaries and remit payment to the plans along with their regular group premiums. Partial payments will not be accepted.

Eligibility rules are to be interpreted broadly. Thus, a person formerly covered as a dependent child is eligible for Extended Coverage by reason of superannuation, marriage, or other loss of dependent status. Also, since the Public Health Service Act does not define "gross misconduct," it may be incorrect to assume that every termination for cause is a termination for gross misconduct.

If a Local Employer decides to deny COBRA coverage in the case of gross misconduct (we suggest that you obtain legal advice), the Local Administrator should send a letter to all Qualified Beneficiaries stating that COBRA coverage will not be offered. Remember that a denial of coverage for gross misconduct affects all Qualified Beneficiaries, not just the employee who engaged in misconduct. As a plan administrator, a Local Employer has a duty to provide notice so that the affected individuals may, for example, obtain other available coverage.

All dates are unalterable. Sixty days, for example, means exactly 60 calendar days,

except that the last day of the period must end on a business day. The days on which an event occurs (for example, giving notice is not counted in the period. All dates are counted from the date when the notice, Enrollment Form, etc., are sent, not the date received.

Qualifying Event election notices should be complete (including rate information) and, preferably, delivered in person or by U.S. Postal Service. Although the affected person may not be an employee of the employer, he or she is closely connected to an employee or ex-employer and has a lawful claim on the employer's assistance. If an employee's family is enrolled in a health benefits membership when a Qualifying Event occurs, each Qualified Beneficiary must be given notice and be offered the opportunity to make an independent election of coverage.

In addition, the Local Employer must notify covered persons affected by the death or termination of an employee or the reduction in work hours to less than full time of their rights to Extended Coverage. This notice must be delivered within 14 days of the Qualifying Event.

An affected person must give notice to the Local Employer of divorce or loss of dependent child status within 60 days of the event. Once the Local Employer has been notified, the Local Employer must give notice to the affected person of the availability of Extended Coverage within 14 days. Failure of an affected person to deliver timely notice ends eligibility for Extended Coverage.

Once the Local Employer has given notice to a Qualified Beneficiary, that person has 60 days from the date of notice (or the date the person would lose coverage, if later) to elect Extended Coverage for a period that begins from the date of the Qualifying Event. The available period of Extended Coverage is unchanged. If the person wants coverage, the Local Administrator will process through normal channels a properly completed Enrollment Form.

For example, on May 18 an employee or spouse notifies a Local Employer that a divorce became final on March 29. If the notice had not been given to the Local Employer by May 28, the last day of the required notice period, the ex-spouse would not be eligible for Extended Coverage. However, having received the notice May 18 (within 60 days of the Qualifying Event), the employer notifies the ex-spouse on May 21 regarding the availability of Extended Coverage. The 60-day election period starts on May 21, the date of notice, since that date is later than April 1st, the day on which the ex-spouse lost coverage. If the ex-spouse wants Extended Coverage, he or she must file an Enrollment Form with the Local Employer before July 20. The employer certifies the eligibility of the spouse, determines the number of months of coverage available, set the effective date (April 1), and transmits the Enrollment Form to the plan with the Group Transmittal Form. The plan bills for premiums, through the employer, from the effective date (April 1). After the plan receives payment for coverage, the ex-spouse would receive an enrollment card showing coverage from April 1.

The Enrollment Form should be completed as usual, except as noted here:

In the "Reason Enrollment Form is being submitted" section (Part C) check "Enroll in Extended Coverage" and name and date of the Qualifying Event in "Other." In the Group Approval/Verification section, provide the information on the number of months of Extended Coverage in "Duration of Contract."

Where the names of the plans are entered on the Enrollment Form (Part C), check the plan in which the Qualified Beneficiary is to be enrolled, then add a dash followed by the words “Extended Coverage.”

If there is an SSA determination of disability within the required timeframe and the Qualified Beneficiary wants to extend membership from 18 months to 29 months, he or she must notify the Local Employer and provide the employer with a copy of the SSA disability certification. The notice must be made prior to the end of the 18-month period of coverage in order to extend the coverage to 29 months. The Local Employer must then notify the plan and provide the plan with a copy of the SSA certification.

With an extension to 29 months, after the initial 18 months, the administrative fee for the remaining 11 months of coverage will increase from 2% to 50% of total premium. During the initial 18 months of Extended Coverage, the Local Employer may keep the 2% administrative fee to offset administrative costs, however, the 50% fee must be remitted to the plan to offset additional plan risk.

Send the Extended Coverage enrollment form directly to the plan. The effective date of coverage must be the day after the day that the member was dropped from the Active Group (or should have been dropped if not for the coverage being continued under a TLC policy). A person may not be transferred to Extended Coverage until his or her membership in the Active Group has been terminated.

It is possible that a Qualified Beneficiary will contact the Local Employer in the future for service, perhaps a claim or eligibility question. Agencies should receive these persons, as they would service any other member of the Group.

It is extremely important that current rules on membership be enforced strictly. For instance, do not remove a spouse from an existing Family membership on the grounds of “separation.” Question any change from Family or Employee Plus One to see if a second Qualifying Event has occurred. If so, give the required notice to the affected person.

Although it may sometimes be difficult to secure the cooperation of the employee in securing address or delivering notices to affected persons, the Local Employer must make a reasonable effort to do so. As a last resort, send the required notice to the employee’s address for the affected person and document the reasonable effort.

There are cases where a previous employer provides a new employee continued health benefits for a limited period of time. If the new employee submits a signed Enrollment/Waiver Form within 31 days of employment with The Local Choice Health Benefits Program employer showing the appropriate effective date for coverage, the employee may postpone enrollment in Employee Plus One or Family membership in the Program to the time when the other coverage terminates. In order to postpone Employee Plus One or Family membership, it must take effect the first of the month after termination of the other employer coverage. The employee must furnish the name and address of the other benefits plan.

The employee has 31 days from the date of hire to enroll in a health benefits plan for coverage to be effective at the earliest date available.

COBRA Financial Responsibility

The Local Employer must use TLC COBRA forms or assume financial responsibility for errors. Failure to appropriately terminate a COBRA participant at the conclusion of their benefit period will result in a dollar for dollar assumption of claim liability by the local employer without credit for stop loss protection.

(On Employer Letterhead)
GENERAL NOTICE OF EXTENDED COVERAGE RIGHTS
Date:

Address this notice as appropriate to:
- o The employee, or
- o The employee and spouse, or
- o The newly covered spouse

at the mailing address(es) of record.

Introduction

You are receiving this notice because you are covered under The Local Choice (TLC) Health Benefits Program (the Plan) sponsored by **(Insert Name of Local Employer)**. This notice contains important information about your right to temporarily extend your coverage under the Plan. **This notice generally explains Extended Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. Only employers with 20 or more employees may offer Extended Coverage.**

The right to Extended Coverage was created for private employers by federal law through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and these rights are reflected in the continuation coverage provisions of the Public Health Service Act that covers employees of state and local governments. Extended Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the plan and under the law, you should contact your designated Group Benefits Administrator. Resources for additional information are provided on page 4.

What is Extended Coverage?

Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, Extended Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. These rights are also available to children covered through a Qualified Medical Child Support Order (QMCSO). Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost for Extended Coverage. Time limitations for making Extended Coverage premium payments will be included in the Election Notice provided at the time of the qualifying event.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

- Your hours of employment are reduced. This would include periods of leave without pay (even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage) and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee or retiree group participant, you will become a qualified beneficiary if you lose your coverage under the plan because of any one of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with

Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any one of the following qualifying events:

- The parent/employee/retiree dies;
- The parent's/employee's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- The parent/employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced, resulting in loss of dependent eligibility;
- The child stops being eligible for coverage as a dependent child under the plan.

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. If termination occurs under this condition but notification of the qualifying event is received from the employee, qualified beneficiary or a representative within 60 days of the date coverage would have been lost due to the qualifying event, Extended Coverage must be made available and effective on the date coverage would have been lost due to the event, but not before.

When is Extended Coverage Available?

Your Group Benefits Administrator will automatically offer Extended Coverage to qualified beneficiaries upon the occurrence of the following qualifying events:

- Termination of employment;
- Reduction in hours of employment resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage, including leaves without pay;
- Death of the employee.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), you or your representative must notify your Group Benefits Administrator within 60 days of the qualifying event (or within 60 days of the date coverage would be lost due to the qualifying event) by submitting written notification to include the following information:

- The type of qualifying event (e.g., divorce, loss of dependent child's eligibility--including reason for the loss of eligibility);
- The name of the affected qualified beneficiary (e.g., spouse's and/or dependent child's name/s);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree, dependent child's marriage certificate);
- The written signature of the notifying party;
- If the address of record is incorrect, an address for mailing the Election Notice.

Failure to provide timely notice of these qualifying events will result in loss of eligibility for continuation coverage. One notice will cover all affected qualified beneficiaries. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by your Group Benefits Administrator.

How is Extended Coverage Provided?

Once your designated Group Benefits Administrator becomes aware or is notified that the qualifying event has occurred, Extended Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered employees may elect Extended Coverage on behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their eligible children.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee/retiree, your divorce, or a dependent child's loss of eligibility as a dependent child, Extended Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before his coverage ends due to termination of employment, Extended Coverage for his covered spouse and/or children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date that coverage was lost due to termination of employment (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of employee's hours of employment, Extended Coverage may last for only up to a total of 18 months. There are two ways in which this 18-month period can be extended.

1.) Disability extension of 18-month period of continuation coverage

You and anyone in your family covered under the Extended Coverage provisions of the Plan (due to termination of employment or reduction of hours) may be entitled to receive up to an additional 11 months of continuation coverage if it is determined by the Social Security Administration that any covered family member is disabled at some time during the first 60 days of continuation coverage and which lasts at least until the end of the 18-month initial period of continuation coverage. Your Group Benefits Administrator (see page 4) must receive notification of the disability determination within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through this General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary;
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative);
- If the address of record is incorrect, a correct mailing address.

2.) Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of Extended Coverage, the spouse and dependent children in your family can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given (in the format and time frame specified below) to your Group Benefits Administrator (see page 4). The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee/former employee dies, the employee/former employee becomes divorced from the covered spouse, or the covered dependent child ceases to be eligible under the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- The type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;

- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party;
- If the address of record is incorrect, a correct mailing address.

Failure to furnish timely and complete notification of the second qualifying event or disability determination will result in loss of additional Extended Coverage eligibility. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by your Group Benefits Administrator.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to you, see your Group Benefits Administrator for more information.

If you have questions:

Questions concerning your Plan or your Extended Coverage rights should be addressed to the contacts listed below under **"Plan contact information."**

Keep your Group Benefits Administrator informed of address changes

In order to protect your family's rights, you should keep your Group Benefits Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Group Benefits Administrator.

The Plan Administrator is:

The Department of Human Resource Management
101 N. 14th Street, 13th Floor
Richmond, Virginia 23219

Plan contact information

For information about Extended Coverage, initial notification of qualifying events, and initial enrollment, contact your Group Benefits Administrator.

To makes changes to Extended Coverage after initial enrollment, contact your Group Benefits Administrator:

Group Benefits Administrator (If you use the name of your Group Benefits Administrator, you will have to re-send this announcement if that person changes jobs or responsibilities.)
-Insert Name of Local Employer
-Insert Address of Local Employer

(On Employer Letterhead)
Extended Coverage Election Notice

Date:

Address this notice as appropriate to:

- **The employee, or**
- **The employee and spouse, or**
- **The employee, spouse and family, or**
- **The spouse or child who is losing coverage**

At the mailing address(es) of record

Dear **(Insert Name and/or Status of Qualified Beneficiary/ies):**

This notice contains important information about your right to continue your health care coverage in The Local Choice (TLC) Health Benefits Program (the Plan) sponsored by (**Insert Name of Local Employer**). Please read the information contained in this notice very carefully.

To elect Extended Coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it, along with your TLC Enrollment Form, to your Group Benefits Administrator noted at the bottom of this page. Additional resources are included in the attachment, Important Information About Your Extended Coverage Rights.

If you do not elect Extended Coverage, your coverage under the Plan will end on **(Enter date coverage would be lost due to the qualifying event*)*** due to:

- ❑ End of employment
- ❑ Reduction in hours of employment resulting in loss of coverage (including loss of or change to employer premium contribution)
- ❑ Death of employee or retiree
- ❑ Divorce from the employee or retiree
- ❑ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect Extended Coverage, which will continue group health care coverage under the Plan for up to **(Insert 18 or 36)** months:

- ❑ Employee or former employee
- ❑ Spouse or former spouse
- ❑ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- ❑ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, Extended Coverage will begin on **(Insert date)** and can last until **(Insert date)**. At the start of your Extended Coverage period, you may elect any of the plan options offered by (**Insert Name of Local Employer**).

Attached is a premium rate summary that provides the cost for Extended Coverage based on the elected membership level and plan. You do not have to send any payment with the Election Form. Important additional information about payment for Extended Coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to Extended Coverage, you should contact:

-Insert Name of Local Employer
-Insert Group Benefits Administrator
-Insert Local Employer Address
-Insert Local Employer Telephone Number

Extended Coverage Election Form

INSTRUCTIONS: To elect Extended Coverage, complete this Election Form and return it to your Group Benefits Administrator listed on page one of this notice. By law, you must have 60 days after the date of this notice (or from the date that coverage is lost due to the qualifying event, whichever is later) to decide whether you want to elect Extended Coverage under the Plan.

This means that this form, along with a The Local Choice Health Benefits Program Enrollment Form (enclosed), must be delivered to your Group Benefits Administrator by **(Insert end of 60-day enrollment period)**. An Election Notice and Enrollment Form that are mailed will be considered timely if postmarked by that date. If they are hand-delivered, they will be considered timely if received by the Group Benefits Administrator by that date.

If you do not submit a completed Election Form and Enrollment Form by the due date shown above, you will lose your right to elect Extended Coverage. (If you have elected an alternative coverage that runs concurrently with Extended Coverage, such as coverage while on leave, and that coverage will be exhausted before the end of the maximum Extended Coverage period available to you, see your Group Benefits Administrator for additional information.) If you decline Extended Coverage before the due date, you may change your mind as long as you furnish a completed Election Form and Enrollment Form before the due date. However, if you change your mind after first rejecting Extended Coverage, your Extended Coverage will not begin until the first of the month after you furnish the completed forms.

Be sure to read the important information about your Extended Coverage rights included in the pages following this Election Form.

I (We) elect or decline Extended Coverage as indicated below. If coverage is elected, please check whether you will continue Medical Coverage:

Name	Date of Birth	Current ID Number	Social Security No.	Elect Medical (√)	Decline (√)
Employee*:					
Spouse:					
Child:					
Child:					
Child:					

If additional qualified beneficiaries should be listed, please attach a separate sheet.

_____ _____

**Signature Date

_____ _____

Print Name Relationship to individual(s) listed above

_____ _____

Print Address Telephone Number

*If the employee became entitled to Medicare (Part A or B) within the 18 months prior to termination of employment or reduction of hours, please indicate eligibility date here _____.

**A covered employee may elect coverage on behalf of his/her eligible spouse, and parents may elect on behalf of their eligible children. Indicate individual elections on the Enrollment Form(s).

IMPORTANT INFORMATION ABOUT YOUR EXTENDED COVERAGE RIGHTS

What is Extended Coverage?

Federal law requires that most group health plans (including this Plan) give employees/former employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, the covered employee's or former employee's spouse, and the dependent children of the covered employee or former employee. This includes children covered through a Qualified Medical Child Support Order (QMCSO).

Extended Coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects Extended Coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment, if applicable, special enrollment rights, and changes consistent with the qualifying midyear events listed in your handbook.

How long will Extended Coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment (including long-term disability, leave of absence without pay), coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's or former employee's death, the employee's or former employee's divorce, or the loss of dependent child status under the Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts up to 36 months from the month that Medicare entitlement occurred. It is the responsibility of the employee to advise the Group Benefits Administrator of Medicare entitlement within the 18 months before the qualifying event so that the appropriate duration of coverage may be offered. This notice describes the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid on time (see **"When and how must payment for Extended Coverage be made?"**); or;
- A qualified beneficiary becomes covered, after electing Extended Coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary*; or,
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage*; or,
- A qualified beneficiary ceases to be disabled during the 11-month disability extension.*

Extended Coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving Extended Coverage (such as fraud).

*It is the obligation of the qualified beneficiary to notify the Group Benefits Administrator within 30 days of the start of coverage under another group health plan or Medicare after the election of Extended Coverage or loss of disability status during the 11-month disability extension. This should be sent in writing by a qualified beneficiary or representative to:

-Insert Name of Local Employer
-Insert Group Benefits Administrator
-Insert Local Employer Address
-Insert Local Employer Telephone Number

Upon report of other group health plan coverage or entitlement to Medicare, Extended Coverage will be terminated at the end of the month in which that coverage begins. Upon report of loss of disability status during the 11-month disability extension, Extended Coverage will be terminated the first day of the month that is more than 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. Failure to report these events within the 30-day time limit will not preclude termination retrospectively to the date that coverage would have been terminated had the events been reported timely. Premiums paid during that period will be refunded, and any paid claims will be retracted.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to you, see your Group Benefits Administrator for more information.

(Group Benefits Administrators--Insert the following section if the period shown on page one of this notice is less than 36 months)

How can the duration of Extended Coverage be increased?

If you elect Extended Coverage due to termination of employment or reduction of hours, an extension of the 18-month maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your Group Benefits Administrator at **(Insert address and phone number of Group Benefits Administrator),** of a disability or a second qualifying event in order to extend the period of continuation coverage from 18 up to 29 or 36 months. Failure to provide timely notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage; however, one notice will cover all affected qualified beneficiaries.

o Extension due to disability

An 11-month extension of coverage may be available if any qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled at some time during the first 60 days of Extended Coverage and lasts at least until the end of the initial 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. Notification of the disability determination must be given to the Group Benefits Administrator (see above) within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through the this notice or the General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary (e.g., employee, spouse or dependent child);
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative).

If the disability ends prior to the end of the 11-month disability extension, it is the responsibility of the qualified beneficiary or his/her representative to notify the Group Benefits Administrator at the address noted previously within 30 days of the loss of disability status by providing documentation from the Social Security Administration. Failure to report the end of the disability status within the 30-day time limit will not preclude termination retrospectively to the date that coverage would have been terminated

had it been reported timely (the first of the month that is more than 30 days after the determination). Premiums paid during that period will be refunded, and any claims paid will be retracted.

o Extension due to a second qualifying event

An 18-month extension of coverage will be available to spouses and dependent children who elect Extended Coverage due to the employee's termination of employment or reduction of hours if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee/former employee, divorce from the covered employee/former employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Group Benefits Administrator if you want to exercise your rights to the additional Extended Coverage period. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- The type of second qualifying event (e.g., death, divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support, death certificate);
- The written signature of the notifying party.

Failure to provide timely and complete notification of the second qualifying event will result in loss of additional Extended Coverage eligibility.

How is Extended Coverage elected?

To elect Extended Coverage, you must complete the Election Form and TLC Enrollment Form and furnish it to the Group Benefits Administrator designated at the beginning of this package. Each qualified beneficiary has a separate, independent right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect Extended Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Extended Coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event for which this notice was provided. You will also have the same special enrollment right at the end of Extended Coverage if you utilize the maximum period available to you.

How much does Extended Coverage cost?

Generally, qualified beneficiaries must pay the full cost of Extended Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage. The required monthly payment for each continuation coverage period for each option is described in an attachment to this notice.

When and how must payment for Extended Coverage be made?

o First payment for Extended Coverage

If you elect Extended Coverage, you do not have to send any payment with the Election Form. However, you must make your first payment not later than 45 days after the date of your election. (If the Election Form is mailed, this would be 45 days from the postmark.) If you do not make your first payment within this time limit, you will lose all continuation coverage rights under the Plan. The first payment should include premiums for the period of coverage starting with the date coverage was lost due to the qualifying event and any regularly scheduled monthly premium that becomes due between your election and the payment date. You are responsible for making sure that the amount of your first payment is correct. After the initial payment, **(Insert your billing and/or premium collection requirements here.)**

o Periodic payments for Extended Coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage month. The amount due for each coverage month for each membership level is attached to this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of each coverage month.

o Grace periods for periodic payments

Although periodic payments are due on the first day of the coverage month, you will be given a grace period of 30 days to make each periodic payment. If you fail to make your monthly payment by the end of the grace period (30 days after the start of the coverage period), you will lose all rights to continuation coverage under the Plan effective the first of the month for which payment was not received. Your premium payments should be sent to the former employer in the manner that they outline for you. Payments are considered made when mailed.

For more information

This notice does not fully describe Extended Coverage or other rights under the Plan. Questions concerning your Plan or your Extended Coverage rights should be addressed to the contacts listed below.

Contact information

o For information about Extended Coverage, initial notification of qualifying events, and initial enrollment:

-Insert Name of Local Employer
-Insert Group Benefits Administrator
-Insert Local Employer Address
-Insert Local Employer Telephone Number

o To makes changes to Extended Coverage after initial enrollment:

-Insert Name of Local Employer
-Insert Group Benefits Administrator
-Insert Local Employer Address
-Insert Local Employer Telephone Number

o The plan administrator is:

Department of Human Resource Management
101 N. 14th Street, 13th Floor
Richmond, VA 23219
Telephone: 804/225-2131

Keep your plan informed of address changes:

In order to protect your and your family's rights, you should keep the Group Benefits Administrator informed of any changes in your address and the addresses of family members that occur after initial enrollment. You should also keep a copy for your records, of any notices you send to either administrator listed above.

Attachments: HIPAA Certificate of Creditable Coverage
Premium Rate Information
TLC Enrollment Form

Sample

EXTENDED COVERAGE (COBRA) TERMINATION LETTER
(On Employer Letterhead)

To be sent by Local Employer to all Extended Coverage Participants prior to their coverage termination. Employer must check appropriate box and list termination date. Make sure you issue a HIPAA Certificate of Coverage at termination of coverage.

Date:

Participant's Name: _____

Participant's Social Security Number: _____

Dear: _____:

Extended Coverage is a term for a benefit resulting from Federal law, The Public Health Services Act. This is the same requirement that applies to non-government employees under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The guidelines governing Extended Coverage are strictly enforced.

____ Your coverage will be cancelled on _____ retroactive to your premium paid to date unless the total amount due is received prior to _____. If you have made a payment, you should call your group to be sure it has been received and correctly posted to your account.

____ Your coverage will terminate on _____ with the expiration of your 18-, 29- or 36-month Extended Coverage eligibility.

____ Your coverage will terminate on _____ with your initial eligibility for Medicare.

____ Your coverage will terminate on _____ with your eligibility for coverage under another group plan that does not exclude or limit pre-existing conditions.

If your coverage is cancelled, you will be responsible for claims incurred on or after the contract cancellation date. Neither Anthem (Trigon Blue Cross Blue Shield) nor The Local Choice will pay claims incurred after your termination date.

If your coverage terminates and you wish to retain Anthem (Trigon) insurance on a non-group basis, you may call (800) 334-7676 within 31 days of the termination date for information on obtaining personal health care.

Sincerely,

(Group Benefits Administrator or Local Employer)

B. HIPAA

HIPAA Financial Responsibility*

The Local Employer must use TLC HIPAA forms or assume financial responsibility for errors. Copies of TLC HIPAA forms are found at the end of this section.

All persons who cease to be covered under the Local Employer's Health Benefits Program for any reason must be issued a Certificate of Group Health Plan Coverage, as required by the Health Insurance Portability and Accountability Act (HIPAA).

The Office of Health Benefits Programs, as the health plan for the Commonwealth of Virginia and The Local Choice, is required to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. These federal regulations impose standards for safeguarding personal individually identifiable medical information, also referred to as "protected health information (PHI)." The Rule creates significant requirements and limitations in the way that PHI is handled within the Office of Health Benefits Programs, TLC and the Local Employer's Benefits Offices.

Specifically, the Privacy Rule:

- Sets boundaries on how an employee's personal health records are used or disclosed
- Establishes safeguards that the health plan and benefits offices must follow to protect
- PHI
- Restricts employers from using PHI in employment decisions (particularly against employees, such as in hiring/firing or promotion decisions)
- Holds violators accountable with civil and criminal penalties
- Gives employees more control over their own personal health information

HIPAA requires the health plan to provide employees and plan participants with a notice of privacy rights. The notice describes, in general terms, how the health plan will protect health information, and specifies individuals' right to:

- Obtain a copy of their PHI
- Correct errors in their PHI
- Get an accounting of how their PHI has been used and to whom it has been disclosed
- Request limits on access to their own PHI
- Complain and seek relief if they believe their own PHI has been mishandled

As required by HIPAA, this notice is to be distributed by the Agency's benefits office to all new hires and new plan participants, no later than 60 days after their enrollment into the TLC (self-insured) health plan.

Each participating TLC employer is required to sign and return a Memo of Understanding, found below, which outlines responsibilities for compliance with HIPAA regulations.

Memorandum of Understanding
(Privacy of Protected Health Information)

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, and its implementing regulation, the Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. Section 84,462 et seq. (Dec. 28, 2000) and all subsequent provisions and Federal guidance ("HIPAA Privacy Rule"), The Office of State and Local Health Benefits Programs (OHB), and plan sponsor, named on the signature page of this agreement, wish to enter into an agreement that addresses the requirements of the HIPAA Privacy Rule with respect to the local plan sponsor's role in administering the health benefits plan for the group's employees.

I. This agreement is intended to ensure that the plan sponsor will establish and implement appropriate safeguards (including certain administrative requirements) for Protected Health Information (PHI) as regulated by the Office of Health and Human Services and outlined in the OHB HIPAA implementation package.

As used in this agreement PHI means individually identifiable health information maintained and transmitted in any form or medium, including, without limitation, all information (including demographic, medical, and financial information), data, documentation, and materials that is created or received by a health care provider, health plan, plan sponsor, or health care clearinghouse, and relates to: (A) the past, present, or future physical or mental health or condition of an individual; (B) the provision of health care to an individual; or (C) the past, present, or future payment for the provision of health care to an individual, and that identifies or could reasonably be used to identify an individual.

II. The plan sponsor acknowledges and agrees that in providing administrative assistance to employees and The Health Benefits Plan for State and Local Employees,
   a. The plan sponsor may, receive, use, or disclose PHI. However, the sharing of PHI is restricted to those individuals who have a need to know the information in order to assist the affected individual and the information will be maintained in the strictest of confidence.
   b. When requesting, using or disclosing PHI the plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.
   c. All protected information received by the plan sponsor should be secured and accessible only to benefits personnel who have been authorized to assist the employee.

III. As a member of The Local Choice (TLC) program it is understood that the employee handbooks serve as part of the TLC wraparound plan document for plan sponsors who participate in the program. It is further understood that such booklets have been amended (as prescribed by the HIPAA privacy rule) to permit the TLC program to release PHI to the plan sponsor so that the plan sponsor has the ability to analyze renewals, or to secure other coverage outside of the TLC program. Furthermore, the plan sponsor agrees to: (1) not use or further disclose protected health information other than as permitted or required by the plan documents or as required by law; (2) ensure that any subcontractors or agents to whom the plan sponsor provides protected health information agree to the same restrictions; (3) not use or disclose the protected health information for employment-related actions; (4) report to the group health plan any use or disclosure that is inconsistent with the plan documents or this regulation; (5) make the protected health information

accessible to individuals; (6) allow individuals to amend their information; (7) provide an accounting of its disclosures; (8) make its practices available to the Secretary for determining compliance; (9) return and destroy all protected health information when no longer needed, if feasible; and (10) ensure that the firewalls have been established between those functions required to administer the health benefits plan and all other functions conducted by the employer.

III. The plan sponsor acknowledges that any infraction of these referenced regulations by the plan sponsor or plan sponsor representative may result in sanctions or penalties for noncompliance. These penalties are imposed by the Office of Civil Rights (OCR), which include criminal fines of up to $250,000 and imprisonment for up to 10 years. The severity of the penalties varies depending on the violation (see the implementation package for more specific information). The plan sponsor agrees that any such penalty imposed by OCR, which is resultant of any action, or inaction taken by one of their representatives, will be the responsibility of the plan sponsor.

IV. The undersigned hereby agree to the provisions contained in this memorandum of understanding:

by:_____

Name Date
(Title)
(Plan sponsor's Name)

by:_____

Mary P. Habel Date
Director
Office of State and Local Health Benefits Programs

The Local Choice
Employee/Retiree Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Office of State and Local Health Benefits Programs of the Department of Human Resource Management, and the agents acting on its behalf, as the group health plan (the "Plan"), sponsored by your employer through The Local Choice ("TLC") program.

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your health plan including Medical, Prescription Drug, Dental and Vision benefits. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

The Office of Health Benefits Programs' Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI:

For Treatment. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the

Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to employees working under the Director of Contracts and Finance for the Commonwealth of Virginia, Department of Human Resource Management in summary fashion so they can decide what coverages the Plan should provide. The Plan will remove information that identifies you from health information disclosed to these individuals so it may be used without these individuals learning who the specific participants are.

The Plan may disclose your PHI to designated Commonwealth of Virginia, Department of Human Resource Management personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Director of the Department of Human Resource Management and/or the Director of the Office of Contracts and Finance . These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other employee or department of your employer and (2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by your employer.

To a Business Associate. Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Workers' Compensation. The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funerals Directors. The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by the Plan, submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.

Right to An Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.

To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

Note: ***The Plan is not required to agree to your request.***

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

To request confidential communications, make your request in writing to the Plan Administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will provide a copy of the current notice to be posted in the Employer's Benefits Office at all times.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: ***You will not be penalized or retaliated against for filing a complaint.***

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose

your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

The Office of Health Benefits Programs
c/o The Department of Human Resource Management
101 North 14th Street, 13th Floor
Richmond, VA 23219
804/225-2131

Notice Effective Date: April 14, 2003

Health Benefits Plan for State and Local Employees

AUTHORIZATION
TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

EMPLOYEE/RETIREE
Name: _____ ID Number: _____

MEMBER
Name:
_____
Date of Birth: _____ ID Number:_____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:
_____
_____
_____

WHO IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION?
_____
_____
_____

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION?
_____
_____
_____

REASON THE INFORMATION WILL BE USED OR DISCLOSED (IF THE MEMBER INITIATES THE AUTHORIZATION, THE STATEMENT "*AT THE REQUEST OF THE INDIVIDUAL* "IS SUFFICIENT)**:**
_____
_____
_____

EXPIRATION DATE OR EVENT: _____

NOTICE TO MEMBER

YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME. TO REVOKE THIS AUTHORIZATION, SEND A WRITTEN STATEMENT TO THE OFFICE OF HEALTH BENEFITS, 12TH FLOOR, PRIVACY OFFICAL, 101 N. FOURTEENTH ST., RICHMOND, VA 23219. THE STATEMENT MUST IDENTIFY THIS AUTHORIZATION IS NO LONGER IN FORCE.

IF YOU REVOKE THIS AUTHORIZATION, WE MAY STILL USE AND DISCLOSE THE INFORMATION FOR THE PURPOSES LISTED ABOVE, IF WE HAVE ALREADY TAKEN ACTION IN RELIANCE ON THIS AUTHORIZATION.

ALSO, IF THIS AUTHORIZATION IS TO PERMIT DISCLOSURE OF INFORMATION TO AN INSURANCE COMPANY, INORDER FOR YOU TO OBTAIN INSURANCE COVERAGE, THE INSURANCE COMPANY MAY STILL HAVE THE LEGAL RIGHT TO USE THE INFORMATION TO CONTEST A CLAIM OR TO CONTEST YOUR COVERAGE. YOU MAY REFUSE TO SIGNTHIS AUTHORIZATION.

THIS AUTHORIZATION TO RECEIVE PAYMENT, TO ENROLL IN HEALTH BENEFITS PLAN FOR STATE AND LOCAL EMPLOYEES' HEALTH BENEFIT PALN, OR TO BE ELIGIBLE FOR BENEFITS, EXCEPT:

IF THIS AUTHORIZATION IS SOUGHT FOR THE PURPOSE OF DETERMINING YOUR ELIGIBILITY FOR BENEFITS OR ENROLLMENT, THEN YOU MUST AUTHORIZE THE PLAN TO OBTAIN THE NECESSARY INFORMATION OR THE BENEFITS OR ENROLLMENT MAY BE DENIED.

UNDER FEDERAL LAW, YOU DO NOT HAVE TO AUTHORIZE US TO RECEIVE THE PRIVATE NOTES FROM COUNSELING SESSIONS THAT ARE KEPT BY A MENTAL HEALTH PROFESSIONAL, AS A CONDITION OF PAYMENT, ENROLLMENT IN A EMPLOYEE HEALTH BENEFIT PLAN, OR ELIGIBILITY FOR BENEFITS. A PERSON OR ORGANIZATION THAT RECEIVES YOUR INFORMATION BECAUSE OF THIS AUTHORIZATION MAY HAVE THE LEGAL RIGHT TO DISCLOSE THIS INFORMATION TO OTHER PEOPLE OR ORGANIZATIOS WITHOUT YOUR KNOWLEDGE OR CONSENT.

SIGNATURE: _____ DATE: _____

IF THIS AUTHORIZATION IS SIGNED BY SOMEONE WHO IS NOT THE MEMBER LISTED AT THE TOP OF THIS FORM, PROVIDE A DESCRIPTION OF THE SIGNER'S AUTHORITY TO ACT FOR THE MEMBER.

The Local Choice
Certificate of Group Health Plan Coverage

Date of This Certificate: _____

Name of Participant: _____

Name of Health Care Plan: _____

Participant's Identification Number: _____

Membership Level (Single, Employee + One, Family): _____

Name of Individuals to Whom This Certificate Applies: _____

_____

Was the Period of Creditable Coverage More Than 18 Months? (Yes/No): _____
(Disregard periods of coverage before a 63-break.)

If Less Than 18 Months, Date Coverage Began: _____

Date Coverage Ended: _____

Date Waiting Period Began (If applicable)_____

Person preparing this certificate and to who questions should be addressed:

Name: _____
Address: _____
_____
Telephone No: _____E-mail Address: _____
Employer: _____

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Statement of HIPAA Portability Rights

This certificate is evidence of your coverage under the plan. You may need evidence of coverage to reduce a pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is furnished to everyone leaving the State Health Benefits Program or the State Retiree Health Benefits Program (except for Medicare Supplement Plans). You may obtain additional certificates for you or your covered family members from your Agency Benefits Administrator (or the Virginia Retirement System for retirees) should you need them during the 24 months following your termination from the plan.

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, Extended Coverage (COBRA), coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk with your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additionally, special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Rights to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for Extended Coverage (COBRA) or you have exhausted your Extended Coverage (COBRA) benefits; and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

For more information. If you have questions, you may contact the person who prepared this certificate. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) or the CMS publications hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at http://www.dol.gov/ebsa, the U.S. Department of Labor's interactive web pages – Health Elaws, or http://www.cms.hhs.gov/hipaa.

V. PREMIUM / ACCOUNTING PROCEDURES

A. PREMIUM REMITTANCE DATE

The regulations that govern the program require that TLC groups remit their monthly contributions and transmittal form in a timely manner. Premiums are due on the first of each month. The regulations provide for a 10-day grace period, however, if payment is not received by the 10th of the month due, an interest penalty of 12% per annum shall be imposed. If the premium is not received during the grace period, a delinquency notice will be sent to the Local Employer advising of the premium due and the penalty application. If the premium remains unpaid as of the 20th of the month, all claims will be pended and the Department of Human Resource Management will place a notice of nonpayment in a newspaper of general circulation notifying covered enrollee of the delinquency and restriction on claims payment.

B. TRANSMITTAL FORM

The health benefits plans must keep accurate records in order to deliver health benefits coverage to employees as quickly and efficiently as possible.

One of your most important responsibilities as Benefits Administrator is keeping the plans informed of the membership status of employees.

Transmittal Form

Benefits Administrators must use this as a tool to identify discrepancies between the two records. Discrepancies must be resolved, as they have the potential of creating unexpected liability for the employee or employer.

Group Listing

The Group Listing tells you what plan records show about employees – I.D. numbers, type of membership, coverage codes, individual rate and arrears, and enrollment changes that have been made since your last bill (including additions, cancellations, or changes in type of membership or coverage).

The Group listing sent to you with the Payment Transmittal Form also shows billing detail of employees for whom you are being billed. Before you begin to complete your Payment Transmittal, please check the Group Listing to ensure that all participants are listed and that the plan has made changes you noted on your previous Payment Transmittal Form.

Payment Transmittal Form

The Payment Transmittal Form is the statement of your employer's premiums for participants shown on the Group Listing. The information you record on the Payment Transmittal Form is essential to keeping accurate records on employees enrolled in the health benefits plan.

VI. PLANS OFFERED

A. ACTIVE EMPLOYEE AND RETIREE NOT ELIGIBLE FOR MEDICARE (IF OFFERED) PLANS:

All self-funded Key Advantage medical plans are administered by Anthem Blue Cross and Blue Shield. Dental coverage is administered by Delta Dental of Virginia. Behavioral Health and our Employee Assistance Program are administered by ValueOptions, Inc. and outpatient pharmacy coverage is administered by Medco Health Solutions, Inc.

On July 1, 2006, we will introduce a totally new High Deductible Health Plan (HDHP) that is Health Savings Account (HSA) compatible. Anthem Blue Cross and Blue Shield will administer all aspects of the HDHP. While the HDHP will be compatible with an HSA, TLC will not provide the HSA account. Participants will have the flexibility to contract with a bank or financial institution offering an HSA. The HDHP will also have a separate dental component that is not part of the HDHP and will be administered by Anthem.

In all statewide self-funded plans admission to a hospital for an inpatient stay must be approved in advance, or within 48 hours in the case of an emergency or the birth of a child. The plans do not require specialist referrals, but you are encouraged to have Behavioral Health treatments preauthorized to assure medical necessity and that providers are in network.

Statewide Employee Plan Options

You may choose from:

- Key Advantage Expanded
- Key Advantage 200
- Key Advantage 300
- Key Advantage 500
- High Deductible Health Plan (available 7/1/2006)

Statewide plans utilize a preferred Anthem Blue Cross and Blue Shield provider organization (PPO) for medical services. They provide routine medical care and specialist care without requiring referrals. In addition, preventive medical care, immunizations, outpatient prescription drug, Behavioral Health and EAP services, and preventive, primary and major restorative dental benefits with orthodontia are standard benefits. Vision care is available only with Key Advantage Expanded.

Participating Provider Networks

The statewide self-funded medical plans all use the same broad network of doctors and hospitals. All four Key Advantage products offer BlueCard. Out-of-network coverage is available in all statewide plans but requires higher participant cost sharing.

Medco, Delta Dental and ValueOptions all maintain their own networks as does Kaiser, our Regional HMO. A member should check with the appropriate plan administrator to determine if a specific provider participates in the network.

Pre-existing Conditions and Waiting Periods

There are no pre-existing condition exclusions in any TLC medical plan. Orthodontic benefits paid under previous coverage will not count against the lifetime maximum orthodontic benefit. Please note, however, that members changing from one plan to another with the same TLC employer will not receive a new or updated orthodontic lifetime maximum.

COMMONHEALTH

The CommonHealth wellness program is a value-added benefit provided at no cost to TLC member groups. (A small charge may be made to the employee for participation in various programs.) CommonHealth provides medical screenings, health risk appraisals, Baby Benefits (pre-natal risk management), weight loss programs, and stress management programs as well as other health and wellness programs. Since wellness programs often can help control claims costs, we strongly encourage you to take advantage of this program. The CommonHealth program is provided and administered by Continental Health Promotion, Inc. and all employees and their dependents covered by any TLC program are eligible to participate.

- **Key Advantage Medical Services**
  While members receive the highest level of benefits when visiting an in-network provider, all statewide plans also provide out-of network coverage for covered medical services. Key Advantage Expanded offers out of network services at a 25% reduction in reimbursement. Key Advantage 200, 300 and 500 provide out-of-network services with additional deductibles and/or coinsurance. The Anthem Blue Cross and Blue Shield BlueCard PPO network allows for in-network care outside of Virginia, without penalty, through BlueCard participating providers.

- **Key Advantage Behavioral Health Services**
  As with medical services, members receive the highest level of benefits when visiting an in-network provider for Behavioral Health services. Key Advantage Expanded offers out of network services at a 25% reduction in reimbursement while Key Advantage 200, 300 and 500 provide out-of-network services with additional deductibles and/or coinsurance. Members are encouraged to contact ValueOptions for prior authorization of benefits to verify medical necessity. Under the EAP, members may receive up to four visits per incident at no cost. The Employee Assistance Program (EAP) is only available in network through ValueOptions, Inc.

- **Key Advantage Dental and Outpatient Prescription Drug Benefits**
  Preventive, primary and major restorative dental benefits with orthodontia are provided in all plans through Delta Dental Plan of Virginia, while the outpatient prescription drug program is administered by Medco Health Solutions, Inc. You are not required to use an in-network provider for dental or prescription drug services. However, members pay less when using an in-network dentist or pharmacy. Non-network providers may balance bill members and may not offer negotiated discounts. To maximize prescription drug savings, Home Delivery mail service is available. Both Medco and Delta Dental offer national networks of providers.

- **High Deductible Health Plan (HDHP)**
  This plan is Health Savings Account (HSA) compatible. Medical, behavioral health and EAP and prescription drugs for this new plan are administered by Anthem Blue Cross and Blue Shield. Dental is also provided and administered by Anthem but is not part of the HDHP. The dental product will cover preventative, primary and major restorative services and orthodontia. HDHP coverage is in-network only except in the event of an emergency.

Retiree Coverage

You may include your eligible retirees in your membership. Retirees must be at least age 55 with 5 years of service with the Local Employer or age 50 with 10 years of service with the Local Employer. They must also be eligible for and receive an annuity payment from your primary retirement vehicle. If you cover your retirees that are not eligible for Medicare you may also provide coverage for your Medicare retirees. We offer Advantage 65 or Advantage 65 with Dental/Vision for Medicare retirees. (Some groups have retained Medicare Complementary for their retirees.) You are not required to contribute to the cost of retiree coverage.

Retirees not eligible for Medicare have the same benefit plans available to them as your active employee group. Medicare Eligible Retirees may not remain in active coverage. If they participate it must be in a Medicare Supplemental Plan.

It is important to remember that a local employer may select only one plan for Medicare eligible retirees. These plans are available if your active employees are enrolled in a statewide self-funded plan and you elect to offer coverage to both Retirees Not Eligible for Medicare and Retirees Eligible for Medicare.

B. MEDICARE ELIGIBLE RETIREES PLANS

Advantage 65

Advantage 65 provides supplemental health benefits for your Medicare eligible retirees. Out of country major medical benefits are included in the plan. Outpatient prescription drug coverage is not available under Advantage 65.

Advantage 65 with Dental/Vision

As a group option, you may elect to add Dental/Vision coverage to Advantage 65. This product provides Advantage 65 coverage plus dental and vision coverage. Anthem Blue Cross and Blue Shield administers both dental and vision coverage, as outlined below:

Dental: The plan pays 100% of Allowable Charge (AC) for diagnostic and preventive services and 80% of AC for primary services. Up to $1200 per member per plan year is payable.

Vision: Once every 24 months, the plan pays up to $40 for one routine eye exam, up to $75 for one pair of frames, up to $50 per pair of single lenses, up to $75 per pair of bifocal lenses, up to $100 per pair of trifocal lenses, and up to $100 for contact lenses.

Both Advantage 65 and Advantage 65 with Dental/Vision require participation in Parts A & B of Medicare to receive maximum benefits. Retirees who desire prescription drug coverage should join Medicare D.

Medicare Complementary

Prior to 1995, Medicare Complementary was an available retiree choice for TLC Groups. This product is no longer available for group selection. Groups currently participating in this contract are allowed to continue. Medicare Complementary also requires participation in Parts A & B of Medicare to receive maximum benefits. NOTE: Outpatient prescription drug coverage was eliminated from all Medicare Supplemental plans effective 1/1/2006 with the advent of Medicare D.

Three Tier Prescription Drug Coverage for Key Advantage Statewide TLC Active Employee Plans & Retirees not eligible for Medicare Plans

Outpatient Prescription drugs are divided into three-tiers or categories. You pay the appropriate co-payment by tier. To determine in which tier a prescription drug falls, go to www.medco.com. The chart below illustrates drug tiers.

First Tier	Second Tier	Third Tier
Typically Generic Drugs	Lower Cost Brand Name Drugs and Some Generic Drugs	Typically Higher Cost Brand Name Drugs

The three-tier prescription drug benefit is a mandatory generic program. If a generic drug is available and you purchase a brand name drug, you pay the appropriate co-pay and the difference in brand and generic cost.

C. REGIONAL PLAN

In Northern Virginia, Kaiser Permanente offers a fully insured Regional HMO for TLC groups in that service area. A more detailed outline of the service area and benefit outline may be found in the Kaiser HMO brochure. Prescription drug, Behavioral Health and dental coverage are included in this plan.

D. PLAN CHOICES

Larger employers may offer employees one plan or a combination of plans. You may choose from:

- Key Advantage Expanded
- Key Advantage 200
- Key Advantage 300
- Key Advantage 500
- Regional HMO Plan (*if available in your area*)

- Groups with 25 or fewer eligible employees may offer only one benefit plan.
- Groups with 26 to 100 eligible employees may offer up to two plan options.
- Groups with more than 100 eligible employees may offer 2 statewide plans plus the regional HMO (if available in your area).

VII. DISPUTES

A. APPEALS

The following information discusses the appeals process, which provides employees with the full and fair opportunity to request reconsideration of coverage decisions with which they disagree. For the ease of communication with employees, the information in this section has been written as if it is being read directly by employees.

You have access to both a complaint process and an appeal process. Should you have a problem or question about your health plan, the appropriate Plan Administrator's member services department will assist you. Most problems and questions can be handled in this manner. For medical and the optional vision and hearing benefits, your Plan Administrator is Anthem. For behavioral health and EAP benefits, your Plan Administrator is ValueOptions. For routine dental and the optional expanded dental benefits, your Plan Administrator is Delta Dental. For your prescription drug benefits, your Plan Administrator is Medco Health. You may also file a written complaint or appeal. Complaints typically involve issues such as dissatisfaction about your plan's services, quality of care, the choice of and accessibility to your plan's providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

If you elect to file an appeal, please keep in mind that there are strict limits on each stage of appeal. You will be notified of these limits in correspondence that denies your claim. Look for and observe these strict time limits. You must initiate an appeal to the Plan Administrator within 15 months of the date of service or 180 days from the date you were notified of the adverse benefit determination, whichever is later.

The appeal must be written and include your full name, the Enrollee's Identification number (indicated on your membership card), the date of the service, the name of the Provider for whose services payment was denied, and the reason you think the claim should be paid (Alternatively, Anthem will accept a verbal request for appeal by calling a member services representative). You are responsible for providing the Plan Administrator with all information necessary to review the denial of your claim. The Plan Administrator will review your appeal and respond in writing within 60 days of the appropriate time frame following the Plan Administrator's receipt of all information necessary to make a decision. For pre-service claims, the Plan Administrator will respond within 30 days after receipt of the request to appeal. For post-service claims, the Plan Administrator will respond within 60 days after receipt of the request to appeal.

In situations requiring immediate medical care, the Plan Administrator provides a separate expedited emergency appeal process. You or your Provider may request an expedited review. The Plan Administrator will provide resolution within one business day of receipt of all information.

All appeals to the Plan Administrator must be exhausted before an appeal can be made to DHRM. If, after review, the claim remains denied, the denial is final, unless you appeal that determination to the Commonwealth of Virginia, Department of

Human Resource Management (“the Department”).

To appeal a claim decision made by the Plan Administrator, you must submit to the Director of the Department in writing, within 60 days of the Plan Administrator’s denial, your full name, the Enrollee’s identification number, the date of the service, the name of the Provider for whose services payment was denied, and the reason you think the claim should be paid. You are responsible for providing the Department with all information necessary to review the denial of your claim. The Department will ask you to submit any additional information you wish to have considered in its review, and will give you the opportunity to explain, in person or by telephone, why you think the claim should be paid. Claims denied due to such things as contractual or eligibility issues will be reviewed by the Director. Claims denied because the treatment provided was considered not medically necessary will be referred to an independent medical review organization. If, after review, the claim remains denied, that denial is final, unless you appeal that determination within 30 days as provided under the Administrative Process Act. A copy of the Appeal Form follows or you may print “The Local Choice Health Benefits Program Appeal Form” from the Web at www.thelocalchoice.virginia.gov.

THE LOCAL CHOICE HEALTH BENEFITS PROGRAMS APPEAL FORM

Persons enrolled in the statewide plans under The Local Choice Health Benefits Programs may use this form to appeal to the Director of the Commonwealth of Virginia's Department of Human Resource Management (DHRM) regarding a denied claim. ***To be considered a valid appeal, the Director must receive it within 60 days of the final adverse decision of the plan.*** Also, this form may be used to appeal directly to the Director of DHRM on matters of eligibility, regardless of The Local Choice plan in which the appellant is enrolled.

Your Employer_____
Your Name_____ Member I.D. #_____
Name of Enrolled Employee_____
Address_____
City_____ State_____ Zip_____
Home Phone ( )_____ Business Phone ( )_____
Patient Name_____ Date of Service_____

Name of Physician, Hospital, or
Other Health Care Provider_____

CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR THE APPEAL:

☐ Believe the claim was for a covered service and should not be denied for payment
☐ Believe a service was medically necessary, though denied as not medically necessary
☐ Eligibility issue. Please describe_____
_____
_____
☐ Other. Please describe _____
_____

PLEASE ATTACH DOCUMENTS RELEVANT TO YOUR APPEAL. For example: Explanations of Claims Processed, other correspondence from plan, letter from your physician, bill from your health care provider. Are documents attached? ☐ Yes ☐ No

APPEALS TO THE DIRECTOR OF THE DEPARTMENT OF HUMAN RESOURCE MANAGEMENT should be addressed as follows:

Director, Department of Human Resource Management
101 North 14th Street
Richmond, Virginia 23219

Please mark the envelope Confidential – Appeal Enclosed

What specific remedy do you seek in filing this appeal?_____
_____
_____
_____

SIGNATURE _____ DATE _____

Please note: If your appeal is related to medical or mental health and substance abuse claims, DHRM must have a completed HIPAA Authorization Form before the appeal can be processed. The form is available on The Local Choice Web site at www.thelocalchoice.virginia.gov under General Information or from your Group Benefits Administrator.

5/05

B. OMBUDSMAN

The Department of Human Resource Management shall appoint an Ombudsman to promote and protect the interests of covered employees under any state or local employee's health plan.

The Ombudsman shall:

- Assist covered employees in understanding their rights and the processes available to them according to their state or local health plan.
- Answer inquiries from covered employees by telephone and electronic mail.
- Provide information to covered employees concerning the TLC health plans.
- Develop information on the types of health plans available, including benefits and complaint procedures and appeals and to make it available, either separately or through an existing Internet web sit utilized by the Department of Human Resource Management.
- Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.
- Upon request, assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.
- Ensure that covered employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses to the inquiries from the Ombudsman or his representatives.
- Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year.

VIII. UNDERWRITING POLICIES

A. RATING CATEGORIES

Rating Pools

Premiums for Kaiser HMO plan are community rated. The size and demographic composition of an individual employer are not applicable.

Our HDHP is self-funded but will be pooled for all groups regardless of size.

Anthem Blue Cross and Blue Shield administers the medical portion of TLC's statewide Key Advantage self-funded plans. Value Options, Inc., Medco Health Solutions and Delta Dental of Virginia provide Behavioral Health and EAP, Outpatient Prescription Drugs and Dental Claims administration. There are four medical rating pools for the Program. Each employer group's premiums are developed based on the relationship of group-specific information to the pool norm for the appropriate rating geographical area.

Rates for the statewide self-funded plans are based on the following rating pools (categories) in addition to group demographics.

1. Community or pooled - group size of 1 through 49 employees

2. Pooled / Experience Rated

Group Size	Experience Credibility Factor
• 50 – 99	41% of the group's medical experience
• 100 – 149	58% of the group's medical experience
• 150 – 199	71% of the group's medical experience
• 200 – 249	82% of the group's medical experience
• 250 – 299	91% of the group's medical experience

3. Experience Rated
   - 300 - 1499 100% of the group's medical experience

4. Experience Rated
   - Cost Plus1500 + For groups with effective dates of 7/1/2002 or later

The goal of the program is to continue the financial stability that has been established. Special underwriting and administrative policies will be established for Category 4 groups that join TLC after 7/1/2002. The policies shall contain, but not exclusively, the following areas of underwriting and administration.

- The groups will be cost plus at a minimum for medical and prescription drug claims.
- Settlements will be required of all deficits on an annual basis and may be more frequently depending upon the group size and experience.
- There will be a twenty four (24) month run out of claims with deficits settled monthly.
- An executed special terms and conditions Addendum is added to the standard adoption agreement which shall remain in force for the term of the

group's membership in the Local Choice program subject to any annual modifications which will be presented with the renewal proposal.

Outpatient Prescription Drug, Behavioral Health and Dental Premiums

In our self-funded Key Advantage plans with effective dates prior to July 1, 2006 and all groups with fewer than 1500 employees, premiums for the Outpatient Prescription Drug, Behavioral Health and Dental components are pool-rated based on the experience of the total TLC program, including all groups regardless of size. Costs for the pool's components are included in the rates provided for the self-funded Key Advantage plans. Groups with more than 1500 employees and effective dates after July 1, 2006 will be underwritten on a cost plus basis.

Risk-Sharing Pool/Stop Loss Coverage

There are excess claim limits included in the self-funded plans. Groups with fewer than 300 participating employees have a $70,000 per enrollee claim limit while larger groups (with more than 300 employees) have a $90,000 limit. Effective with the 2006-07 renewal groups over 1000 participating employees will have a $125,000 stop loss attachment point. The program self-funds these excess claims. The impact of this benefit is to spread the cost of catastrophic claims over the entire Local Choice program, sharing the risk among all of the member groups.

B. EMPLOYER CONTRIBUTIONS

Groups may select any combination of our Key Advantage plan offerings but the required minimum funding will be based on the un-weighted average single rate of the plans offered. For example, if a group offers Key Advantage Expanded and Key Advantage 500, you would add the single rates for each and divide by two. The minimum requirement would then be 80% of the average single rate.

The required minimum employer contributions are:

Full Time Employees

- 80% of the average single employee premium rate
- 20% of the average additional dependent cost, if applicable *****

Part Time Employees

- 40% of the average single employee premium rate
- 10% of the average additional dependent cost, if applicable [*]

Groups selecting the High Deductible Health Plan may not use the averaging method to determine contributions. HDHP requires the employer to pay at least 80% of single premium and 20% of dependent premiums.

C. GROUP WITHDRAWAL – NOTICE TIMING AND ADVERSE EXPERIENCE ADJUSTMENT

To protect current TLC groups, an Adverse Experience Adjustment (AEA) may be applied to groups terminating participation in TLC. The AEA assures that current groups will not be penalized for a terminating group's losses.

THE LOCAL CHOICE PROGRAM
Procedures for Determining Adverse Experience Adjustment

The Local Choice Program (TLC) requires an employer who withdraws from the program to reimburse the program if the employer's premiums are less than the employer's share of losses for the last full fiscal year of membership. This is called the Adverse Experience Adjustment (AEA).

The AEA amount is determined by 1) the amount of the appropriate pool's loss, if any, for the most recent plan year, 2) the experience of the employer who is withdrawing, and 3) the ratio of the employer's enrollment to the total enrollment in the applicable rating pool. An employer falls into one of four rating pools:

1. 1 – 49 enrollees
2. 50 – 299 enrollees
3. 300 - 1499 enrollees
4. Over 1,500 enrollees (with effective dates of 7/1/2006 or later)

There is no AEA if the appropriate pool ends the fiscal year with a surplus.

[*] If 75% of all eligible employees enroll, the dependent contribution requirement is waived.

Procedure to Determine the AEA for Employers with 1 – 299 Enrollees

Step 1. TLC will determine the total number of annual contract units (C/Us) for the appropriate rating pool based on the following factors multiplied by 12 months:

Type of Membership	Monthly Contract Unit (C/U)
Employee Only	1.0
Employee + One	1.85
Family	2.7

Step 2. Determine the total number of C/Us for the withdrawing employer during the plan year. Apply the withdrawing employer's pro rata share of the C/U to the pool's total loss, if any, to determine the AEA for the withdrawing employer.

Sample AEA Calculation for Employers with fewer than 300 Enrollees:

Pool loss for plan year	$100,000
Total C/Us	18,140
Employer's C/Us	1,878

Calculation: Employer's C/Us 1,878 / Total C/Us 18,140 = 10.35% employer's pro rata share times $100,000 total pool loss = $1,035 employer's AEA

Procedure for Determining the AEA for Employers with 300+ Enrollees

The maximum AEA amount due from an employer withdrawing from the program is the employer's loss during the immediate past plan year based upon the employer's plan expenses plus a pro rata share of the program overhead and pooled coverages. Prior years' performance during which the employer was experience rated are also taken into consideration, if favorable to the employer. However, the AEA may never exceed the immediate prior year's loss.

If the employer had a $100,000 loss during the last plan year, the employer would be subject to a maximum AEA of $100,000 to be paid in equal installments over a 12-month period. See the following sample calculation.

Sample AEA Calculation for Employers with over 300 Enrollees:

Incurred Claims	$ 1,417,129
Contractor Administration	128,107
Pooled Coverages	55,290
Program Overhead	19,017
Total Expenses	$ 1,619,543
Income	$ 1,519,543
Operating Gain or (Loss)	($100,000) = Employer's AEA

In this case the maximum AEA amount would be the operating loss of $100,000. However, prior year's accumulated gains could be applied to any current year loss to reduce the AEA.

For all Category 1, 2 or 3 groups, DHRM will notify a terminating local employer of any Adverse Experience Adjustment within six-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.

IX. ADMINISTRATIVE INFORMATION AND CONTACTS

The Department of Human Resources Management administers the Local Choice Health Benefits Programs. The Office of State and Local Health Benefits Programs provides this manual to support Group Benefits Administrators. Additionally, the Programs' Web site, www.thelocalchoice.virginia.gov contains a full library of information on the TLC Health Benefits Program. When you have questions or need information not found in this manual or on the Web site, please write or call the Health Benefits Program.

The Local Choice Health Benefits Programs

The Local Choice
Department of Human Resource Management
101 North 14th Street, 13th Floor
Richmond, Virginia 23219
(804) 786-6460

Statewide Key Advantage Health Plans
When questions arise about medical coverage or claims under the Key Advantage Expanded, Key Advantage 200, 300 or 500 Medicare Complementary (Option 1), Advantage 65 or Advantage 65 with Dental/Vision, call

Anthem Blue Cross Blue Shield
In Richmond: (804) 355-8506
Outside of Richmond: 1-800-552-2682
www.anthem.com

Key Advantage Prescription Drugs – Medco Health
When questions arise about drug coverage or claims under the Key Advantage Expanded, Key Advantage 200, 300 or 500, call

Statewide: 1-800-355-8279
www.medcohealth.com

Key Advantage Dental – Delta Dental of Virginia
When questions arise about dental coverage or claims under the Key Advantage Expanded, Key Advantage 200, 300 or 500, call

Statewide: 1-888-335-8296
www.deltadentalva.com

Dental – Anthem (For Medicare Eligible Retirees)
When questions arise about dental coverage or claims under the Medicare Complementary (Option 1) or Advantage 65 with Dental/Vision, call

Anthem Blue Cross Blue Shield
In Richmond: (804) 355-8506
Outside of Richmond: 1-800-552-2682
www.anthem.com

Key Advantage Behavioral Health/EAP – Value Options, Inc.
When questions arise about Behavioral Health or EAP coverage or claims under the Key Advantage Expanded, Key Advantage 200, 300 or 500, call

Statewide: 1-866-725-0602
www.achievesolutions.net/tlc

High Deductible Health Plan
When questions arise about medical coverage or claims under the HDHP plan or the accompanying Dental coverage,

Anthem Blue Cross Blue Shield
In Richmond: (804) 355-8506
Outside of Richmond: 1-800-552-2682
www.anthem.com

Regional Plan - Kaiser Foundation Health Plans of the Mid-Atlantic States
When question arise about coverage or claims under the Regional HMO, call

Kaiser Permanente
Member Services 1-301-468-6000 or 1-800-777-7902
Account Management: 1-301-816-6871
www.kp.org/ehealth/midia/commonwealthofvirginia

X. REGULATIONS

CHAPTER 20.

COMMONWEALTH OF VIRGINIA HEALTH BENEFITS PROGRAM

1VAC55-20-10. [Repealed]

1VAC55-20-20. 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 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 statewide plan(s).

"Basic statewide plan(s)" means the statewide hospitalization, medical and major medical plan offered at a uniform rate to all state employees pursuant to §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 Human Resource Management.

"Dependent" means any person who is determined to be an eligible family member of an employee pursuant to subsection E of 1VAC55-20-320.

"Director" means the Director of the Department of 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 "health insurance funds" means accounts established by the state treasury and maintained by the 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 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.

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

"Experience adjustment" means the adjustment determined by the department, consistent with its actuarial practices, to 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 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 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 §§15.2-1300, 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 §§15.2-1300, 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 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-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 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 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.

1VAC55-20-30. Designee and delegations of authority.

Pursuant to §2.2-2818 of the Code of Virginia, the Department of 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 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 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.

1VAC55-20-40. 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

human resource advisory council (the "council" or "advisory council"). The council is created pursuant to §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.

1VAC55-20-50. [Repealed]

1VAC55-20-60. 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-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.

1VAC55-20-70. Procurement.

The department shall comply with the Virginia Public Procurement Act, Chapter 43 (§2.2-4300 et seq.) of Title 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.

1VAC55-20-80. 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(s) (the "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.

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.

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.

1VAC55-20-90. 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 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. 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; and

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.

1VAC55-20-100. No presumption of right.

These regulations and the health benefits program herein established shall not be deemed to constitute a contract of employment between any participating employer and any participant. No participant in the program shall acquire any right to be retained in the employer's employ by virtue of the program, nor, upon the participant's dismissal or voluntary termination of employment, shall the participant have any interest in any assets of the program other than as may be specifically provided herein.

Furthermore, these regulations and the health benefits program herein established shall in no event confer upon any participant any rights, duties or responsibilities other than those granted herein. The Commonwealth of Virginia specifically reserves the right to amend, modify or terminate, inclusive of eligibility, coverage and contributions provisions, the health benefits

program or any plan or plans comprising all or part of the program, as they may relate to any active or retired participant.

1VAC55-20-110. Authority to withhold revenues.

In the event of default by any employer participating in the health insurance program authorized by §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.

1VAC55-20-120. [Repealed]

1VAC55-20-130. 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.

1VAC55-20-140. Underwriting.

At the department's discretion, the program may either be created and maintained on a self-funded basis or procured from an insurance company licensed to do business in the Commonwealth of Virginia, or a combination of both. In addition, the department is authorized to contract with any third party providers for any and all services which may be necessary to design, administer, communicate or fund the health benefits program.

1VAC55-20-150. Employer application.

The department shall develop a form on which local employers may apply for participation in the health benefits program and make available such form to local employers joining such program. The department will advise local employers on questions pertaining to the application. Among other items the department may deem necessary, the application may include:

1. Information regarding the political subdivision such as the governing body, individuals or offices responsible to provide, receive and remit information to the department and the method by which information can or will be transmitted.

2. Information regarding the total number of employees and those employees currently covered, those who will immediately become eligible, and those whose participation is anticipated. This information can include but is not limited to demographic data such as the age and sex of employees, geographic location of residence and employment, dependent status, and information concerning employment responsibilities.

3. Information regarding past premiums, claims and enrollment experience, contribution history, financial arrangements with prior underwriters and the types of plans or benefits provided being offered within the five years prior to making the application.

1VAC55-20-160. 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 1VAC55-20-160 A). 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 an actuarial 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 six-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.

1VAC55-20-170. Information to local employers.

The department will provide guidance and support to local administrators in the adoption, implementation and administration of the health benefits program.

The department shall furnish local employers with any and all information necessary for any reports the local employer is required to file with any federal or state agency as well as any information necessary for meeting the qualification or nondiscrimination rules under the Internal Revenue Code which may be applicable to such plans.

1VAC55-20-180. Information to local employees.

The department shall inform local employees when their coverage terminates by reason of nonpayment of premiums for the local employee group by the local employer. The form of the first notice shall be a notice in a newspaper of general circulation in the locality of the local employer. Such notice shall be prospective with respect to the date of termination. The form of the second notice shall be a letter to each contract holder at the contract holder's address of record.

1VAC55-20-190. Confidentiality.

The department will not disclose identifiable individual health data without the consent of the individual being provided coverage. The department may rely on the representations of any parent or guardian regarding such parent's or guardian's consent to the release of information regarding a child of such parent or any other person to which such guardianship shall apply. Data may be compiled into statistical reports provided that the identity of individual persons is not ascertainable by the reader or disclosed by the department.

1VAC55-20-200. Reports.

The department, on an annual basis, shall provide a report to the General Assembly. Such report shall discuss the overall objectives of the health benefits program, including enrollment, income and expense, participation by local employers and additional matters of general concern.

1VAC55-20-210. 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, claims paid by the program during this 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.

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.

1VAC55-20-220. Eligible employers.

Pursuant to §2.1-20.1:02 of the Code of Virginia, local employers may, by making proper application and complying with this chapter, participate in the health benefits program.

1VAC55-20-230. 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, the completion of any 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 beneficiaries qualified under the 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.

1VAC55-20-240. 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 active, 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 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. 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 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 1VAC55-20-370). 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, this health benefits program shall be a secondary payor to the former local employee's new coverage.

1VAC55-20-250. 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. 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.

1VAC55-20-260. 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. 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.

B. Local employers allowing part-time employees to participate in the program must contribute a minimum of 50% of the amount they contribute toward active employee coverage (at all membership levels) on behalf of their participating part-time employees.

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.

1VAC55-20-270. Selection of plans.

Local employers electing to participate in the health benefits program must, as a condition of participation, agree to offer exclusively one or more plans constituting such program. Notwithstanding the above, a local employer, with the approval of the department may offer another accident or health plan provided that such other plan does not duplicate the coverage offered by the health benefits program. Such permission shall not be unreasonably withheld.

Local employers participating in the health benefits program who desire to offer a health maintenance organization (HMO) must offer the HMOs included in the health benefits program and only those HMOs.

1VAC55-20-280. 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 (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.

1VAC55-20-290. 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. Employees of local employers seeking reparticipation may be required to serve a waiting period.

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.

1VAC55-20-300. 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 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.

1VAC55-20-310. Compliance.

The department shall oversee the local employers and state agencies and shall assist the employees thereof in the pursuit of all rights and benefits. The department shall hold the employee harmless for any errors made by local employers and state agencies. The cost of any such errors, where applicable, shall be borne by the local employer or state agency, and not the employee.

Nothing in this chapter shall affect the rights of any local employee to bring a cause of action against a local employer for action taken hereunder with respect to such local employer's willful disregard of this chapter. In the event a local employee brings a cause of action against the department due to a local employer's willful disregard for the requirements of this chapter, the local employer as a condition of initial participation in the program shall reimburse the department for any such settlement required by a court of law.

1VAC55-20-320. Eligible employees.

A. State employees.

1. Full-time salaried, classified employees and faculty as defined in 1VAC55-20-20 are eligible for membership in the health benefits program. A full-time salaried employee is one who is scheduled to work at least 32 hours per week or carries a faculty teaching load considered to be full time at his institution.

2. 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.

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.

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 §2.2-2905 of the 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.

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 1VAC55-20-260 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 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.

4. Retirees who 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 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;

      (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 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.

   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 he becomes self-supporting.

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

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 1VAC55-20-320 E 1 f). Parents, grandparents, aunts and uncles are not eligible for coverage regardless of dependency status.

(2) Under the health benefits program, 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, 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 incapacitation, which was diagnosed while coverage was in force. An enrollment form for continued coverage for a disabled child is required within 31 days prior to the child's age attainment (above) to maintain coverage (see 1VAC55-20-330).

1VAC55-20-330. 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 action is required, for taking the action, and for certifying that the information 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 1VAC55-20-370). 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.

1VAC55-20-340. Payment of contributions.

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

B. State retirees 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. There may be an administrative fee 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 §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.

1VAC55-20-350. 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).

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

B. Changing type of membership.

1. Employees may change membership subject to 1VAC55-20-370.

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. 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 qualifying mid-year event, the employee must certify in the enrollment action the type of event and the date of the event.

1VAC55-20-360. 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 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 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 action will not be accepted outside of open enrollment except for an employee 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.

1VAC55-20-370. 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 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 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.

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.

1VAC55-20-380. 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 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.

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.

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 and the employer contribution ceases on the last calendar day of the previous month.

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

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 taking an enrollment action within 31 days of the date of the move.

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 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 take a new enrollment 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 qualifying mid-year event during the leave. A new enrollment action must be taken. In the case of a qualifying mid-year event, the effective date would follow the rule on initiating dual or family membership at the time of the particular 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 take a new enrollment action to receive coverage. The enrollment action shall indicate the date the employee returned to work as the date that the employee's continuous full-time employment commenced.

    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 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.

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.

1VAC55-20-390. 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 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.

1VAC55-20-400. 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.

1VAC55-20-410. 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 60 days. Retroactive dual or family membership will be available up to a maximum period of 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.

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, he will be given single membership retroactive up to 60 days. Retroactive dual or family membership will be available up to a maximum period of 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.

1VAC55-20-420. [Repealed]

1VAC55-20-430. Coordination of benefits.

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.

1VAC55-20-440. Claims.

Claims must be filed no later than the end of the calendar year after the year in which the claim is incurred. Claims not filed in a timely fashion will not be considered.

1VAC55-20-450. Basic plan.

The department 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.

1VAC55-20-460. 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.

1VAC55-20-470. Benefits coverage.

A. Interpretations of covered services will be made in the following manner, listed in order of priority:

1. The contract documents, including the request for proposal;

2. Member handbooks or contract booklets;

3. The interpretation of the department;

4. The interpretation of the department's contractors.

B. The benefit provisions of the contract documents are contained in the contract booklets or member handbooks distributed to employees by their benefits administrators.

C. The benefits administrators have copies of the contract booklets and member handbooks for all plans offered by that employer. By appointment, any employee or citizen may inspect the entire contract or contracts at the offices of the department.

1VAC55-20-480. Department discretion.

The department reserves the right to change the plans offered and benefits provided thereunder at its sole discretion based upon market and department considerations.